INFLUENCE OF FEMALE CIRMUCISION TYPE ON HER SEXUAL FUNCTIONS

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ABSTRACT

Background: Female genital mutilation/cutting (FGM/C) is a widespread harmful practise in many African, Middle Eastern, and other parts of the world. There are contradicting concepts regarding effects of FGM/C on sexual dysfunction.
Objective: Determination of the impact of type of FGM/C on sexual dysfunction among a sample of Egyptian females.
Methods: In this cross-sectional research, there were a total of 800 married or previously married female participants. They differentiated into two groups: a case group that had been circumcised and a control group that had not been circumcised. Cases underwent detailed present, past and family histories, and the cause of circumcision by parents, history of menstrual cycle, general clinical examination and local genital examination to determine stage of circumcision. Sexual behavior and attitude including orgasm and rigidity, hyper sexuality and dyspareunia was assessed.
Results: In terms of sexual desire, arousal, orgasm, pleasure, and pain, there was a statistically significant difference between type III FGM and other types.
Conclusion: In all instances where FGM was encountered, sexual dysfunction was negatively impacted, particularly with type III.
Keywords: Female Genital Mutilation; Females Sexual Dysfunction; Sexual Desire; Arousal; Pain.

INTRODUCTION

Female genital mutilation/cutting (FGM/C) is a widespread harmful practise in many African, Middle Eastern, and other parts of the world (Sweileh, 2016). WHO defines it as "any operations that result in partial or total removal of the external female genitalia or other forms of damage to the female genital organs for non-medical reasons" *(Ismail et al*., 2017)

In an effort to promote purity, virginity, and chastity, this harmful practise is often performed to restrict a woman's sexual life and diminishes her sexual desire.(Rahman, 2021).Violence against women and girls is a major health and human rights concern. Women can experience physical or mental abuse throughout their lifecycle (Mahfouz *et al.*, 2004).WHO recognises four distinct kinds of FGM/C (Salam, Rehana A.*et al.*, 2016). Type I: Clitoridectomie; partial or total clitoral and/or prepuce removal. Type II: Excision; partial or total clitoral and labia minora excision with or without removing the labia majora. Type III: Infibulation; vaginal aperture reduction with a seal established by the labia minora and/or labia majora being cut and repositioned, with or without clitoris removal. Type IV: All additional potentially dangerous genital operations, including pricking, piercing, incising, scraping, and cauterization.

According to the 2014 Egypt Demographic and Health Survey (EDHS), despite the government's outright ban on this procedure, 92% of married females had undergone FGM/C between the ages of 15 and 49 (El-Zanaty, 2015). In Egypt, Types I and II are commonly the most performed, whereas Type III and type IV are rather uncommon. FGM/C is usually traumatic, and no health advantages have been documented.*(Diouf et al.*, 2020). Its consequences can be medical (ranging from hemorrhage and fatal infection), psychological (including post-traumatic stress and anxiety), or sexual (Andersson *et al*., 2012).

Existing research is ambiguous regarding the effects of FGM/C on sexual dysfunction and desire. Several African research refute the harmful impact of FGM/C on sexual dysfunction. Nonetheless, there is growing evidence that FGM/C harms sexual dysfunction, which seems obvious given the damage to sexually sensitive organs like the clitoris (Biglu *et al*., 2016). Berg and Denison did a meta-analysis on the sexual effects of FGM/C, including 15 papers from seven nations. They reported that the available research were diverse and of different methodological quality (Berg & Denison, 2012).

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This research aimed to determine the effect of FGM/C types on the sexual dysfunction of a sample of Egyptian females who had undergone this operation.

METHODS

This cross-sectional hospital-based research included 800 married or previously married females, between (18 - 40) years old who were apparently healthy. They were recruited from outpatient clinic of Gynecology and Obstetrics in Etay Elbaroud general hospital, Behaira Governate, Egypt. They were classified into:

A. Case group: Circumcised female in middle age in their reproductive life.

B. Control group: Non circumcised females.

Exclusion criteria: Females who had previous history of obstetric complications or any medical conditions affecting sexual dysfunctions as neuropsychiatric disorder or diabetes mellitus, females had body mass index (BMI) more than 25 kg /m^2, females had preexisting liver and kidney diseases, females unable to fill the questionnaire and who refused to participate in the research.

Both groups were subjected to:

- An informed written consent that obtained from participants who shared in the research. The permission of the Ain Shams University Faculty of Medicine's research ethics committee, No. FWA 000017585 at October 2022.
- Detailed present, past and family histories such as chronic diseases (Diabetes, Hypertension, etc), and the cause of circumcision by parents.
- History of menstrual cycle like age of menarche, amount and regularity.
- General clinical examination was done.
- Local genital examination to determine stage of circumcision.
- Sexual behavior and attitude: including Orgasm and Rigidity, Hyper sexuality and Dyspareunia.

Female Sexual Function Index (FSFI): The FSFI is a 19-item measure of female sexual function consisting of six domains: desire, arousal, lubrication, orgasm,

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satisfaction, and pain (Meston, 2003; Rosen *et al*., 2002). Scores for the arousal, lubrication, orgasm, and pain domains range from 0 to 6 using Likert-type scales. Scores for desire range from 1.2 to 6.0, and those for satisfaction range from 0.8 to 6.0. The total score is the sum of the domain scores and ranges from 2 to 36, and the recall period is the past 4 weeks. Higher scores indicate a better level of sexual function.

Satisfaction was measured using related 3 FSFI questions which measured in 3 choices modified Likert scale graded from 0 to 2, where unsatisfaction = 0, indifference = 1, and satisfaction = 2. Satisfaction is considered as (Yes) when the total scores P4 and is considered as (No) when the total score <4.

The Kuppuswamy scale: The modified Kuppuswamy scale is commonly used to measure socioeconomic status (SES) in urban and rural areas. This scale consists of a composite score which includes the education and occupation of the Family Head along with income per month of the family, which yields a score of 3–29. This scale classifies the study populations into five SES (Wani, 2019)

Statistical analysis: Data were entered into the computer using version 24.0 of the IBM SPSS software suite. Quantitative and percentage descriptions were provided for qualitative data. The Chi-square test was used to compare categorical variables between distinct groups. For properly distributed data, the mean and standard deviation were used to characterise quantitative data, whereas for abnormally distributed data, the median, minimum, and maximum were used. For parametric data, the t-test was used to compare two independent populations whereas the F-test (ANOVA) was used to investigate more than two populations. The results of significance tests are expressed as two-tailed probability. At the 5% significance level, the acquired findings were deemed significant.

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RESULTS

Current age in cases group had a range 18-40 with mean value 34.72 ± 3.69 and in controls had a range 18-40 with mean value 28.21± 6.34. Age at marriage in cases group had a range 18-26 with mean value 21.09 ± 2.28 and in controls had a range 1-27 with mean value 20.71 ± 2.93. There was statistical significant difference between the two studied groups regarding basic age (P < 0.05) while there was no statistical significant difference regarding age at marriage (P> 0.05). Table 1

Table (1): Comparison between the two studied groups regarding basic age and age at marriage, socioeconomic status

	Cases "n=400"	**Controls "n=400"**	**t-Test P value**
Current age			
Range	18.0-40.0	18.0-40.0	4.262
Mean	34.72	28.21	0.001*
SD	3.69	6.34	
Age at marriage			
Range	18.0-26.0	1.00-27.0	4.173
Mean	21.09	20.7100	0.092 N.S.
SD	2.28	2.93726	

T = student t-test, N.S. = Not significant, *: statistically significant as P value <0.05

Table (1) showed that, current age in cases group had a range 18-40 with mean value 34.72 ± 3.69 and in controls had a range 18-40 with mean value 28.21± 6.34. Age at marriage in cases group had a range 18-26 with mean value 21.09 ± 2.28 and in controls had a range 1-27 with mean value 20.71 ± 2.93. There was statistical significant difference between the two studied groups regarding basic age (P < 0.05) while there was no statistical significant difference regarding age at marriage (P> 0.05)

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Table (2): Comparison between the two studied groups regarding socioeconomic status between circumcised and non-circumcised females

socioeconomic status	Cases "n=400"		Controls "n=400"		□2 Test P value
Educational level	No	%	No	%	
Read, write	132	33.0	124	31.0	1.320 0.517 N.S.
Secondary	160	40.0	176	44.0	
University	108	27.0	100	25.0	
work status Housewife	240	60.0	196	49.0	9.759 0.001*
Work	160	40.0	204	51.0	
Residence Rural	248	62.0	176	44.0	26.014 0.001*
Urban	152	38.0	224	56.0	
social level (according to income) High	60	15.0	72	18.0	1.869 0.393 N.S.
Low	156	39.0	160	40.0	
medium	184	46.0	168	42.0	

x2 = Chi square-test, N.S. = Not significant, *: statistically significant as P value <0.05

Table (2) showed that, there was statistical significant difference between the two studied groups regarding work status and residence (P < 0.05) while there was no statistical significant difference regarding educational level and social level (P > 0.05)

Table (3): Distribution of cases regarding type of FGM

Type of FGM	No	%
I	220	55.0
II	160	40.4
III	20	5.0
Total	400	100.0

Table (3) showed that type I was higher with 220(55%) followed by type II with 160(40.4%) and type III with 20(5%).

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Table (4): Relation between the sexual function among circumcised and non circumcised females

	Cases "n=400"	**Control "n=400**	**t test P value**
Sexual desire Mean	2.96	3.97	17.31
SD	0.83	0.82	<0.001*
Arousal Mean	2.04	4.06	35.12
SD	0.80	0.83	<0.001*
Lubrication (use of fixed artificial lubricant) Mean	2.60	4.50	24.54
SD	1.11	1.08	<0.001*
Orgasm Mean	1.24	4.01	48.25
SD	0.82	0.81	<0.001*
Satisfaction Mean	2.43	4.31	22.88
SD	1.13	1.19	<0.001*
Pain Mean	2.90	3.84	15.02
SD	0.89	0.90	<0.001*
Total score	14.16 ± 2.37	24.69 ± 2.38	62.86 <0.001*

t= t-test, *: statistically significant as P value <0.05

Table (4) shows that the cases had lower mean sexual function than control in all aspects namely sexual desire, sexual arousal, lubrication, orgasm, satisfaction, and pain, with total score of 14.16 ± 2.37 for cases and 24.69 ± 2.38 for control (P < 0.000)

Table (5): Comparison between the two studied groups as regarding sexual activity

	Cases "n=400"		**Control "n=400"**		**□2 P value**
	No	**%**	**No**	**%**	
Sexual desire No	236	59.0	172	43.0	20.488 0.001*
Yes	164	41.0	228	57.0	
Arousal No	260	65.0	168	42.0	42.528 0.001*
Yes	140	35.0	232	58.0	
Lubrication (use of fixed artificial lubricant) No	196	49.0	204	51.0	5.138 0.14 N.S.
Yes	204	51.0	172	43.0	
Orgasm No	244	61.0	172	43.0	25.96 0.001*
Yes	156	39	228	57.0	
Satisfaction No	256	64.0	192	48.0	20.77 0.001*
Yes	144	36.0	208	52.0	
Pain No	188	47.0	248	62.0	18.147 0.001*
Yes	212	53.0	152	38.0	

X^2= Chi square-test, N.S. = Not significant, *: statistically significant as P value <0.05

Table (5) shows that, there was statistical significant difference between two studied groups regarding sexual desire, arousal, orgasm, satisfaction, and pain (P < 0.05) while there was no statistical significant difference regarding lubrication (P > 0.05)

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Table (6):comparison between the two studied groups as regarding sexual activity

	Type of FGM						□2 P	P1 P2 P3
	I		II		III			
	No	%	No	%	No	%		
Sexual desire No	128	58.2	88	55.0	20	100.0	15.017 0.001*	0.514 0.001* 0.001*
Yes	92	41.8	72	45.0	0	0.0		
Arousal No	148	67.3	92	57.5	20	100.0	15.225 0.001*	0.081 0.003* 0.001*
Yes	72	32.7	68	42.5	0	0.0		
Lubrication (use of fixed artificial lubricant) No	108	49.1	76	47.5	12	60.0	1.113 0.57 N.S	0.685 0.122 0.107
Yes	112	50.9	84	52.5	8	40.0		
Orgasm No	124	56.4	100	62.5	20	100.0	14.926 0.001*	0.110 0.001* 0.003*
Yes	96	43.6	60	37.5	0	0.0		
Satisfaction No	156	70.9	80	50.0	20	100.0	29.419 0.001*	0.036* 0.022* 0.001*
Yes	70.9	64	50.0	100	0	0.00		
Pain No	100	45.5	80	50.0	8	40.0	1.182 0.554 N.S	0.611 0.584 0.399
Yes	120	54.5	80	50.0	12	60.0		
Total	220	100.0	160	100.0	20	100.0		

X2= Chi square-test, *: statistically significant as P value <0.05, p1 comparison betwee type I and II, p2 cmparison between type I and III, p3 comparison between type II and III.

Table (6) showed that, there was statistical significant relation between type of FGM with sexual desire, arousal, orgasm, and satisfaction (P < 0.05), while there was no statistical significant relation regarding lubrication and pain (P > 0.05) in cases group.

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DISCUSSION

This research was conducted to investigate the impact of FGM type on the reproductive and sexual health of females. Etay Elbaroud general hospital's outpatient clinic of gynecology and obstetrics provided the participants for this research, which comprised a total of 800 different ladies. They were separated into two groups: those who had undergone female circumcision and a controls (non-circumcised) group.

According to our results, the age at which female genital mutilation (FGM) was performed had a range 9 to 13 years old, with a mean value of 10.27 0.98. The percentage of females who underwent FGM at the age of 10 to 12 years old was the highest at 67 percent, followed by those who were older than 12 years old at 30 percent (3 percent).

In addition, the educational level indicated no significant difference between the two groups, however there was a substantial variation in the employment position of the participants.

In agreement with our results, Kaplan *et al*. 2011 study the sexual consequences of FGM : A comparitive study, this study was carried on 2000 subjects, there was significant difference between the two studied groups regarding age, work, level of education.(Kaplan *et al*., 2011).

The current study indicated a substantial relationship between female genital mutilation/cutting (FGM/C) and a deterioration in female sexual dysfunctioning, with significant differences in the total and individual FSFIdomain scores between cases and controls.

This drop is also seen by the decrease in sexual activity between cases and controls. Our findings are comparable with those of previous research examining the relationship between FGM/C and female sexual dysfunctiondeclared by Mahmoud *et al.,* 2016 also another study by Biglu *et al.*, 2016.

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In a recent research conducted in Egypt by Mahmoud *et al*.,2016 , the overall FSFI score for patients was 14.3 ± 5.93 against 25.8 ± 3.44 for controls (P = 0.000).

Biglu *et al.* (Biglu *et al*., 2016) also shown that circumcised females had substantially lower overall scores than uncircumcised females (17.9 ± 5.39 against 25.3 ± 4.40, p = 0.000).

In the research conducted by Alsibiani and Rouzi on 260 Saudi females, there was no variations in the mean scores for pain or desire may be due to environmental factors.While there were statistically significant variations in arousal, lubrication, orgasm, and pleasure, as well as the total sexual dysfunction score, between circumcised and uncircumcised females, there were no differences in sexual dysfunction may be due to small sample size compared to this study (Alsibiani & Rouzi, 2010).

In contrast to our study, in a research conducted by Catania et al., females with type III FGM/C exhibited higher scores than controls in FSFI in desire, arousal, orgasm, and satisfaction; however, this research was confounded by a mismatched controls comprised primarily of western females (Catania *et al*., 2007). In this case-controls research, we attempted to minimise this confounding variable by recruiting controls with comparable cultural origins, residences, and levels of education.

In agreement with our results, Yassin *et al*., (2018), study Characteristics of female sexual dysfunctions and obstetric complications related to female genital mutilation in Omdurman maternity hospital, Sudan, The finding of this study showed that the FGM is strongly associated with sexual and obstetric complications. Another key finding of this study is that all the forms of FGM are responsible for a high percentage of complications. (Yassin *et al.*, 2018)

This could be explained by the fibrosis and rigid scar tissue following FGM which predispose to narrowing of the vaginal orifice and muscular spasm that make intercourse painful and difficult. These physical factors again contributed to

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psychological factor, where the painful sexual practice will drive women to lose both sexual desire and satisfaction.

Inconsistent to our study, (Thabet *et al.,* 2003) evaluated 147 Egyptian females and found that those who underwent type I FGM/C did not have a loss in sexual dysfunction, however those who received type II or type III circumcision experienced a number of sexual issues. (Thabet *et al.,* 2003). Andersson et al. found that sexually active females who had undergone FGM/C type III had substantially different SQOL-F scores than sexually active controls, but not types I and II (Andersson *et al*., 2012).

CONCLUSION

In all instances where FGM was encountered, sexual dysfunction was negatively impacted, particularly with type III.

RECOMMENDATION

Further researches are needed to study the full range of FGM effects on physical, mental and psychosocial life of women. Moreover planned health education campaigns are mandatory to elude the drawbacks of FGM and haards of continuation this practice

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تأثير نوع ختان الإناث على وظائفها الجنسية

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المستخلص

الخلفية: يعد تشويه / قطع الأعضاء التناسلية للإناث ممارسة ضارة واسعة الانتشار في العديد من بلدان أفريقيا والشرق الأوسط وأجزاء أخرى من العالم. هناك مفاهيم متناقضة فيما يتعلق بتأثيرات ختان الإناث على العجز الجنسي.

الهدف: تحديد تأثير نوع ختان الإناث على العجز الجنسي للإناث المصريات.

الطريقة: في هذا الدراسة المقطعية، كان هناك مجموعة من ٨٠٠ مشاركة متزوجة أو تزوجت سابقًا تم تقسيمهم بين مجموعة الحالات التي تم ختانها ومجموعة ضابطة لم يتم ختانها. خضعت الحالات للتاريخ التفصيلي والماضي والعائلي، وسبب الختان من قبل الوالدين، وتاريخ الدورة الشهرية، والفحص السريري العام والفحص التناسلي الموضعي لتحديد مرحلة الختان. تم تقييم السلوك والمواقف الجنسية بما في ذلك النشوة والصلابة والجنس المفرط وعسر الجماع.

النتائج: من حيث الرغبة الجنسية، والإثارة، والنشوة، والسرور، والألم، كان هناك فرق ذو دلالة إحصائية بين تشويه الأعضاء التناسلية الأنثوية من النوع الثالث والأنواع الأخرى.

الخلاصة: في جميع الحالات التي تمت فيها مواجهة تشويه الأعضاء التناسلية الأنثوية، تأثر الضعف الجنسي سلبًا، لا سيما مع النوع الثالث.

الكلمات المفتاحية: تشويه الأعضاء التناسلية الأنثوية؛ العجز الجنسي للإناث؛ الرغبة الجنسية إثارة؛ ألم