Female Genital Mutilation/Cutting: Will It Continue?

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ABSTRACT

Introduction. Female genital mutilation/cutting (FGM/C) is a prevalent, deeply rooted traditional practice in Egypt.
Aims. Specification of the motives behind the continuation of FGM/C in Egyptian community and evaluation of the sexual function in women with FGM/C.
Methods. This cross-sectional study, involved 2,106 sexually active female participants with FGM/C. Full history-taking and general examination to evaluate the type of FGM/C were conducted. Sexual function was assessed by using the Female Sexual Function Index (FSFI) questionnaire.
Main Outcome Measures. Enumerate and specify the motivational factors and its percent among the participants. The correlation between FGM/C and FSFI domain scores was done with Pearson's correlation.
Results. Tradition, cleanliness, and virginity were the most common motives empowering the continuation of FGM/C (100%), followed by men's wish, esthetic factors, marriage, and religion factors (45.2–100%). Type I FGM/C was the most common, followed by type II. There was only negative correlation between the type II FGM/C and sexual satisfaction. No statistically significant difference between type I and non-FGM/C was found.
Conclusions. FGM/C remains high. A variety of socio-cultural myths, religious misbelievers, and hygienic and esthetic concerns were behind the FGM/C. Overall, a large proportion of the participants supported the continuation of FGM/C in spite of adverse effect and sexual dysfunction associated with FGM/C. **Mohammed GF, Hassan MM, and Eyada MM. Female genital mutilation/cutting: Will it continue? J Sex Med 2014;11:2756–2763.**

Key Words. Female Genital Mutilation/Cutting; Female Sexual Dysfunction; FSFI Score; Motivational Factors Perpetuating Genital Cutting/Mutilation

Introduction

Female genital mutilation/cutting (FGM/C) is defined as "all procedures which involve partial, or total removal of the female external genitalia, or other injury to the female genital organs for cultural or any other non-therapeutic reasons" [1]. According to World Health Organization, FGM/C or circumcision is classified into four types: type I (clitoridectomy or *suna*), which involves partial or total removal of the prepuce and/or the clitoris; type II, which involves partial or total removal of the clitoris and labia minora, with or without excision of the labia majora; type III (infibulation or *pharaonic*), which entails removing part or all of the external genitalia and narrowing the vaginal orifice by re-approximating the labia minora and/or labia majora; and type IV, which includes any form of other harm done to the female genitalia by pricking, piercing, cutting, scraping, or burning (Sudanese) [1].

Continuation of this practice arises from myths and beliefs, which are lacking scientific basis [2–5], such as retaining the cultural identity [6]; it is a religiously required (grounded in Islam) initiation rite into the tribe [6,7]; ensuring female virginity [8–10], modesty, chastity, and fidelity [6]; that it is required for the sake of female's morality, which is

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preserved by curbing the female's sexual "deviance", and it ensures the male's control over women and decreases women's sexual interests and desire [6,11]; for hygienic reasons; for esthetic reasons; and for various psychosexual needs: "lack of ability to have climax" [12] and "in treatment of frigidity" [13,14]. It even leads to a reduced reproduction rate [6].

Several studies show that FGM/C is often responsible for psychological, health problems and female sexual dysfunction disorders, which negatively affect the well-being [15,16]. The epidemiological studies highlighted the effect of FGM/C on the sexual function, quality of life, and the psychological status of women. To date, no studies are able to specify the motives behind the continuation of FGM/C in Egyptian community.

Objectives

The aims of this study are the specification of the motives behind the continuation of FGM/C in Egyptian community and the evaluation of the sexual function in women with FGM/C.

Methods

This cross-sectional survey-based study was conducted by administering a general demographic survey, the Female Sexual Function Index (FSFI), in a national sample of women aged 18 to 60. It was conducted between August 2011 and August 2012. The chronological steps appear in Figure 1. It received an approval from the Institutional Research Review Board Ethical Committee of the Suez Canal University, Faculty of Medicine, Ismailia, Egypt. It was conducted in accordance with the guidelines of the Helsinki Declaration and performed after obtaining the informed consent from all participants.

Inclusion criteria for this study included sexually active women in Ismailia, Egypt, aged 18 to 60 years who were listed on a public, accessible computer list via the Knowledge Networks (Central Agency for Public Mobilization and Statistics, Egypt). This database has been sampled for numerous health-related research studies, which provided support for the validity of these methods for obtaining a nationally representative sample of the population of Ismailia. Exclusion criteria included women not sexually active, older than 60 years of age, receiving medical treatment, having gynecological, psychological, pregnancy, or chronic medical diseases that may affect the sexual function, or those who refused to participate. "Sexually active" was defined as masturbating and/or being the receptive partner in vaginal or anal sex, for at least four times, on average, in a typical month at the time of the study. This study excluded women who were not sexually active, as they could not apply FSFI.

After the initial computer-based multistage random sampling, a total of 4,350 women were invited to participate in a study about FGM/C. These individuals received up to five telephone invitations or reminders. Of those women, 2,818 responded to the recruitment message and 2,711 women consent to participate. This resulted in a response rate of 62.3%. After interviewing 2,711 females, 504 were excluded according to exclusion criteria. Those with psychiatric and mental illnesses, 101 participants, were excluded by using the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, a widely used manual for diagnosing mental illnesses and is published by the American Psychiatric Association.

Finally, 2,106 sexually active participants were enrolled. All participants (2,106), through a structured personal interview, completed a questionnaire (age, religion, residency, educational level, sexual orientation, motives for FGM/C, having one or more daughters with FGM/C, if the practice should continue, satisfaction of male partner with sexual life, if he prefers marrying women with FGM/C or practicing sex with uncircumcised women). Also, sexual function was assessed by using the FSFI [17]. The 19-item FSFI is a commonly used measure that assesses the sexual function domains of desire, arousal, lubrication, pain associated with vaginal penetration, satisfaction, and orgasm. The total score was summed where higher scores indicate more positive sexual function (e.g., higher scores on the pain subscale indicate no or less pain) [17]. Participants underwent an examination of the external genitalia to identify the type of FGM/C and to exclude any medical disorders at sexology outpatient clinic.

Statistical analysis was performed using the SPSS software version 16 (SPSS Inc, Chicago, IL, USA). Quantitative data were expressed as mean ± standard deviation (SD) while qualitative data were expressed as frequency and percentages. Qualitative categorical variables were compared using chi-square test. Quantitative continuous data were compared using the nonparametric Mann–Whitney test instead of the Student *t*-test as normal distribution of the data could not be assumed. Kruskal–Wallis test was used to assess

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