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## Introduction

Female genital cutting, termed *female genital mutilation* (FGM) by the World Health Organization (WHO) and *female circumcision* by others, is a practice that affects millions of women worldwide (**Cathleen et al., 2007**).

FGM has been defined by WHO as “all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious, or other non-therapeutic reasons.” Various terms are used to describe the intentional alteration or injury of female genitalia. The practice was first referred to as *female circumcision*, but by the late 1970s, FGM became the preferred term. It is the term preferred by WHO (**Lewnes, 2005**).

Recent information using data from demographic and health surveys and multiple indicator cluster surveys suggests that genital cutting is occurring at a much higher rate than previously thought. The most recent estimates suggest that as many as 3 million women undergo FGM each year (**Lewnes, 2005**).

Female genital cutting (FGC) as a custom or ritual was first recorded more than 4000 years ago in ancient Egypt. In fact, one form of cutting is even named “pharaonic circumcision.” FGC spread through migration routes from the Nile River into Africa (**Poterfield, 2006**).

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Some researchers have suggested that FGC is directly related to religious beliefs, but this cannot be substantiated. The practice originated in pre-Judaic, pre-Christian, and pre-Islamic times and is not part of Muslim customs. In a contemporary study of circumcised women of Chad, 65% were Catholic, 35% were Protestant, and 7% were Muslims. In that same study, 80% of young women of Chad and 85% of older women were circumcised (**Poterfield, 2006**).

The cultural factors that support the continuing practice of FGC are several and include cultural identity, gender identity, belief that this controls women's sexual and reproductive function, beliefs about cleanliness and hygiene, and belief that this promotes virginity and chastity and enhancement of male sexual pleasure (**Serour, 2006**).

The World Health Organization (WHO) has distinguished four types of FGC, the first three types being of increasing invasiveness, and the last a general category of unclassified genital injuries. All of these are usually undertaken by medically unqualified personnel, often with crude instruments and without anesthesia. The comprehensive definition for the WHO classification is that:

Female genital mutilation comprises all procedures that involve partial or total removal of the female external genitalia and/or injury to the female genital organs for cultural or any other non-therapeutic reasons.

The classification is based on four types of genital insult, namely:

Type I—Excision of the prepuce (equivalent to the male foreskin) with or without excision of part or all of the clitoris;

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Type II—Excision of the prepuce and clitoris together with partial or total excision of the labia minora;

Type III—Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation);

Type IV—Unclassified: Pricking, piercing, or incision of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissues; scraping (angurya cuts) of the vaginal orifice or cutting (gishiri cuts) of the vagina; introduction of corrosive substances into the vagina to cause bleeding, or of herbs into the vagina with the aim of tightening or narrowing the vagina; any other procedure that falls under the definition of female genital mutilation (**Lewnes 2006**).

Any of the three types of FGC procedures can create health complications for the young girl or woman, although excision and infibulation lead to more severe complications. There are both immediate health effects and long-term consequences for a woman's health (**Elnashar and Abdelhady, 2007**).

In Lower Egypt the procedure done is only circumferential excision of clitoral prepuce (“sunna” circumcision) or removal of the glans clitoridis or even the clitoris itself together with adjacent parts of labia minora. This later form is performed mostly in rural areas. Pharaonic circumcision (total removal of the clitoris and labia) is performed mostly in Upper Egypt and Nubia (**Elnashar and Abdelhady, 2007**).

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Studies related to the effect of female genital mutilation on female sexuality offer varied data that are insufficiently understood. It does, however, seem clear that the various forms of female genital mutilation are not equally devastating to female sexual response. It is also clear that female sexuality is neither completely destroyed nor unaffected by genital mutilation (**Jones et al., 2004**).

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## **Aim of the work**

The aim of this study was to find out the effect of circumcision on female sexual function, to establish to what extent their sexual lives were affected and their perception of their sexuality. Briefly, to assess the effect of circumcision on each corner of the sexual response cycle as desire, arousal, and orgasm taking into consideration pain during intercourse and the effect on overall satisfaction.

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## General Historical Background

### Nomenclature

The terminology applied to this procedure has undergone a number of important evolutions. When the practice first came to be known beyond the societies in which it was traditionally carried out, it was generally referred to as “female circumcision”. This term, however, draws a direct parallel with male circumcision and, as a result, creates confusion between these two distinct practices. In the case of girls and women, the phenomenon is a manifestation of deep-rooted gender inequality that assigns them an inferior position in society and has profound physical and social consequences. This is not the case for male circumcision, which may help to prevent the transmission of HIV/AIDS (**Lewnes, 2005**).

The term female genital mutilation gained growing support in the late 1970s. The word "mutilation" not only established clear linguistic distinction from male circumcision, but it also emphasized the gravity of the act. In 1990, this term was adopted at the third conference of the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) in Addis Ababa. In 1991, the World Health Organization (WHO), a specialized agency of the United Nations (UN), recommended that the UN adopt this terminology; subsequently, it has been widely used in UN documents (**Wikipedia, 2009**).

The use of the word “mutilation” reinforces the idea that this practice is a violation of girls’ and women’s human rights, and thereby helps

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promote national and international advocacy towards its abandonment. At the community level, however, the term can be problematic. Local languages generally use the less judgmental “cutting” to describe the practice; parents understandably resent the suggestion that they are “mutilating” their daughters. In this spirit, in 1999, the UN Special Rapporteur on Traditional Practices called for tact and patience regarding activities in this area and drew attention to the risk of “demonizing” certain cultures, religions and communities. As a result, the term “cutting” has increasingly come to be used to avoid alienating communities. (Lewnes, 2005)

In 1996, the Uganda-based initiative REACH (Reproductive, Educative, And Community Health) began using the term female genital cutting, observing that female genital mutilation may "imply excessive judgment by outsiders as well as insensitivity toward individuals who have undergone some form of genital excision." While some international organizations, such as the UN and the WHO, continue to use the earlier term of female genital mutilation, a number of agencies, like UNICEF, now use the term female genital mutilation/cutting (FGM/C) (wikipedia, 2009).

## **History of FGC**

FGC as a custom or ritual was first recorded more than 4000 years ago in ancient Egypt. In fact, one form of cutting is even named “pharaonic circumcision.” FGC spread through migration routes from the Nile River into Africa. (Porterfield, 2006).

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The history of FGC has been traced back as far as the 2nd century B.C. when a geographer, Agatharchides of Cnidus, wrote about FGC as it occurred among tribes residing on the western coast of the Red Sea (now modern-day Egypt). Based on current geographic locations of FGC, the practice seems to have originated in Egypt and have spread south and west (**Todd-Chattin, 2005**).

Some believe that FGC was rooted in the Pharaonic belief in the bisexuality of the gods. According to this belief, mortals reflected this trait of the gods; every individual possessed both a male and a female soul. The feminine soul of the man was located in the prepuce of the penis; the masculine soul of the woman was located in the clitoris. For healthy gender development, the female soul had to be excised from the man and the male soul from the woman. Circumcision was thus essential for boys to become men and girls to become women. Prior to the rise of Islam, Egyptians raided territories to the south for slaves, and slaves from Sudan were exported to areas along the Persian Gulf. Reports from the 15th and 16th centuries suggest that female slaves were sold at a higher price if they were "sewn up" in a way that made them unable to give birth. After the region converted to Islam, this practice was no longer possible because Islam prohibits Muslims from enslaving others of their own religious beliefs (**Todd-Chattin, 2005**).

**Barstow, (1999)**, said that medical examination of Pharaonic mummies from the early, middle, and late dynastic periods of Egypt shows that circumcision was common among the rich and powerful.



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Elliot Smith, an Egyptologist, states that there is no clear and convincing evidence of circumcision in the pre-dynastic or later Egyptian mummies, as the pelvic viscera were so completely excised by the embalmer and the remains of the labia so stretched by the plugging of the pelvis for the mummification process, that nothing can be sure about the condition of the vulva during life (**Cloudsley, 1983**).

Writings by Herodotus in the Fifth Century B.C. described female and male circumcisions. His writings indicated that circumcisions were performed among the Egyptians, Ethiopians, Phoenicians, and the Hittites. The Ethiopians referred to the process as “pharonic circumcision,” implying that the Egyptians were the first with this practice, yet in some Egyptian writings there was indication that the practice was from Ethiopia. Circumcision was believed to be an economic necessity since the men would be away from their homes for long periods of time, and therefore, wanted assurance that any children born during their absence were their own (**Watson, 2005**).

Sources from Dutch and British travelers in the 16th and 17th Centuries provided evidence of the continuation of the practice of male and female circumcision that was first reported in the writings of Herodotus (500 b.c.e.) (**Watson, 2005**).

Some researchers have suggested that FGC is directly related to religious beliefs, but this cannot be substantiated. The practice originated in pre-Judaic, pre-Christian, and pre-Islamic times and is not part of Muslim customs. In a contemporary study of circumcised women of

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Chad, 65% were Catholic, 35% were Protestant, and 7% were Muslims. In that same study, 80% of young women of Chad and 85% of older women were circumcised (**Porterfield, 2006**).

Some people believe that FGC is a barbaric practice done to girls and women in some remote villages in some foreign countries of the world. However, up until a few decades ago, it was still believed that the clitoris is a very dangerous part of the female anatomy. Sigmund Freud who stated in one of his books entitled *Sexuality and the Psychology of Love* that the "elimination of clitoral sexuality is a necessary precondition for the development of femininity" ( **Sarkis, 2003**).

Because of the large number of cases of FGC and some of the deaths it has caused, FGC is now outlawed in some European countries (Britain, France, Sweden, and Switzerland) and some African countries as Egypt, Kenya, Senegal ( **Sarkis,2003**).

FGC is practiced by the minority Ethiopian Jewish community (Beta Israel), formerly known as Falasha, most of whom now live in Israel. The operation may only be performed by a Jewish female. Those Ethiopian Jews who have immigrated to Israel no longer practice of FGC; they abandon this practice immediately upon arrival in Israel, suggesting that rapid cultural change is possible when individuals accept a new identity (**Grisaru et al., 1997**).

Christianity's lack of FGC tradition is inherited from Judaism. FGC has never been part of Christianity as a faith system . There are no

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scriptural or doctrinal documents existing within the larger Christian tradition that even address the issue. The only contemporary examples of Christians practicing FGC are in Africa. As FGC rituals predated the missionaries work in North Africa, many African tribes continue the practice as a matter of cultural tradition, unrelated to religious belief (**Wikipedia, 2009**).

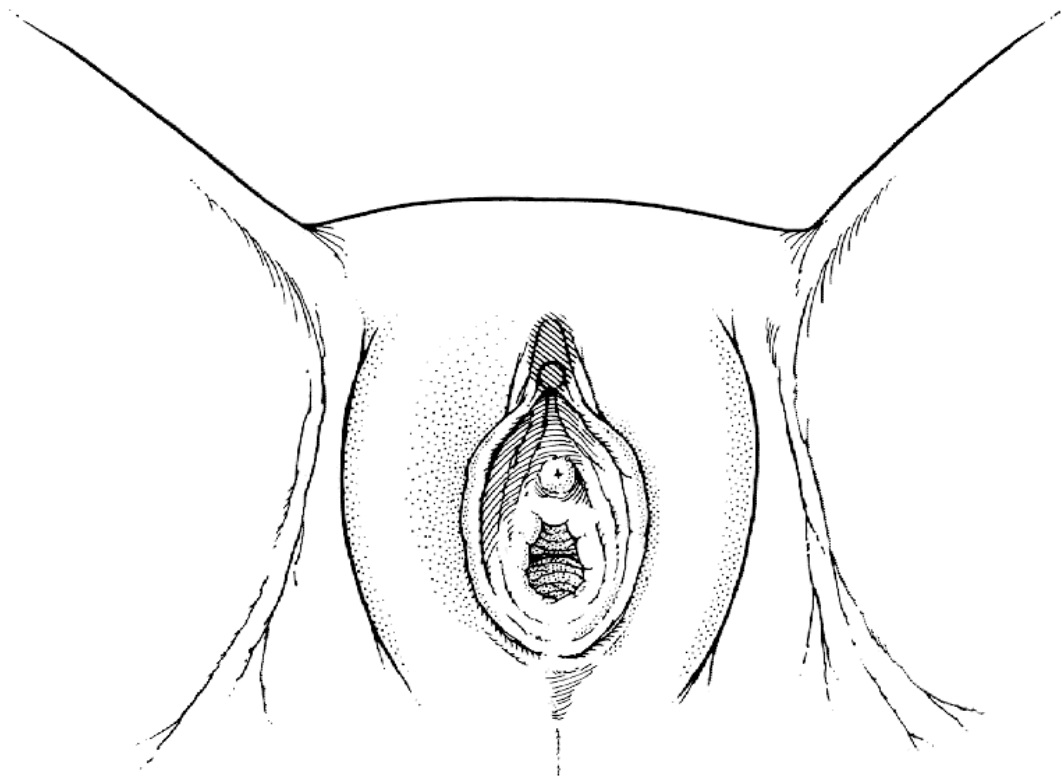
In many civilizations, certain surgical procedures have profound cultural and social meanings. Male circumcision, for example, has deep importance as a symbol of religious and ethnic identity and has played a major part in the political and social history of many peoples. Female circumcision has particularly strong cultural meaning because it is closely linked to women's sexuality and their reproductive role in society (**Toubia, 1995**).

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## Types of Female Genital Cutting

The often quoted Shandall system of clinical classification adopted by Verzin in 1975 was not accurate and proved to be of little clinical use. In 1993 Nahid Toubia advanced a newer system of classification that grouped the most common forms of female circumcision into two broad categories: clitoridectomies (type I and II procedures) and infibulations (type III and IV procedures) (**Toubia, 1995**).

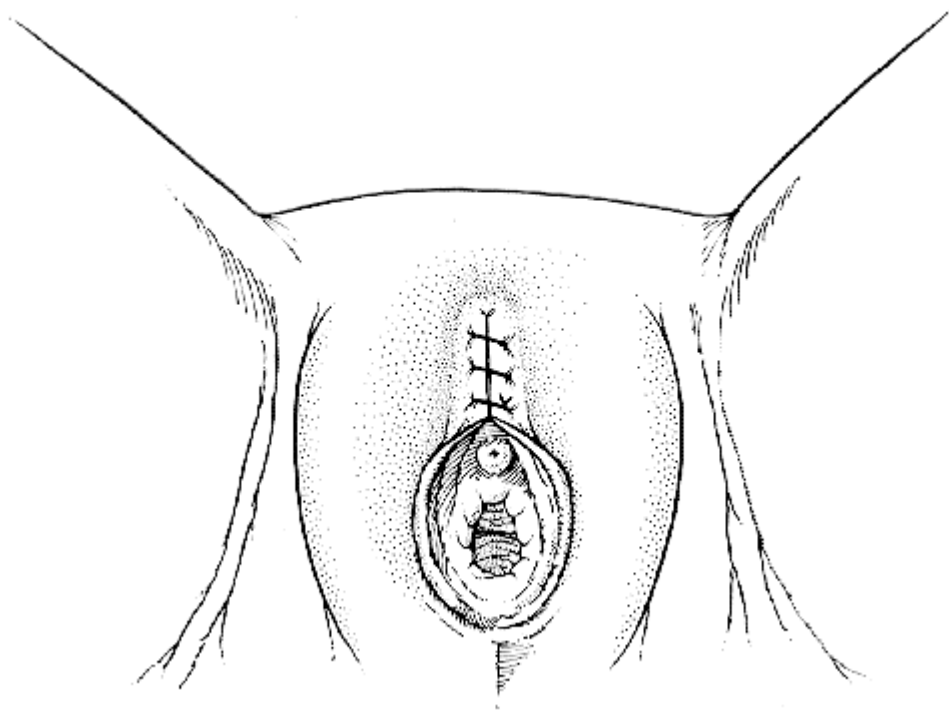
Type I clitoridectomy (Fig.1) involves the removal of a part of the clitoris or the whole organ. This is what is commonly referred to as "Sunna circumcision



**Fig.1.** Type I Clitoridectomy. The hatched area indicates the tissue to be removed.

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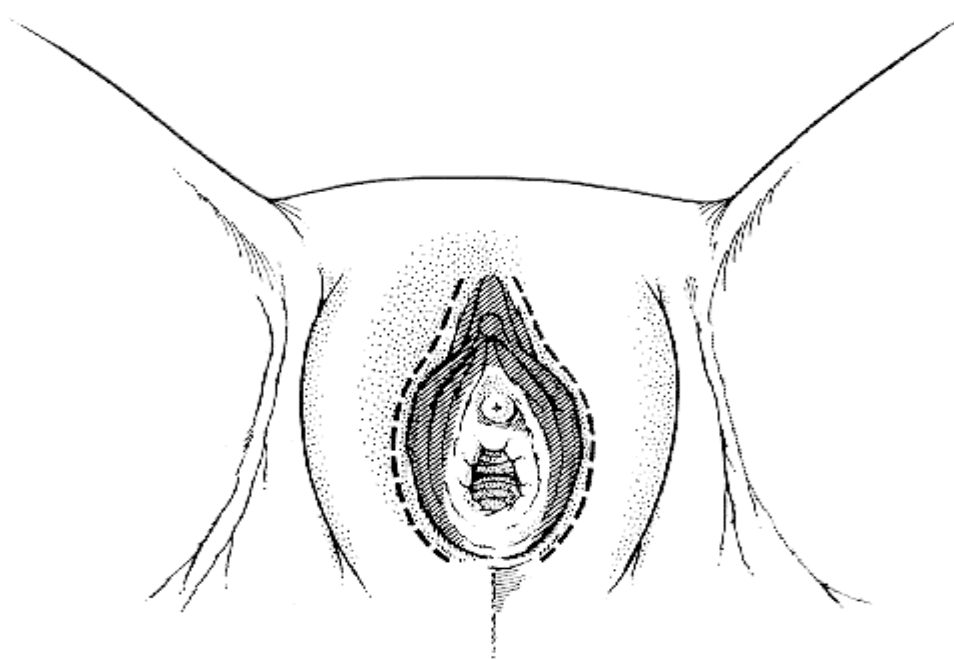
Type II clitoridectomy, or excision, involves excision of the clitoris and part of the labia minora. Bleeding from the raw surfaces and from the clitoral artery may be halted with a few stitches of catgut or thorn or by the application of homemade poultices (Fig.2). After healing, the clitoris is absent, but the urethra and the vaginal introitus are not covered.



**Fig. 2.** Type II Clitoridectomy (excision) after hemostatic stitching.

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Type IV, or total infibulation, involves the removal of the clitoris and the labia minora, plus incision of the labia majora to create raw surfaces (Figure 3) that are stitched together to cover the urethra and the entrance to the vagina with a hood of skin, leaving a very small posterior opening for the passage of urine and menstrual blood (Fig.4).



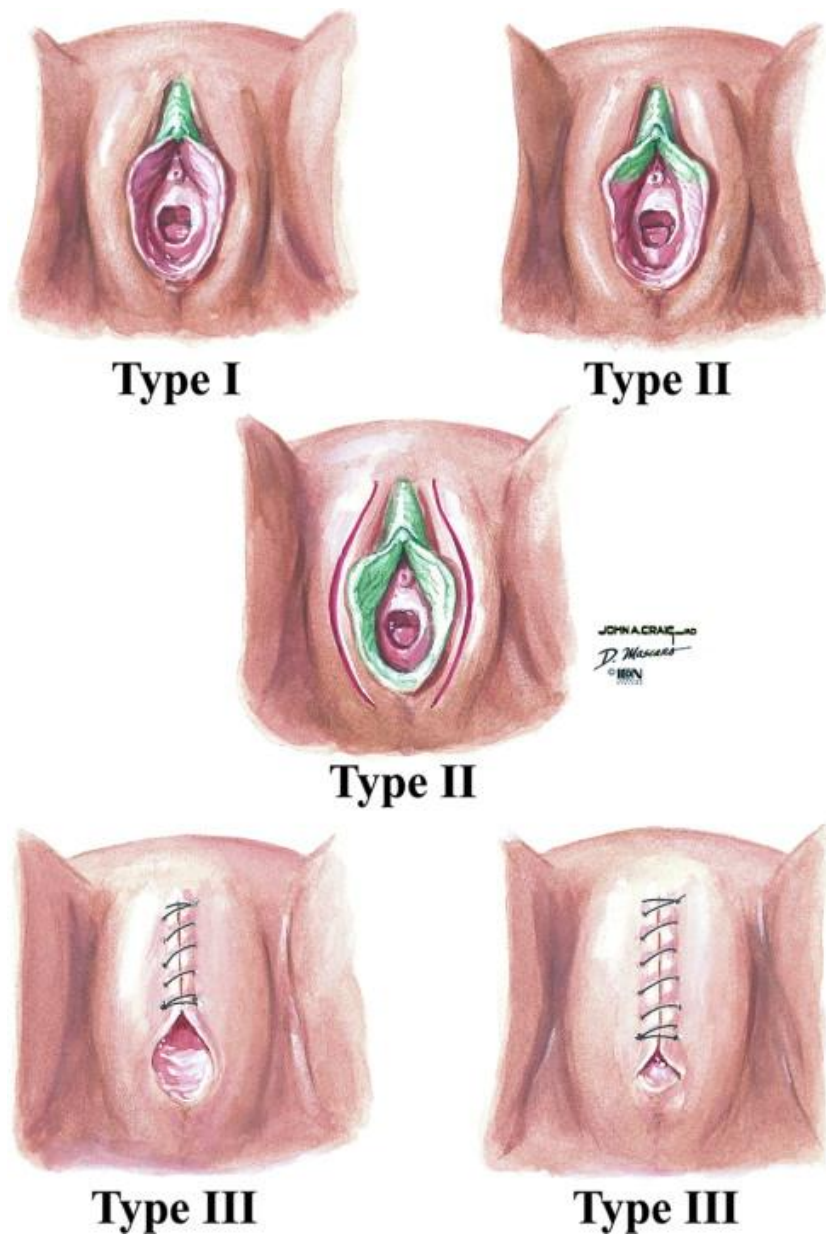
**Fig. 3.** Type IV Total Infibulation. The hatched area indicates the tissue to be removed, and the dotted lines the labial incisions.



**Fig. 4.** Seven-Year-Old Sudanese Girl with Type IV Infibulation.

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Type III, or modified (sometimes called intermediate) infibulation, is a milder form of infibulation, which involves the same amount of cutting, but in which only the anterior two thirds of the labia majora are stitched, thus leaving a larger posterior opening(**Toubia, 1995**).



**Fig.5.** Female genital cutting has been classified by the World Health Organization into 4 types by the extensiveness of the excision (shaded areas represent excised tissue): partial or total clitoridectomy (type I); clitoridectomy and partial or total excision of labia minora (type II); infibulation, with labia majora also excised and remnants of labia majora approximated (type III); and all other types that do not fit into the first 3 types (type IV, not shown) (Cathleen et al., 2007).



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## Prevalence

Female genital mutilation is a widespread practice. The World Health Organization estimates that between 100 and 140 million women and girls have experienced female genital mutilation globally. At least two million girls are believed to undergo some form of the procedure each year. While most women who have experienced FGM live mainly in Africa, FGM also occurs in the Middle East and in some Asian countries, including Malaysia and Indonesia. It is becoming increasingly common among immigrant populations in the West, with cases reported in Europe, Canada, Australia, New Zealand, and the US (**Jones et al., 2004**).

Demographic and health surveys, conducted between 1989 and 1996, in seven countries (Central African Republic, Côte d'Ivoire, Egypt, Eritrea, Mali, Sudan and Yemen), and including more than 55 000 women, showed that genital cutting occurs among all socioeconomic groups, approval of FGC among women in countries with high prevalence appears widespread and enduring, and that no major decrease in prevalence levels was evident across generations, though the daughters of urban and educated women may be less likely than others to undergo genital cutting. A recent decrease in female genital cutting has been reported among Ibo girls in Nigeria, and largely attributed to the rising rate of formal education among women (**Cook et al., 2002**).

Female circumcision is practiced in 28 African countries, with prevalence rates ranging from 5 percent to 99 percent. It is rarely practiced in Asia. The practice is known across socioeconomic classes and

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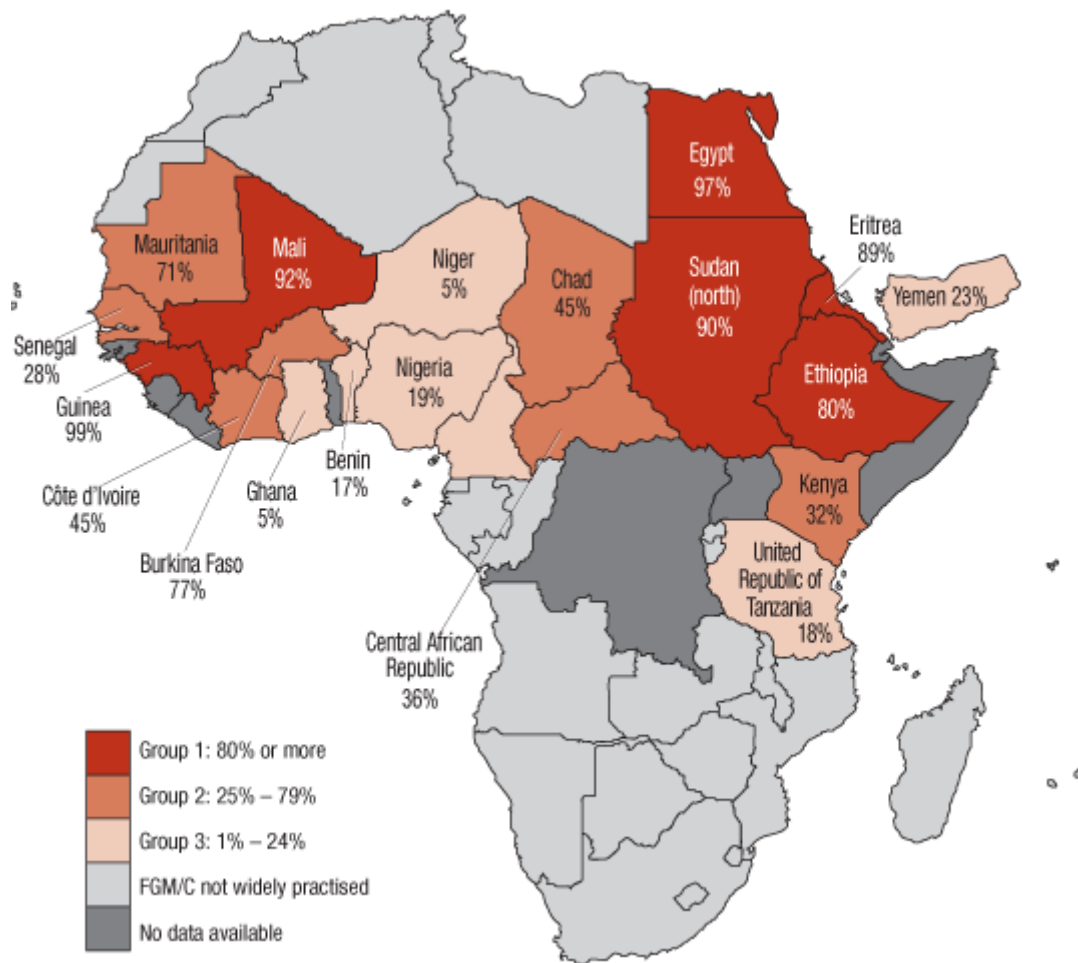
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among different ethnic and cultural groups, including Christians, Muslims, Jews, and followers of indigenous African religions (**Toubia, 1995**).

Some forms of female genital mutilation have also been reported from other countries, including certain ethnic groups in Central and South America. Growing migration has increased the number of girls and women living outside their country of origin who have undergone female genital mutilation (**Yoder et al., 2004**).

Estimates based on the most recent prevalence data indicate that 91,5 million girls and women above 9 years old in Africa are currently living with the consequences of female genital mutilation (**Yoder and Khan, 2008**).

The prevalence of female genital mutilation has been estimated from large-scale, national surveys asking women aged 15–49 years if they have themselves been cut. The prevalence varies considerably, both between and within regions and countries with ethnicity as the most decisive factor. In seven countries the national prevalence is almost universal, (more than 85%); four countries have high prevalence (60–85%); medium prevalence (30–40%) is found in seven countries, and low prevalence, ranging from 0.6% to 28.2%, is found in the remaining nine countries. However, national averages hide the often marked variation in prevalence in different parts of most countries (**WHO 2008**).



**Fig. 6. Prevalence of female genital cutting in Africa and Yemen (women aged 15–49)**

The type of procedure performed also varies, mainly with ethnicity. Current estimates indicate that around 90% of female genital mutilation cases include Types I or II and cases where girls' genitals were "nicked" but no flesh removed (Type IV), and about 10% are Type III (**Yoder and Khan, 2008**).

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## Prevalence in Egypt

In Egypt many studies were done to assess the prevalence of FGC in the period from 1977 to 1985 by many investigators as shown in the following table

**Table (1) The prevalence of FGC in Egypt (Badawi, 1989).**

	<b>Badawi (1985)</b>	<b>Smith (1980)</b>	<b>Assaad (1979)</b>	<b>Baashar (1979)</b>	<b>Saadawy (1977)</b>
Percent*	81.6%	77%	90.8%	70.0%	81.8%
Sample Size	n=350	n=125	n=54	n=70	n=16
Population	General	Students	Patients	Patients	Patients
Location	Cairo	Alexandria	Cairo	Alexandria	Cairo
<i>*80.5% is the average of female genital mutilation in the above studies</i>					

Statistics compiled in 1994 by Egypt's former ministry of population estimated that between 70% and 90% of Egyptian women were circumcised. A survey conducted by international group Macro puts the figure even higher, with 97% of women in both rural and urban areas reporting that they have been circumcised (**Elnashar and Abdelhady, 2007**).

Study presented by **Elnashar and Abdelhady, (2007)**, revealed that 75.8% of the studied sample was circumcised; this lower non-expected rate reflects the trend towards rejection of circumcision particularly in

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some classes. In this study no illiterates were found among the non-circumcised females and the majority of them (67.2%) were at university level or higher, furthermore, the majority was working (76.6%). Also, all non-circumcised women were living in urban residential areas.

A study done by **Tag-Eldin et al. (2008)**, showed that the overall prevalence rate of FGC was 50.3% among girls in the age group 10-18 years. In rural schools the prevalence rate was 61.7% compared to 46.2% in urban schools, in private urban schools the prevalence rate was 9.2%.

FGC differs in prevalence between the governorates. In Upper Egypt governorates the prevalence was high. In Luxor city, 85.5% while in Assuit and Bani Suif rates were 75.5% and 73.1% respectively. In Lower governorates the prevalence rates were 49.8% and 73.9% in Dakahlyia and Sharkia. The lowest rates of FGC were seen in Port Said, Demiatta and North Sinai (**Tag-Eldin et al., 2008**).

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## Cultural Aspects

Alteration of normal genitalia may seem inappropriate and even cruel in Western culture, but to many in the culture where it is practiced it is seen as a necessary and desirable practice for their children. In order to understand the persistence of this act in modern times, it is important to explore the deep cultural context and importance among the people that practice this tradition (**Horowitz and Jackson, 1997**).

This practice is most often seen as a “rite into womanhood” and thus is commonly done during pre-adolescence. However, some cultures choose infancy, betrothal, or pregnancy as the time to perform genital alterations (**Toubia, 1995**).

In communities that practice more radical types of FGC, virginity and chastity are highly valued and are seen as necessary for suitability for marriage (**Althaus, 1997**).

In certain highly agricultural societies, proof of lineage for property transfer may be intimately related to physical proof of virginity. There may be tremendous societal pressure for covering of the introitus as a prerequisite for marriage, with uncircumcised girls being excluded from their community (**Dire and Lindmark 1991**).

Many cultural myths are present in societies where female circumcision is practiced. Female genitals may be seen as unattractive, with the smooth hairless appearance having greater aesthetic value.

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Uncontrolled genital growth, infertility, poor hygiene, and fetal death at the time of delivery have all been given as justification for the need for genital alteration. Circumcision is thought to heighten male sexual pleasure. The unfortunate reality is, however, that the risk of sexual dissatisfaction and even infertility resulting from inability to satisfactorily penetrate the scarred introitus is higher. As many as 35% of women may have coital difficulty requiring medical intervention (**Strickland, 2001**).

The justifications offered for the practice of FGC are numerous. These justifications may vary among communities; they follow a number of common themes: FGC ensures a girl's or woman's status, marriageability, chastity, health, beauty and family honor. In some cases they are presented positively to emphasize the advantages of undergoing FGC, while in others they point to the consequences of not undergoing the procedure (**Lewnes, 2005**).

For example, the Taguana from Côte d'Ivoire are among a number of groups who believe that women who have not undergone the procedure are unable to have children (**Dorkenoo and Elworthy, 1992**).

In some communities it is said that a woman's external genitalia have the power to blind anyone attending her during childbirth or to cause the death of her newborn if the child's head touches the mother's clitoris during delivery. Others believe that a woman who has not been cut may become physically deformed or mad, or may cause the death of her husband (**WHO, 2001**).

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Important and instructive parallels exist between FGC and the well-documented practice of footbinding in China, which help to explain how such harmful social conventions first developed. FGC, like footbinding, is thought to have evolved in the context of a highly stratified empire, in which the emperor and his elite used the practice to control the fidelity of their many female consorts. With time, these practices came to be adopted by families in lower strata of society to enable their daughters to marry into higher strata. Footbinding and FGC eventually became essential signs of marriageability throughout the respective empires and in all but the poorest groups in society. In this way, the practices became social conventions that had to be observed if a girl was to find a husband—convention that persisted after the original imperial conditions faded (**Gerry, 1996**).

Additional reasons that the practice of FGC continues include economic, moral, esthetic, and gender identity. The male's prepuce, which is the soft part of his nature, is removed to transform him from a “neutral child” to a real man by making him all male or “hard.” For the girl child, the clitoris must be removed, because it is the only part of her body that equates to maleness or hardness, when removed this makes her all female or soft (**Porterfield, 2006**).

FGC was also performed to control sexuality and marital chastity. A woman who is circumcised is considered pure or chaste. This symbolizes the stability, respect, and continuation of the group as expressed in the obedience, docility, faithfulness, and maintenance of tradition of its females. FGC has been epitomized as an intrinsic part of a total cultural

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experience. The practice is the essence of womanhood, family system, and religious belief; age, class, power, social identity and responsibility. The practice does vary as the group's cultural values vary (**Porterfield, 2006**).

The clitoris has been a victim of assault as a result of society's view of female sexuality. In England, Europe and the USA, many clitoridectomies were performed by gynecological surgeons in the second half of the 19th century on allegedly medical grounds. Clitoridectomy was considered necessary not only to cure such sexual deviations as 'nymphomania' but also to prevent masturbation and to cure a number of disorders, some of which were alleged to be caused by masturbation such as hysteria, epilepsy, melancholia and insanity. Also, it was unthinkable that any decent woman should derive pleasure from sex (**Fathalla, 2000**).

Girls who undergo the procedure are provided with rewards, including celebrations, public recognition and gifts. Moreover, in communities where FGC is almost universally practiced, not conforming to the practice can result in stigmatization, social isolation and difficulty in finding a husband (**Lewnes, 2005**).

Understanding FGC as a social convention provides insight as to why women who have themselves been cut and suffer the health consequences favor its continuation. They resist initiatives to end FGC, not because they are unaware of its harmful aspects, but because its abandonment is perceived to entail loss of status and protection (**Lewnes, 2005**).

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The continuation of this practice is fostered by many views and cultural beliefs. Reasons for female genital mutilation as found in WHO fact sheet were:

- Psychosexual reasons
- Reduction or elimination of the sensitive tissue of the outer genitalia
- Attenuation of sexual desire in the female
- Maintenance of chastity or virginity before marriage
- Maintenance of fidelity during marriage
- Increased male sexual pleasure
- Sociological reasons
- Identification with the cultural heritage
- Initiation of girls into womanhood
- Social integration
- Maintenance of social cohesion
- Hygienic and Aesthetic reasons
- External female genitalia are considered dirty and are removed to promote hygiene

**(WHO, 2000).**

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## Medical Aspects

### Age of FGC

According to a WHO report on FGC, some communities in Africa perform FGC on infants a few days old. Generally the average age of performing FGC is lower in other African countries than in Egypt (**Tag-Eldin et al., 2008**).

In Egypt, the peak ages for circumcision are 9-13 years, prior to or at earliest stage of puberty just before menarche (**ElGibaly et al., 2002**). The average age at which the procedure of FGC was performed was  $10 \pm 2$  years (**Tag-Eldin et al., 2008**).

### Practitioner

The practitioner is usually not medically trained and is often a family member or one of the elderly women in the village. When the procedure is performed without anesthesia, the woman or child is usually held in the lithotomy position by others. This method of restraint can lead to trauma and bony fractures.

In large cities, the procedure may be performed under sterile conditions with anesthesia; however, sterile procedures and anesthesia are not available in most rural settings. Nonsterile instruments are commonly used, and even the use of rusty knives, razors, scissors, sharp stones, or shards of glass has been reported. (**Nour, 2004**).

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In Egypt, in the past, the majority of cases of FGC procedures were performed by traditional midwives, called dayas. However, according to the Demographic and Health Survey (1995), the number of procedures performed by medical practitioners tripled with a concomitant drop in the use of dayas (**Tag-Eldin et al., 2008**). About 60% of the procedures were performed by physicians and about 80% were done under anesthesia at home (**Elnashar and Abdelhady, 2007**).

Instruments are often used more than once without decontamination or without any type of sterilizing procedure between patients (**Kun, 1997**).

Depending on the local tradition, various methods are applied to ensure hemostasis. Some practitioners require bed rest for a prescribed period of time after the procedure and may even bind the ankles and thighs of the girl or woman to encourage compliance and healing (**Nour, 2000**).

In recent decades, heated debates surrounding the practice of female circumcision have often centered on the health risks associated with genital cutting procedures. The adverse health consequences of female genital cutting are central in two prominent arguments. On one hand, by emphasizing that female genital cutting exposes women to unnecessary medical risks. On the other hand, any efforts to minimize the health risks by providing or improving medical support are strongly opposed by anti-circumcision advocates, based on the belief that medicalization counteracts efforts to eliminate the practice (**Duncan, 2001**).

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Medical interventions have been attempted in various forms, ranging from promoting precautionary steps, such as the use of clean sterile razors on each woman and dispensing prophylactic antibiotics, to obtaining genital operations in clinics or hospitals by trained nurses and physicians. The impact of these interventions on the health of women has received surprisingly little attention (**Duncan, 2001**).

The medicalization of FGC has been condemned by WHO and is considered to perpetuate and promote FGC rather than to prevent or reduce its practice (**Tag-Eldin et al., 2008**).

Female genital mutilation is associated with a series of health risks. Almost all those who have undergone female genital mutilation experience pain and bleeding as a consequence of the procedure. The intervention itself is traumatic as girls are usually physically held down during the procedure (**Chalmers and Hashi, 2000**).

Generally, the risks and complications associated with Types I, II and III are similar, but they tend to be significantly more severe and prevalent in type III. Immediate consequences, such as infections, are usually only documented when women seek hospital treatment. Therefore, the true extent of immediate complications is unknown (**Obermeyer, 2005**).

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### **Immediate risks of health complications from Types I, II and III:**

-*Severe pain*: Cutting the nerve ends and sensitive genital tissue causes extreme pain. Proper anesthesia is rarely used and, when used, not always effective. The healing period is also painful. Type III female genital mutilation is a more extensive procedure of longer duration (15–20 minutes); hence the intensity and duration of pain are more extensive. The healing period is extended and intensified accordingly (**ElDefrawi et al., 2001**).

-*Excessive bleeding* (hemorrhage) and septic shock have been documented.

-*Shock* can be caused by pain and/or hemorrhage (**Dire and Lindmark, 1992**).

-*Difficulty in passing urine*, and also passing of feces, can occur due to swelling, edema and pain (**ElDefrawi et al, 2001**)

-*Infections* may spread after the use of contaminated instruments (e.g. use of same instruments in multiple genital mutilation operations), and during the healing period (**Almroth et al, 2005**).

-*Hepatitis B&C*, Use of the same surgical instrument without sterilization could increase the risk for transmission of hepatitis B&C (**Hakim, 2001**).

-*Human immunodeficiency virus (HIV)*, Use of the same surgical instrument without sterilization could increase the risk for transmission of HIV between girls who undergo female genital mutilation together (**Klouman et al, 2005**).

-*Psychological consequences*: The pain, shock and the use of physical force by those performing the procedure are mentioned as reasons why many women describe female genital mutilation as a traumatic event (**Behrendt and Moritz, 2005**).

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*-Unintended labia fusion:* Several studies have found that, in some cases, what was intended as a Type II female genital mutilation may, due to labia adhesion; result in a Type III female genital mutilation (**Dare et al, 2004**).

**Long-term health risks from Types I, II and III (occurring at any time during life):**

*-Pain:* Chronic pain can be due to trapped or unprotected nerve endings (**Fernandez-Aguilaret and Noel, 2003**).

*-Infections:* Dermoid cysts, abscesses and genital ulcers can develop; with superficial loss of tissue. Chronic pelvic infections can cause chronic back and pelvic pain (**Thabet and Thabet, 2003**). Urinary tract infections can ascend to the kidneys, potentially resulting in renal failure, septicemia and death. An increased risk for repeated urinary tract infections is well documented in both girls and adult women (**Almroth et al, 2005**).

*Keloid:* Excessive scar tissue may form at the site of the cutting.

*-Reproductive tract infections and sexually transmitted infections:* An increased frequency of certain genital infections, including bacterial vaginosis has been documented (**Okonofua, 2002**).

*-Human immunodeficiency virus (HIV):* An increased risk for bleeding during intercourse, which is often the case when defibulation is necessary (Type III), may increase the risk for HIV transmission. The increased prevalence of herpes in women subjected to female genital mutilation may also increase the risk for HIV infection, as genital herpes is a risk factor in the transmission of HIV (**Thabet and Thabet, 2003**).

*-Birth complications:* The incidences of caesarean section and postpartum

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hemorrhage are substantially increased, in addition to increased tearing and recourse to episiotomies. The risks increase with the severity of the female genital mutilation. Obstetric fistula is a complication of prolonged and obstructed labor, and hence may be a secondary result of birth complications caused by female genital mutilation.

*-Danger to the newborn:* Higher death rates and reduced Apgar scores have been found, the severity increases with the severity of female genital mutilation (**WHO study group, 2006**).

*-Psychological consequences:* Some studies have shown an increased likelihood of fear of sexual intercourse, post-traumatic stress disorder, anxiety, depression and memory loss (**Behrendt and Moritz, 2005**).



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## Physiology of Female Sexual Function

The sequence of events that characterizes the progression from the sexually unaroused to the aroused state and the resolution of these changes are described as the human sexual response cycle, with genital and non-genital components. The latter include increased heart rate, blood pressure and respiration, nipple erection, myotonia and dilated pupils (**Levin, 2001**).

Based on observations of the sexual responses of men and women in their laboratory, Masters and Johnson identified four phases, namely: Excitement (E), Plateau (P), Orgasm (O) and Resolution (R) – the EPOR model – but they neglected to include a phase that initiated sexual activity. Most people do not suddenly become sexually active; they normally experience an initiating phase of sexual desire (D). This can come about either spontaneously (proceptive desire – D1) or by activation through sexual excitation (responsive desire – D2); the mechanisms of D1 and D2 are not necessarily different but are initiated at different times. The original EPOR model has now become modified as the DEOR model (or more accurately the D1D2EOR model) as it has become clear that the Plateau or P-phase was misnamed because it was actually a phase of increasing sexual excitement, basically, the end of the E-phase into which it has now been incorporated (**Levin, 2001**).

The sexual response activated by effective sexual stimulation can be viewed as the algebraic sum of positive (sexually stimulating) and negative (sexually inhibiting) stimuli. Sexually stimulating factors may

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be psychogenic or reflexogenic. Psychogenic sexual stimulation arises in the brain and may be triggered by input from the special senses (vision, hearing, taste and smell) or by consciously contrived sexual fantasies. Inhibiting factors can be varied, such as religious feelings, guilt, shame, disgust, ignorance of sexual technique etc. Reflexogenic sexual stimulation arises from genital stimulation and/or erotogenic sites (breasts, nipples, inner thighs, and perineum) (**Levin and Riley, 2007**).

During sexual stimulation, the genital female sexual arousal response is elicited by sensory stimulation as well as central nervous system activation. This culminates in a series of vasocongestive as well as neuromuscular events leading to physiologic changes—vaginal lubrication, increased length and width of the clitoris, engorgement of the labia as well as increased sensitivity of the genitalia— representing the physiologic genital arousal response in women (**Graziottin and Giralddi, 2006**)

The normal sexual response in the female depends on the integrity of afferent sensory input from the genital region. Genital sensory thresholds measured by quantitative sensory testing were compared in a non excitatory versus excitatory state in normal sexually functioning female and a significant decrease in clitoral vibratory sensation threshold was observed between the baseline and the arousal phase ( **Gruenwald et al., 2007**).

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The mechanism and control of clitoral tumescence is similar to that of the penis involving vasoactive intestinal polypeptide and nitric oxide. The body of the clitoris containing erectile tissue extends around the vagina and urethra deep to the labia minora, giving rise to the vestibular bulbs, and may extend into Halban's fascia between the anterior vaginal wall and the bladder (**Levin and Riley, 2007**).

Human sexuality depends on a complex interaction of cognitive processes, relational dynamics, and neurophysiological and biochemical mechanisms. It is influenced and modulated by many factors (biological, psychosexual, and social/ contextual dependence) which act in a way that one factor can improve or inhibit the other and vice versa.

The erectile organs (trigger of the orgasm) in females and in males have the same embryologic origin. The vulva is the homologue of the male penis and scrotum; the clitoris is equivalent to only a part of the male penis (corpus cavernosum and glans of male penis). The female erectile structures are the labia minora, the whole clitoris (glans, body, crura), the vestibular bulbs with the corpus spongiosum, and the corpus spongiosum of the female urethra; these structures are situated under the urogenital diaphragm and in front of the pubic symphysis in the anterior perineal region. The corpus spongiosum surrounds the female urethra, as in the male, and becomes engorged (becomes erect) during arousal (**Catania et al, 2007**).

The vagina is a potential space lined by a squamous epithelium devoid of glands. The epithelial cells have a limited capacity to transfer sodium ions from the lumen to blood; this transfer powers the osmotic

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reabsorption of vaginal fluid. The wall has two layers of smooth muscle, an inner longitudinal layer (contraction shortens and widens the vagina) and an outer circular layer (contraction constricts the vagina). These muscles are under autonomic nervous control and their tone is not consciously perceived. At its distal end, the vagina is surrounded by the bulbocavernosus and ischiocavernosus (striated) muscles. The bulbocavernosus muscle is more superficial and surrounds the vaginal introitus: its contraction narrows the introitus. The ischiocavernosus muscle extends from the ischial ramus and tuberosity of the pelvis to either side of the introitus (**Levin and Riley, 2007**).

In the unaroused state the vaginal blood flow is minimal. This is achieved by a high adrenergic tone and ‘vasomotion’, a process where random opening and closing of capillaries occurs to just satisfy local metabolic demands. The initial change that characterizes vaginal sexual arousal is an increased blood flow mediated by a reduction in the adrenergic tone and activation of the VIPergic innervation with a small component of NO. More capillaries become recruited and opened; when all are open with increased flow the tissue is full of blood creating vasocongestion. An increase in vaginal lubrication usually occurs within seconds of the onset of sexual arousal created by neurogenic transudation, probably mediated by VIP and calcitonin gene-regulating peptide, which increases the permeability of the capillaries (**Levin and Riley, 2007**).

The ultrafiltered plasma transudate powered by the vasocongestion permeates through the intercellular channels of the epithelium saturating its limited sodium ion reabsorptive capacity and leaking through,

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appearing as bead-like droplets on the surface of the vaginal epithelium. These coalesce forming a thin lubricating surface film (**Levin and Riley, 2007**).

The transudate, a slippery smooth fluid, probably picks up cervically secreted sialoproteins coating the vaginal epithelium to give it its lubricating properties (**Levin and Riley, 2007**).

When arousal is high the distal end of the vagina balloons out and the uterus is elevated away from the posterior vaginal wall (vaginal tenting). This has been proposed as an important feature of reproduction (**Levin and Riley, 2007**).

Some women experience a discharge of fluid from the urethra at orgasm and high levels of sexual arousal, often by stimulation of the so-called G-spot on the anterior wall of the vagina, and this has been termed ‘female ejaculation’. Whether this discharge is urine or a product of the paraurethral glands or a mixture of both continues to be debated (**Levin and Riley, 2007**).

Orgasm is the tantalizingly brief ecstatic pleasure of the sexual climax lasting from 5 to 60 seconds. They can occur without having to be awake as they are experienced in sleep both in men (‘wet dreams’) and women (**Levin and Riley, 2007**).

In women, orgasm is initiated with a transient sensation of ‘suspension’ or ‘stoppage’ and then a thrust of intense clitoral sensual

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awareness that radiates out into the pelvis. This is followed by suffusion of warmth felt first in the pelvic area which then spreads to the rest of the body. Finally, intense pleasure sensations are concomitant with rhythmic clonic contractions of the pelvic muscles. Uterine and anal contractions also occur. Involuntarily groans or vocalizations are often present at each orgasmic contraction and a post-orgasmic feeling of calm and satisfaction from the dissipation of their sexual tension experience. Controversy still exists in relation to the typology of women's orgasms, namely those induced by clitoral or by vaginal stimulation, as claims are made that they are subjectively felt as different. There is now limited physiological evidence that the pelvic/genital muscular contractions are different (**Levin and Riley, 2007**).

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## FGC and Women's Sexuality

Virginity at the time of marriage and fidelity after marriage are vitally important in many cultures that practice FGC. This practice is perceived as the key mechanism for ensuring that girls arrive at their marriage beds untouched. In a society where genital mutilation is perceived to protect virginity, and virginity is directly linked to marriageability, we can begin to understand why genital mutilation might be viewed as an important step to assure future marriage (**Little, 2003**).

Some doctors thought that clitoridectomy was necessary not only to cure such sexual conditions as nymphomania, but also to prevent masturbation, hysteria, epilepsy, melancholia, and insanity. Similar practices in the United States existed as well and, in the United States from the 1880s to the 1950s, excision was performed to supposedly prevent masturbation, frigidity, hysteria, depression, epilepsy, lesbianism, kleptomania, nymphomania, and melancholia. Even into the 1970s, 3,000 such operations were performed (**Watson, 2005**).

In 1979, the Love Surgery was performed on women in the United States. Dr. James E. Burt, the so-called Love Surgeon, introduced "clitoral relocation" (i.e. Sunna circumcision) to the medical establishment. He believed and acted upon the idea that excision does not prevent sexual pleasure but enhances it (**Sarkis, 2003**).

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The effect of FGC on women sexuality is not well known and often it is neglected by gynecologists, urologists and sexologists. Physicians caring for women with FGC have little understanding of the customs, culture and tradition and the roles they play in women's sexual experiences. Sexuality must be considered in the context of the environment in which a woman and her partner live (**Fourcroy, 2006**).

The most of the exciting studies suffer from conceptual and methodological shortcomings, and the available evidence does not support the hypothesis that FGC destroys sexual function or precludes enjoyment of sexual relations (**Obermeyer, 2005**).

FGC has a negative impact on female sexual life, this result agreed with **Ryemer, (2003)** who stated that even if the FGM has resulted in minimal physical damage, the sexual response is often decreased or absent. If the clitoris has been removed, orgasm is impossible (**Ryemer, 2003**).

Most women who have had FGC have problems with penetration following marriage. Sometimes the scar tissue is so thick that penetration is impossible. The scarring may lead to either recutting (this is traditionally done on the night of her wedding) or forced penetration leading to perineal lacerations. If penetration is impossible, anal intercourse may become the substitute, which can lead to fistulae, fissures and fecal incontinence (**Ryemer, 2003**).

Also, **El-Defrawi et al. (2005)** found that the cut women complained

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more significantly of dysmenorrhea (80.5%), vaginal dryness during intercourse (48.5%), lack of sexual desire (45%), being less pleased by sex (49%), being less orgasmic (39%), and less frequency of orgasm (25%), and having difficulty reaching orgasm (60.5%) than the uncut women. This opinion was also in agreement with **Elnashar and Abdelhady, (2007)** who found that FGC has a negative impact on a woman's sexual life. Marital problems were significantly higher among circumcised women. It was revealed that 40.5% of circumcised women had dyspareunia while only 18.8% of non-circumcised women mentioned that. Loss of libido was the complaint of 28.5% and 15.6% of circumcised and non-circumcised women respectively. 17.5% of circumcised women feel their husband's unsatisfaction, compared with 4.7% of those non-circumcised. Regarding wife satisfaction 43% of circumcised women were unsatisfied compared with 10.9% of those non-circumcised.

Being circumcised does not lead to early sexual experience; indeed, being uncircumcised may in fact lead to early sexual experience, an uncircumcised woman is more likely to initiate sexual intercourse than a circumcised girl, and that the frequency of sexual intercourse was more in uncircumcised students than circumcised ones (**Nwajei and Otiono, 2003**).

Cut women were less likely to cite the clitoris, and more likely to identify their breasts, as their most sensitive body part. Genital cutting does not eliminate a woman's sexual sensation, but instead, shifts the point of maximal sexual stimulation from the clitoris or labia to the

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breasts (**Elnashar and Abdelhady, 2007**).

Also, **Okonofu et al. (2003)** stated that the uncut women were significantly more likely to report that the clitoris is the most sexually sensitive part of their body while cut women were more likely to report that their breasts are their most sexually sensitive body parts.

On the other hand, many authors find that FGC may alter rather than eliminate women s' sexual sensations (**Jones et al, 2004**).

The various forms of female genital mutilation are not equally devastating to female sexual response. It is also clear that female sexuality is neither completely destroyed nor unaffected by genital mutilation (**Coren, 2003**).

Also, **Karim and Ammar (1965)** found that woman's sexuality is affected according to the extent of the operation and the degree to which other social messages inhibiting sexual expression are internalized.

Other authors found that FGC is innocent from affecting female sexuality as **Catania et al. (2007)** who suggested that FGC does not necessarily have a negative impact on psychosexual life (fantasies, desire, pleasure, ability to experience orgasm. Their findings suggest that healthy mutilated women, who did not suffer from grave long-term complications and have a good and fulfilling relationship, may enjoy sex. In FGM/C women, when their culture makes them live their mutilation as a positive condition, orgasm is experienced . When there is a cultural conflict, the

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frequency of the orgasm is reduced even if the anatomical and physiological conditions make it possible.

Also, **Rossem and Gage (2007)** found that the type of FGC had a significant zero order effect on the onset of sexual activity and marriage.

In another major study, **Okonofu et al. (2003)** stated that no significant differences between cut and uncut women were observed in the frequency of reports of sexual intercourse, the frequency of early arousal during intercourse and the proportions reporting experience of orgasm during intercourse. FGC in this group of women did not attenuate sexual feelings.

In a study that determined the effect of FGC on coital frequency **Stewart et al. (2002)** found no association between FGC and coital frequency, only coital frequency was higher in more educated women and those who wanted to get pregnant.

About males' preference of cut women **Sakeah et al. (2006)** showed that the illiterate men and those who have been to primary school are more likely to prefer cut women than those with higher education. In addition, ethnicity and religion are also significant factors that influence males' preference to marry cut women.

Variations in sexual behavior, therefore, were unrelated to the type of FGC, but reflected differences in the social characteristics of the participants (**Rossem and Gage, 2007**).

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So women's sexuality must be considered in the context of the environment in which a woman and her partner live. Culture, social customs of the community and religion often determine the acceptance and achievement of a healthy sexual life for both men and women (**Fourcroy, 2006**).

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## **Prospects for Eradication of Female Genital Cutting in Egypt**

As with any self-enforcing social convention, the choice of an individual – in the case of FGC, a single family's choice of whether or not to cut its daughter or daughters – is conditioned by the choice of others. This social pressure tends to perpetuate the practice. It can also be the key to promote rapid collective abandonment. The practice of footbinding in China, for example, which lasted some 1000 years, was abandoned in little more than a generation (**Lewnes, 2005**).

In communities where cutting is a prerequisite for marriage, if only one family abandons FGC, its daughter will not get married. A critical mass is needed to bring about change. Once enough individuals are willing to abandon FGC they will work to convince others to follow suit because this will reduce the social stigma associated with not cutting (**Lewnes, 2005**).

For abandoning female genital cutting there are six key elements for change:

1. A non-coercive and non-judgmental approach whose primary focus is the fulfillment of human rights and the empowerment of girls and women. Communities tend to raise the issue of FGC when they increase their awareness and understanding of human rights and make progress toward the realization of those they consider to be of immediate concern, such as health and education.

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Despite taboos regarding the discussion of FGC, the issue emerges because group members are aware that the practice causes harm. Community discussion and debate contribute to a new understanding that girls would be better off if everyone abandoned the practice.

2. An awareness on the part of a community of the harm caused by the practice. Through non-judgmental, non-directive public discussion and reflection, the costs of FGC tend to become more evident as women – and men – share their experiences and those of their daughters.

3. The decision to abandon the practice as a collective choice of a group that is closely connected in other ways. FGC is a community practice and, consequently, is most effectively given up by the community acting together rather than by individuals acting on their own. Successful transformation of the social convention ultimately rests with the ability of members of the group to organize and take collective action.

4. An explicit, public affirmation on the part of communities of their collective commitment to abandon FGC. It is necessary, but not sufficient, that most members of a community favor abandonment. A successful shift requires that they manifest– as a community – the will to abandon. This may take various forms, including a joint public declaration in a large public gathering or an authoritative written statement of the collective commitment to abandon.

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5. A process of organized diffusion to ensure that the decision to abandon FGC spreads rapidly from one community to another and is sustained. Communities must engage neighboring villages so that the decision to abandon FGC can be spread and sustained. It is particularly important to engage those communities that exercise a strong influence. When the decision to abandon becomes sufficiently diffused, the social dynamics that originally perpetuated the practice can serve to accelerate and sustain its abandonment. Where previously there was social pressure to perform FGC, there will be social pressure abandon FGC. When the process of abandonment reaches this point, the social convention of not cutting becomes self-enforcing and abandonment continues swiftly and spontaneously.

6. An environment that enables and supports change. Success in promoting the abandonment of FGC also depends on the commitment of government, at all levels, to introduce appropriate social measures and legislation, complemented social measures and legislation, complemented by effective advocacy and awareness efforts. Civil society forms an integral part of this enabling environment. In particular, the media have a key role in facilitating the diffusion process. (Lewnes, 2005).

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A number of non-governmental organizations (NGOs) exist in Egypt to combat this practice. A Task Force was formed under the aegis of the National Commission for Population and Development (an NGO) following the 1994 International Conference on Population and Development (ICPD). It is taking a leading role in addressing this issue and reaching the community through various local NGOs. The Task Force meets on a quarterly basis in different parts of Egypt and invites representatives from different local and international organizations that work in this area. The group targets mothers, clinics, family planning centers, secondary school students and young men and women workers. Members of the Task Force continue to teach, raise awareness about the issue and compare notes on successful strategies (**U.S. Department of State, 2001**).

Current efforts have focused on community-based approaches and the Positive Deviance Approach that uses individuals who have deviated from tradition and stopped, prevented or oppose the practice, to advocate for change (**U.S. Department of State, 2001**).

Other NGO activities in 2000 included several seminars on this practice by the National Commission for Population and Development and a seminar by the Population Council for NGOs, donors and researchers with the purpose of sharing experiences in the fight against this practice (**U.S. Department of State, 2001**).

The government and NGOs have used the mass media to disseminate information on the health risks of this practice. Government newspapers and magazines publish stories presenting the views of prominent figures

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in medicine and academia that oppose this practice. The government broadcasts television programs condemning this practice. Senior government officials, including the Minister of Health and Population, have appeared on television to discuss the issue as both a health issue and a religious issue. (**U.S. Department of State, 2001**).

A number of programmes, working at the community level, are protecting girls from FGC. The most successful are participatory in nature and generally guide communities to define the problems and solutions (**Lewnes, 2005**).

Activities carried out by the Coptic Evangelical Organization for Social Services (CEOSS) and the Centre for Education, Development and Population Activities (CEDPA) in Egypt also point to the effectiveness of a holistic, human rights-based approach that enables communities to discuss and subsequently abandon FGC (**Lewnes, 2005**).

Village-level activities support a variety of development projects aimed at empowering communities and individuals in all aspects of life including education, health, income-generation, agriculture and environmental protection (**Lewnes, 2005**).

The experience in the village of Deir el Barsha, in the governorate of Minya in Upper Egypt, demonstrates that change is possible. An external evaluation conducted in 1997-1986 found a clear change in both attitudes and behavior towards FGM/C in the village, with the proportion of uncut girls reaching 50 percent (**Lewnes, 2005**).

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In partnership with CEDPA, UNICEF supports nongovernmental organizations that have organized peer educators and advocates in four governorates of Upper Egypt (Assiut, Sohag, Quena and Minya) and who, with the assistance of religious leaders lead discussion groups and make house-to-house, visits to raise awareness within communities (Lewnes, 2005).

In cooperation with the Egyptian government, USAID Cairo is currently carrying out the following efforts to eradicate this practice:

- Support training on the hazards of this practice as part of reproductive health training programs for Ministry of Health and Population workers who provide family planning services through a network of 3,800 clinics in all 27 governorates.

- The "Healthy Mother/Healthy Child" project, which focuses on in-service training for physicians, nurses and social workers, includes anti-FGC activities. Recent activities included preparation of a short documentary video featuring testimonials against this practice by five women for use in group discussions, as well as an accompanying guide for facilitators. The Child Survival Project that preceded the "Healthy Mother/Healthy Child" project incorporated information on the hazards of the practice into training courses for traditional birth attendants (TBAs) who frequently perform the procedure. Between 1985 and 1996 approximately 14,000 TBAs, located throughout Egypt, received this training.

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-A USAID grant to the Research, Action and Information Network for Bodily Integrity of Women (RAINBO) supported work with Egypt's FGC Task Force to develop training materials, including a manual with a major section on common beliefs and misconceptions about the practice, for community workers with a low level of literacy.

-USAID has provided funding to a UNICEF safe motherhood program with a major component on this practice; a Center for Development and Population Activities (CEDPA) project aimed at eradication of this practice in Fayyoun governorate and a project with CEDPA and the Coptic Evangelical Organization for Social Services to produce and air video programs on the harmful effects of this practice and the importance of eradicating the practice.

The U.S. Embassy's Participating Agency Support Agreement program funded several workshops and publications for public awareness on this practice by the ISIS Center in Aswan in 1999-2000, as well as a series of health awareness workshops (including anti-FGC materials) for adolescent girls by the Egyptian Women's Medical Association in 2000.

Egyptian activists working on the subject are beginning to shift efforts from an approach based on health concerns (that appears to have caused parents to resort increasingly to doctors rather than TBAs to perform the procedure), to one based on bodily integrity and women's status. Activists also are focusing on transforming the attitudes of entire communities rather than just of individuals, due to families' continuing concern about marriageability for their daughters (**U.S. Department of State, 2001**).

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## Legal Aspects

The legislative background has changed over the years. In 1959, a ministerial decree forbade the practice and made it punishable by fine and imprisonment. A series of later ministerial decrees allowed certain forms but prohibited others. Doctors were also prohibited from performing the procedure in government health facilities. Non-medical practitioners were forbidden from practicing any form.

In 1994, due to public outcry over a CNN television broadcast of the procedure performed on a nine year old girl by a barber, the then-Minister of Health decreed that the procedure should be performed one day per week in government facilities but only by trained medical personnel, if they failed to persuade the parents against it. He rescinded his decision in 1995, however, after various protests and international outcry deploring the "medicalization" of the practice.

In December 1997, the Court of Cassation (Egypt's highest appeals court) upheld a government ban on the practice of FGC. Issued as a decree by the Health Minister in 1996, the ban prohibits all medical and non-medical practitioners from performing FGC in either public or private facilities, except for medical reasons certified by the head of a hospital's obstetric department. Perpetrators are subject to the loss of their medical licenses and can be subjected to criminal punishments. In cases of death, perpetrators are also subject to charges of manslaughter under the Penal Code.

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There have been press reports on the prosecution of at least 13 individuals under the Penal Code, including doctors, midwives and barbers, accused of performing FGC that resulted in hemorrhage, shock and death. We cannot confirm these reports (**U.S. Department of State, 2001**).

Major international conferences have supported governments in their efforts to introduce appropriate national legislation and social mobilization initiatives on FGC. In June 2003, the Afro-Arab Expert Consultation on Legal Tools for the Prevention of Female Genital Mutilation served to define both legal content and strategies for more effective legislation to prevent FGC. The resulting “Cairo Declaration” makes 17 concrete recommendations, including that government adopt specific legislation addressing FGC, and that these laws be one component of a multi-disciplinary approach to stopping the practice. The declaration also recommends that governments and NGOs work together to support an ongoing process of social change leading to the adoption of legislation against FGC (**Lewnes, 2005**).

Egypt's health ministry announced 28<sup>th</sup> June 2007 that it would close a legal loophole allowing FGC days after a 12-year-old girl died from the procedure. Although FGM was officially banned in Egypt in 1997, the practice was still legal when deemed medically necessary by a doctor and has continued largely unimpeded throughout the country (**Feminist Daily News, 2007**).

In the wake of the death of 12-year-old Bedur Ahmed Shaker Health

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Minister Hatem al-Gabali issued a "permanent ban" on FGM, prohibiting every medical professional in public or private practice from performing the procedure. In a statement, he said any genital cutting "will be viewed as a violation of the law and all conventions will be punished," (**Feminist Daily News, 2007**).

The national council for childhood and motherhood (NCCM) had established a hotline number 16000 for any information or questions on FGC. Religious, medical and psychological experts will be manning the telephon 24 hours a day (**AL-Ahram Weekly, 2007**).

Under the new child law, which the Shoura Council passed, performing female genital mutilation is punishable by three months to two years in prison and a fine of LE 1,000 to LE 5,000 (**Daily News Egypt, 2008**).

## ختان الإناث في الإسلام

### الآراء التي تؤيد الختان:

يقول الشيخ جاد الحق على جاد الحق مفتى الديار المصرية الأسبق: في فقه الإمام أبي حنيفة والمشهور في فقه الإمام مالك أن الختان للرجال سنة ، وهو من الفطرة ، وللنساء مكرمة. و الإمام الشافعي يرى إن الختان واجب على الرجال والنساء. و الإمام أحمد بن حنبل يرى أن الختان واجب على الرجال ومكرمة في حق النساء وليس بواجب عليهن ، وفي رواية أخرى عنه أنه واجب على الرجال والنساء . كمذهب الإمام الشافعي .

و خلاصة هذه الأقوال إن الفقهاء اتفقوا على أن الختان في حق الرجال والخفاض في حق الإناث مشروع . ثم اختلفوا في وجوبه ، فقال الإمامان أبو حنيفة ومالك هو مسنون في حقهما وليس بواجب وجوب فرض ولكن يأثم تاركه بتركه (ولكن السنة عندهم يأثم تاركها ، فهم يطلقونها على مرتبة بين الفرض والندب ) ، وقال الإمام الشافعي هو فرض على الذكور والإناث ، وقال الإمام أحمد هو واجب في حق الرجال . وفي النساء عنه روايتان أظهرهما الوجوب . والختان في شأن الرجال قطع الجلد التي تغطي الحشفة ، بحيث تنكشف الحشفة كلها . وفي شأن النساء قطع الجلد التي فوق مخرج البول دون مبالغة في قطعها ودون استئصالها ، وسمى بالنسبة لهن خفاضاً.

وقد استدلل الفقهاء على خفاض النساء بحديث أم عطية رضي الله عنها قالت إن امرأة كانت تختن بالمدينة ، فقال لها النبي صلى الله عليه وسلم ( لا تنهكي ، فإن ذلك أحظى للزوج ، وأسرى للوجه ) (1) ، وجاء ذلك مفصلاً في رواية أخرى تقول ( إنه عندما هاجر النساء كان فيهن أم حبيبة ، وقد عرفت بختان الجوارى ، فلما رآها رسول الله صلى الله عليه وسلم قال لها يا أم حبيبة هل الذي كان في يدك ، هو في يدك اليوم . فقالت نعم يا رسول الله ، إلا أن يكون حراماً ففتنهاني عنه . فقال رسول الله صلى الله عليه وسلم بل هو حلال . فادن مني حتى أعلمك فدنت منه . فقال يا أم حبيبة ، إذا أنت فعلت فلا تنهكي ، فإنه أشرق للوجه وأحظى للزوج ) (1) ومعنى ( لا تنهكي ) لا تبالغى في القطع والخفض. ويؤكد هذا الحديث الذي رواه أبو هريرة رضي الله عنه أن الرسول صلى الله عليه وسلم قال ( يا نساء الأنصار اختفضن ( أى اختتن ) و لا تنهكن ( أى لا

(1) رواه أبو داود في السنن وقال عنه ضعيف

تبالغن في الخفاض ) وهذا الحديث جاء مرفوعا برواية أخرى عن عبد الله بن عمر رضى الله عنهما (1).

وهذه الروايات وغيرها تحمل دعوة الرسول صلى الله عليه وسلم إلى ختان النساء ونهيه صلى الله عليه وسلم عن الاستئصال . وقد علل هذا في إيجاز وإعجاز ، حيث أوتى جوامع الكلم فقال ( فإنه أشرق للوجه وأحظى للزوج ) . وهذا التوجيه النبوى إنما هو لضبط ميزان الحس الجنسى عند الفتاة فأمر بخفض الجزء الذى يعلو مخرج البول ، لضبط الاشتهاة ، والإبقاء على لذات النساء ، واستمتاعهن مع أزواجهن ، ونهى عن إبادة مصدر هذا الحسن واستئصاله ، وبذلك يكون الاعتدال فلم يعدم المرأه مصدر الاستمتاع والاستجابة ولم يبقها دون خفض فيدفعها إلى الاستهتار ، وعدم القدرة على التحكم فى نفسها عند الإثارة . لما كان ذلك كان المستفاد من النصوص الشرعية ، ومن أقوال الفقهاء على النحو المبين والثابت فى كتب السنة والفقه أن الختان للرجال والنساء من صفات الفطرة التى دعا إليها الإسلام وحث على الالتزام بها على ما يشير إليه تعليم رسول الله صلى الله عليه وسلم كيفية الختان ، وتعبيره فى بعض الروايات بالخفض ، مما يدل على القدر المطلوب فى ختانهن .

قال الإمام البيضاوى إن حديث ( خمس من الفطرة ) (2) عام فى ختان الذكر والأنثى وقال الشوكانى فى نيل الأوطار إن تفسير الفطرة بالسنة لا يراد به السنة الاصطلاحية المقابلة للفرض والواجب والمندوب ، وإنما يراد بها الطريقة ، أى طريقة الإسلام ، لأن لفظ السنة فى لسان الشارع أعم من السنة فى اصطلاح الأصوليين . ومن هنا اتفقت كلمة فقهاء المذاهب على أن الختان للرجال والنساء من فطرة الإسلام وشعائره ، وأنه أمر محمود ، ولم ينقل عن أحد من فقهاء المسلمين فيما طالعنا من كتبهم التى بين أيدينا - القول بمنع الختان للرجال أو النساء ، أو عدم جوازه أو إضراره بالأنثى ، إذا هو تم على الوجه الذى علمه الرسول صلى الله عليه وسلم لأم حبيبة فى الرواية المنقولة آنفا . أما الاختلاف فى وصف حكمه ، بين واجب وسنة ومكرمة ، فيكاد يكون اختلافا فى الاصطلاح الذى يندرج تحته الحكم . يشير إلى هذا ما نقل فى فقه الإمام أبى حنيفة من أنه لو اجتمع أهل مصر (بلد) على ترك الختان ، قاتلهم الإمام ( ولى الأمر ) لأنه من شعائر الإسلام وخصائصه . كما يشير إليه أيضا أن مصدر تشريع الختان هو اتباع ملة إبراهيم ، وقد اختتن ، وكان الختان من شريعته ، ثم عده الرسول صلى الله

(1) ضعيف رواه البزار و البيهقى فى شعب الایمان.

(2) متفق عليه



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عليه وسلم من خصال الفطرة ، وأميل إلى تفسيرها بما فسر لها به الشوكاني -  
حسبما سبق - بأنها السنة التي هي طريقة الإسلام ومن شعائره وخصائصه ، كما  
جاء في فقه الحنفيين .

وإذا قد استبان مما تقدم أن ختان البنات من فطرة الإسلام وطريقته على الوجه  
الذي بينه رسول الله صلى الله عليه وسلم ، فإنه لا يصح أن يترك توجيهه وتعليمه  
إلى قول غيره ولو كان طبيبا ، لأن الطب علم والعلم متطور ، تتحرك نظريته  
ونظرياته دائما ، ولذلك نجد أن قول الأطباء في هذا الأمر مختلف . فمنهم من يرى  
ترك ختان النساء ، وآخرون يرون ختانهن ، لأن هذا يهذب كثيرا من إثارة الجنس  
لا سيما في سن المراهقة التي هي أخطر مراحل حياة الفتاة ، ولعل تعبير بعض  
روايات الحديث الشريف في ختان النساء بأنه مكرمة يهدينا إلى أن فيه الصون ، ،  
انه طريق للعفة ، فوق أنه يقطع تلك الإفرازات الدهنية التي تؤدي إلى التهابات  
مجرى البول وموضع التناسل ، والتعرض بذلك للأمراض الخبيثة .

هذا ما قاله الأطباء المؤيدون لختان النساء . وأضافوا أن الفتاة التي تعرض  
عن الختان تنشأ من صغرها وفي مراهقتها حادة المزاج سيئة الطبع ، وهذا أمر قد  
يصوره لنا ما صرنا إليه في عصرنا من تداخل وتزاحم ، بل وتلاحم بين الرجال  
والنساء في مجالات الملاصقة والزحام التي لا تخفى على أحد ، فلو لم تقم الفتاة  
بالاختتان لتعرضت لمثيرات عديدة تؤدي بها - مع موجبات أخرى ، تذخر بها حياة  
العصر ، وانكماش الضوابط فيه - إلى الانحراف والفساد .

وإذا كان ذلك فما وقت الختان شرعا اختلف الفقهاء في وقت الختان فقل حتى  
يبلغ الطفل ، وقل إذا بلغ تسع سنين . وقل عشرا ، وقل متى كان يطيق ألم الختان  
وإلا فلا والظاهر من هذا أنه لم يرد نص صريح صحيح من السنة بتحديد وقت  
للختان ، وأنه متروك لولى أمر الطفل بعد الولادة - صبيا أو صبية - فقد ورد أن  
النبي صلى الله عليه وسلم ختن الحسن والحسين رضى الله عنهما يوم السابع من  
ولادتهما ، فيفوض أمر تحديد الوقت للولى ، بمراعاة طاقة المختون ومصلحته ( **دار الافتاء المصرية، 2007** ) .

### **الآراء التي تحرم الختان:**

أكد د. على جمعة مفتى الديار المصرية أن ختان الإناث يعد عدوانا على النفس  
يستوجب القصاص الشرعى من مرتكبه لقول الرسول صلى الله عليه وسلم لا ضرر  
ولا ضرار فى الإسلام مشيرا إلى أن دار الافتاء المصرية كانت قد

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أصدرت فتوى فى هذا الشأن خلال عهد د.نصر فريد واصل المفتى الأسبق  
(جريدة الراية القطرية، 2007).

وأكدت د. آمنة نصير أستاذة الفلسفة الإسلامية بجامعة الأزهر أن رأي الدين قد أقحم لكي يبقى هذا الموروث البيئي قائماً ولو كانت عادة حقيقية لنزل بها القرآن فهناك 80% من العالمين العربي والإسلامي ليس لديهم ختان مثلما يحدث في مصر والسودان وكل ما حدث أنه جري الاعتماد علي حديث ضعيف لا ينضم الي سنة صحيحة ولا يؤسس فرضاً علي ضرورة ختان الفتاة وهو حديث الرسول صلي الله عليه وسلم لأم عطية عندما سألها مستكراً أما زلت تفعلين وردت نعم فقال لها اذا كنت تفعلين فاخفضي ولا تنهكي.

وقالت د. آمنة نصير انه جري التحايل علي هذا النص ودفعناه بقوة ووضعناه في قالب عقلي لكي تنتشر هذه العادة السيئة مشيرة الي أنها تنادي منذ ربع قرن مضي بضرورة إصدار قانون يجرم ممارسة عادة ختان الإناث (جريدة الراية القطرية، 2007).

#### الآراء الوسطية:

قال د. أحمد عمر هاشم رئيس جامعة الأزهر السابق و رئيس لجنة الشؤون الدينية بمجلس الشعب ان أعضاء مجمع البحوث الإسلامية لم يقولوا بتحريم الختان وإنما تحدثوا عن منعه لما يترتب عليه من أضرار خاصة أنه لا توجد أحاديث صحيحة بتحليله أو تحريمه.

وقال د. محمد رأفت عثمان عضو مجمع البحوث الإسلامية إنه لا يوجد نص صريح في الشريعة الإسلامية يحرم ختان الإناث مشيراً الي أن كل ما يستند اليه القانون بوجوب ختان الإناث هو حديث أم عطية حينما قال لها رسول الله صلي الله عليه وسلم أشمي ولا تنهكي ارتفعي بموضع الختان ولا تجوري عليه. وأوضح د. عثمان أن علماء الحديث أثبتوا ضعف هذا الحديث وحتى علي فرض ثبوته فإن الرسول صلي الله عليه وسلم لم يأمر بالختان وإنما نصح باتباع الطريقة التي يتم بها.

ومن جانبه قال الشيخ علي أبو الحسن مستشار شيخ الأزهر لشؤون الفتوى ان الرسول صلي الله عليه وسلم لم ينه او يحرم ختان الاناث وإنما قال بعض الأحكام المتعلقة به للدلالة علي جوازه اذا اقتضي الأمر. وقال لم يثبت وجود أي حديث

شريف للرسول صلى الله عليه وسلم ينهي عن الختان وإنما الذي يثبت فيه وجود بعض الأحاديث التي تفيد الاشمام حتي يقلل شيئاً من طاقة المرأة أو إقبالها علي الشهوة ( جريدة الراية القطرية، 2007).

ويقول فضيلة الدكتور يوسف القرضاوي عن الختان:  
هو مندوب في حق المرأة عند المالكية. وعند الحنفية والحنابلة - في رواية يعتبر ختان المرأة مكرمة وليس سنة. وذهب الشافعية والحنابلة في الرواية الأشهر إلي أن الختان واجب علي الجنسين: الذكر والأنثي جميعاً. واستدلوا علي وجوبه بقوله تعالى: (ثُمَّ أَوْحَيْنَا إِلَيْكَ أَنْ اتَّبِعْ مِلَّةَ إِبْرَاهِيمَ حَنِيفاً وَمَا كَانَ مِنَ الْمُشْرِكِينَ) النحل : 123

وقد ثبت في الصحيحين: أن إبراهيم عليه السلام اختتن وهو ابن ثمانين بالقدم (1). وناقش بعضهم الاستدلال بالآية علي الوجوب، وقال النووي: الآية صريحة في اتباعه فيما يفعله، وهذا يقتضي إيجاب كل فعل فعله، إلا ما قام الدليل علي أنه سنة في حقنا كالسواك ونحوه.

كما استدلوا بأنه لو لم يكن الختان واجبا لما جاز كشف العورة من أجله للختان. وأرد علي هذا الاستدلال: أنه يجوز كشف العورة للمداواة التي لا تجب، ما دامت المصلحة فيها راجحة علي المصلحة في المحافظة علي المروءة وصيانة العورة. واستدل بعضهم: أن الختان من شعار المسلمين فكان واجبا، كسائر شعاراتهم. وهناك قول ثالث، ذكره ابن قدامة في (المغني) وهو: أن الختان واجب علي الرجال، ومكرمة في حق النساء، وليس بواجب عليهن.

وأنا أرجح القول الأول، الذي يري أنه سنة شعائرية مميزة بالنسبة للرجال، ومكرمة للنساء، وأري أنه قريب من القول الثالث الذي يري وجوبه علي الرجال.

مناقشة أدلة الوجوب:

علي أن أدلة الوجوب كلها لا تسلم من المناقشة، والأمر باتباع ملة إبراهيم لا يعني الأمر باتباع جزئيات شريعته وتفصيلها، ولهذا لم يذكر في القرآن أي شيء عن هذه الفرعات، إنما المراد: اتباعه في إقامة التوحيد والدفاع عنه، والدعوة إليه بالحجة والحكمة، كما نري ذلك في دعوة إبراهيم لأبيه وقومه، ورده علي محاجتهم له، ومبادرة إبراهيم في التسليم لأمر الله، كما في ذبح ولده إسماعيل. فالاتباع في هذا هو المطلوب، وقد قال تعالى: (قَدْ كَانَتْ لَكُمْ أُسْوَةٌ حَسَنَةٌ فِي

(1) واختلفوا: هل (القدم) اسم بلد بالشام، أو هي آلة النجار المعروفة

إِبْرَاهِيمَ وَالَّذِينَ مَعَهُ إِذْ قَالُوا لِقَوْمِهِمْ إِنَّا بُرَاءُ مِنْكُمْ وَمِمَّا تَعْبُدُونَ مِنْ دُونِ اللَّهِ كَفَرْنَا بِكُمْ وَبَدَا بَيْنَنَا وَبَيْنَكُمُ الْعَدَاوَةُ وَالْبَغْضَاءُ أَبَدًا حَتَّى تُؤْمِنُوا بِاللَّهِ وَحْدَهُ (الممتحنة: 4). وعليه آية حال، نري المسلمين عامة لا يقصرون في الختان للذكور في جميع الأقطار.

ولكن القول بالوجوب قد يكون فيه تشديد علي الداخلين الجدد في الإسلام. وقد حدثني وزير الشؤون الدينية في إندونيسيا في أول زيارة لي إليها في أواسط السبعينيات من القرن العشرين: أن قبيلة كبيرة من قبائل إندونيسيا أرادوا الدخول في الإسلام، فاتصل زعمائهم ببعض كبار المشايخ من المسلمين، ليعرفوا منهم: ماذا يطلب منهم من طقوس للدخول في دين الإسلام. فما كان من هؤلاء المشايخ إلا أن قالوا لهم أول ما يطلب منكم أن تختنوا جميعا! وكانت النتيجة المؤسفة أن القوم توجسوا من هذه الجراحة الجماعية، وأعرضوا عن الإسلام، وخسرهم المسلمون، وبقوا علي الوثنية البدائية. وذلك أن مذهب هؤلاء المشايخ هنا هو المذهب الشافعي، وهو أشد المذاهب في قضية الختان. ومعني أنه مكرمة: أنه شيء مستحسن عرفا لهن، وأنه لم يجئ نص من الشارع بإيجابه ولا استحبابه.

رأينا في ختان النساء:

ورأيي: أن كل ما استدلوا به علي الوجوب أو السنية لا يدخل فيه النساء. ولا يوجد دليل صحيح من الأحاديث يدل علي الوجوب أو السنية بالنسبة لهن. أما حديث (إذا التقى الختانان وجب الغسل)(1) فهو يدل علي أن النساء كن يختن، أي علي جواز الختان، وهو ما لا نجادل فيه، إنما نجادل في الوجوب أو السنية.

حديث أم عطية:

وأما حديث أم عطية عند أبي داود: أن امرأة كانت تختن بالمدينة، فقال لها النبي صلي الله عليه وسلم: لا تنهكي، فإن ذلك أحظي للمرأة، وأحب إلي البعل فإن أبا داود قال عن محمد بن حسان - أحد رواة - مجهول، والحديث ضعيف. وقد روي هذا الحديث من طرق كلها ضعيفة، وإن صححه بتعدد الشيوخ الألباني، ولكن في النفس شيء من هذا التصحيح، فإن هذا أمر يهم كل بيت مسلم، وهو مما تتوافر الدواعي علي نقله، فلماذا لم ينقل إلا بهذه الطريقة الضعيفة؟

علي أننا لو سلمنا بصحة الحديث، فما الذي يفيد هذا الأمر النبوي: أهو أمر إيجاب أم أمر استحباب أم أمر إرشاد؟ الأرجح أن الأمر في مثل هذه الأمور

(1) صحيح رواه أحمد. وفي مسلم بلفظ: ومس الختان الختان

للإرشاد، ولا يدل علي أصل الوجوب أو السنية، لأنه يتعلق بتدبير أمر دينوي، وتحقيق مصلحة بشرية للناس، حددها الحديث بأنها: نضارة الوجه للمرأة، والحظوة عند الزوج. فهو يرشد عند وقوع الختان علي استحباب عدم الإنهاك والمبالغة في

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القطع، لما وراء ذلك من فائدة ترتجي، وهو أنه أحظي للمرأة عند الجماع، وأحب إلي زوجها أيضا. ولكنه يدل علي إقرار الخاتنة علي هذا الختان أو الخفاض كما يسمى وأنه أمر جائز، وهو ما لا ننكره.

علي أن الذي أراه وأرجحه هنا: أن الختان للبنات ليس بواجب ولا سنة، وإنما هو أمر جائز مباح، والمباحات يمكن أن تمنع إذا ترتب علي استعمالها ضرر، بناء علي قاعدة: لا ضرر ولا ضرار . كما يمكن أن تبقي وتطور ويحسن أداؤها، وهو ما أشار إليه حديث أشمي ولا تنهكي.

وهذا أمر يجب أن يخضع للبحث والدراسة، فإذا أثبتت الدراسة الموضوعية من قبل الخبراء والمتخصصين المحايدين، الذين لا يتبعون هواهم، ولا أهواء غيرهم: أن الختان يضر بالإناث، ضررا مؤكدا: وجب إيقاف هذا الأمر، ومنع هذا المباح، سدا للذريعة إلي الفساد، ومنعا للضرر والضرار. وإذا ثبتت الحاجة إلي بعض الإناث، وفق تشخيص الطبيب المختص: وجب أن تستثنى تحقيقا للمصلحة ودرءا للمفسدة. فالذي نخرج به من هذا: أن الختان للمرأة مباح بشرط عدم الإنهاك والمبالغة في القطع، وإنما يقطع منها شيء من الطرف. وإذا كان من الأمور المباحة، فإن المباحات قد تمنع أحيانا لمصلحة راجحة، كما تمنع إذا كان في بقائها مفسدة خاصة أو عامة (الدكتور يوسف القرضاوي، 2007) .

## Materials and Methods

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This study included 150 married women attending the family planning center located in maternal and childhood center in Damanhour. They were informed about the nature of the study and asked to participate. Other than those 150 women, there were 3 unfinished interviews where one woman refused to participate and two women stopped the interview before completing it. Face to face interviews were conducted with participants after obtaining their approval.

Those women were divided into 2 groups:

- 50 genitally uncut women; the control group.
- 100 genitally cut women.

All investigated women were healthy and randomly selected after being examined by female gynecologist to exclude major complications.

Exclusion criteria were: severe complications such as fistulae, big cysts and severe infections of urogenital tract.

At the time of interview; all women were sexually active (married and living with their husbands).

The study was done using face to face interview, not using sheet filled by the women alone. This method was used to permit more contact with the women and more understanding of their answers. Also to take into consideration the unpredicted answers given by some women. The questionnaire was asked in Arabic terms in common usage in Egypt, and the more common words used to describe sexuality and all aspects regarding this topic.

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The instrument used was 33 items questionnaire developed by the investigators. The questions asked were:

- 1- Age.
- 2- Other marriages.
- 3- Residence (Rural or urban).
- 4- Education (Illiterate, read and write, secondary school, university degree)
- 5- Who performed the operation (Medical doctor, nurse, dayas, barber, other).
- 6- At about what age?
- 7- Was it under anesthesia?
- 8- What were the complications after the operation? (Pain, hemorrhage, infection, urinary problem, none).
- 9- If you were to choose for yourself would you be circumcised?
  - Yes (tradition, religion, chastity, cleanliness, esthetic, marriage)
  - No
- 10- Would your daughter be circumcised? (Yes, no).
- 11- If yes who makes the decision? (Mother, father, grandmother, others).
- 12- What motivates you to have sexual intercourse? (Duty, get pleasure, be pregnant, pleasure for husband, not to let husband marry another wife, other).
- 13- Do you have sexual desire or interest? (Yes, no).
- 14- If you have interest, what provokes your desire? (Your husband and you co-operate, yourself, others).
- 15- If never why don't you think about sex? (Disgusting, it makes no difference, fear, pain, hostility).
- 16- How often do you feel sexual desire or interest during sexual

- 
- intercourse? (Frequent, infrequent, never).
- 17- How often do you have sexual intercourse? (Daily, 3-6/w, 1-2/w, <once/month)
- 18- Does that frequency suit you? (Yes, no, want less, want more).
- 19- Do you have enough foreplay? (Yes, no, want less, want more).
- 20- Which part you need more to be stimulated during foreplay? (Genital, breast, neck, tongue, skin).
- 21- Do you have difficulty to become lubricated during sexual intercourse? (Yes, no).
- 22- Does your husband have any sexual problem? (Yes, no).
- 23- How often do you reach orgasm? (Frequent, infrequent, never)
- 24- What is the preferred position to reach orgasm? (Missionary, woman on top, rear entry, position makes no difference).
- 25- What is your best way to reach orgasm? (Vaginally, externally, both).
- 26- Do you have multiple orgasms? (Yes, no).
- 27- Did you reach orgasm by masturbation before or after marriage? (Yes, no).
- 28-Do you have spontaneous orgasm? (Yes, no).
- 29-Do you practice anal sex? (Yes, no).
- 30-Do you fake orgasm? (Yes, no).
- 31-Do you experience discomfort or pain during or following vaginal penetration? (Yes, no).
- 32-What is the cause of that pain? (Vaginally, externally, trauma by the husband).
- 33- How satisfied have you been with your overall sexual life? (High, moderate, low, none).
-



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## **Results**

**Epidemiological data:**

**Table (2) Age and FGC**

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Age	No	%	Total No.
<20			
Cut	20	66.7	30
Uncut	10	33.4	
21-30			
Cut	58	74.4	78
Uncut	20	25.6	
31-40			
Cut	14	41.2	34
Uncut	20	58.8	
>40			
Cut	8	100	8
Uncut	-	-	

FGC was decreasing in incidence.

**Table (3) Residence and FGC**

Residence	No	%
Rural:		
Cut	70	70
Uncut	0	0
Urban:		
Cut	30	30
Uncut	50	100

FGC was commoner in rural than in urban areas.

**Table (4) Education and FGC**

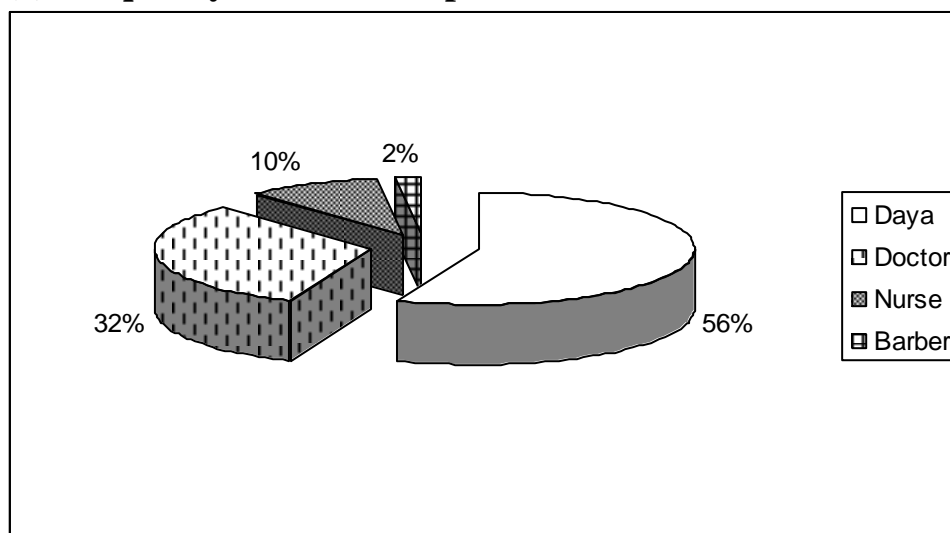
Education	Total No.	No	%
Illiterate:			
Cut	28	28	100
Uncut		-	-

Read & write:			
Cut	4	4	100
Uncut		-	-
Secondary school:			
Cut	50	50	100
Uncut		-	-
University:			
Cut	68	18	26.5
Uncut		50	73.5

Incidence of female genital cutting decreased with increase in level of education.

### Data related to the practice of FGC:

**Fig. (7) Frequency of different operators of FGC**



The majority of cases were cut by traditional birth attendant (daya) followed by doctors.

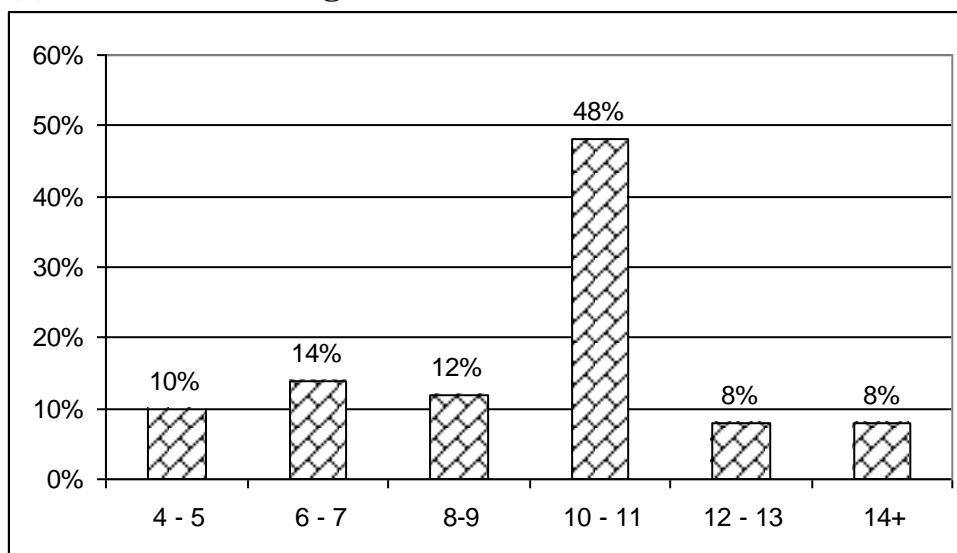
**Table (5) Relation between age and performer of FGC**

Age	Total No.	Doctor	%	Nurse	%	Daya	%	Barber	%
<20: Cut	20	8	40%	6	30%	6	30%	-	-

21-30 Cut	58	20	34.5%	2	3.4%	34	58.6%	2	3.4%
31-40 Cut	14	4	28.6%	2	14.3%	8	57.1%	-	-
>40: Cut	8	-	-	-	-	8	100%	-	-

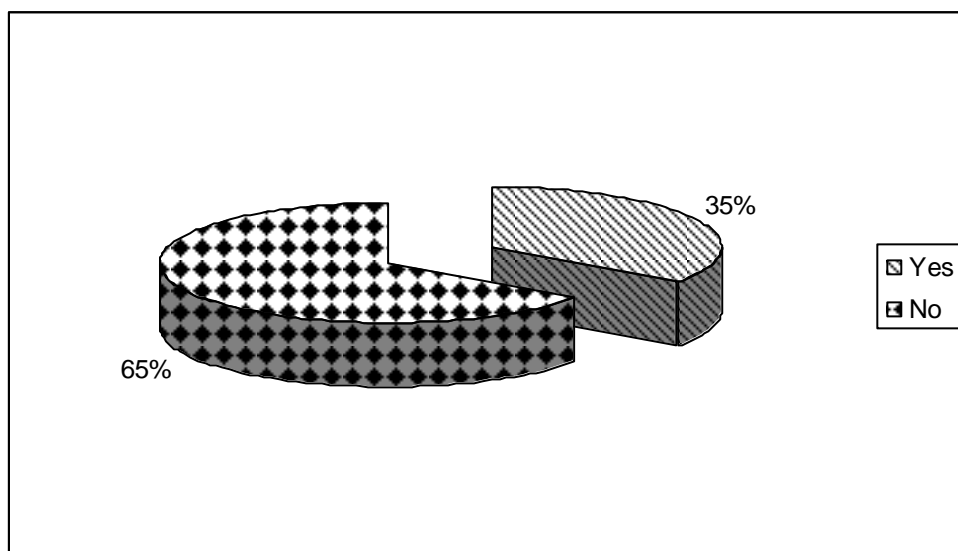
For young age there was an increased incidence for cutting to be performed by doctors but for older women the upper hand was for dayas.

**Fig. (8) Distribution of age at time of FGC**



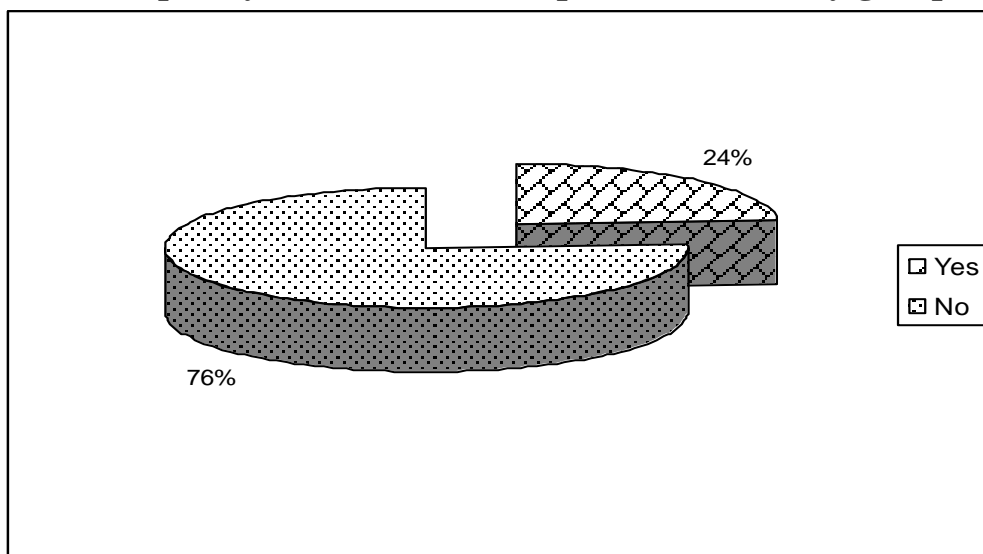
The commonest age at which cutting was performed was 10-11 years.

**Fig. (9) Anesthesia during FGC**



The majority of cases were performed without anesthesia.

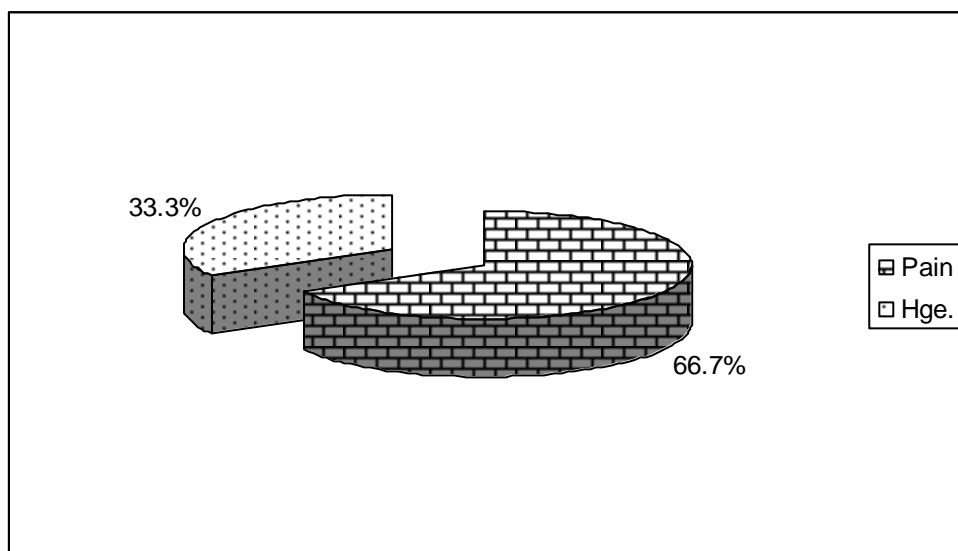
**Fig. (10) Frequency of short term complications in study group**



Most patients did not suffer from short term complications.

**Fig. (11) Types of short-term complications**

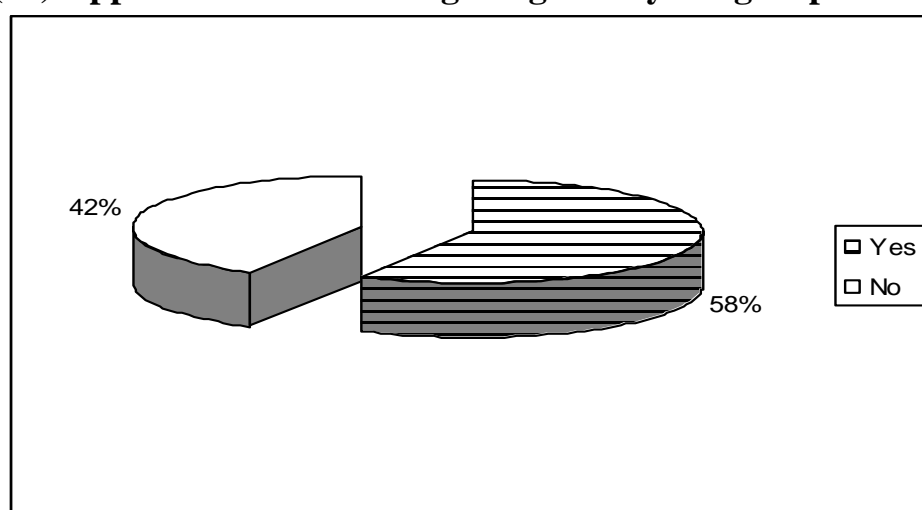
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The main complication was pain then hemorrhage. None reported infection or urinary problems.

#### Data related to attitude toward FGC:

**Fig. (12) Approval of FGC among the genitally cut group.**



The majority of cases approved FGC.

**Table (6) Relation between age and approval of FGC**

Age	Total no.	Yes	%	No	%
<20:					
Cut	20	14	70	6	30
Uncut	10	-	-	10	100
21-30:					
Cut	58	32	55.2	26	44.8
Uncut	20	2	10	18	90
31-40:					
Cut	14	8	57.1	6	42.9
Uncut	20	-	-	20	100
>40					
Cut	8	4	50	4	50
Uncut	-	-	-	-	-

Old cut women had less approval for cutting than younger ones.

**Table (7) Relation between residence and approval**

	Rural	%	Urban	%
Yes	46	65.7	12	40
No	14	34.3	18	60
Total	70		30	

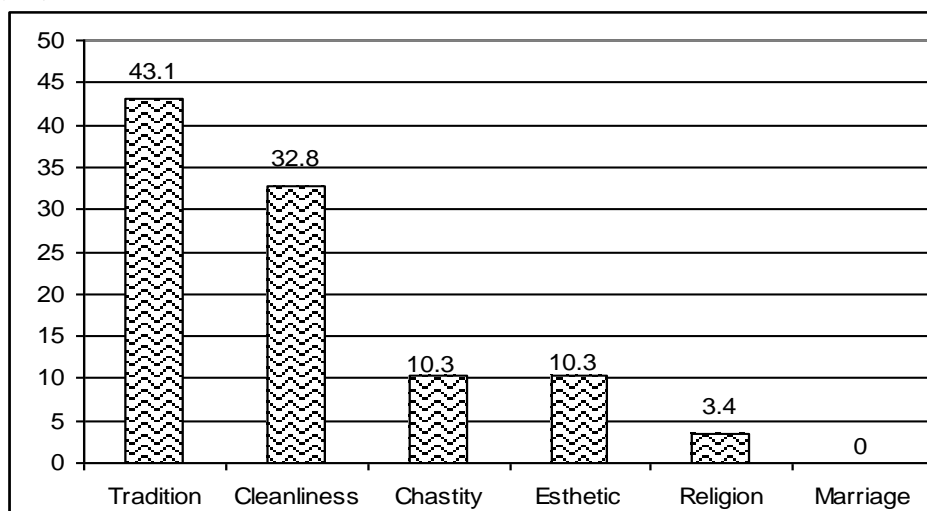
Cut women from rural areas agreed with cutting more than those from urban areas.

**Table (8) Relation between education and approval**

	Illiterate	%	R&W	%	2ndry	%	University	%
Yes	16	57.1	2	50	30	60	10	55.6
No	12	42.9	2	50	20	40	8	44.4
Total	28		4		50		18	

More approval for cutting was found between 2ndry school and illiterate women.

**Fig. (13) Causes of FGC**



Tradition was the main cause of FGC followed by cleanliness.

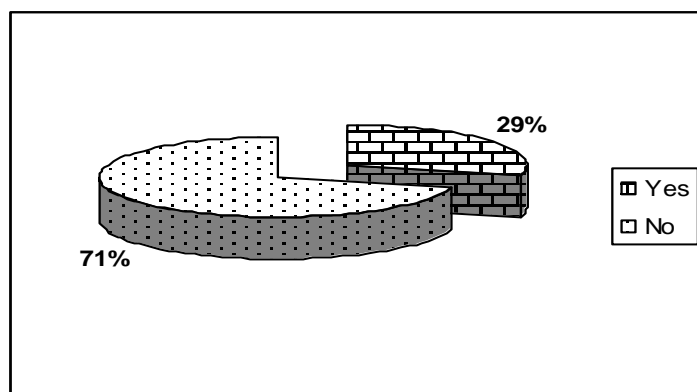
**Table (9) Relation between education and reasons for FGC**

	Illiterate	%	R&W	%	2ndry	%	University	%
Tradition	14	87.5	2	100	8	26.7	2	20
Cleanliness	2	12.5	-	-	14	46.7	2	20
Chastity	-	-	-	-	4	13.3	2	20
Esthetic	-	-	-	-	2	6.7	4	40
Religion	-	-	-	-	2	6.7	-	-
Marriage	-	-	-	-	-	-	-	-
Total	16		2		30		10	

For illiterate and read and write (R&W) women tradition was the most important reason. For 2ndry school women it was cleanliness. For university women it was esthetic.

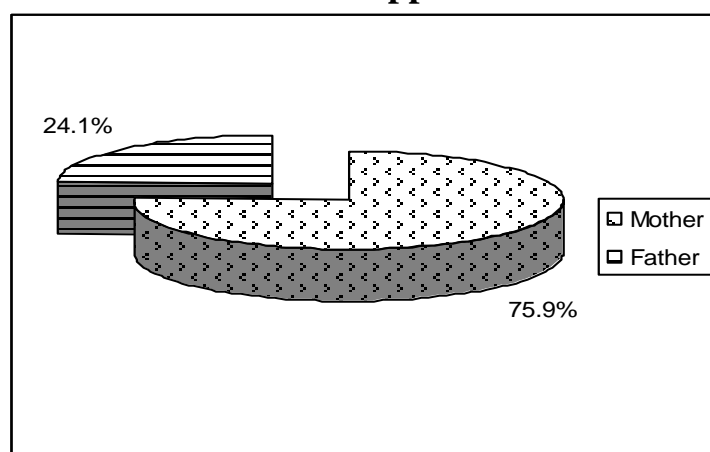
**Fig. (14) Approval of cutting for their daughters**





The majority of cases refused cutting for their daughter.

**Fig. (15) Decision maker in case of approval**



Mothers were the main decision maker, fathers played a minor role.

**Data related to sexual desire:**

**Table (10) Motives to have sex in cut and uncut women**

Motives	NO.	%
Duty:		
Cut	33	33
Uncut	16	32
To get pleasure:		
Cut	68	68
Uncut	46	92
To be pregnant:		
Cut	7	7
Uncut	-	-
Giving pleasure to husband:		
Cut	68	68
Uncut	14	28
Not to marry another wife:		
Cut	2	2
Uncut	-	-

The most important motive to have sex for cut women was to give pleasure to husband and to receive pleasure, but for uncut women it was to get pleasure. Most women gave more than one motive to have sex.

**Table (11) Relation between education and motives to have sex**

	Illiterate Total no. Cut 28 Uncut -		R&W Total no. Cut 4 Uncut -		2ndry Total no. Cut 50 Uncut -		University Total no. Cut 18 Uncut 50	
	No.	%	No.	%	No.	%	No.	%
Duty:								
Cut	14	50	2	50	18	36	2	11.1
Uncut	-	-	-	-	-	-	16	32
To get pleasure:								
Cut	16	57.1	2	50	34	68	14	77.8
Uncut	-	-	-	-	-	-	46	92
To be pregnant:								
Cut	-	-	-	-	2	4	4	22.2
Uncut	-	-	-	-	-	-	-	-
Giving pleasure to husband:								
Cut	18	64.3	4	100	36	72	10	55.6
Uncut	-	-	-	-	-	-	14	77.8
Not to marry another wife:								
Cut	-	-	-	-	2	4	-	-
Uncut	-	-	-	-	-	-	-	-

For illiterate, R&W and 2ndry school women giving pleasure to the husband was the most important motive to have sex, but in university degree women was to get pleasure.

Most women gave more than one choice.

**Table (12) Relation between residence and motives to have sex**

	Rural Total no.: Cut 70 Uncut -		Urban Total no.: Cut 30 Uncut 50	
	No.	%	No.	%
Duty:				
Cut	23	32.9	10	33.3
Uncut	-	-	16	32
To get pleasure:				
Cut	50	71.4	18	60
Uncut	-	-	46	92
To be pregnant:				
Cut	5	7.1	2	6.7
Uncut	-	-	-	-
Giving pleasure to husband:				
Cut	50	71.4	18	60
Uncut	-	-	14	28
Not to marry another wife:				
Cut	2	2.9	-	-
Uncut	-	-	-	-

The most important motives for cut women from rural areas were to get pleasure and to give pleasure to husband which were also the most important motives for cut women from urban areas.

**Table (13) Frequency of sexual desire among the study group**

Desire	No	%
Yes:		
Cut	90	90
Uncut	44	88
No:		
Cut	10	10
Uncut	6	12

Presence or absence of libido was similar for cut and uncut women.

---

**Table (14) Source of libido in the study group**

Source	No. Total no.: Cut 90 Uncut 44	%
Your Husband		
Cut	40	44.4
Uncut	14	31.8
Yourself		
Cut	50	55.6
Uncut	30	68.2

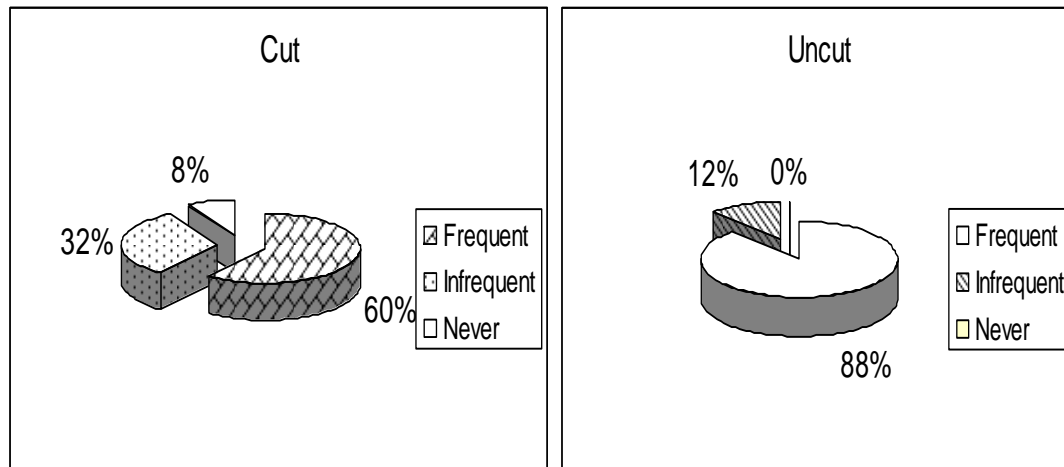
There was a lower rate of spontaneous provocation of libido in cut than uncut.

**Table (15) Reasons for absence of sexual desire in those who have no libido**

	No Total no.: Cut 10 Uncut 6	%
Hostility:		
Cut	4	40
Uncut	6	100
Not important:		
Cut	4	40
Uncut	-	-
Disgusting:		
Cut	2	20
Uncut	-	-

The most important cause for absence of libido was hostility to the husband for both cut and uncut. But none reported fear or pain.

**Fig. (16) Frequency of sexual desire during coitus among the study group**



Frequency of libido during coitus in uncut women was more than that in cut.

-Frequent (In at least 50% of coital encounters).

-Infrequent (In less than 50% of coital encounters).

#### **Data related to coital frequency:**

**Table (16) Frequency of coitus in the study group**

Coital frequency	No	%
Daily:		
Cut	9	9
Uncut	-	-
3-6/wk:		
Cut	71	71
Uncut	30	60
1-2/wk:		
Cut	18	18
Uncut	16	32
<one/month:		
Cut	2	2
Uncut	4	8

Coital frequency in cut women was more than in uncut.

**Table (17) Relation between age and coital frequency**

	Daily		3-6/week		1-2/week		Every month	
	No.	%	No.	%	No.	%	No.	%
<20:								
Cut (20)	-	-	20	100	-	-	-	-
Uncut (10)	-	-	6	60	4	40	-	-
21-30:								
Cut (58)	9	15.5	31	53.4	16	27.6	2	3.4
Uncut(20)	-	-	14	70	6	30	-	-
31-40:								
Cut (14)	-	-	14	100	-	-	-	-
Uncut (20)	-	-	10	50	6	30	4	20
>40:								
Cut (8)	-	-	6	75	2	25	-	-
Uncut (-)	-	-	-	-	-	-	-	-

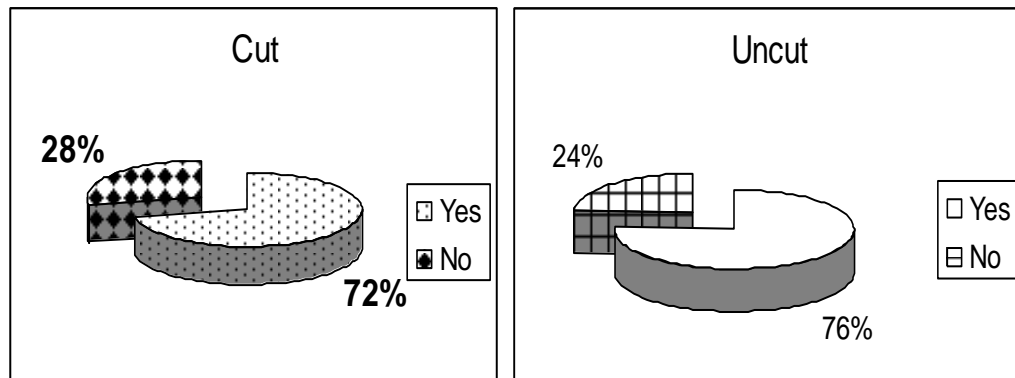
There was a trend of decreased coital frequency with increase in age.

**Table (18) Relation between education and coital frequency**

	Illiterate Total no. Cut 28 Uncut -		R&W Total no. Cut 4 Uncut -		2ndry Total no. Cut 50 Uncut -		University Total no. Cut 18 Uncut 50	
	No.	%	No.	%	No.	%	No	%
Daily:								
Cut	-	-	-	-	-	-	9	50
Uncut	-	-	-	-	-	-	-	-
3-6/w:								
Cut	22	78.6	4	100	38	76	7	38.9
Uncut	-	-	-	-	-	-	30	60
1-2/w:								
Cut	6	21.4	-	-	12	24	-	-
Uncut	-	-	-	-	-	-	16	32
Every month:								
Cut	-	-	-	-	-	-	2	11.1
Uncut	-	-	-	-	-	-	4	8

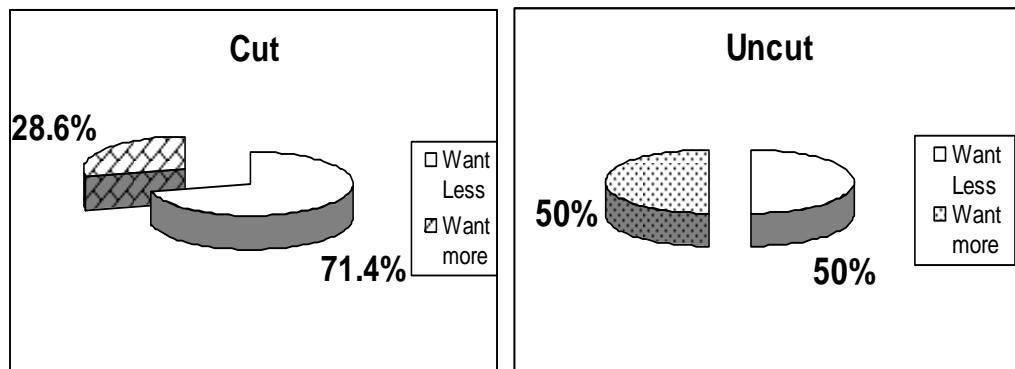
For cut women, coital frequency increase with education.

**Fig. (17) Suitability of coital frequency in the study group**



Coital frequency was suitable for both cut and uncut.

**Fig. (18) If coital frequency is not suitable**



Cut women needed less coital frequency than uncut.

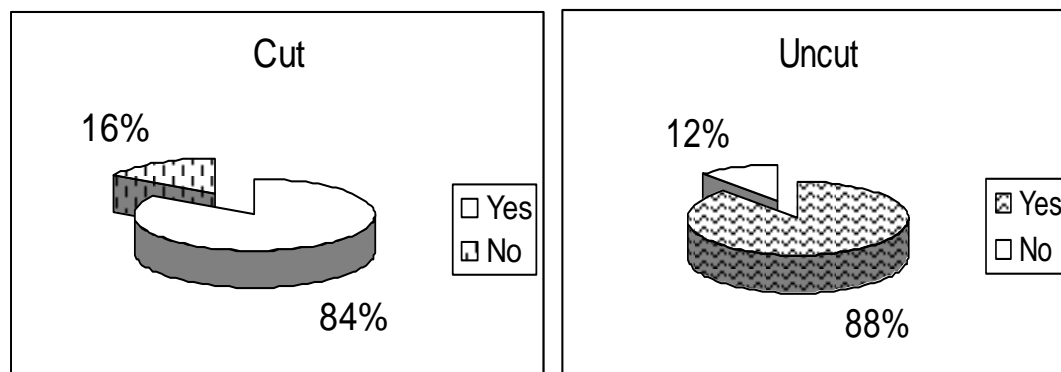
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**Table (19) Relation between age and suitability**

	Yes		Want less		Want more	
	No.	%	No.	%	No.	%
<20:						
Cut 20	20	100	-	-	-	-
Uncut 10	6	60	-	-	4	40
21-30:						
Cut 58	38	65.5	20	34.5	-	-
Uncut 20	20	100	-	-	-	-
31-40:						
Cut 14	10	71.4	4	28.6	-	-
Uncut 20	14	70	6	30	-	-
>40						
Cut 8	4	50	2	25	2	25
Uncut -	-	-	-	-	-	-

After the age of forty, cut women were more likely to find the current coital frequency unsuitable than those who were less than twenty years old.

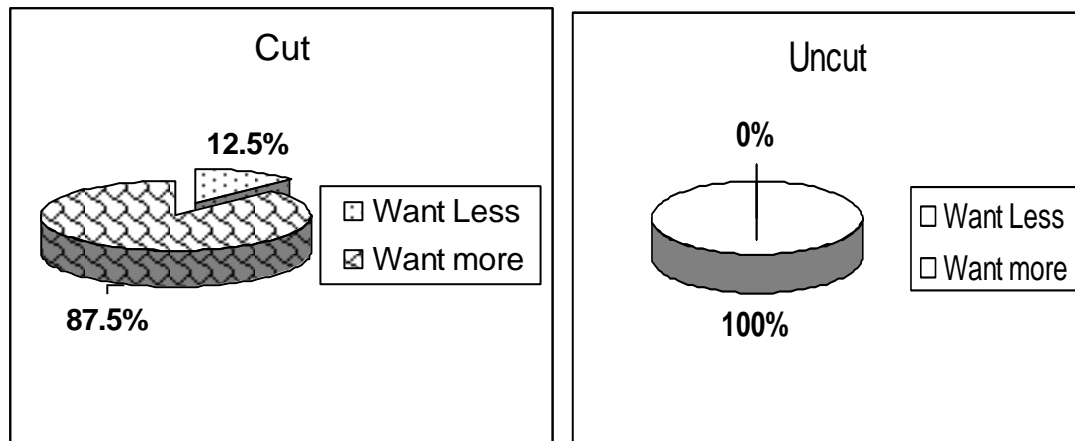
#### Data related to sexual arousal:

**Fig. (19) Having enough foreplay**

Having enough foreplay before sex was approximately the same in cut and uncut women.

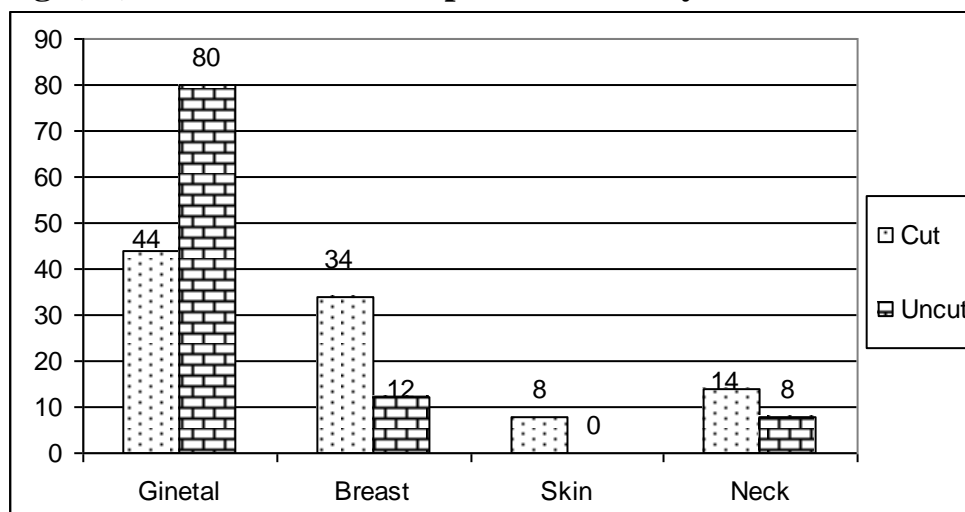


**Fig. (20) If no**



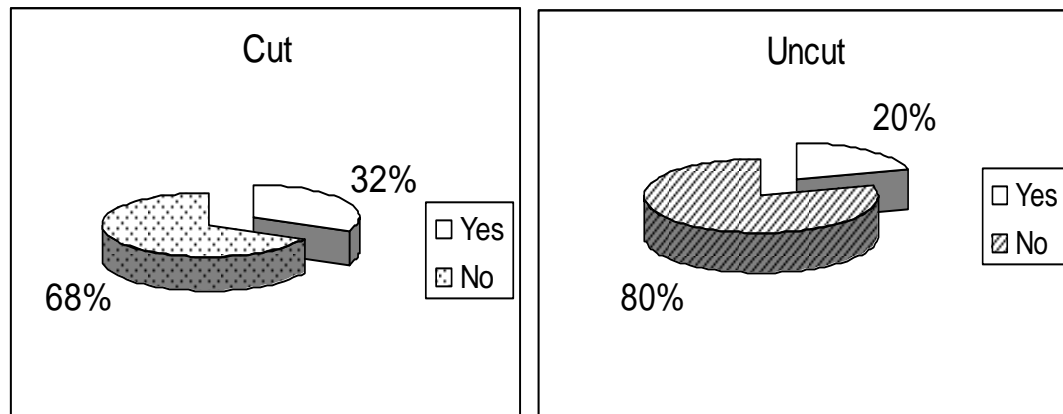
Cut and uncut women reported the need for more foreplay.

**Fig. (21) The most sensitive part of the body in cut and uncut women**



The area most commonly reported to be the most important area needed to be stimulated was the genital area for uncut women. For cut women it was the breast

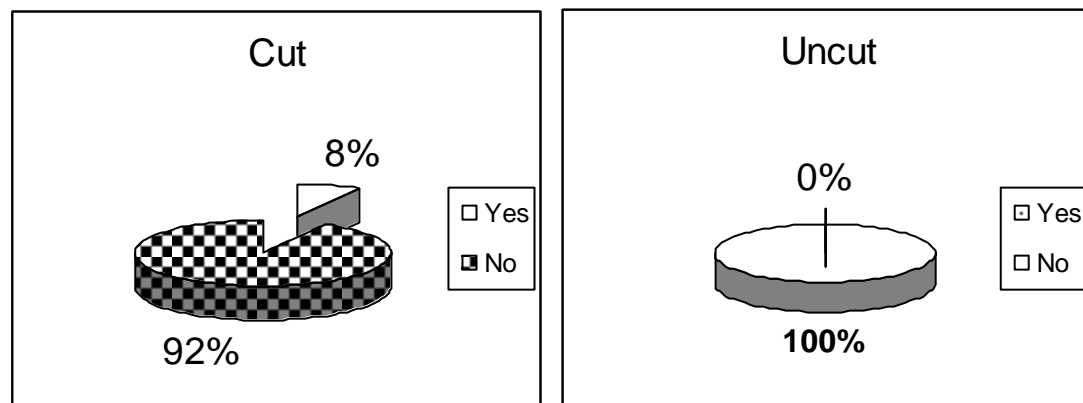
**Fig. (22) Difficulty of lubrication among the study group**



Difficulty of genital lubrication was encountered more in cut women.

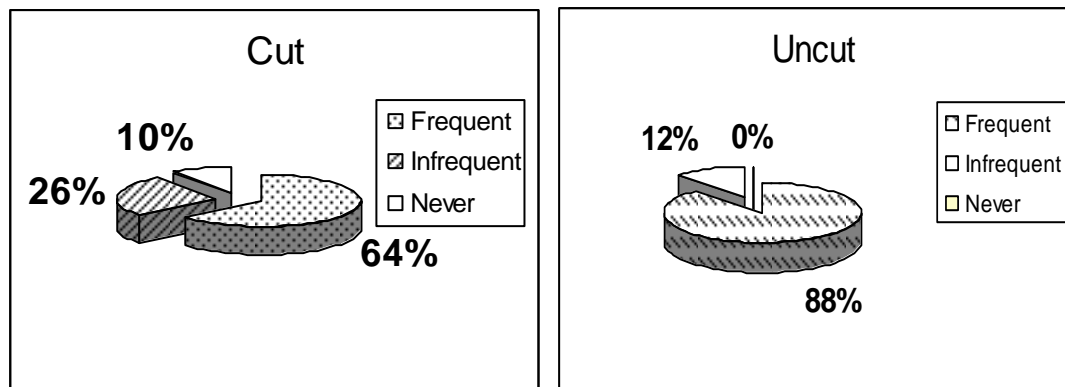
**Data related to orgasm:**

**Fig. (23) Presence of sexual dysfunction among the husbands of women in the study group**



Presence of sexual dysfunction in the husbands was reported only by cut women.

**Fig. (24) Frequency of orgasm among the study group**



More uncut women reported reaching orgasm than cut ones. 10% of cut women never reached orgasm.

**Table (20) Relation between age and frequency of reaching orgasm**

	<20ys Total no. Cut 20 Uncut 10		21-30ys Total no. Cut 58 Uncut 20		31-40ys Total no. Cut 14 Uncut 20		>40ys Total no. Cut 8 Uncut -	
	No.	%	No.	%	No.	%	No.	%
Frequent:								
Cut	16	80	34	58.6	8	57.1	6	75
Uncut	10	100	20	100	14	70	-	-
Infrequent:								
Cut	4	20	14	24.1	6	42.9	2	25
Uncut	-	-	-	-	6	30	-	-
Never:								
Cut	-	-	10	17.2	-	-	-	-
Uncut	-	-	-	-	-	-	-	-

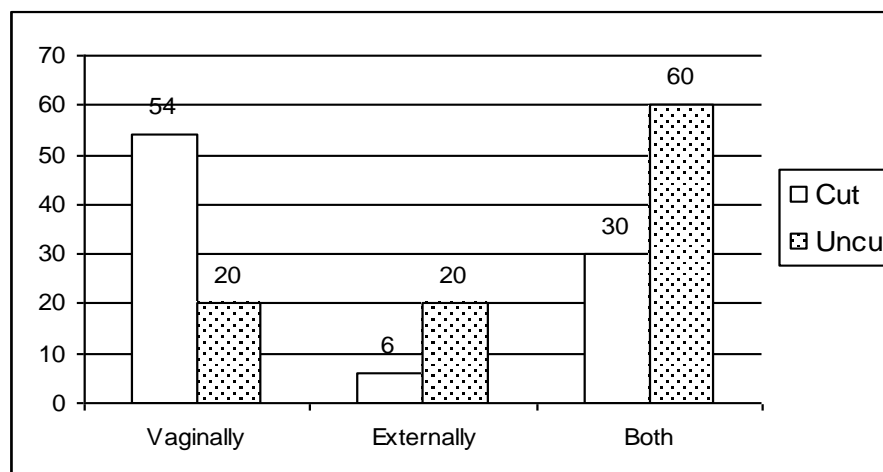
Frequency of orgasm decreased with age for cut and uncut women.

**Table (21) Relation between coital position and reaching orgasm**

	No	%
Missionary:		
Cut	30	30
Uncut	20	40
Woman on top:		
Cut	4	4
Uncut	20	40
Rear entry:		
Cut	-	-
Uncut	4	8
Position makes no difference:		
Cut	56	56
Uncut	6	12

For cut women position made no difference in reaching orgasm while for uncut ones missionary and woman on top were the most common positions for reaching orgasm.

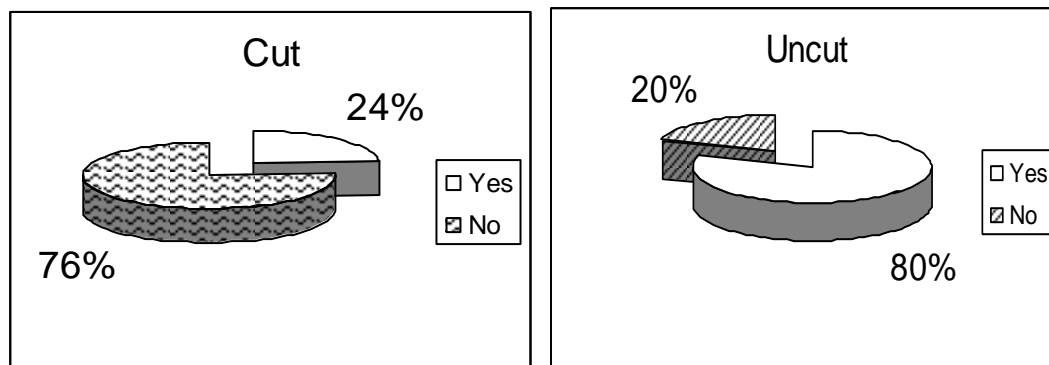
**Fig. (25) Difference in the way of reaching orgasm between cut and uncut women**



For cut women vaginal stimulation was the best way to reach orgasm while uncut women reached orgasm both vaginally and externally.

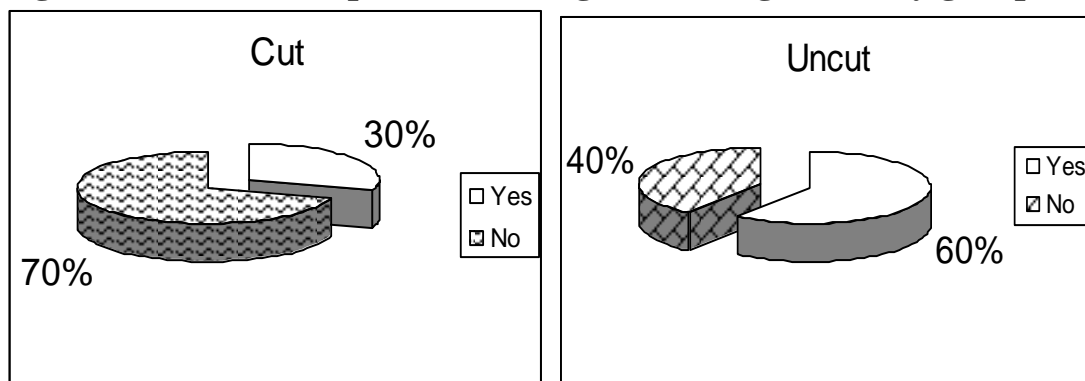
\* By stimulating clitoris

**Fig. (26) Effect of FGC on multiple orgasms**



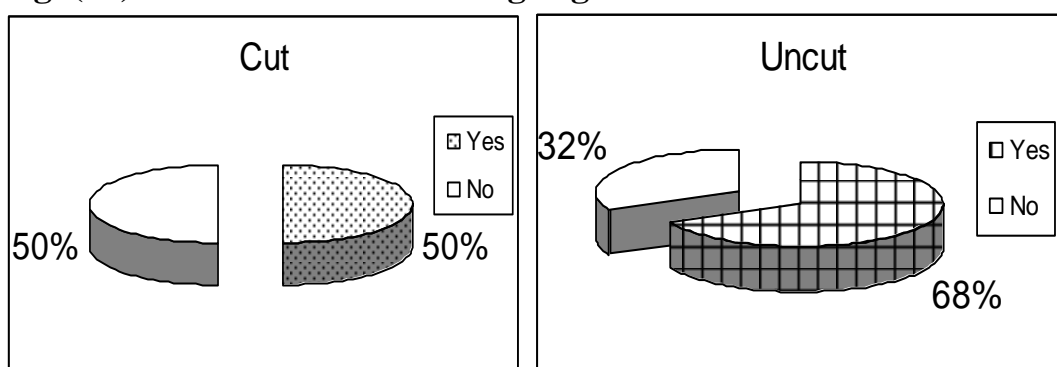
A vast difference was found between uncut and cut women in reporting occurrence of multiple orgasms.

**Fig. (27) Presence of spontaneous orgasm among the study group**



A great difference was reported between cut and uncut women for spontaneous orgasm.

**Fig. (28) Effect of FGC on faking orgasm**



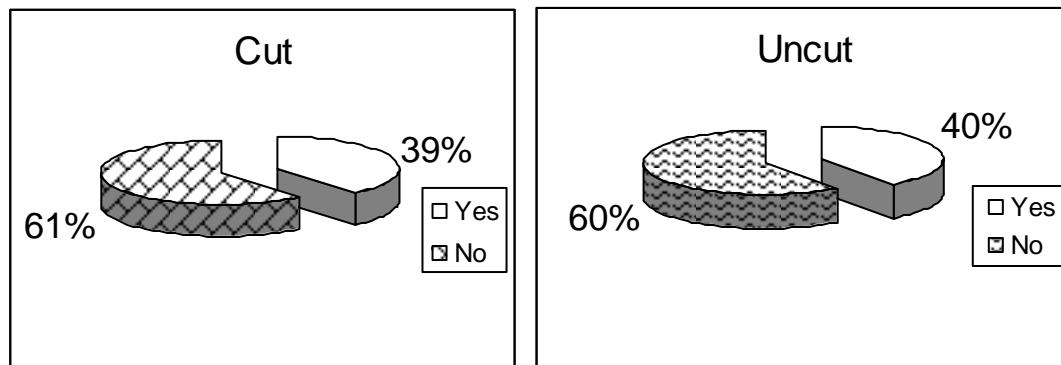
Faking orgasm was much more common in uncut than in cut women.

**Table (22) Frequency of overall satisfaction among the study group**

	No	%
High:		
Cut	56	56
Uncut	30	60
Moderate:		
Cut	32	32
Uncut	14	28
Low:		
Cut	10	10
Uncut	6	12
Non:		
Cut	2	2
Uncut	-	-

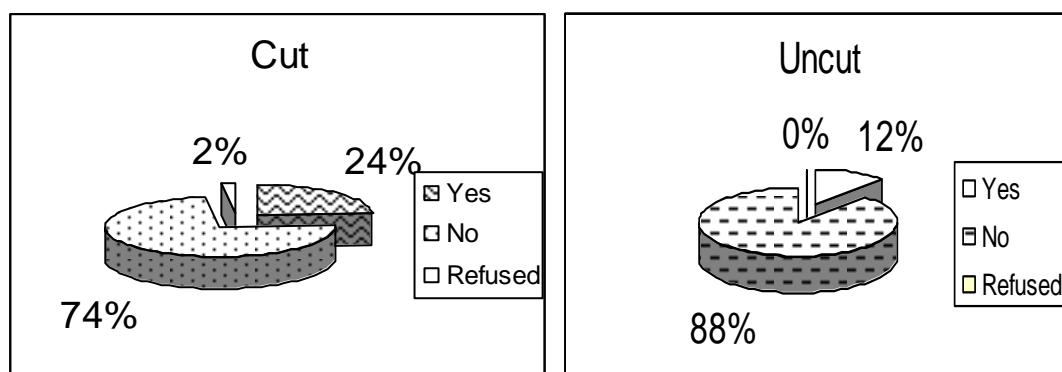
Overall satisfaction was more prevalent in uncut than cut women.

**Fig. (29) Presence of premarital masturbation among the study group**



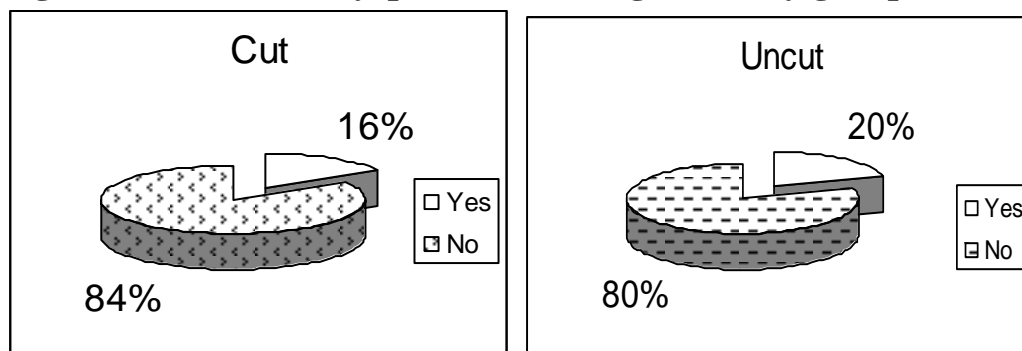
Very close percent was found between cut and uncut women in reporting the occurrence of premarital masturbation.

**Fig. (30) Occurrence of anal sex in the study group**



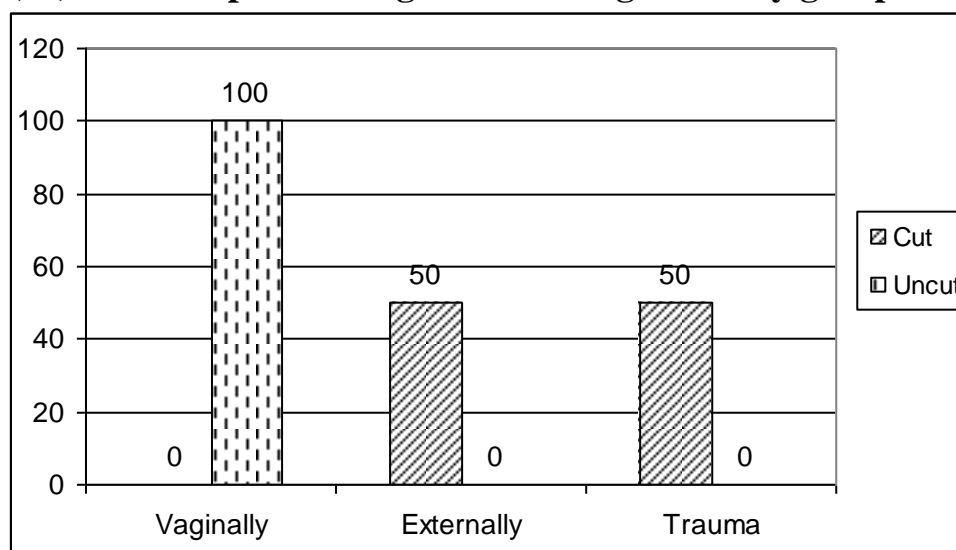
Anal sex was more practiced in cut than in uncut women.  
 - 2% of cut women refused to answer this question.

**Fig. (31) Presence of dyspareunia among the study group**



The uncut women had dyspareunia more than the cut women.

**Fig. (32) Cause of pain during coitus among the study group**



The cause of pain in uncut women was mainly vaginal but in cut ones the cause of pain was external and trauma by the husband in equal percents.

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## Discussion

FGC is an important and culturally sensitive issue in Egypt and to be able to solve this problem health care professionals must have an accurate understanding of the cultural background and believes surrounding this practice.

The present study showed that the incidence of FGC is declining in Egypt, these results were in agreement with **ElGibaly et al. (2002)** who reported that girls today are 10% less likely to be circumcised than their mothers. This apparent drop in prevalence is attributable to diffusion effects and advocacy on the part of women's health activists. On the other hand, because increasing levels of maternal schooling are associated with a reduced likelihood of circumcision, this decline may be simply a result of the fact that educational attainment among Egyptian women has risen.

As regard education and residence the present study showed that FGC is widely practiced in low educated females and those from rural areas. These results were in agreement with **Allam et al. (2001)** who found that females in an educated population are less likely to have FGC as compared to those in rural and uneducated population. Also, the results were in agreement with **Tag Eldin et al. (2008)** who found the prevalence of FGC among school girls in Egypt to be 46.2% in government urban schools, 9.2% in private urban schools, and 61.7% in rural schools.

Looking at attitudes towards FGC the present study showed that the



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majority of genitally cut women (58%) approved FGC, this conforms with **Gage and Rossen (2005)** who found that approximately 65% of women, aged 15-49 years, reported social approval of FGC. The majority of women in **Gage and Rossen** study group were Muslims with low level of education and live in rural areas.

It was noted that old genitally cut women have less approval for cutting than younger women. This may be because after years of marriage they realized that it was not necessary or that it was the reason of affection of their sexual life.

These results were not in agreement with **Lewens (2005)** who found that younger cut women are generally less likely to agree with FGC than older women where 63% of women between 45–49 years of age supported FGC compared to only 36% of women between 15 – 19 years of age.

But our results are in agreement with **ElGibaly et al. (2002)** who studied the attitude of 16-19 years old adolescence and found that 59% of girls believed that FGC was necessary.

These results were also in accordance with **Mostafa el al. (2006)** who explored the attitude toward FGC of 330 5<sup>th</sup> years medical students in Alexandria University (ages between 19–21 years) and found that 52% of the students supported the continuation of the practice.

We found that women 's education might contribute to a reduction of

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the practice, but it did not terminate its incidence, it was still found in women with a university degree. There were more approval between secondary school and illiterate women (60% vs. 57.1%) but still there were high approval between university degree women (55.5%). On the contrary genitally cut women from rural areas agreed with cutting more than those from urban areas did. These results were in agreement with **ElGibali et al. (2002)** and **Lewens (2005)** who found that educated women who lived in urban governorates were more likely to believe that FGC was not obligatory. This change in attitude appeared to be prompted by the social diffusion of new ideas, whether through contacts at schools or through exposure to wider circles of influence by residence in urban areas.

Looking at the attitude towards performance of FGC to their daughters, the results of the present study showed that the majority of cases refused performance of cutting for their daughters. For those who agreed with the practice, the decision makers were mothers and fathers played a minor role.

These results were in agreement with **Tag Eldin et al. (2008)**, but not in agreement with **El Defrawi et al. (2001)** who found that about two thirds of women among their study group reported having circumcised their daughters or intended to do so.

However, the lack of support for FGC was not always translated into a change in behavior where most genitally cut women said that they would not circumcise their daughters but they already had circumcised one or two of their daughters.

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Throughout this study the most important cause of FGC was tradition followed by cleanliness. Many of these responses reflect the content of messages against FGC that have been conveyed in recent years by a variety of media, non governmental organization and governmental efforts. For illiterate women and those who read and write, tradition is the most important reason. But for those women who have been to secondary school it was cleanliness and for women who have been to the university it was esthetic. These results were not in agreement with **Tag Eldin et al. (2008)** who found that the main cause was religious tradition followed by cleanliness. Our study showed that, religion had a very minor role in their judgment which highlights the efforts done by Islamic and Coptic Church leaders.

The majority of women were cut by traditional birth attendants (dayas) followed by doctors (56%, 32% respectively). Looking at the relation between age of women and performer of FGC, in young age doctors took the upper hand but in older ones it was done by traditional birth attendants, these results are in agreements with **Lewens (2005)** who stated that the analysis survey data in Egypt by age group revealed that the medicalization of FGC increased dramatically in recent years. It was also in accordance with **ElNashar and Abdelhady (2007)** who found that about 60% of FGC was performed by physicians.

About the age of cutting, the present study showed that the peak age for circumcision was 10–11 years. These results are in agreement with the Demographic and Health Survey in Egypt, which was carried out in 1995 and 2000 and found that 90% of girls were cut between the ages of 5 - 14

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years with peak incidence at 10-12 years in Lower Egypt.

The majority of cases were done without anesthesia and on the contrary only one quarter of women suffered from short-term complications which were only pain during or following the procedure and bleeding which did not lead to shock. These results were in agreement with **Tag Eldin et al. (2008)** who revealed that 21.8% of girls suffered from mild pain after the operation and 1.5% of girls had severe bleeding.

Looking at the sexual aspects, the results of the present study were in agreement with some authors and in contrast with others and sometimes no studies were found to discuss the effect of FGC on some aspects on women's sexuality.

About the motives of women to have sex, the present study showed that for uncut women the main motive was to get pleasure (92%), but for genitally cut women it was for getting pleasure and giving pleasure to the husband too (68%). It's clear that the uncut women were more aware about their needs, and they respect their demands more than the cut ones do. We should note that all uncut women were highly educated and live in urban areas, so they may be exposed to new ideas and heterogeneous norms and behaviors, so they safeguard their rights.

Also, looking at the relation between education and motives to have sex, for genitally cut women who are illiterate, those who can only read and write and those who have been to secondary school, giving pleasure

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to the husband was the most important motive. But for women of university degree the most important motive for genitally cut and uncut was to get pleasure, although the percent of uncut was higher than those of genitally cut (92% vs.77.8%). This means that education affects the motive to have sex but FGC is still affecting this motive. In other words, women's education may contribute to changing the motive to have sex as education makes women more aware and more open minded even if they were genitally cut. But, the uncut educated women still have higher percentage in recording getting pleasure as the most important motive.

For genitally cut women from urban and rural areas the most important motive was to give pleasure to the husband and to get pleasure, but for uncut ones who were from urban areas the most important motive was to get pleasure. So, education and residence alone are not sufficient for women to safeguard their sexual rights but the intact clitoris is the most important factor.

The present study showed that both cut and uncut women had almost the same sexual desire. But the frequency of sexual desire during coitus showed a vast difference where the uncut women had more frequency of sexual desire during coitus (88% vs. 60%). Initiation of sexual activity was more among uncut women than among cut ones.

These results about sexual desire were in agreement with **El Defrawi et al. (2001)** who stated that most of genitally cut women reported less frequency of sexual desire and less initiation of sexual activity with their husbands. But not in agreement with **El Defrawi et al. (2001)** about lack

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of sexual desire in genitally cut women because they found that about 41.5% of genitally cut women in their study group reported lack of sexual desire, while only 16% of uncut women reported this lack of sexual desire. Also these results were in agreement with **Nwajei and Otiono (2003)** who stated that uncut women were more likely to initiate sexual intercourse than cut ones.

The present study showed that coital frequency in genitally cut women was more than in uncut women. About its suitability the cut women needed less coital frequency than do the uncut women.

The relation between age and suitability showed that uncut women less than 20 years need more coitus than the cut ones of the same age. However, cut and uncut women of older age (21-40years) wanted less coital frequency than the younger ones. But after forty, one quarter of cut women wanted more coital frequency. This means that no definite relation between FGC and coital frequency.

These results were in agreement with **Stewart et al. (2002)** who found no association between female genital cutting and coital frequency. Also these results were in agreement with **Okonofu et al. (2003)** who found no significant differences between cut and uncut women as regard the frequency of sexual intercourse. These results were not in agreement with **Nwajei and Otiono (2003)** who stated that uncut students engaged in sexual intercourse more than the cut ones.

Looking at the relation between age and coital frequency our study

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showed tendency towards decreased coital frequency with aging but there was no definite relation between FGC and coital frequency taking age into consideration.

The present study showed that coital frequency increased with education for cut women (all uncut ones were highly educated). The cut educated women had more coital frequency than the uncut educated ones. Hence, coital frequency increased with education but there was no relation between FGC and coital frequency considering education. These results were in agreement with **Stewart et al. (2002)** who found that coital frequency was higher in more educated women but it was not possible to draw conclusions about how FGC affected sexual intercourse.

Approximately, most of genitally cut and uncut women had enough foreplay before sex. There was no significant relationship between FGC and foreplay before sex. These results were in agreement with **ElDefrawi et al. (2001)** who found that foreplay before sex did not differ between genitally cut and uncut women.

The present study showed that 80% of uncut and 44% of genitally cut women felt that the clitoris was the most sensitive part of the body. Among genitally cut women sensitive areas were widespread while in uncut ones sensitive areas were concentrated mainly in the clitoris followed by the breasts.

These results were in agreement with **Nwajei and Otiono (2003)** who found that 51% of uncut women identified the clitoris as the most

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sensitive part and 41% of genitally cut women agreed. They stated that the reason for identifying the clitoris in cut women was due to the type of circumcision which was type I where the clitoris was still intact.

In the Egyptian Delta (like Elbehaira governorate), the procedure done was only circumferential excision of the clitoral prepuce (Sunna circumcision) (**ElNashar and Abdelhady, 2007**), so, the results of the present study agreed with **Nwajei and Otono (2003)**.

Once the clitoris had been tampered with, the cut women seem to shift their most sensitive part to other parts of the body (**Nwajei and Otono, 2003**). This finding agreed with **Okonofu et al. (2003)** who found that uncut women were more likely to report that the clitoris was the most sexually sensitive part of their body while cut women were more likely to report that their breasts were their most sexually sensitive parts. It was also in accordance with **ElNashar and Abdelhady (2007)** who found that FGC did not eliminate women's sexual sensation, but instead shifted the point of maximal sexual stimulation to the breast.

About the difficulty of lubrication among the study group cut women had more difficulty of lubrication (32% vs 20%) these results were in accordance with **ElDefrawi et al. (2001)** who found that cut women reported more dryness during intercourse than uncut women ( 48.5% vs. 30%).

Before asking about orgasm first we excluded the male factor and presence of sexual dysfunction of the husband reported only by cut

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women (8%), and it was mainly premature ejaculation. Orgasm was experienced by both cut and uncut women (90% for cut and 100% of uncut).

These results were in agreement with **Catania et al. (2007)** who stated that 90.51% of interviewed women reported that sex gave them pleasure and could reach orgasm. These women were adult women affected by different types of FGC.

Looking at the frequency of reaching orgasm, genitally cut women were less orgasmic than uncut women. This result agreed with **ElDefrawi et al. (2001)** who also found that the cut women were less orgasmic than uncut ones.

Taking age into consideration, the frequency of orgasm decreased with aging, although the decrease of frequency was more in cut than the uncut women. This might be due to the fact that FGC affects the frequency of orgasm, even if age was taken into consideration, but it does not inhibit orgasm totally. Hence, FGC alters rather than eliminate orgasm.

Furthermore, in the present study almost 84% of cut women could reach orgasm with penetrative vaginal sex and 36% of them could reach orgasm with manual stimulation by their husbands and 30% of cut women could reach vaginally and manually. For uncut women 80% of them can reach orgasm vaginally and 80% could reach orgasm by manual stimulation. About 60% of uncut could reach both vaginally and manually.

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While for cut women the results of the present study were, to some extent, in agreement with **Catania et al. (2007)** who found that about 86% of women with different types of FGC reported orgasm with penetrative vaginal sex and 78% of the same group reported reaching orgasm also with manual masturbation by their partner.

**Thabet and Thabet (2003)** stated that the integrity of the considerable bulk of the clitoris and labia minora might be essential for experiencing satisfactory sex, this clitorolabial orientation was important for initiating proper desire and arousal; these parts were more sensitive to manipulation and touch and in turn to the maximum excitation needed to initiate orgasm. Also, **Thabet and Thabet (2003)** found that sexual scores obtained from the uncut and cut women who were minorly circumcised type I were not significantly different, on the other hand the cut women with type II showed significant drop in sexual scores than control.

Also the results of the relation between position of coitus and occurrence of orgasm confirmed the previous results of the present study where most of cut women reported that position made no difference in reaching orgasm, in other words they could reach orgasm with any position that permitted penetration of vagina. But uncut women preferred the missionary and women on top positions which in addition to penetration of vagina permitted clitoral stimulation.

**ElNashar and Abdelhady (2007)** stated that Women experienced two kinds of orgasm clitoral and vaginal. For cut women clitoral orgasm might be inhibited according to the type of FGC but the cut women still

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experience the vaginal orgasm so FGC reduced the capacity of women to reach orgasm.

The present study showed no significant difference between cut and uncut women for occurrence of premarital masturbation.

These results were in agreement with **Rossem and Gage (2007)** who stated that FGC had no effect on the age at first marriage and prevalence of premarital sex.

The present study showed that there was a vast difference between uncut and cut women in occurrence of multiple orgasms and spontaneous orgasm.

There were no studies yet developed to compare the incidence of multiple orgasms and spontaneous orgasm among the cut and uncut women.

Speaking about multiple orgasms and spontaneous orgasm was surprising to most of cut women and they asked about its real presence.

Also, asking about anal sex among the study group was difficult and some considered speaking about it was disgusting and against religion, but the present study showed that it was practiced more among the cut women (24% vs. 12%). This might be explained by the fact that most of cut women were ignorant or from rural areas.

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**Ryemer (2003)** who stated that if penetration was impossible, anal intercourse might become the substitute, which could lead to fistulae, fissures and fecal incontinence.

**Mukhlis (1981)** stated that cut women had difficulty in penetration and painful intercourse so some of them preferred anal sex.

The present study showed that faking orgasm was much more common between uncut than cut women (68% vs. 50%). No studies discussed this item or its relation to FGC.

The reason for this result might be due to that the uncut women fake orgasm to cover their unusual inability to reach orgasm, they were used to reach orgasm most of times. But the cut women had more difficulty and less frequency of reaching orgasm so, they had no need to fake orgasm than do the uncut ones.

The present study showed that dyspareunia was complained of by cut and uncut women with slight difference. These results were in agreement with **ElDefrawi et al. (2001)** and **ElNashar and Abdelhady (2007)** who found that cut and uncut women did not differ as regard dyspareunia.

Looking at the cause of dyspareunia, in 100% of who agreed dyspareunia among uncut women the cause of it was vaginally while, in about 50% of cut ones dyspareunia was caused by husband trauma while in the rest of them the cause was external.

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As regard the overall satisfaction, it was more in uncut women than in the cut ones but the difference was only minimal by a small difference.

This result was in agreement with **ElDefrawi et al. (2001)** and **ElNashar and Abdelhady (2007)** who stated that cut women were less pleased by sex than the uncut ones.

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## Summary

FGC violates human rights although, the incidence of FGC is declining it is still widely practiced in Egypt.

The aims of this study were to determine the real attitude of women toward cutting and to establish how FGC affects women's perception of their sexuality. The study included 150 married women, of them 100 were genitally cut and 50 were not and served as controls. All studied individuals were subjected to a questionnaire-based interview.

Throughout this study, we found that education and urbanization make women more open minded and aware about their rights where FGC was less practiced and had less approval among educated women from urban areas.

Furthermore, throughout this study we found that FGC altered women's sexuality rather than completely eliminating it. While cut and uncut women had sexual desire, the uncut ones were more frequently to have desire during intercourse. Initiation of sexual activity, even if we take education and residence into consideration, is more in uncut women so the intact clitoris is the most important factor. There was no definite relation between FGC and coital frequency.

Orgasm can be experienced by cut and uncut women but, the cut ones preferred more penetrative vaginal sex than manual stimulation. On the other hand, the uncut ones preferred manual stimulation.

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The intact clitoris gave chance for uncut women to enjoy multiple orgasms and spontaneous orgasm but it had no role in premarital masturbation.

Anal sex was more in cut women and faking orgasm was more among the uncut ones. The actual reasons were not known so; more studies must be developed around this topic.

Cut and uncut women do not differ as regard dyspareunia but, for overall satisfaction it was more in uncut than cut ones.

## **Conclusion:**

Even if FGC did not present physical and psychological harm, it will still constitute a violation of women's human rights as innately sexual being, where suppression or control of women's sexuality through clitoridectomy or lesser forms of FGC is accordingly demeaning to women in denying an aspect of their humanity. FGC really affects some aspects of women's sexuality.

Although sexual desire is not affected with FGC but the clitoris was the most driving factor to initiate sexual activity, its presence is needed to translate this desire into actual act. But sexual arousal is greatly affected with genital cutting. Although the cut and uncut women can find their way to experience orgasm which is the main goal of the sexual experience, the uncut women have less difficulty and more frequency to reach orgasm and had more overall satisfaction.

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## **Recommendation**

1- This study should be done in other governorates separately to recognize the actual reasons and believes behind this practice and to be able to solve this problem and to terminate it, as each cultural group has its own practices with its own meaning attached.

2- Both the wife and her husband should be included in other studies related to this topic to achieve better understanding of the effect of FGC on female and male sexuality where male preference or oppression of women with FGC is still controversy.

3- Little is known about the relation between FGC and anal sex and nothing is known about the effect of FGC on multiple orgasms, spontaneous orgasm, faking orgasm and the preferred positions during coitus, where no studies are found to deal with this topics so, more studies are needed in this era to help in deepening the understand of problems facing the genitally cut women.

4- Sexologist should pay a good attention to the care of women who already had undergone FGC especially those with sexual dysfunction with appropriate sexual therapy.

5- Elimination of FGC can be promoted effectively by counseling and education of women and the community about the procedure and its negative impact concentrating on any place having clusters of illiterate people also, positive aid from Mosques and Churches is really helpful. Intensive enforcement of criminal lows is not the appropriate way to get

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ride of this problem as many people can find their way to continue this practice in secret.

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## الملخص العربي

تعتبر عملية ختان الإناث إنتهاكاً لحقوق الإنسان وعلى الرغم من أن هذه الظاهرة قلت ممارستها عن ذى قبل إلا أنها مازالت تمارس على نطاق واسع فى مصر.

وتهدف هذه الدراسة إلى التعرف على موقف المرأة الحقيقى تجاه عملية ختان الاناث وكيف تؤثر هذه العملية على إدراك المرأة لشؤونها الجنسية.

إشتملت هذه الدراسة على مائة و خمسين امرأة متزوجة ، مائة منهن مختنات و خمسين أخريات غير مختنات وخضعت جميع السيدات محل الدراسة لمقابلة إستبائية ، وتبين من خلال الدراسة ان التعليم والتحضر جعل المرأة اكثر تفتحا ووعيا بحقوقهن حيث ان عملية ختان الإناث تمارس بشكل اقل وتحظى بإستحسان اقل بين السيدات المتعلّقات من سكان المدينة.

وتبين ايضا من خلال الدراسة أن عملية ختان الإناث غيرت من الميول الجنسية للمرأة بدلا من تدميرها بصورة كاملة ، فبينما تبين أن كلا من النساء اللاتى تعرضن للختان والأخريات اللاتى لم يتعرضن له توجد لديهن رغبة جنسية ، فإن هؤلاء اللاتى لم يتعرضن للختان تكون معدل وجود الرغبة الجنسية لديهن اعلى أثناء الجماع ، ويكون الإقدام على البدء بالعلاقة الجنسية اكثر فى الغير مختنات - حتى لو اخذنا فى الإعتبار التعليم والمكان -ولذلك فإن البظر البكر الذى لم يتم قطعه هو العامل الاكثر أهمية وأيضا لم يتبين ان هناك علاقة محدده بين عملية الختان وعدد مرات الجماع فى السيدات محل الدراسة .

كان بإمكان المختنات وغير المختنات الوصول للذروه الجنسيه ولكن غير المختنات كن يفضلن الجماع عن طريق المهبل على الإثارة باليد من الخارج و هذا على عكس الغير مختنات اللاتى يفضلن الإثارة الخارجيه حيث أن البظر البكر الذى لم يتم قطعه أعطى فرصة اكبر لغير المختنات للتمتع بعدد مرات أكثر للوصول للذروه الجنسيه والوصول للتلقائى للذروه الجنسيه ولم يكن له أى علاقه بممارسه العاده السريه قبل الزواج.

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كما بينت الدراسة أن معدل ممارسة الجنس الشرجى تكون أكبر فى النساء اللاتى تعرضن للختان ، بينما يظهر تصنع الوصول للذروه الجنسيه بصورة اكبر بين السيدات الغير مختنات والاسباب الحقيقية لذلك غير معروفة ، لذلك فمن الضروري إجراء دراسات حول هذا الموضوع . ولم يلاحظ إختلاف بين المختنات و غير المختنات بالنسبه للالم اثناء الجماع بينما كان الإستمتاع الكلى بالجماع اكبر فى الغير مختنات.

و قد خلصت هذه الدراسه إلى أن ختان الإناث حتى و إن لم يتسبب فى أى أذى عضوى أو نفسى فإنه لا يزال انتهاكا لحقوق الإنسانيه للمرأة كغرائزها الجنسيه الفطريه، حيث أن للكبت او التحكم بميول المرأة الجنسيه سواء من خلال الختان أو أى صورة اخرى من الختان أقل فتكاً بالبظر يحط من قدر المرأة عن طريق إهمال جانب من إنسانيتها . فإن هذه العملية تؤثر بالفعل على بعض جوانب النشاط الجنسى للمرأة.

وعلى الرغم من أن الرغبة الجنسية لا تتأثر بعملية الختان إلا أن البظر كان عاملاً اساسياً لدفع المرأة للإقدام على البدء بالعلاقة الجنسية فكان وجوده ضرورياً لتحويل الرغبة إلى فعل حقيقى . و لكن الإثارة الجنسيه كانت قد تأثرت بالختان كلياً و على الرغم من أن السيدات المختنات و غير المختنات قد وجدن طريقتهن للوصول للذروه الجنسيه فقد كانت الغير مختنات أقل صعوبة و أكثر عدداً فى الوصول للذروه الجنسيه.