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Research Article

Effect of Female Genital Mutilation on Female Quality of Life

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Abstract

Objectives: To answer the question, is female genital mutilation has effect on different domains of female QoL (psychological, social, environmental and physiological)?

Patients and methods: The study included 40 men mutilated females and 160 mutilated females. Our candidates were subjected to two questionnaires: 1-WHO QoL BREF questionnaire. All questions were answered by choosing one of five answers then the answer has a score range from one to five. 2- Sexual quality of life questionnaire. Each female was asked 18 questions about their sexual life. All questions were answered by choosing one of ix answers. Finally, comparing total score with QoL BREF questionnaire.

Results: Generally, FGM has inverse proportion relationship with QoL. There were significantly different results between type I & type II only in the social domain and in the total score of sexual QoL questionnaire as P values were 0.019, 0.001 respectively. The higher scores were for type I. Also there were significantly different results between Health-Related QoL (HRQOL) and sexual QoL in total score and in two domains (physical and social) a P value for them was 0.053, 0.056 and < 0.001 respectively.

Conclusion: FGM habit should not be routinely done, and the people should be helped to change these cultural multitudes toward this habit.

Introduction

The joint statement on female genital mutilation issued in April 1997 by WHO, UNICEF and UNFPA gave the following definition to the practice (23): "Female genital mutilation comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural or other non-therapeutic reasons".

The three agencies classified the different types of female genital mutilation as follows:

Type I : Excision of the prepuce, with or without excision of part or the entire clitoris

Type II : Excision of the clitoris with partial or total excision of the labia minora

Type III : Excision of part or all of the external genitalia and stitching/ narrowing of the vaginal opening (infibulations).

Type IV Unclassified: includes pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissue; scraping of tissue surrounding the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts); introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purposes of tightening or narrowing it; and any other procedure that falls under the definition of female genital mutilation given above.

The Islamic Shari 'a Council, the Muslim College and the Muslim Council of Britian (MCB) have condemned the practice of FGM within the Muslim community.

FGM is not an Islamic requirement. There is no reference to it in the Holy Qur'an that states girls must be circumcised. Nor is there any authentic reference to this in the Sunnah, the sayings or traditions of our Prophet (PBUH).

One of the basic principles of Islam comes from the Prophet (PBUH) when he said: "Do not harm yourself or others."

Most Muslims and Muslim countries around the world do not practice FGM. The practice of FGM predates Islam.

FGM is bringing the religion of Islam into disrepute.

"In Islam it is forbidden to mutilate the body, in this sense Female Genital Mutilation is condemnable as it irreversibly harms the woman. It is also prohibited to compel an individual to undertake this operation (Conference, 2006).

Dar al-lfta convened an international conference in November 2006 on the topic of FGM. Participants included scientists, scholars of Islamic law, specialist researchers on the topic, and activists from civil rights organizations in Egypt and around the world. Upon hearing an array of presentations from across the spectrum the conference concluded that the mutilation presently practiced in some parts of Egypt, Africa and elsewhere represents a deplorable custom which finds no justification in the authoritative sources of I lam, the Qur'an and the practice of the Prophet Muhammad.

One of the recommendations of the conference was that taking active action on this front is crucial if we are to remain true to our Islamic values and principles. Islam is a religion of knowledge, learning and research. While it was previously practiced as a social custom (and not a religious matter), the state of today's knowledge makes clear the serious negative effects on women of such practices. As such, it becomes a religious obligation to say unequivocally that the practice of FGM is today forbidden in Islam.

Female Genital Mutilation or FGM is a cultural practice that involves cutting, removing or altering the female external genitalia for non-medical reasons.

FGM is also sometimes known as female circumcision.

Other local terms are:

- Tahoor
- Absum
- Halalays
- Khitan
- Ibi
- Sunna
- Gudnii
- Bondo
- Kutairi

It is estimated that over 24,000 girls under the age of 15 living in the UK are at risk of undergoing the most severe form of FGM at any one time.

FGM results in serious and sometimes life threatening health complications. These include:

- Pain
- Bleeding
- Infections
- Difficulties with childbirth

The health complications are both short and long-term. Some women live with these health complications for the rest of their lives.

The findings of the conference represented a call to the peoples of the Muslim world-in Egypt and beyond-to hold fast to their Islamic identity by ending this deplorable custom in their communities. Injuring oneself or another in any form is expressly and categorically forbidden. In connection with this, it is enough for us to quote the example of our Beloved Prophet-the Mercy to all Mankind-who never subjected any of his daughters to this practice 11.

FGM can result in excessive bleeding during the procedure and can be fatal.

FGM is carried out by untrained women with no medical knowledge in unsanitised and unclean conditions. In the long-term women and girls who have undergone FGM can have problems during menstruation, complications in pregnancy and cysts and scarring. FGM has been shown to cause problems with childbirth and can cause the death of the baby and mother. FGM can be emotionally very damaging. Some girls and women go on to suffer emotional distress, sexual problems and post-traumatic stress.

It is not helpful to define degrees within the practice of female genital mutilation (FGM). Nothing is acceptable, not even a symbolic scratch, since that would be the start of a slippery slope (Mrs. Unaiza Malik).

The Female Genital Mutilation Act 2003 makes it illegal for FGM to be performed in the UK or anywhere in the world on UK citizens or permanent residents of any age.

If you carry out or help in carrying out FGM or if you arrange for someone to undergo FGM you face up to14-years in prison. This means that parents or family members who help arrange FGM in any way are committing a crime.

It is also illegal to take a British national or a permanent resident abroad for FGM or to help anyone trying to do this. There is now a powerful movement against the practice of FGM and anyone who helps to carry out FGM or arranges for someone to undergo FGM or helps to take a British national or British resident abroad to undergo FGM, runs an increasingly high risk of being prosecuted by the police.

FGM is not only illegal in the UK but it is illegal in a growing number of countries where this cultural practice has been prevalent, such as:

- Benin
- Central African Republic
- Chad
- Cote d'Ivoire
- Djibouti
- Egypt
- Eritrea
- Ethiopia
- Ghana
- Guinea
- Kenya
- Niger
- Nigeria
- Senegal
- Tanzania
- Togo
- Uganda

"FGM is prohibited by many international and regional human rights conventions that protect women and children from cruelty and violence as well as protecting them from harmful traditional practices."

FGM and quality of life

FGM is a painful physical and emotional experience for many women and young girls in developing countries. It persists in many African and some Asian and Middle Eastern countries, even where illegal. It is considered a violation of human rights by UNICEF and WHO; it can result in Post-Traumatic Stress Disorder (PTSD) (WHO, 2014).

According to the WHO (2001), about 100 to 140 million girls and women worldwide have undergone FGM; at least two million girls are annually at risk of mutilation. Although most victims are in the countries identified above, they are also increasingly found in Europe, Australia, Canada and the US, primarily among immigrants from Africa and South Western Asia. FGM is a harmful and unacceptable practice. Women who have undergone Female Genital Mutilation (FGM) have a significantly lower sexual quality of life (Wiley, 2012).

Subjects and Methods

This study was conducted at Al-Azhar University hospitals during the period from January 2013 to November 2013.

The study included 200 married sexually active females (aging 18-40 years old). The subjects were divided into 2 groups:

- **Group A:** included 40 non-mutilated females
- **Group B:** included 40 mutilated females

Inclusion criteria

- Married female
- Age ranges from 18 to 40 years old
- Husband not complaining of any sexual problem e.g., erectile dysfunction (ED) or premature ejaculation (PE)

Exclusion criteria

- Patients with psychiatric disorders
- Mentally retarded patients
- Patients with chronic debilitating medical disorders e.g., cardiac disease, renal disease, liver disease or diabetes

Ethical consideration

All subjects were informed about the aim of the study and an informed consent was taken from them (All participants were assured of confidentiality, this interview took place at a separate partition in the outpatient clinic (about 500 females subjected to the interview but only 200 agreed about the questionnaire). Permission was obtained from the Obstetrics and Gynecology Department, AlAzhar University.

All participants were subjected to:

Historv taking: Demographic characteristics, including subjects age, living (urban/rural), originally from (urban/rural) educational level (low, moderate or high) and occupational status (presence/absence).

Chronic illness (diabetes, chronic renal failure and chronic hepatic failure), psychotic patients, drug use, patients under antipsychotic therapy all were excluded.

FGM, complications of mutilation, who performed the FGM (midwives, physicians, nurses or barbers), who decided that (mother, father, the family or grandmothers), their attitude towards FGM for their daughter (agree/disagree/accordingly), reasons given to support the practice (custom, religion, cleanliness, chastity or marriage).

Inspection of the vulva and perineal region to detect local lesions and inspect (type) of FGM to determine whether:

Type I

Partial or total removal of the clitoris (clitoridectomy)

Type II

"Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision) (WHO, 2008).

"Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision) (WHO, 2008).

Assessment of female quality of life: Our candidates were subjected to two questionnaires.

• **WHO QOL BREF questionnaire (WHO, 1997):** General QOL was assessed in our study by Arabic translated version (o- - Gb.) of HRQOL questionnaire.

Each female subject will be asked 26 questions about their life during the past 2 weeks.

All questions were answered by choosing one of five answers then the answer has a score range from one to five. The questions will be classified to four main domains Physical, Psychological, Social relationships (including Sexual) and Environmental.

The sum of the scores of the domain gives us the final score for each patient. This final score was divided on the number of questions for each domain. The result was multiplied by 4.Then we subtract 4 from the result above. Then the resulted number was multiplied by 6.25.The result number was subtracted from 100.This will give us the percentage of affection of QOL for each domain separately. The collected data were analyzed statistically and were presented in tables.

• **Sexual quality of life questionnaire:** Each female was asked 18 questions about their sexual life. All questions were answered by choosing one of six answers then the answer has a score range from zero to five. Then we will compare each question between both our two groups, and two types of FGM in group B.

There was no significant different result between mutilated and non-mutilated groups in the mean age (P value> 0.497) but there was highly significant different in the mean age of marriage (P value < 0.0001), where there was lower age of marriage among mutilated females. Also, there was no significant different result between our two groups in the place of residence (P value > 0.096), but there was significant different results in the place of origin (P value < 0.001) with higher rural origin among mutilated females. There were significant different results in the educational level and in the occupational status as P value was (< 0.001) (Figure 1).

There were significantly different results in physical domain with higher score for age group below 20 years old and in total score of sexual QOL for age group between 20 to 30 years old (P value of both < 0.001) (Table 1).

There was significantly different result in the comparison between groups A&B (P value was <0.001), as majority(60%) of non-mutilated females had moderate educational level, on the other side 72.5% of mutilated female had low level or were uneducated (Table 2).

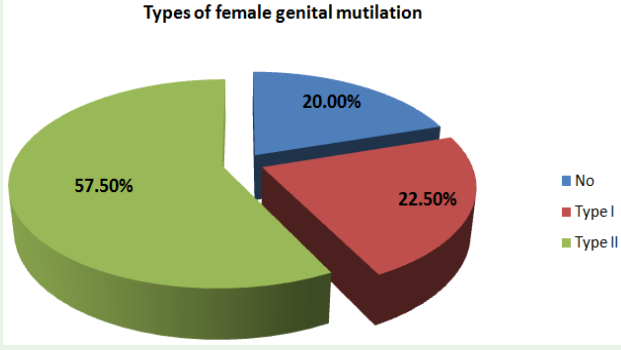

Figure 1: Types of FGM.

Table 1: Effect of age on QoL.

Age groups	<20			20-30			>30			ANOVA	
	Mean	+	SD	Mean	±	SD	Mean	±	SD	F	P-value
Physical	28.333	±	2.605	23.862	±	3.847	23.000	±	5.091	7.982	<0.001*
psychological	16.000	±	3.411	18.655	±	3.843	18.222	±	5.848	1.811	0.166
Social	11.333	±	2.995	10.517	±	3.094	9.611	±	3.187	2.653	0.073
Environment	25.667	±	5.549	25.276	±	5.532	24.111	±	6.543	0.974	0.380
Total QOL	81.333	±	8.414	78.310	±	13.363	74.944	±	17.859	1.598	0.205
Sexual questionnaire	44.333	±	6.457	47.034	±	18.610	33.111	±	16.638	14.281	<0.001*

Table 2: Educational level of the studied groups.

Education	Groups						Chi-Square	
		Group A	Group B		Total			
	N	%	N	%	N	%	X^2	P-value
Low	8	20.00	116	72.50	124	62.00	40.879	<0.001*
Moderate	24	60.00	40	25.00	64	32.00		
High	8	20.00	4	2.50	12	6.00		

Generally FGM has inverse proportion relationship with QoL. As there were significantly different results between groups A & Bin total scores of both questionnaires and in all domains except environmental. With higher scores in all domains including the environmental for the favor of non-mutilated females (Table 6).

There were significantly different results between Type I & Type II only in the social domain and in the total score of sexual QoL questionnaire as P values were0.019&0.001respectively. The higher scores were for type II (Table 7).

Table 3: Educational level of the studied population.

Education level	Low			Moderate			High			ANOVA	
	Mean	+	SD	Mean	+	SD	Mean	+	SD	F	P-value
Physical	23.290	±	4.307	24.500	±	4.646	25.667	+	3.846	2.727	0.068
Psychological	17.968	±	5.334	18.750	±	3.371	20.000	±	2.256	1.407	0.247
Social	10.129	±	2.860	9.875	±	3.632	13.333	±	0.985	6.658	0.002*
Environment	24.774	±	5.414	25.688	±	6.971	21.667	+	3.447	2.420	0.092
Total QOL	76.161	±	14.726	78.813	±	16.206	80.667	±	9.585	0.987	0.375
Sexual questionnaire	37.516	±	18.193	47.563	±	16.824	56.333	±	16.935	11.071	<0.001*

Effect of education on QOL on all subjects, there were significantly different results only in social domain and total score of sexual QOL which were directly proportion with the educational level, as P values of both were 0.002 &0.001 respectively (Table 3).

There was a significantly different result in the comparison between groups A&B (P value was 0.024) as 60% of non- mutilated females were housewives while 77.5% of mutilated females were housewives, indicating higher occupational status among non-mutilated females (Table 4).

Effect of occupational status on QOL on all subjects, working females had higher scores in the whole domains, indicating that occupational status is directly proportion with the QoL. There were significantly different results in all domains and total scores of both questionnaires as P value for all was (**<0.001**) except physical domain which had a P value of (0.002) (Table 5).

Table 4: Occupational status of the studied groups.

Occupation	Groups						Chi-Square	
	Group A		Group B		Total			
	N	%	N	%	N	%	X^2	P-value
Housewife	24	60.00	124	77.50	148	74.00	5.094	0.024*
Working	16	40.00	36	22.50	52	26.00		

Table 5: Effect of occupational status on QoL.

	Occupational status						T-Test	
	Working			Housewife				
	Mean	±	SD	Mean	±	SD	t	P-value
Physical	24.378	±	4.550	22.231	±	3.676	3.069	0.002*
Psychological	19.730	±	3.901	14.385	±	4.420	8.205	<0.001*
Social	10.892	±	2.585	8.385	±	3.830	5.261	<0.001*
Environmental	26.378	±	5.493	20.615	±	4.955	6.670	<0.001*
Total QOL	81.378	±	13.329	65.615	±	13.281	7.343	<0.001*
Total (26)	87.784	±	14.638	70.538	±	14.641	7.308	<0.001*

Table 6: FGM has inverse proportion relationship with QoL

	Groups						T-Test	
	Group A			Group B				
	Mean	±	SD	Mean	±	SD	t	P-value
Physical (DF)	44.929	±	17.529	37.178	±	15.424	2.764	0.006
Psychological (DF)	39.000	±	12.969	30.375	±	24.963	2.112	0.035
Social (DF)	44.166	±	32.479	36.793	±	24.550	2.446	0.015
Environmental (PF)	48.752	±	18.192	46.878	±	18.599	0.572	0.568
Total QOL (DF)	49.791	±	12.850	41.428	±	16.258	3.024	0.0028
Sexual questionnaire	49.800	±	10.236	39.875	±	19.650	3.087	0.002*

Table 7: Effect of FGM type on QoL.

	Type						T-Test	
	Type I			Type II				
	Mean	±	SD	Mean	±	SD	t	P-value
Physical (DF)	43.571	±	14.658	38.850	±	15.575	1.752	0.082
Psychological (DF)	34.000	±	29.127	33.130	±	23.269	0.198	0.844
Social (DF)	36.957	+	24.186	47.038	±	24.242	2.369	0.019*
Environmental (DF)	49.378	±	22.511	45.900	±	16.836	1.064	0.289
Total QOL (DF)	47.154	±	17.927	43.362	±	15.509	1.330	0.186
Sexual questionnaire	31.844	±	15.591	43.017	±	20.231	-3.335	0.001*

Table 8: Correlation between health-related QoL (HRQOL) and sexual QoL.

Correlations		
QOL (HRQOL)	Sexual questionnaire	
	r	P-value
Physical	0.126	0.056
Psychological	0.082	0.251
Social	0.293	<0.001*
Environmental	-0.025	0.725
Total	0.137	0.053*

Table 9: Type of FGM among study population.

	N	%
No	40	20.00
Type I	45	22.50
Type II	115	57.50

Table 10: The previous data are gathered in the following table.

	Group B (mutilated) (%)
Mean age of circumcision ±SD	**10.6 ± 1.6**
Decision- makers	
Whole family	23%
Mother	55%
Grandmother	**20%**
Father	**2%**
Type of FGM	
Type I	28%
Type II	72%
Who performed the procedure	
Traditional midwives (dayas)	46%
Physicians(Doctors)	42%
Nurses	**12%**
Agree/disagree	
Agree	48%
Disagree	52%
Why supporting the procedure	
Cleanliness purposes	42%
Marriageable reasons	23%
Chastity protection	15%
Traditional custom	**10%**
Religious beliefs	**10%**

There were significantly different results between Health-Related QOL (HRQOL) and sexual QoL in total score and in two domains (physical and social) as P value for them was 0.053, 0.056 and < 0.001 respectively (Table 8).

40 females (20%) were non mutilated and 160females (80%) were mutilated. Type I FGM accounts for 23% among whole study population (N: 45) and Type II accounts for 57% (N: 115) (Tables 9 and 10).

Discussion

QOL is the way patients sense and react to their health conditions and to non-medical aspects of their lives. According to this viewpoint, one's QOL comprises factors such as physical, functional, emotional, and intellectual well-being, work, family, friends, and other particulars (Potocka et al., 2009).

L Differentiation must be made between a general and a health related quality of life (HRQOL). The latter includes all QOL areas of life which affect relevant dimensions of the individual's health (Augsutin et al., 2000).

Female genital cutting (FGC), which has also been called female circumcision, is a procedure that has existed for over **2,000** years and is practiced worldwide in many different cultures for a variety of reasons. It is defined as the "medically unnecessary modification of female genitals" (Monahan, 2008).

We assessed the health related quality of life in general with giving special attention to sexual quality of life in females undergone FGM by analyzing a sample group of Egyptian women using a translated version of a validated study instrument (HRQOL) and (sexual QOL) questionnaires.

This study was conducted at Al-Azhar University hospitals (Al-Hussein & Sayed Gala) during the period from January 2013 to November 2013.

The study included 200 married sexually active females. We excluded cases with psychiatric disorders or patients with chronic debilitating medical disorders e.g.: Cardiac disease, renal disease, liver disease or diabetes as their diseases can affect their QOL.

Also we exclude females with husband complaining of any sexual problem e.g.: Erectile Dysfunction(ED) or Premature Ejaculation (PE).

The "Educational Level" for both mutilated and non-mutilated females has a positive correlation with sexual QoL as P value was (0.001) and it's directly proportion with social level as P value was (0.002). In this study the majority (72.5%) of the mutilated females were low or not educated, while the majority (60%) of non-mutilated females were moderately educated. This goes with UNICEF (2005) which states that, FGM prevalence levels are generally lower among females with higher education, indicating that mutilated girls may also likely to grow up with lower levels of education attainment.

Establishing a relationship between a woman's FGM status and her educational level can often be misleading, as FGM usually takes place before education is completed and often before it commences. Therefore, Mothers' level of educational attainment, moreover, appears to be a significant determinant of the FGM status of daughters. It is generally observed that women with higher education

are less likely to have mutilated daughters than women with lower or no formal education (UNICEF, 2005).

Regarding degree of affection of QoL in relation to the "occupation status", we found that the occupational status has positive correlations with the four domains and with the total scores, P values for all was (0.001) except physical domain which had P value of (0.002).Also there were significant different results(P-value: 0.024) among our 2 groups A & B .In the present study, the majority of the mutilated respondents were housewives (77.5%); while non-mutilated females tend to get employed. Also occupation status has significant effect on all domains of quality of life and on both total scores, P value was<0.001 for all. We can conclude that gainful employment empowers women in various spheres of their lives, influencing sexual and reproductive health choices, education and healthy behavior.

For this reason the UNFPA (2007) served Programs which foster women's economic empowerment; so that they are likely to contribute to progress as they can provide incentives to change the patterns of traditional behavior to which a woman is bound as a dependent member of the household.

"Residence" is another variable that can be expected to be associated with the levels of FGM prevalence. In this study it doesn't affect the observed levels of FGM perhaps this because the study was conducted at the capital city. As 90.2% and 86.5% mutilated and non- mutilated females respectively were living in urban areas. Furthermore, 9.8% and 13.5% mutilated and non-mutilated females were living in rural areas respectively. This finding contradicts that of Tag El D in et al.,) (2008) which reports that urban areas contribute with 46.2% while, rural areas 61.7%. However, this finding is in agreement with that reported by UNICEF (2005) as there were some countries in which place of living doesn't affect the observed levels of FGM e.g. Egypt, Guinea, Mali, Ethiopia, Sudan(north), Eritrea, Chad. Also Al-Hussaini (2003) reported that 44.9% of his mutilated cases were living in urban areas and 55.1% were living in rural ones. In addition, some researchers argue that what are observed as clear urban-rural differences "may be somewhat understated due to urban-rural migration. Many of the countries studied are becoming increasingly urbanized. The influx of girls from the rural areas, where prevalence levels are generally higher, into urban areas (UNICEF, 2005).

Hometown, 40.5% of the non-mutilated females and 71.2% of mutilated were from rural areas, (p<0.001). These results were not in agreement with what has been reported by UNICEF which indicates that few differences in prevalence rates can be observed at the regional levels (UNICEF, 2005).This also can be due to the conflicts of urban-rural migration.

The results of the present study show that FGM has a negative impact on both HR-QOL and sexual QOL. This negative impact was obvious in all domains accept environmental and in the total scores of the two questionnaires.

Regarding the "physical domain" of quality of life, There were statistical significant difference between group A and group B as regards the aspect of dissatisfaction with sleep, and this is in agreement with Meyer et al. (1997) who studied life satisfaction with sexual dysfunction and found satisfaction with sexual life has been shown to be an important predictor of satisfaction with life as a whole and reflected on many aspects of life especially satisfaction with sleep.

Other aspects in this domain were not largely affected and this can be explained by the fact that FGM is not that procedure which directly affects energetic activities but has indirect effect on physical aspect through influencing sleep quality or psychological aspect of life.

The present study shows that, the psychological domain of Health related QOL was greatly impaired, There were significant different results between group A and group B showing more degree affection of group B, this can be explained by the significant differences in both groups regarding sexual quality of life, as the development of sexual dysfunction can cause intense emotional distress, depression, loss of self-esteem, poor self-image, and marital discord. The emotional distress may be great enough for the individual to withdraw from his partner. Sexual dysfunction may limit the individual's willingness to initiate a sexual relationship because of a fear of inadequate sexual performance or rejection by the partner. And thus FGM can cause a vicious circle of psychological problems. This is compatible with Laumannand Waite (2008) who demonstrated that sexual dysfunction had an effect on quality of life especially the low feelings of emotional satisfaction and low feelings of emotional satisfaction and low feelings of happiness, Jeong et al., (2011) reported significantly associated sexual dysfunction with highly depressive symptoms, regardless of age, health habit or concomitant comorbidity.

Far from the sexual problems and its impact on psychological domain, other factors should be kept in mind such as, the significant differences in the level of education and occupation, etc.... This affection was obvious in their answer to the question: to what extent do you feel your life to be meaningful? Educated working females seemed to know the aim and purposes of their life much more than others females in our study. This also was clear when we assessed the effect of occupational status on our candidates of both groups. We can conclude that this domain (psychological) shows multi factorial affection and reflects the defects in other aspects of life.

As regards the "social domain" of quality of life, the present study shows that there are significant differences between our two groups. And this can be explained by the negative affection on physical, psychological and sexual aspects of life. Also mutilated females are under depressive irritated mood with lower self-esteem, as mentioned before; this mood exerts a negative impact on their social relationships. This is compatible MacDonach et al., (2002) who observed that sexual dysfunction has a negative impact on their social relationships.

As regards "sexual quality of life", this study shows a statistically significant difference between both groups in satisfaction with overall sexual life (p<0.002), which was not in agreement with Al-Sibiani and Rouzi (2010) study, satisfaction score was 4.5±1.2 in FGM group versus 5±1.4 in control group. This may be attributed to the low rate of overt complaint relative to sexual problems among Egyptian women; it does not indicate lack of sexual interest but rather reflects cultural factors, i.e. shyness, embarrassment and reluctances. In addition, lack of physicians' awareness and training leads to inadequate identification and management of such problems (El-Nashar et al., 2007). And may be explained as a state of deny meaning that, the mutilated females are denying being mutilated and being inferior to the normal females through their statement of being satisfied. This may be considered as the sexual habit of the Egyptian wives due to

many reasons such as sexual inhibition of the female due to lack of sexual culture.

The variation in female sexual function has been shown to be largely explained by non-genetic factors. Such factors may include partner sexual function and perception of sexual compatibility with a partner, factors which may also be associated with sexual distress.

There was positive correlation between total scores of both questionnaires as P value was 0.053.This is compatible with Meyer et al., (1997) who studied life satisfaction with sexual dysfunction and found satisfaction with sexual life has been shown to be an important predictor of satisfaction with life as a whole and reflected on many aspects of life.

When we compared the group of type I mutilated females (23%) with the group of type II mutilated females (57%), we found that there were statically different results between total scores in both HRQOL questionnaire and sexual QOL questionnaire (P-value[1] 0.002^# This means that the psychosexual complication is type dependent and the more severe the operation, the more the complication. This was in agreement with what had been reported by one major study by two Egyptian psychologists who suggests that a woman's sexuality is affected according to the extent of the operation and the degree to which other social messages inhibiting sexual expression are internalized (Karim and Am mar, 19The age at which FGM is performed on girls varies between countries and even from area to area within the same country. FGM is typically performed on young girls who are between 4 and 12 years old, however, the procedure may be carried out shortly after birth to sometime before the age of marriage (WHO,2006).

In the current study, the mean age at which the procedure of FGM was performed was (10.6±1.6) years. This finding largely corresponds with other studies as Tag El-Din et al., (2008) the average age was 10.1±2.3 years. Also it goes in line with UNICEF's data stating that girls in Egypt generally undergo FGM between the ages of 7 and 11 (UNICEF, 2005). And Al-Hussaini (2003) also reported mean age at which FGM was performed was 7.25±2.09 years.

The most common forms of FGM still widely practiced in this study are type II (commonly referred to as excision) and type I (commonly referred to as clitoridectomy). Type II was found in (72 %) while Type I in (28%). Contradicting with, Al-Hussaini (2003) who found that 51% of his respondents performed Type I and 49% Type II and it may refer to the higher percentage of females originated from rural areas and the higher percentage of cases of FGM which performed by traditional midwives in his study.

We noticed during our study that most of females who underwent type I FGM were older than 30 years old, and that was statically confirmed. With adding this note to what was declared by the Demographic and Health Survey (1995), the number of procedures performed by medical practitioners (doctors, nurses or trained midwives) tripled to 55% with a concomitant drop in the use of study. We can explain the shift from type 1 to type 2.The most common form was (type 2a) as noticed during our clinical examination, as doctors prefer to cut from libiaminora than clitoris considering less side effects or affection of sexuality butting most of cases in type 2a.

In the present study, day as (midwives) performed (46%) of FGM and physicians mostly GP or young doctors in their clinics performed (42%) of FGM, while nurses performed only (12%).while. This is in agreement with the report of UNICEF (2005) which stated that in the majority of countries, FGM is performed by traditional practitioners, including midwives. Also, Al-Hussaini's (2003) results showed the majority of the traditional midwives as the practitioners for FGM procedure 79.1%, while, 10.6% were performed by physicians and 4% by nurses. And we disagree with Tag El-Din et al., (2008) whose results showed that 57.3%of the FGM procedure was performed by physicians and 29.3% and 10.4% were performed by midwives and nurses respectively. As in Egypt, in Benin, the Demographic and Health Survey data found that over 90% of daughters' mutilation was performed by traditional practitioners. In developed countries, immigrants asked doctors originally from their own community to circumcise their girls illegally. More frequently, traditional practitioners are brought into the country or girls are sent abroad to be mutilated (Amnesty, 2004).

Although the order of the percentage of FGM performers is the same in our results and the above mentioned results but there is difference in the percentage value of doctors as performers. This can be explained by the increasing trend of the parents for preferring doctors over day as in performing the procedures for their daughters (WHO, 2013).

The results of the present study showed that the mother is the main decision-maker for the procedure of FGM (55%). While, the family as a whole took the decision in (23%) of our respondents. At this point we agree with Tag El-Din et al., (2008) who reported that the main decision maker was the mother 65.2%, while, the whole family represented 24.2% of the decision makers.

This result should direct our strategy to concentrate on changing the attitude of mothers and grandmothers towards the prevention of this violence against girls (Figure 2).

In this study (48%) of mutilated and all non-mutilated refused circumcision for their daughter for its complications but (52%) of mutilated females agreed for continuation of circumcision, and when asked what they believed to be the main reason for continuation of FGM; the majority of them(42%) answered for 'cleanliness or hygiene'. On the contrary to Tag El-Din et al., (2008) it was 18.9%

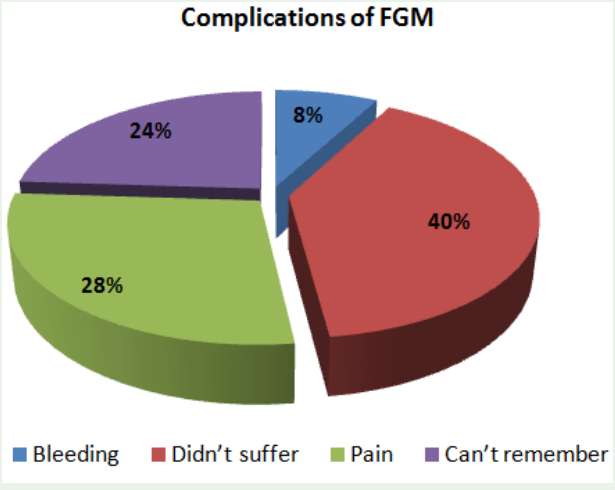

Figure 2: Complications of FGM.

and for Al-Hussaini (2003) warmly 2.4% . This difference may be also attributed to regional variation, which reflects cultural issues. But when we searched deeply for the reasons of this wide difference in our results we came to an explanation which suggests that the candidates by saying cleanliness they refer to the aesthetic judgments of physical appearance, rather than to a concept of actually being dirty, and from our previous local examination we noticed that the general external shape of the genitalia was sometimes distorted with no complain of the female even when she was asked about. This means that it's just a fixed believe that there is something must be remodeled without knowing how it should be like.

Other frequently mentioned reasons include 'marriage', in our study it was the answer of (23%) of the participants, they believed that a girl cannot be married unless she is mutilated. They strongly believed on this up to some of them mentioned that they have been subjected to the circumcision twice, one when they were children and the other one just before marriage. Fourteen and a half percent (14.5%) of respondents in this study cited Chastity protection and inhibition of lustful cravings and so preserves a girl's virginity, prevents her from engaging in immoral behavior as a reason which comes in line with the 15.9% in Tag El-Din et al., (2008) study. While, for Al-Hussaini's (2003) study 10.2% answered so. And as for 'religious' and 'customs' reasons, each of them took (10%).On contrary of the result of UNICEF which claimed that 31% of females in Egypt believe FGM is required by religion (UNICEF, 2005).This difference may result from mixing up who did it for 'chastity' causes with who did it for religious causes as it sometimes can be confusing. Of note, Tag El-Din et al (2008) and Al-Hussaini (2003) who had 33.4% and **0.8**% of their respondents acquired those religious beliefs respectively. Tag El-Din et al., (2008) respondents were 17.9% for custom and tradition' or that it is a 'good tradition' as a reason for their support.

Conclusion

- Generally female quality of life in Egypt is negatively affected by the circumstances in the country and worse among mutilated females.
- Female quality of life among mutilated females with Type I was not much affected if we compare it to non-mutilated females'. But it's much worse among Type II.
- There is a new trend from parents to choose doctors over day as for doing FGM.
- Many doctors just do FGM after they fail to persuade the parents with the hazards of this operation as the doctors know the parents will do it any how and if performed by day as it will carry more risks, so they just cut as little as possible only from libiaminora away from clitoris or even make a tiny wound so the parents will be convinced with the bleeding they see.
- Circumcised women are more likely to flavor continued FGC for their daughters than those who are uncircumcised.
- FGM is multifaceted and complex, legislation alone can't eradicate this deeply rooted social practice.

In conclusion, these findings suggest that this habit should not be routinely done, and the people should be helped to change these cultural attitude toward this habit, and if indicated medically, it should be medically advised and practiced (by a doctor) to avoid over excision of these very sensitive, very important structures, and in operating theater under anesthesia to avoid as much as possible the psychological and organic side effects.

Recommendations

- Although banning of circumcision is a worldwide need, yet banning by law may be associated with the illegal increase of such a procedure practiced by the non-medicals as well as paramedicals. In the latter situation, the procedure is commonly associated with increased risks and complications, in spite of being considered a minor surgical procedure. Successful banning must be conducted through a protocol which includes proper and convincing medical facts against the procedure.
- Any action against FGM is an issue that demands a collaborative approach involving health professionals, religious leaders, educationalists and nongovernmental organizations.
- Improving education level among females will be gradually associated with decrease in its prevalence, and it may die in peace.
- Message to doctors is to convince people, particularly mothers, that this procedure is not routinely indicated, except in rare cases of clitoromegaly or enlarged redundant labia, which are rare cases needs plastic procedure.
- We need to formulate a national questionnaire of sexual function because of difficulty in understanding the universal questionnaire for cultural difference.

Our Study Design has Several Strengths and Weaknesses

1) The study group consisted of women 18 years old up to 40. For this reason our study was limited when we consider females in menopause.
2) This study was done in the capital city of Egypt. For this reason it could not be representative of the situation of rural areas. Therefore, this study does not reflect regional differences among Egyptian females.
3) The possibility of underreporting biases in face-to-face interviews should be considered because of occasional lack of adequate privacy during interviews and women's reluctance to talk about such sensitive issues. Some participants required repeated questioning before they understood the questions.
4) It is noteworthy that the results from this study reflect the practice of FGM in the past, in many cases more than 18 years ago. In more recent years there has been increased awareness of problems associated with FGM in Egypt together with moves towards involvement of the medical profession in this practice.
5) All information with regards to the health and sexual problems of the husband was provided by their wives, as the men were not personally interviewed.

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