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# Experience of Female Genital Cutting and Sexual Satisfaction Among Rural Married Women in El Beheria Governorate

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**Abstract**

**Background:** Female Genital Cutting is a complex issue requiring continuing care for girls and women who may be at risk or may have been undergone this harmful practice.

**Objective:** Assess the experiences of Female Genital Cutting and its relation to sexual satisfaction among rural women in El Beheria Governorate.

**Design**: cross-sectional descriptive design.

**Settings:** The study was carried out at 16 rural health units representing the 16 health zones in El Beheria Governorate.

**Subjects:** A convenience sample of 800 women selected from the previously mentioned setting (50 from each health unit).

**Tools:** Two tools were used for data collection. The first tool was women's experience of FGC structured interview schedule to identify data related to personal and socio-demographic characteristics, their experience of FGC, as well as their attitude towards FGC, which was assessed through 21 statements in three points Likert scale. The second tool was sexual satisfaction Scale to assess the sexual satisfaction among the married women.

**Results**: Findings of the present study revealed that the majority (90.0%) of the women had undergone FGC. Moreover, less than two thirds (63.0%) of the women had positive attitude toward combating FGC. Additionally, around one tenth 9.8% of the women suffered from low sexual satisfaction compared to 18.4% of them who had high satisfaction. Moreover, significant correlations were found between women's experience of FGC and their attitude toward it as well as with their sexual satisfaction.

**Conclusion:** The study concluded that FGC is highly prevalent practices among rural women. There are a significant association between women's experience of FCG and their attitude towards it as well as with the women's sexual satisfaction.

**Keywords:** female genital cutting, rural areas, violence against women

## 1. Introduction

Women represent half of the society. They are the cornerstone of the family and assume responsibility for many of its most function, not only in regard to health and education, but also in food production and income generation. Therefore, the health of the women is prerequisite for the health of the whole family and by extension of communities and societies (United Nations, 2014).

Women health is often characterized by neglect, abuse, violence, and discrimination. Women are vulnerable to violence and its profound effect at all stages of life (United Nations, November 2018).

Violence against women and girls is perhaps the most widespread and socially tolerated patterns of human right violation. It remains a key global public health problem associated with poor physical, sexual and mental outcomes for victims and has potential negative lifelong consequences (United Nations November 2018; Guimei, Fikry & Esheiba, 2012).

Throughout the last two decades, women health became a major concern for the international society in order to

end all forms of violence against women including Female Genital Cutting (FGC) (United Nations, November 2018; September 2018).

Female Genital Cutting (FGC) is one of the most traditional practices which is harmful to health and is profoundly rooted in many Sub- Saharan African countries. It is estimated that more than 200 million girls and women alive today have undergone female genital mutilation in the countries where the practice is concentrated. Furthermore, there are an estimated 3 million girls at risk of undergoing female genital mutilation every year. The majority of girls are cut before they turn 15 years old. (UNICEF, 2016; WHO, 2018)

The practice of Female Genital Cutting is still widely prevalent in Egypt despite efforts to eradicate it. According to Egypt Demographic Health Survey (EDHS) 2015, the prevalence of FGC among ever married women aged 15 to 49 years is 78%. Furthermore, it more prevalent in rural governorates where its prevalence reaches 92.6% (El Zanaty 2015).

Unlike most other countries where FGC is prevalent, in Egypt, the practice is performed mainly by medical personnel. According to the EDHS 2015, around two thirds of the circumcisions performed by trained medical personnel. However, Daya was performing more circumcision in rural areas (El Zanaty, 2015; UNICEF, 2013)

The reasons given to justify FGC are numerous and reflected the ideological and historical situation of the societies in which it has been developed. Reasons cited are generally related to tradition, power in equalities. Additional causes may include maintaining tradition, reducing sexual desire, hygiene, cleanness, and religious approval (Yirga, Kassa, Welday et al 2012; Berg & Denison, 2013)

The immediate and long-term health consequences of FGC vary according to the type and severity of procedure performed. However, all types include both physical and psychological, sexual consequences. It may result in sever deterioration of the current and future quality of life. The consequences of this harmful practice can range from infection to problems in child bearing and marital life (WHO, 2011)

Female genital mutilation (FGM) is a deeply rooted tradition in Egypt, and is a problem that matters a lot and that needs to be studied and understood. Assessing the experience and attitude of FGC and its consequences among the main victims is a very important measure towards the movement of discharging this long held tradition from the society which is suffering from its immediate as well long-term consequences. It has a great significance in the preparation for bringing an attitude change in mothers and to empower them above all by understanding that most common reasons for the practice of FGM stem from direct or indirect attitude of down grading women and looking at them as beings created to serve the other sex and it is this social attitude which is playing an important role that needs to be destroyed in order to achieve at behavioral change (UNICEF, 2018; Varol, Fraser, Jaldesa et al 2014)

Improvement of maternal health is incorporated in the sustainable development goals (SDG) as one of the prerequisites for development and poverty reduction (Byrne,2013; Edouard, Olatunbosun, Edouard 2013) The study results will be used at all levels that are hoped to play a part in the improvement of maternal health which is the main role of the community health nurse.

Female Genital Cutting is a complex issue requiring vigilance and continuing care for girls and women who may be at risk or may have been undergone this harmful practice (United Nations, November 2018). Through frequent and intensive contact with clients in different settings, community health nurses are in a prime position to act on prohibition of this harmful practice. Community health nurses play a crucial role in preventing FGC through promoting girls' and women's health and identifying those who are at risk for FGC and taking action to protect them (McCrae and Bynoe 2015; Clark 2008)

### *1.1 Aims of the Study*

The aim of the study is to:

1. Assess the experiences of female genital gutting among rural women in El Beheria Governorate.

2. Identify the effect of female genital cutting on marital and sexual life satisfaction.

### *1.2 Research Questions*

1. How do rural women who have undergone female genital cutting perceive the practice?

2. What is women’s attitude towards FGC?

3. What is the effect female genital cutting on marital and sexual life satisfaction?

## 2. Materials and Method

### *2.1 Materials*

#### 2.1.1 Research Design

The cross-sectional descriptive design was adopted to carry out this study.

#### 2.1.2 Setting

The study was carried out at 16 rural health unit/center representing the 16-health district in El Beheria Governorate. The selected units have the highest attendance rate. They are illustrated as follow;

| Health district | Selected health center |
|---|---|
| Abo El Matameer | El huria |
| Housh Isa | Elkom elakhder |
| El Delingate | Zaweyt Hammour |
| El Tahreer | Abobaker elsedeek |
| West El Noubarya | Biesar |
| El Natroan Valley | Elhamraa |
| Damanhour | Kfr Bny Helal |
| El Mahmoudya | Sronbay |
| Abo Homous | Gwad hosny |
| Kafr Eldawar | Kom elbraka |
| El Rahmanya | Somokhratt |
| Shoubrakhiet | lakanh |
| Kom Hamada | Saftt elenb |
| Itay Al Baroud | Elawamer |
| Edco | Elmaadia |
| Rosetta | Mahlt Elamir |

#### 2.1.3 Subjects

- The sample size was estimate using Epi info 7 statistical program using the following parameters; prevalence of FGC 78%, with 99% confidence level and 5% maximum error. The minimum sample size estimated to be 673 women. The final sample size will be 800 women to compensate for possible non-response.
- A convenient sample of 50 married women were selected from each of the previously mentioned settings. Married women should be willing to participate in the study.

#### 2.1.4 Tools for Data Collection

In order to collect the necessary data for the study three tools were used:

**Tool (I): Women's experience of FGC structured interview schedule:** It was developed by the researchers to collect the necessary data from the married women. It included two parts:

**First part: Married women's personal and socio-demographic data:** It included the age, level of education, occupation, income, living condition and husband's age, level of education and occupation, religion.

**Second part: Women's experience of FGC:** It included data about experiences of FGC, person conducting FGC, place and time of conducting FGC, causes behind acceptance/ non-acceptance of FGC, health problems experienced during and after circumcision and their intent to circumcise their daughters.

**Third part: Women's attitude towards FGC:**

It was developed by the researchers after reviewing of recent literatures. It is a three-point Likert scale with 21 statements related to the following domains; societal & religious beliefs about FGC (3 items), Benefits of FGC (6 items), Consequences/harms of FGC (8 items), and Own and community support of FGC (4 items). Participants should indicate the extent of their agreement or disagreement with each statement using a three-point Likert scale ranging from agree, undecided and disagree. The scoring was as follows: agree (2), undecided (1), and disagree (0). The total score was calculated and converted into percent score classified as follow, women with positive attitude towards FGC (those who discourage FGC) were those who had total attitude % score ≥ 50 % score. On the other hand, those with negative attitudes towards FGC (those who

encourage FGC) were those who had total attitude % score < 50 % score.

**Tool (II): Sexual Satisfaction scale:**

It was developed by the researchers after reviewing of recent literatures. The sexual satisfaction scale comprised 9 questions with three responses [ agree = (2), undecided= (1) and disagree= (0)].The total score of sexual satisfaction scale distinguished between low satisfaction (score 0-6), moderate satisfaction (score 7- 13) and high satisfaction (score 14-18).

*2.2 Method*

- Approval of responsible authorities was obtained through official letters from the Faculty of Nursing.
- Meetings were held with the directors of the selected settings to clarify the purpose of the study and to gain their cooperation and support during data collection.
- Tool (I) and (II) were developed by the researchers after reviewing the recent relevant literature. It was validated by juries of (5) experts in the field. Their suggestions and recommendations were taken into consideration.
- Cronbach Alpha Coefficient was used to ascertain the reliability of tool (I) parts (II and III) and (II) after translation into Arabic language, (r = 0.89 for tool I part I, r = 0.83 for part III and 0.91 for tool II).
- Pilot study was carried out on 80 women who were randomly chosen from a family health center not included in the sample namely, "Sharnoub in Damanhour, Feesha in Elmahmoudya and om hakim in Shoubrakhiet " in order to ascertain the relevance, clarity and applicability of the tools, test wording of the questions and estimate the time required for the interview. Based on the obtained results, the necessary modifications were done.

*2.3 Ethical Considerations*

- Informed oral consents were obtained from the married women after brief explanation of the purpose and nature of the research.
- The anonymity and confidentiality of responses, voluntary participation and right to refuse to participate in the study were emphasized to women. The researcher explained the objectives of the study to the participants.
- Data was collected by the researchers during the period from January 2018 to May 2018 (18 weeks).

*2.4 Statistical Analysis*

- After data were collected, they were coded and transferred into specially designed formats so as to be suitable for computer feeding. Following data entry, checking and verification processes were carried out to avoid any errors during data entry, frequency analysis, cross tabulation and manual revision were all used to detect any errors. The statistical package for social sciences (SPSS version 20) was utilized for both data presentation and statistical analysis of the results. The level of significance selected for this study was P equal to or less than 0.05.

**3. Results**

Table 1 shows that less than half (45.2%) of the women aged less than 30 years old, while 17.8% of them aged forty years and more with a mean of 32.45±7.203. The vast majority (96.2%) of the women were Muslims and more than half (54.5%) were urban dwellers. Concerning their educational level, the table shows that more than one quarter (27.4%) of them were illiterate or just could read and write while those who completed their university education constituted 15.5%. On the other hand,85.7% of them were housewives. The table also portrays that 25.8% of the women's husbands were illiterate and the vast majority (97.5%) of them were working. Furthermore, the table reveals that the mean marriage age for the studied women was 21.65±.3.245 and more than one third (37.8%) of the women had been married for less than 5 years, while the mean family size was 4.52±1.348. Additionally, less than three quarters (72.0%) of the studied women reported income insufficiency and 15.3% of them were of lower social level compared to 22.3% of them who were of high social level.

Table 2 portrays the experience of FGC among the studied women. It was found that the majority (90.0%) of the studied women had undergone FGC and around one fifth (20.8%) of them had undergone FGC at age of less than ten years, compared to 25.7% of them who were circumcised at age of fifteen years and more**.** Furthermore, the table illustrated that more than one third (35.0%) of the circumcised women had the procedure done by physicians, while Daya /traditional birth attendant (TBA) had conducted FGC for 38.6% of them. The same table shows that all women mentioned that their opinion was not taken before the procedure and 80.0% of them were

circumcised at home. Furthermore, two fifths (40.0%) of the women experienced immediate consequences of FGC mainly pain, urinary problems and fear (75.0%, 59.7% and 47.9% respectively). Lastly, more than one quarter (29.7%) of the circumcised women mentioned that they suffered from FGC's long-term complications, mainly diminished sexual pleasure, dyspareunia as mentioned by 73.8% and 47.7% of them respectively.

Table 2 illustrates the experience of FGC among the studied women's daughters. It was noticed that among those who have daughters, more than half (51.6%) of them had undergone FGC for their daughters and the decision for FGC taken mainly by grandparents (66.0%) followed by mothers themselves (50.3%) and fathers (23.4%). One the other hand, less than three quarters (73.1%) of them was circumcised by physicians and the rest with circumcised by Daya or Traditional birth attendants, while, less than three quarters (72.8%) of them experience immediate complications after FGC in the form of psychological shock (31.7%) and fever (25.4%). Concerning the causes for FGC, it was mainly for religious requirement, preserve pureness and chastity, and social tradition as mentioned by 76.9%, 58.7% and 53.5% of them respectively.

The same table portrays that young age of the daughters, fear of complications and fear of law criminalization were the main causes mentioned by those who did not perform FGC for their daughters (60.6%, 33.3% and 18.8% respectively). On the other hand, 61.7% of those women claimed that they have the intention to perform FGC to their daughters in the future.

Figure 1 portrays that more than half (51.6%) of the women did not circumcise their daughters yet and less than two thirds (61.7%) of the women intend to circumcise their daughters in the future.

Figure 2 shows that less than two thirds (63.0%) of the women had positive attitude towards combating FGC. Concerning benefits of FGC, 31.6% of the women had positive attitude compared to 61.0% of them who had positive attitude towards its harms. While, 36.4% of the women had positive attitude regarding societal and religious beliefs about FGC. On the other hand, 45% of the women had positive attitude towards own and community support of FGC.

Figure 3 illustrates that less than one tenth (9.8%) of the women had low sexual satisfaction compared to 18.4% of had high satisfaction. While, less than three quarters (71.8%) of the women had moderate sexual satisfaction.

Table 4 illustrated the correlation between the women's demographic characteristics and their attitude toward FGC. The table reveals a significant correlation between the women's age and their attitude towards FGC where positive attitude toward FGC was more prevalent among those aged less than thirty years compared to those aged more than 40 years (74.0% and 72.5% respectively) ($X^2$ = 65.89 P=0.000).

Furthermore, positive attitude toward FGC was more encountered among Christians and those women from urban areas (73.3% and 64.9% respectively).

It was found that women's education and occupation had a significant effect on their attitude toward FGC ($X^2$= 53.09 P=0.000, $X^2$= 23.58 P=0.000 respectively), where positive attitude was more encountered among highly educated and working women (76.6% and 83.3% respectively).

The same table portrays that husbands' education and occupation had a significant effect on the women's attitude toward FGC ($X^2$= 90.22 P=0.000, $X^2$= 12.71 P=0.000 respectively), where positive attitude was more encountered among highly educated and working husbands (76.6% and 83.3% respectively).

Additionally, positive attitude toward FGC was more encountered among those women from higher social class and those who reported income sufficiency (73.6% and 71.5% respectively) with a statistically significant relation between attitude toward FGC and family social level and income sufficiency ($X^2$= 71.43 P=0.000, $X^2$= 46.18 P=0.000 respectively).

Lastly, statistically significant relations were found between attitude toward FGC and circumcision of daughters and intention to do so in the future ($X^2$= 37.95 P=0.000, $X^2$= 13.54 P=0.000 respectively) where positive attitude toward FGC was less prevalent among those women who circumcised their daughters and declared that they would do so in the future (59.3% and 54.5% respectively).

Table 5 illustrated the correlation between the women's demographic characteristics and their sexual satisfaction. The table portrays a significant correlation between the women's age and their sexual satisfaction where high satisfaction was less encountered among those aged less than thirty years compared to those aged more than 40 years (65.2% and 73.2% respectively) ($X^2$ = 114.75 P=0.000).

Moreover, high sexual satisfaction was more prevalent among Christians and those women from urban areas (46.7% and 28.0% respectively) with statistically significant relations between sexual satisfaction and religion and place of residence ($X^2$= 17.88 P=0.000, $X^2$= 61.31 P=0.000 respectively).

It was noticed that women's education and occupation had a significant effect on their sexual satisfaction ($X^2$= 74.03 P=0.000, $X^2$= 222.90 P=0.000 respectively), where high sexual satisfaction was more encountered among highly educated and working women (43.5% and 43.9% respectively).

The same table portrays that husbands' education and occupation had a significant effect on the sexual satisfaction ($X^2$= 91.08 P=0.000, $X^2$= 23.21 P=0.000 respectively), where low satisfaction was more encountered among illiterate and nonworking husbands (15.5% and 40.0% respectively).

Additionally, women's age at marriage has a significant effect on the women sexual satisfaction ($X^2$= 324.82 P=0.000) where low sexual satisfaction was more encountered among those women who married at age less than 20 years old (39.3%) compared to 4.8% of those married at age 30 years and more. On the other hand, it was found that the larger the family size, the lower the sexual satisfaction as low sexual satisfaction was more encountered among those families with nine members and more compared to those families with three to five members (15.0% and 8.8% respectively).

Lastly, statistically significant relations were found between sexual satisfaction and income sufficiency and family social level ($X^2$= 9.973 P=0.000, $X^2$= 392.59 P=0.000 respectively) where low sexual satisfaction was less prevalent among those women from high social class and those who reported income sufficiency (3.4% and 1.9% respectively).

Table 6 illustrated the correlation between the women's experience of FGC and their attitude toward FGC and sexual satisfaction.

The table reveals a significant correlation between the women's experience of FGC and their attitude towards FGC (F= 33.138, P= 0.000) where total attitude toward FGC mean score was higher among non-circumcised women (31.28 ± 7.630) than circumcised women (14.17 ± 3.861).

Additionally, the total sexual satisfaction mean score was lower among circumcised women compared to non-circumcised women (4.32 ± 1.425, and 6.227 ± 2.691 respectively) with a significant correlation between the women's experience of FGC and their sexual satisfaction (F= 5.812, P= 0.000).

Table 1. Distribution of the women according to their socio demographic characteristics

| Subjects' characteristics | Total N=800 | |
|---|---|---|
| | No | % |
| **Age (years)** | | |
| - 20- | 362 | 45.2 |
| - 30- | 296 | 37.0 |
| - 40+ | 142 | 17.8 |
| X ± SD | 32.45 ±7.203 | |
| **Religion** | | |
| - Muslims | 770 | 96.2 |
| - Christians | 30 | 3.8 |
| **Place of residence** | | |
| - Urban | 436 | 54.5 |
| - Rural | 364 | 45.5 |
| **Wife's level of education** | | |
| - Illiterate / read & write | 220 | 27.4 |
| - Completed basic education | 108 | 13.6 |
| - Completed secondary / technical education | 348 | 43.5 |
| - Completed university education and more | 124 | 15.5 |
| **Wife's occupation** | | |
| - Working | 114 | 14.3 |
| - Non-working (housewife) | 686 | 85.7 |
| **Husband's level of education** | | |
| - Illiterate / read & write | 206 | 25.8 |
| - Completed basic education | 68 | 8.4 |
| - Completed secondary / technical education | 360 | 45.0 |
| - Completed university education and more | 166 | 20.8 |
| **Husband's occupation** | | |
| - Working | 780 | 97.5 |
| - Non-working | 20 | 2.5 |
| **Wife's age at marriage(year)** | | |
| - <20 | 150 | 18.7 |
| - 20- | 464 | 58.0 |
| - 30+ | 186 | 23.3 |
| X ± SD | 21.65±3.245 | |
| **Duration of marriage (year)** | | |
| - <5 | 302 | 37.8 |
| - 5- | 136 | 17.0 |
| - 10- | 132 | 16.5 |
| - 15+ | 230 | 28.7 |
| X ± SD | 10.13±7.635 | |

Table 1 cont.

| Items | Total N=800 | |
|---|---|---|
| | No | % |
| **Family size** | | |
| - 3- | 434 | 54.2 |
| - 6- | 306 | 38.3 |
| - 9+ | 60 | 7.5 |
| X ± SD | 4.52 ±1.348 | |
| **Income sufficiency** | | |
| - Enough | 576 | 72.0 |
| - Not enough | 224 | 28.0 |
| **Crowding index** | | |
| - <2 | 774 | 96.8 |
| - 2 | 16 | 2.0 |
| - >2 | 10 | 1.2 |
| **Family social level** | | |
| - Low | 122 | 15.3 |
| - Middle | 500 | 62.5 |
| - High | 178 | 22.2 |

Table 2. Distribution of the studied women according to their experience of FGC

| Items | Total N=800 | |
|---|---|---|
| | No | % |
| **Experience of FGC** | | |
| - Yes | 720 | 90.0 |
| - No | 80 | 10.0 |
| **Age at FGC** | **N= 720** | |
| - <10 | 150 | 20.8 |
| - 10- | 385 | 53.5 |
| - 15+ | 185 | 25.7 |
| **Who perform FGC** | | |
| - Physician | 252 | 35.0 |
| - Nurse | 140 | 19.4 |
| - Daya/ TBA | 278 | 38.6 |
| - Health barber | 50 | 6.9 |
| **Place of conducting FGC** | | |
| - Home | 576 | 80.0 |
| - Private hospital/ clinic | 137 | 19.0 |
| - Governmental hospital | 7 | 1.0 |
| **Opinion taken before FGC** | | |
| - Yes | 0 | 0.0 |
| - No | 720 | 100.0 |
| **Circumcised alone or with other girls** | | |
| - Alone | 502 | 69.7 |
| - With other girls | 218 | 30.3 |
| **Immediate reaction to FGC** | | |

| | | |
|---|---|---|
| - No | 432 | 60.0 |
| - Yes# | 288 | 40.0 |
| • Pain | 216 | 75.0 |
| • Bleeding | 60 | 20.8 |
| • Fever | 48 | 16.7 |
| • Inflammation | 63 | 21.9 |
| • Urinary problems | 172 | 59.7 |
| • Fear and shock | 138 | 47.9 |
| **Long term complications** | **N= 720** | |
| - No | 506 | 70.3 |
| - Yes# | 214 | 29.7 |
| • Diminished sexual pleasure | 158 | 73.8 |
| • Dyspareunia | 102 | 47.7 |
| • Psychological problems | 72 | 33.6 |
| • Urinary problems | 66 | 30.8 |

# Multiple answers were allowed

Table 3. Distribution of the studied women according to their daughters' experience of FGC

| **Items** | **Total N=800** | |
|---|---|---|
| | **No** | **%** |
| **Having female daughters** | | |
| - Yes | 713 | 89.1 |
| - No | 87 | 10.9 |
| **Daughters' experience of FGC** | **N= 713** | |
| - Yes | 368 | 51.6 |
| - No | 345 | 48.4 |
| **Reasons of FGC #** | **N= 368** | |
| - Cleanliness | 142 | 38.6 |
| - Pureness & chastity | 216 | 58.7 |
| - Religious requirement | 283 | 76.9 |
| - Social tradition | 197 | 53.5 |
| - Enhance fertility | 146 | 39.7 |
| | | **Who perform FGC** |
| - Physician | 269 | 73.1 |
| - Daya / TBAs | 99 | 26.9 |
| **Who took the decision of FGC#** | | |
| - Mother | 185 | 50.3 |
| - Fathers | 86 | 23.4 |
| - Grandmother/grandfather | 243 | 66.0 |
| **Immediate reactions to FGC** | | |
| - No | 100 | 27.2 |
| - Yes# | 268 | 72.8 |
| • Pain | 20 | 7.5 |
| • Bleeding | 49 | 18.3 |
| • Fever | 68 | 25.4 |
| • Urinary problems | 59 | 22.0 |
| • Fear and shock | 85 | 31.7 |
| **Reasons for not performing circumcision#** | **N= 345** | |
| - Young age of the daughter | 209 | 60.6 |
| - Fear of complications | 115 | 33.3 |
| - Fear of law criminalization | 65 | 18.8 |
| **Intension to circumcise the daughters** | | |
| - Yes | 213 | 61.7 |
| - No | 132 | 38.3 |

# Multiple answers were allowed

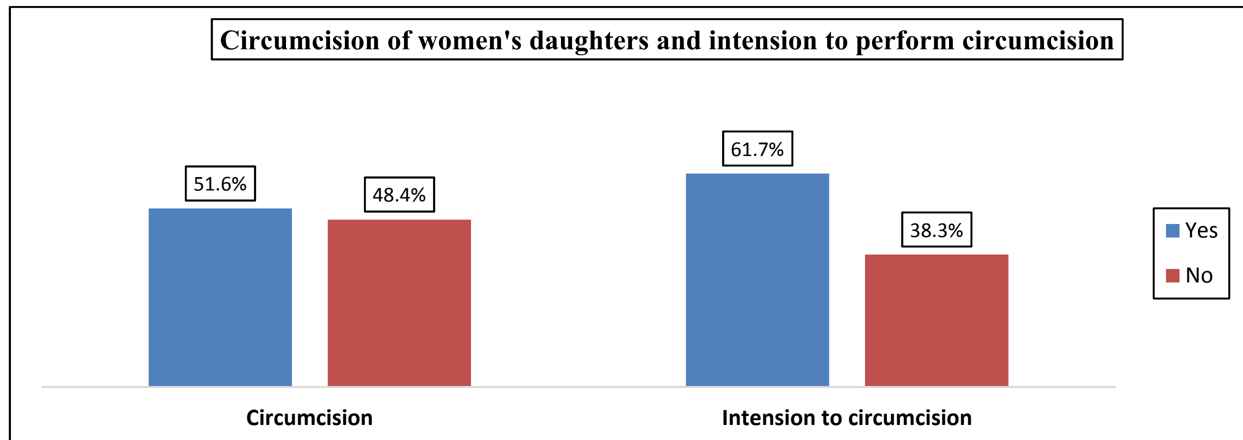


Figure 1. Distribution of the studied women according to their daughters' circumcision and intension to circumcision

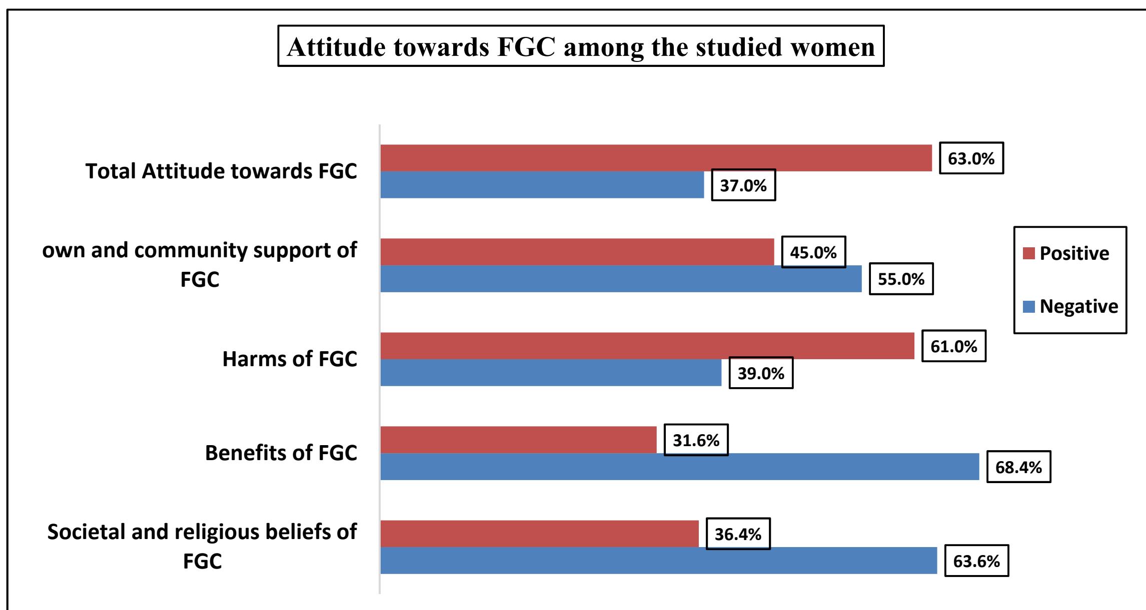


Figure 2. Distribution of the studied women according to their attitude towards FGC

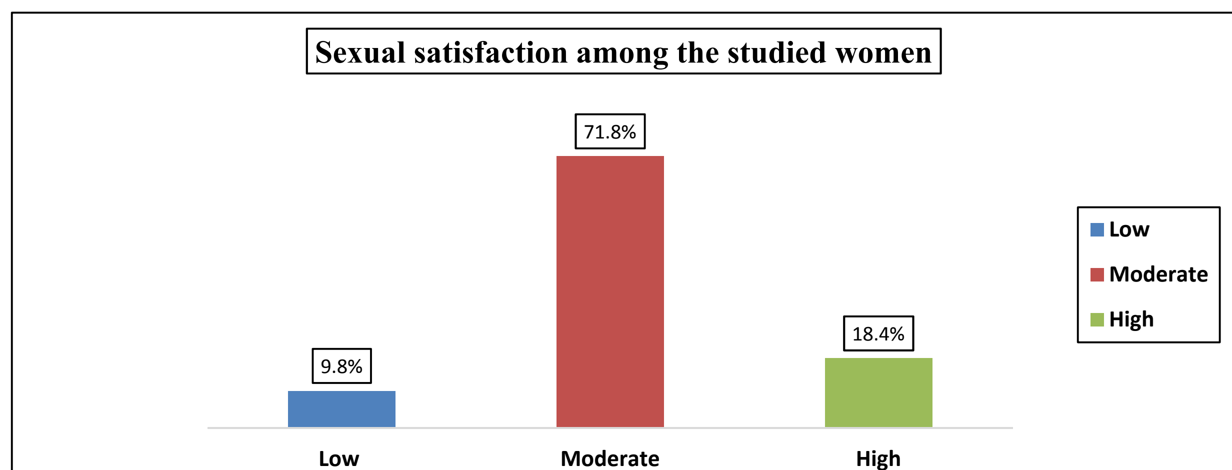


Figure 3. Distribution of the studied women according to their sexual satisfaction

Table 4. Relation between the women's attitude towards FGC and their socio demographic characteristics

| Items | Attitude towards FGC | | | | Total | | Test of significance |
|---|---|---|---|---|---|---|---|
| | Negative (those who encourage FGC) (N=296) | | Positive (those who discourage FGC) (N= 504) | | (N= 800) | | |
| | No | % | No | % | No | % | |
| **Age (years)** | | | | | | | |
| - 20- | 94 | 26.0 | 268 | 74.0 | 362 | 45.2 | $X^2$= 65.89 |
| - 30- | 163 | 55.1 | 133 | 44.9 | 296 | 37.0 | P= 0.000* |
| - 40+ | 39 | 27.5 | 103 | 72.5 | 142 | 17.8 | |
| **Sex** | | | | | | | |
| - Muslims | 288 | 37.4 | 482 | 62.6 | 770 | 96.2 | $X^2$= 1.428 |
| - Christians | 8 | 26.7 | 22 | 73.3 | 30 | 8.3 | P=0.232 |
| **Place of residence** | | | | | | | |
| - Urban | 153 | 35.1 | 283 | 64.9 | 436 | 54.5 | $X^2$= 1.497 |
| - Rural | 143 | 39.3 | 221 | 60.7 | 364 | 45.5 | P=0.221 |
| **Women's education** | | | | | | | |
| - Illiterate / read & write | 119 | 54.1 | 101 | 45.9 | 220 | 27.4 | $X^2$= 53.09 |
| - Basic education | 50 | 46.3 | 58 | 53.7 | 108 | 13.6 | P=0.000* |
| - Secondary education | 98 | 28.2 | 250 | 71.8 | 348 | 43.5 | |
| - University education | 29 | 23.4 | 95 | 76.6 | 124 | 15.5 | |
| **Women's occupation** | | | | | | | |
| - Working | 19 | 16.7 | 95 | 83.3 | 114 | 14.3 | $X^2$= 23.58 |
| - Non-working (housewife) | 277 | 40.4 | 409 | 59.6 | 686 | 85.7 | P=0.000* |
| **Husbands' education** | | | | | | | |
| - Illiterate / read & write | 123 | 59.7 | 83 | 40.3 | 206 | 25.8 | $X^2$= 90.22 |
| - Basic education | 39 | 57.4 | 29 | 42.6 | 68 | 8.4 | P=0.000* |
| - Secondary education | 100 | 27.8 | 260 | 72.2 | 360 | 45.0 | |
| - University education | 34 | 20.5 | 132 | 79.5 | 166 | 20.8 | |
| **Husband's occupation** | | | | | | | |
| - Working | 281 | 36.0 | 499 | 64.0 | 780 | 97.5 | $X^2$= 12.71 |
| - Non-working | 15 | 75.0 | 5 | 25.0 | 20 | 2.5 | P=0.000* |
| **Income sufficiency** | | | | | | | |
| - Enough | 164 | 28.5 | 412 | 71.5 | 576 | 72.0 | $X^2$= 64.18 |
| - Not enough | 132 | 58.9 | 92 | 41.1 | 224 | 28.0 | P=0.000* |
| **Family social level** | | | | | | | |
| - Low | 86 | 70.5 | 36 | 29.5 | 122 | 15.3 | $X^2$= 71.43 |
| - Middle | 163 | 32.6 | 337 | 67.4 | 500 | 62.5 | P=0.000* |
| - High | 47 | 26.4 | 131 | 73.6 | 178 | 22.3 | |
| **Circumcision of daughter** | | | | | | | |
| - Yes | 290 | 40.7 | 423 | 59.3 | 713 | 89.1 | $X^2$= 37.95 |
| - No | 6 | 6.9 | 81 | 93.1 | 87 | 10.9 | P=0.000* |
| **Intension to daughter's circumcision** | N=131 | | N=214 | | N=345 | | |
| - Yes | 97 | 45.5 | 116 | 54.5 | 213 | 61.7 | $X^2$= 13.54 |
| - No | 34 | 25.8 | 98 | 74.2 | 132 | 38.3 | P=0.000* |

$X^2$ Chi square test * Significant at $P \leq 0.05$

Table 5. Distribution of the studied women according to their sexual satisfaction and their socio demographic characteristics

| Items | Sexual Satisfaction | | | | | | Total (N= 800) | | Test of significance |
|---|---|---|---|---|---|---|---|---|---|
| | Low (N=78) | | Moderate (N= 574) | | High (N= 148) | | | | |
| | No | % | No | % | | | No | % | |
| **Age (years)** | | | | | | | | | |
| - 20- | 10 | 2.8 | 236 | 65.2 | 116 | 32.0 | 362 | 45.2 | $X^2$= 114.75 |
| - 30- | 36 | 12.2 | 234 | 79.1 | 26 | 8.8 | 296 | 37.0 | P= 0.000* |
| - 40+ | 32 | 22.5 | 104 | 73.2 | 6 | 4.2 | 142 | 17.8 | |
| **Religion** | | | | | | | | | |
| - Muslims | 78 | 10.1 | 558 | 72.5 | 134 | 17.4 | 770 | 96.2 | $X^2$= 17.88 |
| - Christians | 0 | 0.0 | 16 | 53.3 | 14 | 46.7 | 30 | 8.3 | P=0.000* |
| **Place of residence** | | | | | | | | | |
| - Urban | 46 | 10.6 | 268 | 61.5 | 122 | 28.0 | 436 | 54.5 | $X^2$= 61.31 |
| - Rural | 32 | 8.8 | 306 | 84.1 | 26 | 7.1 | 364 | 45.5 | P=0.000* |
| **Women's education** | | | | | | | | | |
| - Illiterate / read & write | 24 | 10.9 | 180 | 81.8 | 16 | 7.3 | 220 | 27.4 | $X^2$= 74.03 |
| - Basic education | 12 | 11.1 | 82 | 75.9 | 14 | 13.0 | 108 | 13.6 | P=0.000* |
| - Secondary education | 30 | 8.6 | 254 | 73.0 | 64 | 18.4 | 348 | 43.5 | |
| - University education | 12 | 9.7 | 58 | 46.8 | 54 | 43.5 | 124 | 15.5 | |
| **Women's occupation** | | | | | | | | | |
| - Working | 45 | 39.5 | 19 | 16.7 | 50 | 43.9 | 114 | 14.3 | $X^2$= 222.90 |
| - Non-working (housewife) | 33 | 4.8 | 555 | 80.9 | 98 | 14.3 | 686 | 85.7 | P=0.000* |
| **Husbands' education** | | | | | | | | | |
| - Illiterate / read & write | 32 | 15.5 | 156 | 75.7 | 18 | 8.7 | 206 | 25.8 | $X^2$= 91.08 |
| - Basic education | 10 | 14.7 | 52 | 76.5 | 6 | 8.8 | 68 | 8.4 | P=0.000* |
| - Secondary education | 20 | 5.6 | 284 | 78.9 | 56 | 15.6 | 360 | 45.0 | |
| - University education | 16 | 9.6 | 82 | 49.4 | 68 | 41.0 | 166 | 20.8 | |
| **Husband's occupation** | | | | | | | | | |
| - Working | 71 | 9.1 | 567 | 72.7 | 143 | 18.3 | 780 | 97.5 | $X^2$= 23.21 |
| - Non-working | 8 | 40.0 | 7 | 35.0 | 5 | 25.0 | 20 | 2.5 | P=0.000* |
| **Wife's age at marriage** | | | | | | | | | |
| - <20 | 59 | 39.3 | 63 | 42.0 | 28 | 18.7 | 150 | 18.7 | $X^2$= 324.82 |
| - 20- | 10 | 2.2 | 419 | 90.3 | 35 | 7.5 | 464 | 58.0 | P=0.000* |
| - 30+ | 9 | 4.8 | 92 | 49.5 | 85 | 45.7 | 186 | 23.3 | |
| **Family size** | | | | | | | | | |
| - 3- | 38 | 8.8 | 306 | 70.5 | 90 | 20.7 | 434 | 54.3 | $X^2$= 5.218 |
| - 6- | 31 | 10.1 | 227 | 74.2 | 48 | 15.7 | 306 | 38.3 | P=0.265 |
| - 9+ | 9 | 15.0 | 41 | 68.3 | 10 | 16.7 | 60 | 7.5 | |
| **Income sufficiency** | | | | | | | | | |
| - Enough | 11 | 1.9 | 476 | 82.6 | 89 | 15.5 | 576 | 72.0 | $X^2$= 9.973 |
| - Not enough | 67 | 29.9 | 98 | 43.7 | 59 | 26.3 | 224 | 28.0 | P=0.007* |
| **Family social level** | | | | | | | | | |
| - Low | 52 | 42.6 | 50 | 41.0 | 20 | 16.4 | 122 | 15.3 | $X^2$= 392.59 |
| - Middle | 20 | 4.0 | 450 | 90.0 | 30 | 6.0 | 500 | 62.5 | P=0.000* |
| - High | 6 | 3.4 | 74 | 41.6 | 98 | 55.1 | 178 | 22.3 | |

$X^2$ Chi square test * Significant at $P \leq 0.05$

Table 6. Correlation between the mothers' experience of FGC, attitude towards FGC, their sexual satisfaction

| Items | Mothers' Circumcision | | Total | Test of significance |
|---|---|---|---|---|
| | Yes (N= 720) X ± SD | No (N= 80) X ± SD | (N= 800) X ± SD | |
| **Attitude towards FGC** | 14.17 ± 3.861 | 31.28 ± 7.630 | 22.78 ± 5.435 | F= 33.138 P= 0.000* |
| **Sexual satisfaction** | 4.32 ± 1.425 | 6.227 ± 2.691 | 11.36 ± 3.412 | F= 5.812 P= 0.000* |

F Student t test * Significant at P≤0.05

## 4. Discussion

Female Genital Cutting is a harmful practice which affects all aspects of women's health negatively. It is an extreme form of violence against women which impedes their ability to fully participate in public life, resulting in a disempowering effect on them. (UNFPA, 2018)

According to EHIS 2015 (El Zanaty 2015), 87% of all Egyptian women age 15-49 years have undergone FGC reflecting the fact that FGC is still prevalent in the country. This high prevalence was noticed in the current study finding where the vast majority of the studied married females were circumcised.

Concerning the age at which females undergo FGC, it differs from one community to another. However, FGC is mostly carried out on young girls (UNICEF, 2016; WHO, 2018). In the present study, around three quarters of the circumcised women had undergone FGC at age less than 15 years. This was in accordance with the findings of Rasheed S et al (2011) and EHIS (2015) (El Zanaty 2015) where the highest percentages of the studied females were circumcised at age between nine to less than fifteen years old. The reasons for this practice in this young age are culture based include beliefs that it increases marriage opportunities, enhances fertility, and promotes purity, so it should be done as early as possible. It is viewed as a prerequisite for qualifying for wifehood (Tamire M&Molla M, 2013).

Additionally, the current study findings revealed that none of the studied females were consulted before doing FGC and they were forced to undergo such harmful practice. This finding could be attributed to that in Arabian communities, women raised in a culture of silence marginalizing their opinions and their rights to express them. Additionally, FGC is usually conducted at a young age where little girls may not realize their rights to express their opinions or cannot make decisions that may affect them for the rest of their lives. Similar findings were reported by Hess R et al (2010) who found that more than half of subjects disagreed to undergone FGC. Moreover, Belda S et al (2017) found that the majority of the studied women were forced to undergo FGC.

Regarding the FGC's conductors, in the current study, it was noticed that less than two fifths of the women were circumcised by Dayas/ TBAs which shed the light on the danger role performed by daya or traditional birth attendance particularly among the rural population. Similar findings were reported by EHIS (2015) (El Zanaty 2015)., as Dayas were also responsible for 51.9% of women's circumcision. Furthermore, Rasheed S et al (2011) found that the main perpetrator of this violent practice is Daya.

Concerning the place in which FGC was conducted, the current study revealed that majority of women had undergone FGC at their own homes. This result comes in agreement with Huidy K (2014) and Abo Baker R (2007) who reported that more than three quarters of older females' circumcision had been undertaken at homes. In fact, conducting FGC at homes is very dangerous, as at homes medical care are not available for the victims to undertake if any problem encountered which would worsen and complicate females' health condition with the probability of ending their lives. On the other hand, the study clarified that about one fifth of the women had been circumcised by physicians at private clinics or hospitals. This finding to some extent was similar to what Huidy K (2014) reported that around two thirds of studied subjects had FGC done at private clinics. Performing FGC at health care facilities is an attempt to avoid the harmful consequences of FGC, which have led to medicalization of the such practice. In fact, performance of FGC by health services providers constitutes a break in medical professionalism and ethical responsibility, as well as a violation of the law in most countries. Moreover, increasing trend of medicalization of FGC is considered as a great threat to the abandonment of the practice in many countries. ( UNFPA, 2007; Pearce A,&Bewley S 2014).

FGC is a harmful experience, has may immediate and long-term consequences. The current study showed that two fifths of the studied women undergone FGC reported that they had suffered immediate or short-term

problems. The most frequently mentioned problems were acute pain and urinary problem and psychological shock and fear. This result is expected as one of the FGC conductors is Daya/ TBA who did not use any anesthetic agents or follow any hygienic measures. Psychological trauma was a reaction to the way by which the victims were forced to undergo such dreadful procedure ( Abdel-Azim S 2013 ). This comes in line with Kizilhan J (2011) and Kentenich H (2008) who found that a considerable percentage of subjects experienced immediate complications after FGC. In fact, such findings have to be used to work hardly to raise people's awareness about FGC as inhuman and offensive practice and its harmful impacts on girls' and women's health.

In addition, the current study revealed that more than one quarter of circumcised women suffered long term complications, mainly sexual problems, as they reported having diminished sexual pleasure, dyspareunia and sexual dissatisfaction. These findings come in agreement with Adam T et al (2010), and Sharfi A et al (2013) who found that less than two thirds of circumcised women reported having dyspareunia and did not enjoy sexual intercourse.

Although women‘s sexual satisfaction is determined by several factors, but FGC is a key player. The current study found several significant factors correlates with women’s sexual satisfaction like age, age at marriage and income sufficiency and social level, which were consistent with many researches (Abdel-Azim S 2013; Abd El-Naser T et al 2010; Adam T et al, 2010). The current study found a significant relation between female circumcision and sexual satisfaction, where high sexual satisfaction was more prevalent among uncircumcised women. This may attribute to that FGC entails removal of healthy organs like the clitoris and/or other sensitive parts of the female genitalia without any medical necessity impairing women's sexual functioning and reduces the female sexual response which may lead to anorgasmia and even frigidity (Alsibiani S& Rouzi A,2010; Oyefara J 2015). Furthermore, undergoing such traumatic procedure which occurred in unclear and vague circumstances where little girls did not understand what was going on is a dreadful thing. Also, exposing their own bodies to strangers, who dealt with them in an aggressive way and hurt them, perpetuate those bitter feelings. FGC harmful memories and its accompanying shock and fear may retain with the women and portrays during sexual relations and reflected on their sexual satisfaction. This come in accordance with the study of Oyefara J (2015), Anis T et al (2012) and Andersson S et al (2012) who found that sexual functions were adversely affected among circumcised women. These findings prove that FGC may have negatively affected women's sexual quality of life and these findings have to be taken seriously, as it highlights the serious sexual impacts which make women suffer from such offensive practice depriving them from their sexual rights.

Despite of FGC immediate and long-term consequences, it is still acceptable among the Arabian communities. The current study findings reveal that more than half of the studied women circumcised their young daughters and a considerable proportion of those who did not perform it, expressed intention to circumcise their daughters in the future. Similar findings were reported by Hassanin I et al (2013) and Emam E et al (2011) who found that about three quarters of their subjects had already circumcised their daughters. This could be explained in that it seems that women's attitudes towards FGC had affected their decisions to abstain from subjecting their daughters to FGC (Lien I& Schultz J 2013.) This was reflected in the current study findings, where the majority of those who did not circumcise their daughters or those who do not have intention to do it in the future had positive attitude towards discontinuation of FGC. These findings were in line with those of Afifi M (2017) who found that the intention to perform FGC to the daughters was higher among those women with negative attitude towards discontinuation of female genital cutting.

Furthermore, by looking at the underlying reasons for which women performed FGC for their daughters, it was noticed that the reasons reflecting the fact that culture has the upper hand in formulating people's beliefs in some occasions even where education gets higher. The current study revealed that the among the causes behind supporting FGC among the women were that it preserves girls' pureness and Chasity. In addition, large percentage of the studied women referred to FGC as a religious obligation as well as adherence to social traditions. This result is expected, as when people believe in something, they tend to ignore its harms or bad sides. In addition, FGC is a deeply rooted tradition which passed through from one generation to another despite its devastative effects on girls' and women's health. The inheritance and continuation of such harmful practice reflects the power of culture ( Edouard E,2013; UNFPA,2018). EDHS (2015) (El Zanaty F,2015) reported similar findings, as more than half of women thought that FGC is a religious requirement and less than half of them believed that the practice deters adultery. Furthermore, Yasin B et al (2013) reported that the common reasons for practicing FGC were cultural tradition and religion.

It was surprising to find that more than three quarters of the women in the current study believed that FGC is a religious requirement. In fact, some Muslims still consider FGC as a religious duty which was reflected in the present study where significant association was found between attitude towards FGC and religion where most of

those who courage FGC were Muslims. FGC is practiced by Muslims and others, including Christian and Jewish. Thus, FGC is not confined to Islam. Moreover, Islam and other religions call for human dignity and body integrity instead of violating others' rights and committing violence where Quran and Sunnah don't include them (Asmani I& Abdi M 2008). Such claim reflects lack of religious awareness and misunderstanding as well as misinterpretation of religious texts Thus, true interpretation of religious texts by trusted religious men is essential, as they play an important role in addressing and correcting such illness.

Concerning the women's attitude toward FGC, the present study found that less than two thirds of the women had positive attitudes toward FGC and wanted to combat it especially among those who had been circumcised before. This could be attributed to that the persons' own experience with FGC has a significant impact on formulating their attitudes. These findings come in line with those of Ali A (2012) who found a significant correlation between attitude toward FGC and previous experience of FGC.

Additionally, the current study found that the greater agreement and support for FGC was more prominent among older, rural dweller, less educated, non-working women and those of lower social level. This could be attributed to the fact that attitudes are shaped by peoples' culture in addition to several factors like level of education and social class. Level of education enables the person to be more receptive to new ideas and reject harmful practices and live healthier life. Furthermore, level of income and social class determine the environment in which the person live where believes and traditions play a role in courage or discourage harmful practices like FGC. So, within the rural environment, culture has a significant role in shaping the people's attitude and in turn their practices and in order to portray the full picture of FGC, the role of poverty, low awareness, illiteracy and low social class appear clearly. Such findings come in agreement with Yousef F et al (2017) and Koustuv D et al (2010) who reported that place of residence, education and social class had a significant correlation with the women approval of FGC.

## 5. Conclusion

Based upon the findings of the current study it could be concluded that FGC is a deeply rooted practice particularly among rural population. The majority of the studied women were circumcised at age less than fifteen years old. Moreover, less than two thirds of the studied women had positive attitude towards FGC and their attitude was significantly correlated with age, place of residence, religion, level of education and occupation as well with their social level. The current study found that less than one fifth of the studied women had high sexual satisfaction and several factors were significantly correlated with their satisfaction such as age, marriage' age, income sufficiency and social level. On the other hand, a significant association was found between the women's experience of FGC, attitude towards it and their sexual satisfaction.

## 6. Recommendations

- Raise public awareness about FGC and its legal situation while focusing on women's and girls' rights.
- Enforce the implementation of the laws and legislations which ensure girls' and women's rights and protect them from various forms of violence including FGC.
- Intensify Al Azhar efforts toward combating FGC through publicizing a clear statement on Al Azhar stand with respect to FGC and preparing qualified religious leaders who can convey the FGC abandonment message correctly, preparing and disseminating religious publications that provide arguments disproving the Islamic religious roots of FGC to delink this harmful practice from Islam.

Continue the efforts for empowering girls and women through education and participation economically and socially, using more innovative advanced approaches

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