



Review Article

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# Female Genital Mutilation - Study Sexual Issues



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## Summary

**Background:** Female genital mutilation/cutting has both physiological consequences, including short- and long-term effects. The approach used to perform the procedure may influence sexual issues. Disorder affecting any aspect of female sexual function, such as desire, arousal, lubrication, satisfaction, orgasm, sexual discomfort, or any person suffering during the sexual act, is referred to as female sexual dysfunction.

**Aim:** The present study was carried out to assess effect of FGM among married women on their sexual issues.

**Subject & Methods:** A descriptive cross-sectional study was used. The study population consisted of 2837 females in family health centers (FHCs) in different sitting at Beni-Suef.

**Tools:** A Structured Interviewing Questionnaire sheet was used to collect data and reasons for practicing or refusing FGM/C. Female Sexual Function Index (FSFI).

**Results:** Mutilated females constituted 71.4% of the studied females, 29.7% suffering from complication after FGM. 56% had a misconception that FGM/C does not affect the woman's sexual satisfaction. The mean scores on various domains of married women only were as follows: desire (5.3186; SD±1.728), arousal (12.65; SD±3.546), lubrication (14.24; SD±4.271), orgasm (10.93; SD±3.087), satisfaction (12.19; SD±3.435), pain (9.6432; SD±2.628). The total mean score was (59.79; SD±14.08).

**Conclusion:** Most circumcised married women had unfavorable FSFI scores and were considered to have sexual dysfunction. A significantly higher Desire, Arousal, Lubrication, Orgasm, Satisfaction, and total score among not circumcised married participants than circumcised ones but the Pain domain didn't differ significantly between circumcised, and not circumcised.

**Recommendation:** Design and disseminate brochures work on the sexual effect of female genital mutilation in health centers and hospitals.

**Keywords:** Female genital mutilation; Sexual issues; Lubrication; Sexual dysfunction; Woman's health

**Abbreviation:** FGM/C: Female Genital Mutilation/Cutting; FHCs: Family Health Centers; FSFI: Female Sexual Function Index; SD: Standard deviation; EFHS: Egyptian Family Health Survey

## Introduction

Female genital mutilation/cutting (FGM/C) is a harmful practice that hurts all aspects of a woman's health. It is an extreme form of violence against women that prevents them from fully participating in public life, which has a disempowering effect on them [1-4]. There are two suggested theories about the origin of FGM/C. The first is that it would have been developed in Egypt and spread to other countries, while the second is that it originated in Africa as an African tribal puberty rite and then transmitted to other places like Egypt [5-7]. The origin of infibulation (type of FGM/C) is slightly difficult to be traced, but it'd be dated to the Romans, and mainly performed on slaves

to stop them from making sexual relationships [8-10]. Within the 19th century, the UK allowed the removal of the females' clitoris surgically as a treatment for epilepsy, sterilization, and masturbation [11-13]. Female Genital Mutilation has health consequences and complication. These repercussions may occur immediately or throughout the healing period (during the next eight weeks) as a result of the use of non-surgical, non-sterilized equipment such as razor blades, knives, or broken glass, as well as unsanitary surroundings [14].

Sociological causes include what's called "rite de passage" which suggests a transition within the stage of life from girlhood to womanhood and the entrance of the females to the wedding

age. These traditions and social norms pass between generations resulting in the continuation of the practice. Psychological causes involve the thought of danger. Some tribes consider the clitoris to be a dangerous organ that has got to be removed. Others see that the removal of the sensitive genital tissues curbs sexual pleasure which successively preserves virginity and chastity and maintains the fidelity of females [15-18]. Recent studies indicate that FGM/C still occurs throughout Africa, the Middle East, and Asia. FGM/C can have serious adverse effects as genital tissue swelling, chronic pelvic infections, reproductive tract infections, genital infections, vaginitis, and painful sexual intercourse [19-22].

### Aim of the Study

The present study was carried out to assess effect of FGM among married women on their sexual issues.

### Research Questions

Are sexual issues affected by female genital mutilation among married women?

### Subjects and Methods

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

### Subjects & Setting:

**Setting:** The study was conducted in family health centers (FHCs) in different sitting at Beni-Suef Governorate. Beni-Suef governorate is divided into seven sectors. From every sector the MCH was randomly selected to geographically represent the sector.

### Sample

#### Sample Type

A Convenient sample was used. The study sample was selected according to the following Inclusion criteria: 18-60

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

**Table 1:** A domain score of 0 implies that the subject reported no sexual activity in the previous month within the specific domains.

Doman	Questions	Score Rang	Factor	Minimum Score	Maximum Score	Score
Desire	1,2	5-Jan	0.6	1.2	6	
Arousal	3,4,5,6	0-5	0.3	0	6	
Lubrication	7,8,9,10	0-5	0.3	0	6	
Orgasm	11,12,13	0-5	0.4	0	6	
Satisfaction	14,15,16	0 (or 1) - 5	0.4	0.8	6	
Pain	17,18,19	0-5	0.4	0	6	
Full Scale Score Rang				2	36	

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

years old. Women can read and write.

### 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

A pre-designed structured questionnaire was used to collect data. Data were collected through personal interviews. The questionnaire is divided into six sections:

**Section I:** A Structured Interviewing Questionnaire sheet which includes the following parts: age, residence, level of education, marital status, occupation and experience with mutilation, etc....

**Section II:** Reasons for practicing FGM/C and reasons for refusing FGM Section

**Section III:** Female Sexual Function Index (FSFI).

A four-week self-reported questionnaire that examines the key characteristics of female sexual function. It consists of 19 multiple-choice questions that assess six domains. Each dimension was rated on a scale of 0/1 (no sexual activity or sexual dysfunction) to 5 (complete sexual activity). Researchers used the Arabic version of the FSFI, which was translated by (Anis, et al., 2011), to determine the full-scale score [23]. The domain score is calculated by summing the scores of the domain's questions and multiplying the total by the domain factor. (=2 to 36). It was approved for use among Egyptians. For the Arabic version of the FSFI, a total score of 28.1 was used as the cutoff point to distinguish between women with FSD and those with normal functions (sensitivity 96.7%, specificity 93.2%). The scale has been translated into Arabic.

score of 28.1 was used to discriminate between women with FSD and those with normal functions. A domain score of 0 implies that the subject reported no sexual activity in the previous month within the specific domains (Table 1).

### Validity of the Tool

The tools were reviewed for comprehensiveness, appropriateness, and legibility by an expert panel consisting of five obstetrics of woman health nursing. The panel ascertained the face and content validity of the tools. The tools were modified according to the panel judgment on simplicity of sentences and appropriateness of content.

### Ethical Considerations

A written or oral consent accordingly to conduct the study was taken from each studied women to protect their rights before the start of the study. They were informed that they could withdraw at any time. A unique identifying number (subject ID) was assigned to the data collected from each woman to maintain confidentiality.

### Administrative Considerations

A written permission clarifying the purpose of the study was obtained from the dean of the faculty of nursing in Beni-Suef to the responsible authorities of the study setting (family health centers (FHCs)) to obtain their permission for data collection for our study. These letters provided the study's goal as well as photocopies of data collecting materials to obtain their consent and assistance with data collection.

### Pilot Study

A pilot study carried out on 10% of the women which was equal to (10 women). The aim of this pilot study was to test the clarity, comprehensiveness, and applicability of the tools and to estimate the appropriate time required to fill the questionnaire. Based on the result of the pilot study, no major modifications in the tools were done; the cases of the pilot study weren't excluded.

### Field Work

Data were gathered over six months beginning in November 2021 and ending in April 2022. The researcher was present at the previously mentioned location until the entire sample size

was gathered. Before data collection, the researcher introduced herself to the women and explained the purpose of the study.

### Statistical Analysis

All data were collected, tabulated and statistically analyzed using IBM SPSS 25. Data was supplied, and appropriate analysis was performed for each parameter based on the type of data obtained.

### Descriptive Statistics data were expressed as

- a) Count and percentage: Used for describing and summarizing categorical data.
- b) Arithmetic mean (X-), Standard deviation (SD): Used for normally distributed quantitative data, these are used as measurements of central tendency and dispersion.

### Analytical Statistics

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

### Graphical presentation

- a) Data visualization was done with Bie in 3D chart.

### Results

(Table2) Presents the distribution of participated females according to their mutilation information (Prevalence, age of FGM, person performed, and Complications). Mutilated females constituted 71.4% of the studied females, 41.9% were married. The mean age at the time of mutilation was 12.5±2.5 years. It is worth mentioning that 4 of the participants were mutilated after her marriage their ages ranged between 23-28 years. It shows that doctors were the most common person performing the mutilation (55.6%), followed by nurse (29.8%), dayah (8.4%), and barbers (1.1%). About 29.7% of participants are suffering from complication after FGM, 31.1% suffers from difficult micturition and about 18.6 have a keloid and scar from the mutilation.

**Table 2:** Information about FGM among the Studied Participants.

Variables	Values (no=2837)	
	No.	%
Circumcised		
No	816	28.6
Yes	2021	71.3
Marital status		
Single	1630	57.5
Married	1190	41.9
Divorced	15	0.5
Widow	2	0.1
Age at circumcision (no=2021)		
<5	3	0.1

5-	160	7.9
10-	1533	75.8
>15	321	15.8
Mutilated after the marriage (23-28 years).	4	0.19
Mean age at circumcision (no=2021)	12.5±2.5	
Who perform it? (no=2021)		
Doctor	1124	55.6
Nurse	602	29.8
Dayah	170	8.4
Barber	23	1.1
Don't know	102	5
Did you have complications from the mutilation? (2021)		
Yes	602	29.7
No	1419	70.3
If yes, mention the complication you have (602)		
Pain	290	82.1
Bleeding	120	33.9
Difficult urination	110	31.1
Keloids and scar	66	18.6
Inflammation	20	5.6
Doctor	1124	55.6
Nurse	602	29.8
Dayah	170	8.4
Barber	23	1.1
Don't know	102	5

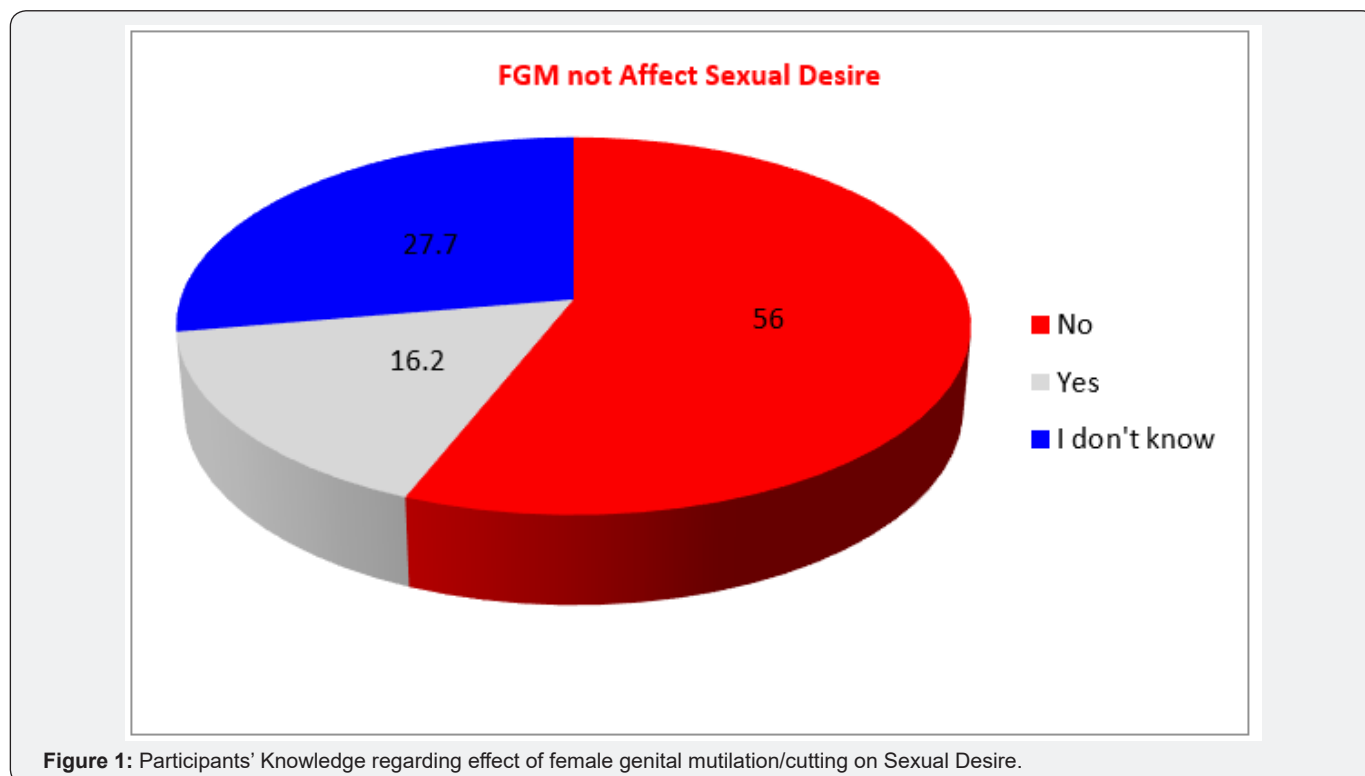


Figure 1: Participants' Knowledge regarding effect of female genital mutilation/cutting on Sexual Desire.

(Figure 1) portrays Participants' Knowledge regarding effect of female genital mutilation/cutting on Sexual Desire. The figure illustrated that almost half of studied participants (56%) had a

misconception that FGM/C does not affect the woman's sexual satisfaction. While only 16.2% mentioned that FGM will affect sexual desire.

**Table 3:** Description of Sexual Score Domains and the Total Score for Married Women Only (No=1190).

Variables	Desire domain	Arousal domain	Lubrication domain	Orgasm domain	Satisfaction domain	Pain domain	Total score
Mean	5.3186	12.65	14.24	10.93	12.19	9.6432	59.79
SD	1.728	3.546	4.271	3.087	3.435	2.628	14.08
Median	5	14	15	11	12	10	62
Range	10	20	20	15	15	14	77
Minimum	0	0	0	0	0	0	0
Maximum	10	20	20	15	15	14	77

(Table 3) presents sexual score domains and the total score for married women only. The table reveals that the mean scores on various domains of married women only were as follows: desire (5.3186; SD±1.728), arousal (12.65; SD±3.546), lubrication (14.24; SD±4.271), orgasm (10.93; SD±3.087), satisfaction

(12.19; SD±3.435), pain (9.6432; SD±2.628). The total mean score was (59.79; SD±14.08). Most circumcised married women had FSFI scores less than 26.55 and were considered to have sexual dysfunction.

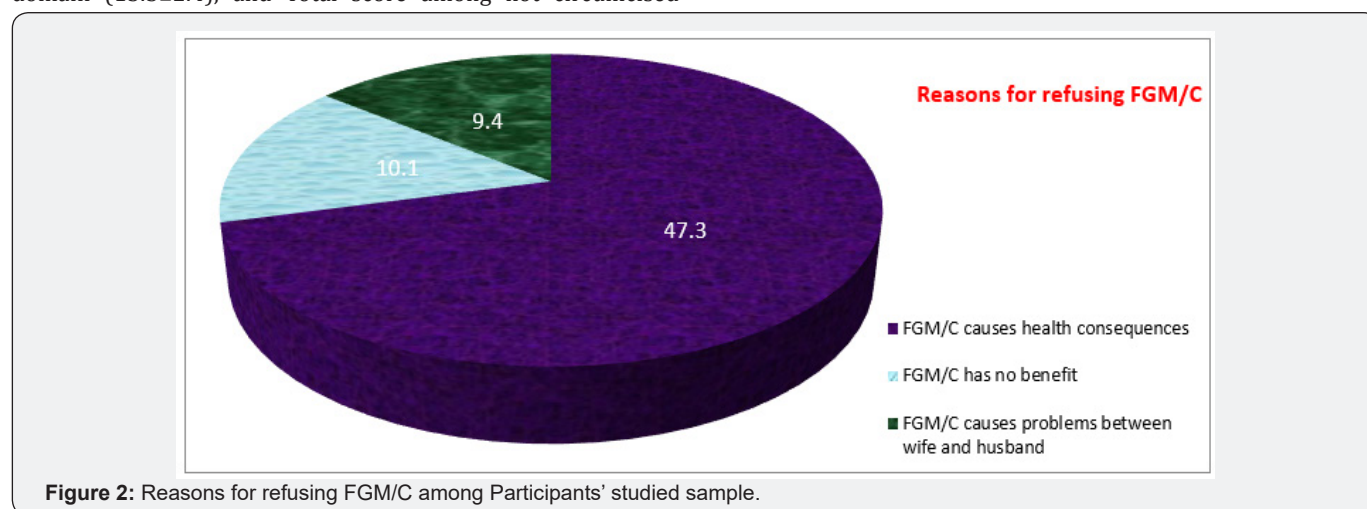
**Table 4:** Association between FGM and the Sexual Score Domains and Total Score for Married Women Only (No=1190).

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

\*P-value is significant (p<0.001).

(Table 4) showed that there was a significantly higher Desire domain (5.8±1.8), Arousal domain (13.7±2.9), Lubrication domain (16±3.4), Orgasm domain (11.7±2.6), Satisfaction domain (13.3±2.4), and Total score among not circumcised

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



**Figure 2:** Reasons for refusing FGM/C among Participants' studied sample.

(Figure 2) shows the distribution of females according to their reasons for refusing FGM/C. Health consequences of FGM/C were the main reason stated by females for refusing the procedure (47.3%), followed by 10.3% of females who stated that FGM/C is not necessary, 9.4% said FGM/C causes problems between wife and husband.

### Discussion

Female genital mutilation/cutting has both physiological consequences, including short- and long-term effects [24-26]. The approach used to perform the procedure may influence the severity of the short-term consequences [27-29]. Results of the current study presents that Mutilated females constituted 71.4% of the studied females, 41.9% were married. The mean age at the time of mutilation was  $12.5 \pm 2.5$  years. This is in agreement with other studies. The prevalence of FGM/C was reported to be half of females in a survey of schoolgirls across Egypt [30]. According to the Egyptian Family Health Survey (EFHS), in 2021, majority of Egyptian married women between the ages of 15 and 49 had undergone FGM. Also study conducted by Barakat and Mosleh in Egypt reported that the prevalence of FGC among university students was half of studied samples [31].

According to a study conducted by Al-Hussaini, all women who arrived at the labor ward at the Assiut University Hospital were circumcised [32]. The results of the current study revealed that 29.7% of participants suffered from complication after FGM. About 82.1% of them suffering from pain after the surgery, also 33.9% mentioned severe bleeding, and 31.1% suffers from difficult micturition. This attribute that as shown from the results of the current study that dayah (8.4%), and barbers (1.1%) were the person who responsible performing the mutilation. Of course, they did not study medicine and did not know anatomy that exposes mutilated ones to complications. This in line with IPPF (2018) and Rouzi, et al. studies that mentioned FGM can cause excruciating pain and tissue damage. Cutting the nerve endings and sensitive genital tissue creates excruciating pain.

Pain severity and duration may be greater. As a result, the healing process is lengthened and enhanced [33]. Moreover, Shabila study mentioned that Hemorrhage is a main complication occurs after FGM [34]. Hemorrhage can happen right after the procedure or later as a result of a clot sloughing over the blood supply due to the infection [35]. Effa, et al. [36] reported that FGM may lead to acute urine retention due to fear of passing urine, pain, or injury: Urinary retention can occur as a result of the FGM/C operation. Swelling of the genitalia or wound inflammation can also cause acute urinary retention [36]. Any disorder affecting any aspect of female sexual function, such as desire, arousal, lubrication, satisfaction, orgasm, sexual discomfort, or any person suffering during the sexual act, is referred to as female sexual dysfunction [37].

Regarding the effect of FGM/C on Female Sexual Function

according to FSDI, the result of the current study illustrated that. There was a significantly higher Desire domain, Arousal domain of, Lubrication domain of, Orgasm domain of, Satisfaction domain of, and Total score of among not circumcised married participants than circumcised ones. But the Pain domain didn't differ significantly between circumcised and not circumcised. These findings were similar to those conducted among Egyptian women that revealed that Un- mutilated subjects showed a considerably higher overall FSFI score. This is agreeing with other studies that reported that un-mutilated subjects scored considerably higher on desire, arousal, lubrication, orgasm, and satisfaction than the mutilated participants. Regarding the sexual pain domain, no apparent difference between the two groups was reported [23, 38].

This attributes to the percentage of those who had been mutilated in the current study was 15.8% at over 15 years old, compared to 75.8% of those who had been mutilated between the ages of 10-15 years old. The mean age at the time of mutilation was  $12.5 \pm 2.5$  years. This the age of puberty and time of growth and development of sexual organs and sexual function; so, exposure to FGM at this age will lead to psychological trauma which lead to impairment of sexual function for this female. It is worth mentioning that 4 of the participants were mutilated after her marriage their ages ranged between 23-28 years. This give an impression for the opinion of upper Egyptian husbands regarding FGM however, it is harmful practice.

According to a study conducted by Abdelhafeez, et al. [39] which stated that there were no statistically significant variations in the pain scores between the mutilated and un-mutilated. However, the satisfaction and orgasmic scores showed anorgasmia in the mutilated group [39]. A study suggests that FSFI domains were significantly lower in women with FGM: for desire, arousal, lubrication, orgasm, satisfaction, and pain [40]. In contrast, according to another study, there were no appreciable variations between the two groups' desire scores, which were respectively for those who had FGM and for the control group [41]. In a study conducted in Sudan, there were no discernible differences between mutilated and non-mutilated women in terms of desire arousal, orgasm, or pain [42]. This lack of discernible changes could be attributed to the traditional obligation of most women to conceal these experiences [43,44].

### Conclusion

Most circumcised married women had unfavorable FSFI scores and were considered to have sexual dysfunction. A significantly higher Desire, Arousal, Lubrication, Orgasm, Satisfaction, and total score among not circumcised married participants than circumcised ones but the Pain domain didn't differ significantly between circumcised, and not circumcised. Health consequences of FGM/C were the main reason stated by females for refusing the procedure.

## Recommendations

- a) Design and disseminate brochures work on the sexual effect of female genital mutilation in health centers and hospitals.
- b) Increase awareness about FGM/C law against all parties, whether parents seeking to perform FGM/C or health care workers or other persons participating in performing FGM/C.

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