# The Effect of Female Genital Mutilation on Post Marital Female Sexual Function

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**Abstract**

**Background:** Female genital mutilation (FGM) is a procedure that had physical, sexual, psychological and social consequences on women and girls. **Aim:** To assess the effect of female genital mutilation on post marital female sexual function. **Design:** A descriptive case control study to compare between mutilated and non-mutilated women. **Setting:** The study was conducted at three maternal and child healthcare centers in different areas in Fayoum governorate (El-Hadaka, EL-Sad El Aly and El-Keman). **Sample:** A purposive sample of 100 women. **Tools:** Three tools were used for data collection: **Tool I (**A Structured interviewing questionnaire), **Tool II (**Standardized Female Sexual Function Index Questionnaire) and **Tool III (**Attitude Likert Rating Scale). **Result:** The current study showed that most (84%) of the studied mutilated women suffer from sexual dysfunction and only one fifth (20%) of the studied non-mutilated women had sexual dysfunction. Additionally, more than three fifths (64%) of the studied mutilated women had negative attitude regarding FGM while, the majority (90%) of the studied non-mutilated women had negative attitude toward the practice. C**onclusion:** The study concluded that female genital mutilation was found to have a significantly negative impact on women's sexual function after marriage. **Recommendation:** Implementing an educational program to raise awareness among women, families and communities about the negative effects of female genital mutilation on women's sexual and psychological health.

**Keywords:** Female genital mutilation- Post marital- Female sexual function.

## Introduction

World Health Organization (WHO) defined female genital mutilation (FGM) as all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. The practice of FGM is recognized internationally as a violation of the human rights of girls and women. It reflects deep-rooted inequality between the sexes and constitutes an extreme form of discrimination against girls and women **(WHO, 2025)**.

According to the United Nation Children's Emergency Fund (UNICEF) reports, FGM is most commonly performed on young girls during infancy and adolescence and occasionally on adult women. According to available data from 31 countries where FGM is practiced in western, eastern and northeastern Africa and parts of the Middle East and Asia, more than 230 million girls and women alive today have been subjected to the practice and it is estimated that more than 4 million girls are exposed to FGM annually so that FGM is a global problem **(UNICEF, 2025)**.

According to the extent of genital tissue damage, FGM has been divided into four categories. Type I entails the prepuce and/or clitoral glans (the exterior portion of the clitoris) being removed entirely or partially. Type II includes excision of the labia majora and partial or complete removal of the clitoral glans and labia minora. Type III, often referred to as infibulation, involves cutting and appositioning the labia minora and/or labia majora with or without excision of the clitoral glans in order to constrict the vaginal entrance and create a covering seal. Type IV involves further damaging non-medical treatments to the female genitalia that do not include the removal of genital tissue such as pricking **(Soltani et al., 2025)**.

FGM has no health benefits; on the contrary, it has several negative health consequences. The health consequences of FGM can be immediate and long-term. Immediate complications include severe pain, excessive bleeding, infection and even death in extreme cases. Long-term complications may involve chronic urinary and menstrual problems, sexual dysfunction, infertility, complications during childbirth and increased risk of newborn death. Moreover, the psychological impact is profound, with many survivors experiencing post-traumatic stress disorder (PTSD), depression, anxiety and a loss of trust in

caregivers. These consequences underline the importance of treating FGM as a public health and mental health emergency **(Pallitto et al., 2025)**.

Female sexual function (FSF) is a complex system of biological, psychological, hormonal and relationship factors that interact to influence a woman's sexual health and satisfaction. Healthy sexual function includes desire, arousal, lubrication, orgasm, satisfaction and pain-free sex. Problems in one or more of these phases can lead to female sexual dysfunction (FSD), a prevalent condition that affects millions of women worldwide. FSD can severely impact quality of life, self-esteem and intimate relationships. FSD is often underestimated due to cultural stigma, lack of awareness and limited access to professional care. Understanding the causes and consequences of FSD is critical to improving women's sexual health and addressing its multiple impacts **(Salari, Hasheminezhad, Hosseinian-Far, & Mohammadi, 2025)**.

Nurses may play a significant role in preventing female genital mutilation in addition to supporting and educating patients and communities on the advantages of ending FGM. This can be achieved by educating women about their own sexual and reproductive health, which will help the women comprehend the dangers of female genital cutting as well as normal bodily processes. Additionally, nurses can make a significant contribution to community outreach initiatives including public health education campaigns and school programs **(Balde et al., 2022).**

**Significance of the study:**

In Egypt, although the prevalence of FGM/C among females aged 15-49 declined from 97% in 1985 to 87% in 2015, the prevalence remains high despite governmental efforts. According to WHO, FGM is practiced in 30 countries in Africa, the Middle East and Asia, where FGM has affected over 230 million girls and women who are alive today. In Africa, every five minutes a girl undergoes FGM **(WHO, 2025)**.

FGM/C has no health benefits and it harms girls and women in many ways. It involves removing and damaging healthy and normal female genital tissue, and this interfere with the natural function of girls and women's body and negatively affects sexual experiences of married women. Although FGM/C has been implicated in sexual complications among girls and women, there is

paucity of research on the sexual experiences of married women with FGM/C. Mutilated women had five folds decrease in desire, four folds decrease in sexual satisfaction and five folds increase in sexual dysfunction and decrease in arousal and orgasm as well as suffering from psychological and social problems related to FGM practice **(Raheem, Eltahalawi, Raia, Elsary, & Ibrahem, 2020)**.

**Aim of the study:**

This study aimed to assess the effect of female genital mutilation on post marital female sexual function.

**Research Question:**

What is the effect of female genital mutilation on post marital female sexual function?

**Subject and Methods:**

**Research design:**

A descriptive case control study to compare between mutilated and non-mutilated women.

**Setting:**

The study was conducted at three maternal and child healthcare centers in different area in Fayoum governorate (El-Hadaka, EL-Sad El Aly and El-Keman). These centers provide free services for rural and urban areas at Fayoum city. The family planning unit is located on the ground floor for all maternal and child healthcare centers and consists of two rooms.

**Sample type:**

Purposive sample was used in this study.

**Sample size:**

Sample size was calculated using open epi-program equation of main difference using the assumption, Power 99% and confidence interval 95%.

Mean of group I: 14.3 , 5.93.

Mean of group II: 25.9 , 3.44.

The calculated size was 100 women (50 per group).

**Inclusion criteria:**

-Married sexually active woman.

-In the reproductive age from 15-49 years.

-With any type of FGM in the mutilated group, and without mutilation in the non-mutilated group.

**Exclusion criteria:**

-Divorced or widow woman.

-Women with chronic physical/ mental disease affecting female sexuality e.g. neuropsychiatric diseases, liver failure and renal failure.

-Women with genital prolapse.

**Tools of data collection:**

The data was collected by using three tools.

**Tool I: Structured Interviewing Questionnaire:**

This tool was developed by the researcher after reviewing the national and international related

literature. It was written in a simple Arabic language, it was divided into two parts and consisted of (15) questions of multiple choice type and close end questions.

**Part I: Socio-demographic characteristics:** It was designed to assess the women's characteristics such as age, residence, occupation, level of education, duration of marriage and number of children.

**Part II:** Mutilation data as the age of FGM, who performs mutilation, the place, type and complications of FGM.

**Tool II: Standardized Female Sexual Function Index (FSFI) Questionnaire:**

This tool (FSFI) is adopted from **(Rosen et al., 2000).** It is a brief, multidimensional, validated tool for assessment of sexual function. It was consisted of (6) domains and (19) questions to assess female sexual function as follows, domain of libido (two questions), arousal (four questions), lubrication (four questions), orgasm (three questions), satisfaction (three questions), and pain (three questions).

**Scoring system:** A cutoff total score of ≤ 26.55 has been proposed for diagnosis of female sexual dysfunction such that any woman who scores less than 26.55 should be considered at risk for sexual dysfunction.

- Normal sexual function if score > 26.55.
- Sexual dysfunction if score ≤ 26.55.

**Tool III: Attitude Likert Rating Scale:**

The Attitude Likert Rating Scale utilized in this study was adapted from **(Hassan, Abd-ELhakam, Ebrahim, & Mohammed, 2022)** and modified by the researcher to assess the women's attitude regarding FGM. The scale comprised 15 statements, and for each statement, women were presented with three response options:

- A positive response, indicating agreement, was assigned a value of 3.
- No opinion or uncertainty, denoted as indifference, was assigned a value of 2.
- A negative response, indicating disagreement, was assigned a value of 1.

**Scoring system of attitude:**

The total score for each participant ranged from 15 to 45. It was classified into 2 categories:

**-Positive level** if the totals score ≥ 60% (27-45 grades).

**-Negative level** if the total score <60% (15-26 grades).

**Tools validity:**

The study tools were tested and evaluated for their face and content

validity by a panel of expertise composed of 3 professors of Maternal and Newborn Health Nursing to ascertain relevance, clarity, understanding, completeness and applicability of the tools. The required corrections and modifications were done by adding, modifying and rearranging some questions.

**Tools reliability:**

Reliability was estimated among the same sample of 10 females by using the test-retest method on two occasions and then compared the scores through SPSS computer package. The Cronbach's coefficient alpha indicated that the questionnaire is reliable to detect the objectives of the study.

| Tool | Alpha Cronbach | Internal consistency |
|---|---|---|
| Standardized Female Sexual Function Index Questionnaire | 0.958 | Excellent |
| Attitude regarding FGM | 0.948 | Excellent |

**Ethical considerations:**

Ethical aspects were considered before starting the study, prior to starting the study, approval from Fayoum University's Ethical Research Committee was acquired. An official permission from the selected study settings was obtained for the fulfillment of the study. The questionnaires confirmed the confidentiality of the data by providing explanations of the study's goals and implications. Prior to data collection, women gave their informed consent. The finished tool was given a code number to guarantee anonymity. The women were told by the researchers that the data they collected would be kept confidential and that they could withdraw at any moment without providing a reason. The study didn't harm dignity, tradition and religious aspects of the women.

**Operational Item:**

Includes the preparatory phase, pilot study and field work.

**A. Preparatory phase:**

It includes reviewing of the current and relevant related literature and theoretical knowledge of the various related aspects of the study using books, articles, scientific journal and internet with the aim of acquiring in-depth knowledge about the study. During this phase, the researcher also visits the selected places to get acquainted with the personnel and the study settings. The development of the tools was under supervisors' guidance and experts' opinions were considered.

**B. Pilot study:**

A pilot study was carried out on 10% (10 women) in a period of three

weeks before conducting the actual study to test the feasibility, clarity, applicability and the efficiency of the tools in addition to estimate the time needed to fill in the tools. The pilot study revealed that some items need to be added which help in achieving the study objectives and some items needed to be modified, such as simplification and rephrasing of some questions to be simpler for understanding and other items need to be omitted. So, pilot study was excluded from the study sample later.

**C. Field work:**

Data were collected after attaining the approval to conduct the study, sample was collected from the family planning unit of the three maternal and child healthcare centers in different area in Fayoum governorate (El-Hadaka, EL-Sad El Aly and El-Keman) 3 days weekly one day for each MCH from 9a.m to 2 p.m. Actual field work was carried out in the period from January 2024 up to April 2024. At the beginning, the researcher introduced herself to the women and explained the purpose of the study to establish trust and encourage their participation. Informed consent was obtained from each participant before proceeding. The structured interviewing questionnaire sheet was filled by the researcher from each woman in the study individually to assess the studied women's characteristics as well as female genital mutilation data. Tool I took from 10-15minutes. Following the questionnaire, the researcher assessed the women's female sexual function using Tool II. Tool II (SFSFIQ) took from 15-20 minutes. The attitude of the women regarding FGM was assessed using the Likert rating scale (Tool III). Tool III took from 5- 10 minutes. The total time needed to fill in the questionnaire was about 30 to 45 minutes.

**Administrative item:**

An official letter to carry out this study clarifying the purpose and setting of the study was obtained from the Dean of the Faculty of Nursing, Fayoum University to the manager of each maternal and child healthcare center as an approval to obtain permission and cooperation.

**Statistical item:**

The collected data organized, tabulated and statistically analyzed using Statistical Package for Social Science (SPSS) version 25 for windows, running on IBM compatible computer. The use of descriptive statistics (e.g. frequency, percentages, mean and standard deviation) was applied. The independent test (t) was utilized to compare the mean score between two groups and the qui square test

(x2) was employed as the test of significance for qualitative variables. The correlation between the studied variables was examined using the correlation coefficient test (r). Cronbach's Alpha was used to assess the study tools' reliability.

**Degrees of Significance of results were considered as the following:**

- P-value > 0.05 indicates statistically insignificant difference (NS).
- P-value ≤ 0.05 indicates statistically significant difference (S).
- P-value ≤ 0.01 indicates statistically highly significant difference (HS).

**Results:**

**Table (1):** shows that, the mean age of the mutilated group was 30.44±4.98 years, while the mean age in the non-mutilated group was 25.84±2.98 years. Regarding to the educational level, more than half (52.0%) of the mutilated and non-mutilated groups had high education. Additionally, more than two thirds (70.0%) of the mutilated group were reside in rural areas while two thirds (66.0%) of the non-mutilated group were reside in urban areas.

**Table (2**): shows that, around three quarters (74%) of the studied mutilated women their age at FGM was 10-15 years. Also, around two thirds (64%) of the studied mutilated women, the mother was responsible for making the decision to undergo FGM. Moreover, majority (90%) of the mutilated women perform FGM at home. Likewise, half of them (50%), the Daya or midwife was responsible for making the FGM. Moreover, most of them (82%) had type II (Excision) of FGM. Also, around two thirds (62%) of the studied mutilated women had history of complications from the mutilation.

**Table (3**): shows that, the studied mutilated women had lower mean sexual function than studied non-mutilated women in all aspects namely desire, arousal, lubrication, orgasm, satisfaction and pain. Furthermore, the mean scores of the total sexual functions score among the mutilated group was 16.95±6.95 while the mean scores among the non-mutilated group was 26.35 ±3.02.

**Figure (1):** shows that; the minority (16.0%) of the studied mutilated women had normal sexual functions. While, most (80.0%) of the studied non-mutilated women had normal sexual functions.

**Figure (2):** shows that; around two thirds (64.0%) of the studied mutilated woman had negative attitude regarding female genital mutilation. While, majority (90.0%) of the studied non-mutilated woman had negative attitude regarding female genital mutilation.

**Table (1):** Frequency distribution of the studied women according to their socio demographic characteristics**.**

| Socio demographic characteristics | Mutilated group (n=50) | | Non-mutilated group (n=50) | | $X^2$ | P-Value |
|---|---|---|---|---|---|---|
| | No. | % | No. | % | | |
| **Age (Years)** | | | | | 19.41 | 0.000** |
| 20-<30 | 25 | 50.0 | 45 | 90.0 | | |
| 30-<40 | 22 | 44.0 | 5 | 10.0 | | |
| ≥ 40 | 3 | 6.0 | 0 | 0.0 | | |
| **Mean ± S.D** | 30.44±4.98 | | 25.84±2.98 | | t=5.597 | 0.000** |
| **Educational level** | | | | | 9.600 | 0.008** |
| Can't read and write | 0 | 0.0 | 0 | 0.0 | | |
| Primary education | 8 | 16.0 | 0 | 0.0 | | |
| Secondary education | 16 | 32.0 | 24 | 48.0 | | |
| High education | 26 | 52.0 | 26 | 52.0 | | |
| **Occupation** | | | | | 0.040 | 0.841 |
| Working | 27 | 54.0 | 26 | 52.0 | | |
| House wife | 23 | 46.0 | 24 | 48.0 | | |
| **Duration of marriage** | | | | | 34.18 | 0.000** |
| <1 year | 1 | 2.0 | 8 | 16.0 | | |
| 1-<5 years | 12 | 24.0 | 32 | 64.0 | | |
| 5-10 years | 17 | 34.0 | 9 | 18.0 | | |
| >10 years | 20 | 40.0 | 1 | 2.0 | | |
| **Place of residence** | | | | | 0.000 | 1.000 |
| Rural area | 35 | 70.0 | 35 | 70.0 | | |
| Urban area | 15 | 30.0 | 15 | 30.0 | | |
| **Religion** | | | | | 1.010 | 0.315 |
| Muslim | 50 | 100.0 | 49 | 98.0 | | |
| Christian | 0 | 0.0 | 1 | 2.0 | | |

**Table (2):** Frequency distribution of the studied mutilated women according to their mutilation history **(n=50).**

| Mutilation history | Mutilated group (n=50) | |
|---|---|---|
| | No. | % |
| **Age at FGM** | | |
| <5 years | 0 | 0 |
| 5-10 years | 5 | 10.0 |
| 10-15 years | 37 | 74.0 |
| >15 years | 8 | 16.0 |
| Mutilated after marriage. | 0 | 0.0 |
| ***The person responsible for making the decision of FGM** | | |
| Mother | 32 | 64.0 |
| Father | 5 | 10.0 |
| Grandmother | 13 | 26.0 |
| Others (as aunt) | 2 | 4.0 |
| Don't know | 1 | 2.0 |
| **Place at which FGM is performed** | | |
| Home | 45 | 90.0 |
| Private clinic | 5 | 10.0 |
| Hospital | 0 | 0.0 |
| Health unit | 0 | 0.0 |
| **Perform medical examination before FGM** | | |
| Yes | 23 | 46.0 |
| No | 27 | 54.0 |
| **The person who performs FGM** | | |
| Daya or midwife | 25 | 50.0 |
| Nurse | 6 | 12.0 |
| Physician | 19 | 38.0 |
| Don't know. | 0 | 0.0 |
| **Types of FGM that you had** | | |
| Type I (Clitoridectomy). | 5 | 10.0 |
| Type II (Excision). | 41 | 82.0 |
| Type III (Infibulation). | 0 | 0.0 |
| Don't know. | 4 | 8.0 |
| **History of complications from the mutilation** | | |
| Yes | 31 | 62.0 |
| No | 19 | 38.0 |
| ***If yes, mention the complications (n=31)** | | |
| Bleeding | 11 | 35.5 |
| Inflammation | 9 | 29.0 |
| Severe pain | 18 | 58.1 |
| Severe anemia | 0 | 0.0 |
| Micturition problem | 2 | 6.5 |

**Table (3):** Frequency distribution of the studied women according to their total score of sexual functions.

| Sexual functions | Mutilated group (n=50) | Non-mutilated group (n=50) | T | P-value |
|---|---|---|---|---|
| | Mean ± SD | Mean ± SD | | |
| Sexual desire | 2.56±1.2 | 4.80±0.92 | **10.25** | **0.000**** |
| Sexual arousal | 2.71±1.3 | 4.85±0.78 | **9.528** | **0.000**** |
| Sexual lubrication | 3.04±1.3 | 4.80±0.75 | **7.894** | **0.000**** |
| Sexual orgasm | 3.09±1.3 | 4.09±0.94 | **4.208** | **0.000**** |
| Sexual satisfaction | 2.50±1.2 | 3.63±1.27 | **4.456** | **0.000**** |
| Sexual pain | 3.02±1.4 | 4.13±1.0 | **4.446** | **0.000**** |
| **Total sexual functions score** | **16.95±6.95** | **26.35 ±3.02** | **8.724** | **0.000**** |

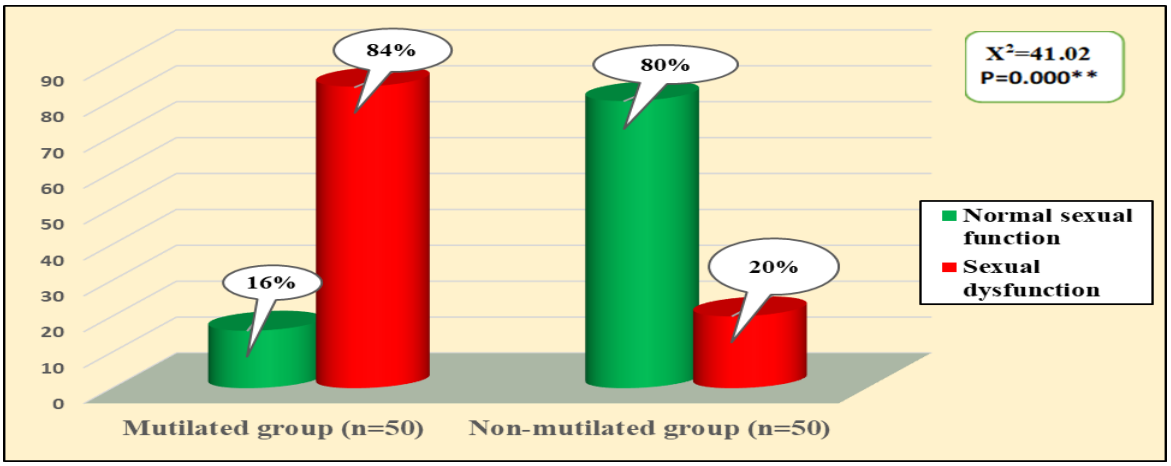


**Figure (1):** Percentage distribution of the studied women according to their total score of sexual functions.

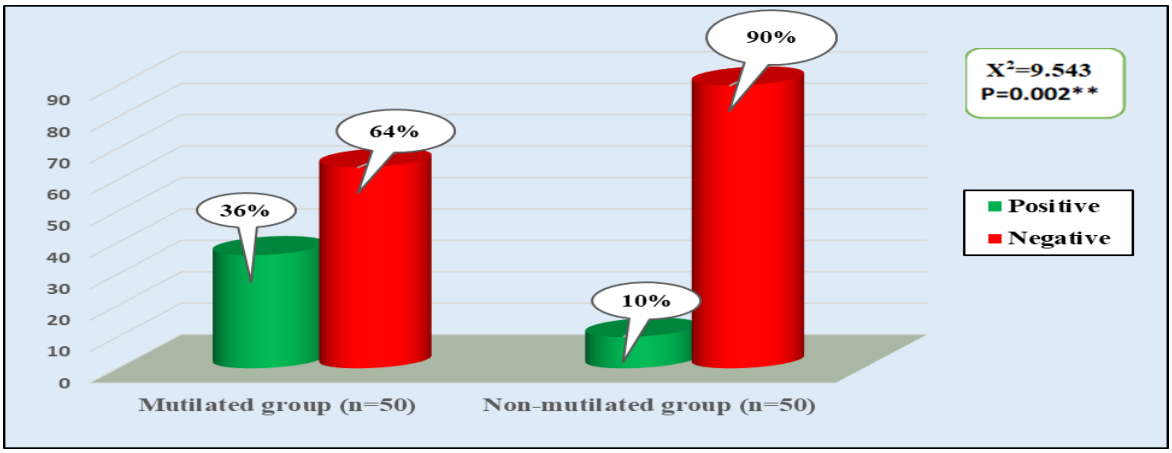


**Figure (2):** Percentage distribution of the studied women according to their total attitude regarding female genital mutilation.

## Discussion:

Female genital mutilation (FGM) remains a deeply rooted cultural practice in many parts of the world, particularly in Africa and the Middle East. Despite growing global efforts to eradicate this harmful tradition, it continues to affect millions of women and girls. The consequences of FGM are not limited to immediate physical harm but extend to long-term psychological, reproductive and sexual health issues. One of the most concerning outcomes is the potential impact of FGM on female sexual function, particularly in the context of marital relationships **(Dura, Salih, Aktürk, & Aslan, 2023).**

Regarding socio-demographic characteristics of the studied sample, the current study revealed that the mean age of the mutilated group was 30.44±4.98 years while the mean age of the non-mutilated group was 25.84±2.98 years. This finding was congruent with a study by **Saleh et al., (2020)** that entitled "Effect of female genital cutting performed by health care professionals on labor complications in Egyptian women: a prospective cohort study" in Faculty of Medicine, Cairo University and reported that; the mean age of the mutilated group type I was 30.6±4.0 and type II was 30.5±4.1 years while the mean age of the non-mutilated group was 29.6±4.2 years.

Concerning mutilated women's educational level, the current study revealed that more than half of them had high education. This finding was congruent with a study by **Hanafy, Elhabak, El-Awady, & Abdou, (2020)** that entitled "Sexual consequences of female genital mutilation/cutting: A comparative study" in Faculty of Medicine, Beni-suef University and reported that; more than two thirds of mutilated women had high education. In contrast, this result was incongruent with a study by **Abd-ELhakam, Ebrahim, Mohammed, & Hassan, (2023)** that entitled "Prevalence of Female Genital Mutilation at Beni-Suef Governorate, Egypt" who reported that; the mutilated females were more likely to be illiterate or have limited reading and writing skills than non-mutilated females.

From the researcher's point of view, the higher prevalence of female genital mutilation among women with higher educational level may be because education alone is not enough to change deep-rooted cultural beliefs. In many communities, female genital mutilation is seen as a sign of morality, marriage readiness and social acceptance. As a result, even educated women may face pressure

from family to follow this tradition. Also, in some areas, education doesn't always include proper awareness about the health risks and human rights issues related to female genital mutilation.

Regarding the women's place of residence, the current study revealed that more than two thirds of mutilated women were from rural area. This finding was congruent with a study conducted in Faculty of nursing, Beni-suef University by **Hassan, Abd-ELhakam, Ebrahim, & Mohammed, (2022)** that entitled "Study Females' Attitude toward Female Genital Mutilation" who reported that; more than two thirds of mutilated women were from rural area. The researcher believes that FGM is more common in rural areas because the people in rural area still follow old traditions and FGM is seen as something normal or even necessary for girls to get married and many families do it because their parents and grandparents did the same.

Regarding mutilation history of the mutilated women, in this present study half of women the Daya or midwife was responsible for making the FGM and majority of the mutilated women perform FGM at home. This finding was congruent with a study by **Mahmoud, (2020)** that entitled "Effect of female genital mutilation on female sexual function, Alexandria, Egypt" who reported that; around half of women reported that the procedure was performed by a traditional birth attendant and the majority of the mutilated women perform FGM at home.

In contrast, this result was incongruent with a study conducted in Faculty of nursing, Beni-suef University by **Hassan, Mohammed, Abd-ELhakam, & Ebrahim, (2023)** that entitled "Female Genital Mutilation-study sexual issues" who reported that; more than half of women the doctor was responsible for making the female genital mutilation.

From the researcher's point of view, the preference for performing female genital mutilation at home by a traditional birth attendant may be linked to cultural norms, ease to access and perceived privacy. In many communities, the daya is a trusted figure who has performed the procedure for generations. Families may also believe that doing it at home avoids legal consequences or public judgment. Additionally, in rural areas, medical services may be less available or less affordable making the home setting with a daya the more practical and familiar choice.

Regarding to age at female genital mutilation, the current study revealed that more than two thirds of the studied mutilated women their age at FGM was 10-15 years. This finding was congruent with a study by **Hassan et al., (2023)** who reported that; around three quarters of the studied mutilated women their age at FGM was 10-15 years.

From the researcher's point of view, FGM is often performed on girls between the age of 10 and 15 for several reasons such as many communities believe that performing FGM at young age helps reduce a girl's sexual desire before puberty, thus preserving chastity and preventing premarital sexual activity and at this age girls still physically and emotionally dependent on their families making it easier for parents to carry out the procedure before girl reaches maturity and is able to resist the procedure.

Regarding the person responsible for making the decision of FGM, the current study revealed that more than half of the studied mutilated women the mother was responsible for making the decision to undergo female genital mutilation. This result was congruent with a study by **Hanafy et al., (2020)** who reported the same result. In contrast, this result was incongruent with a study by **Mahmoud, (2020)** who reported that; around half of the studied mutilated women the grandma was responsible for making the decision to undergo female genital mutilation.

From the researcher's point of view, the mother is often the main decision maker regarding FGM due to her direct role in raising the daughter and managing issues related to her upbringing and behavior. Cultural norms often place the responsibility of preserving the girl's reputation and preparing her for marriage on the mother. Additionally, mothers may feel societal pressure and fear judgment if they deviate from traditional expectation. As a result, the decision to perform FGM is frequently driven by maternal influence within the household.

Regarding the types of FGM, the current study revealed that most of the studied mutilated women had type II (Excision) of FGM. This result was congruent with a study conducted in Faculty of Medicine, Cairo University by **Elbendary, Shokry, Deeb, & Morsi, (2021)** that entitled “Female genital mutilation (FGM): Is it still existing problem in Egypt?” who reported that; most of women who had undergone FGM were subjected to type II of the procedure. In contrast, this result was incongruent with a study by **Raheem et al., (2020)** who reported

that; more than two thirds of the studied mutilated women had type I (Clitoridectomy) of FGM.

Regarding complications of female genital mutilation, the current study revealed that more than half of the studied mutilated women had history of complications from the mutilation and the most frequent complication of FGM was severe pain. This finding comes in line with a study conducted in Sierra Leone by **Bjalkander, Bergstrom, Almroth, & Leigh, (2022)** that entitled "Female Genital Mutilation in Sierra leone: who are the decision makers?" who reported that; the majority of the respondents had history of complications from the mutilation and majority of them suffer from pain.

In contrast, this result was incongruent with a study by **Abd-ELhakam et al., (2023)** who reported that; only around one third of mutilated women had history of complications from the mutilation. From the researcher's point of view, the high rate of complications among mutilated women may be due to the unsafe and non-medical conditions in which the procedure is often performed. Many procedures are carried out by untrained traditional birth attendants using unsterile instruments without anesthesia or proper hygiene. This increases the risk of immediate complications such as bleeding and infections as well as long term issues like scarring, pain or genital deformities. In addition, the lack of medical follow-up or awareness about post-procedural care contributes to the severity and persistence of these complications.

Regarding the female sexual function, the current study revealed that the cases had lower mean sexual function than control in all aspects namely sexual desire, arousal, lubrication, orgasm, satisfaction and pain. Furthermore, the mean scores of the total sexual functions score among the mutilated group was 16.95±6.95 while the mean scores among the non-mutilated group was 26.35 ±3.02 over the past 4 weeks.

This result is, also, in agreement with a study by **Dura, Salih, Aktürk, & Aslan, (2023)** that entitled "The Impact of Female Genital Mutilation on Sexual Function: A Study Conducted in Rural Sudan" who reported that; the mutilated women had lower mean sexual function than non-mutilated women in all aspects namely sexual desire, arousal, lubrication, orgasm, satisfaction and pain. Whereas, the mean scores of the total sexual functions score among the mutilated group was 23.21±3.58 while the mean scores among the non-

mutilated group was 27.37±2.96 over the past 4 weeks.

Furthermore, this result is consistent with a study conducted in Italy by **Pérez-López et al., (2020)** that entitled "Association of female genital mutilation and female sexual dysfunction: a systematic review and meta-analysis" who reported that; the mutilated women had lower mean sexual function in all aspects namely sexual desire, arousal, lubrication, orgasm, satisfaction and pain compared to non-mutilated women.

From the researcher's point of view, female genital mutilation negatively affects female sexual function mainly because it involves the removal or damage of sensitive genital tissues that are essential for sexual pleasure. The clitoris, in particular, plays a central role in female sexual arousal and orgasm. When it is partially or totally removed the woman may experience a significant reduction in sexual desire, arousal and ability to reach orgasm. Additionally, female genital mutilation often lead to pain during intercourse, scarring and psychological trauma which can further reduce sexual satisfaction and function.

Concerning the attitude of the studied women regarding FGM, the present study revealed that there was a statistical significant difference in attitudes toward FGM between mutilated and non-mutilated women. Overall, non-mutilated women demonstrated significantly more negative attitude toward FGM compared to mutilated women. The majority of the studied non-mutilated women had negative attitude regarding female genital mutilation. While, around two thirds of the studied mutilated woman had negative attitude regarding female genital mutilation.

This result was congruent with a study by **Ahmed, Seid, Seid, & Yimer, (2022)** that entitled "Does previous circumcision and wealth index influence women's attitude to discontinue the practice of female genital mutilation and cutting (FGM/C) in Ethiopia?" who reported that; the non-mutilated women demonstrated significantly more negative attitude toward FGM compared to mutilated women. Also, this result was supported by a study conducted in Alexandria University by **Abdou, Wahdan, & El-Nimr, (2020)** that entitled "Prevalence of female genital mutilation, and women's knowledge, attitude, and intention to practice in Egypt: a nationwide survey" who reported that; a significantly more negative attitude toward FGM was observed

among non-mutilated women in comparison to mutilated women.

From the researcher's point of view, women who have not been circumcised usually have a more negative attitude toward female genital mutilation. This is because they often know more about the harm it can cause to the body and mind. They may have learned this through school, health education or awareness campaigns. Since they did not go through FGM themselves, they do not see it as something normal or necessary. On the other hand, women who were circumcised may believe it is a part of tradition or try to accept it as something they had to go through. Also, uncircumcised women may feel more in control of their own bodies and feel more confident to say that FGM is wrong. For these reasons their attitude is often more negative.

**Conclusion:**

Based on the findings of this study, it is clear that the female genital mutilation has a significant negative impact on women's sexual function after marriage. Most (84%) of women who had undergone FGM reported female sexual dysfunctions and only one fifth (20%) of the studied non-mutilated women had female sexual dysfunctions. These results highlight the serious consequences of this harmful practice on women's physical and emotional well-being. Overall, the findings of the current study achieved the study's aim and answered the research question.

**Recommendations:**

- Health education programs should be organized to raise awareness among women, families and communities about the negative effects of female genital mutilation on women's sexual and psychological health.
- Training for healthcare providers is essential to help them deal with FGM-related complications and to provide proper counseling and support for affected women.
- Religious and community leaders should be involved in campaigns to discourage this practice and clarify that FGM is not a religious obligation.
- Strict enforcement of laws that criminalize FGM is necessary to reduce the prevalence of this harmful practice.

**Further researches:**

- Additional research is required to evaluate the factors that are related to and affect women's post-marital sexual function after undergoing female genital mutilation using both qualitative and quantitative methods.
- Conduct a prolonged study involving a large sample across various settings such as: rural and

urban communities, primary health care centers and women's clinics in different areas of Egypt to assess the sexual consequences of female genital mutilation and to be able to generalize the results.

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