Female Circumcision in Ismailia. A Descriptive Study

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Two hundred circumcised married women were randomly selected from those attending the family planning centers of the ministry of health in Ismailia and were compared to a control group randomly selected from noncircumcised women. More than Two thirds of the circumcised women were from rural and one - third from urban population. Both groups were examined gynecologically and for the circumcision group, the degree of circumcision was assessed, further, they were interviewed to obtain psychosexual data using the Sexual Behavior Assessment Schedul-Adult (SEBAS-A).

Our results revealed that while female circumcision was homogeneously distributed in rural (27.5% and 41%) vs urban (31.5%), the highest percentage of uncircumcised women were from Ismailia city (71%, x2= 42.6, P< 0.001).

Circumcised women suffered more from dysmenorrhea (68.5% vs 52.0%, P< 0.05), complications of delivery (P<0.05), dyspareunia (41.5% vs 29.0%, P, 0.05), lack of sexual desire (41.5% vs 26% P< 0.05), loss of sexual enjoyment (44% vs 23%, P< 0.001), and experienced less orgasm (41.5% vs. 29% P< 0.05), than uncircumcised women. However, significantly more circumcised women were inclined and intended to circumcise their daughters in the future (41%) than uncircumcised women (22%, P< 0.001). Our data suggest that the longtudinal transmission of such phenomena should be disrupted through organized programs directed towards young females.

(Egypt.J. Psychiat., 1996,19:137-145).

Introduction

The World Health Organization estimates that over 110 million girls and women have undergone the terror of Female Genital Mutilation (F.G. M.) (Foundation for Women's Health, 1996). Every day 6 thousand african girls undergo this form of cultural torture. Every year 2 million mutilated girls are added to this number. This makes F.G.M. of female african children the widest form of torture in contemporary society and is primarily a children's emergency human right issue. At the time of operation, girls suffer from intense pain and shock. Female Genital Mutilation (F.G.M.) is the term used for

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a variety of genital operations performed on female children (young girls and women) in accordance with traditional beliefs and customs. The severity of the operation varies among communities.

- Circumcision, is the mildest form. It is the cutting of the "hood" of the clitoris.

-Excision is the cutting of the clitoris and all or part of the labia minora is the most severe form in which is excision plus cutting much of the labia majora and the stitching together the sides, leaving a small hole the size of a match stick head for discharge of menstrual blood and urine. The operations are usually carried out without anesthetic on children as young as one month.

Apparently the medical reason for male and female circumcision is hygienic where it indicates a simple removal of the piece of skin and / or membrane covering the external genitalia. However, mutilation of the external sex organs is performed on girls and found in some cultures and countries, like Egypt, involving cutting the clitoris (female circumcision), or more rarely the labia minora nymphectomy) and even the brutal ripping of the vulva (pharaonic mutilation) (Karim, 1993). Apparently the intention is to reduce the sexual responsiveness of women, thus making them safer wives (Kistner, 1986).

Female circumcision is apparently restricted to Egypt and some parts of Africa including Sudan and Ethiopia (Ruminjo, 1992). In female Egyptian mummies from the 16th century B.C. signs of excision were detected (Huber 1966).

In a previous report, Lotfi and El-Defrawi, (1995) suggested that about 80% of the women visiting Maternal and Childhood centers in Ismailia were circumcised and in more than 50% of the sample women suffered complications of such procedures as well as psychosexual problems. The authors have pointed out that female circumcision is still practiced on a large scale in Egypt and called for further systematic studies.

Because previous reports on such procedure have been largely based on selected samples (Karim, 1993), not including urban vs. rural population (Salem 1979, Wassif et al 1994) and focussing mainly on the physical nature and complications of female circumcision rather than the psychological and psychosexual sequaelae (Mahran, 1987). For these reasons, this work was carried out using a systematic random sample of circumcised women, from different urban and rural population and investigating the psychosexual experience using a semistructured interview.

Subjects and Method

Two hundred circumcised married women and a control group of one hundred uncircumcised married women were randomly selected at the family planning centers in Ismailia. Usually the regular procedure at the family planning centers to obtain the client's complain or reason for consultation or visit and then to carry out a general medical and gynecological examinations. These research procedures were initially started by explaining the nature of the study to the women (of both groups) and they were informed about the procedures and content of the work. Over 90% of those women attending the centers agreed to participate in the study because of its benign nature. Also, their consent for the psychiatric interview was obtained before inclusion in the study. This study was carried out in the first six months of the year 1995.

All women of both groups were gynecologically examined for the presence of any gynecological problems in the form of scar, infection and to

exclude any gross pelvic pathology. The percentage of the circumcised women to the total attenders of this centers reached 75%.

Both groups (circumcised and uncircumcised women) were interviewed by a psychiatrist and a trained female nurse who works in the outpatient clinic to obtain information about their psychosexual lives using the Arabic Version of the Sexual Behavior Assessment Schedule - Adult (SEBA-A) (Myer - Bahlburg and Erhardt 1983) in a similar procedures that are described elsewhere (Lotfi and El-Defrawi, 1995). Only items from the interview investigating presence or absence of dyspareunia, sexual desire, sexual enjoyment, and orgasm were used. Data concerning age at menarche, gynecological, obstetric, and events related to the circumcision were obtained.

During the initial gynecological examination the presence or absence of circumcision was established and women were divided into two groups. Those who were randomly selected from the circumcised group were further assessed to determine the degree of circumcision according to:

a- 1st degree, i.e., removal of the excessive skin of the hood of the clitoris and part of labia minora (Sunna circumcision).

b- 2nd degree, i.e., excision the labia minora as well as the clitoris, total or partial, and

c- 3rd degree, i.e., infibulation or removal of the clitoris, labia minora and major a and closure of the orifice which is called sudanese or pharaonic circumcision (Cutner, 1985).

Results

Table 1
Frequency Distribution of the Studied Groups According to Age

Age	Circumcised		Uncircumcised	
	No.	%	No.	%
15-19 Years	44	22.00	19	19.00
20-24 Years	63	31.5	33	33.00
25-29 Years	59	29.5	22	22.00
30-34 Years	21	10.5	15	15.00
35-38 Years	13	6.5	11	11.00
Total	200	100	100	100
Mean	24.29		25.11	
Range	15.38		15.38	
S.D.	5.34		5.97	

t test = 1.2
P Value > 0.05
(i.e. no significant difference)

Table 2
Frequency Distribution of the Studied Groups According to Education

Education	Circumcised		Uncircumcised	
	No.	%	No.	%
Highly educated	48	24.00	37	37.00
Secondary educated	96	48.00	49	49.00
Illiterate	56	28.00	14	14.00
Total	200	100	100	100

Chi square = 9.59
P value > 0.05 (significant)

Table 3
Frequency Distribution of the Studied Groups According to Residence

Residence	Circumcised		Uncircumcised	
	No.	%	No.	%
Ismailia	63	31.5	71	71.00
Kassasin	55	27.5	9	9.00
El Tal El Kabir	82	41.0	20	20.00
Total	200	100	100	100

Chi square = 42.6
P < 0.001 (Highly significant)

Table 4
Frequency Distribution of the Studied Groups According to Marital Status

Marital State		Circumcised				Uncircumcised			
		No.		%		No.		%	
Married	Ismailia	55	177	27.5		66		66	
	Kassasin	49		24.5	88.5	8	92	8	92
	El Tal El Kabir	73		36.5		18		18	
Divorced	Ismailia	8	23	4		5		5	
	Kassin	6		3	11.5	1	8	1	8
	El Tal El Kabir	9		4.5		2		2	
Total		200		100		100		100	

Chi square = 0.54
P < 0.05 (no significant difference)

Table 5
Frequency Distribution of the Studied Groups According to Circumcisers

Circumcisers	No.	%
Daya	97	48.5
Physician	73	36.5
Barber	19	9.5
Don't know	11	5.5
Total	200	100

t test = 1.2
P Value > 0.05
(i.e. no significant difference)

Table 6
Frequency Distribution of the Studied Groups According to Place of Operation

Place	No.	%
Home	115	57.5
Medical clinic	67	33.5
Daya's house	9	4.5
Barber	7	3.5
Government hospitals	2	1.5
Total	200	100

Table 7
Frequency Distribution of the Studied Groups According to Age at Circumcision

Age	No.	%
< 8 Years	43	21.5
8-12 Years	123	61.5
> 12 Years	34	17.0
Total	200	100

Range: 8
Mean: 9.28
S.D. ± 2.10

Table 8
Frequency Distribution of the Studied Groups According to Degree of Circumcision

Degree	No.	%
1 st degree	76	38.0
2nd degree	109	54.5
3rd degree	15	7.5
Total	200	100

Table 9
Frequency Distribution of the Studied Groups According to Immediate Effects

Immediate Effects	No.	%
Pain	103	51.5
Haemorrhage	33	16.5
* Infections	86	43.0
External deformation	19	9.5

* Urinary tract infections were included.

Table 10
Frequency Distribution of the Studied Groups According to Age of the Menarche

Age at Menarche	Circumcised		Uncircumcised	
	No.	%	No.	%
9-11 Years	16	8.00	14	14.0
12-14 Years	151	75.5	73	73.0
15 Years and more	33	16.5	13	13.0
Total	200	100	100	100

Ranage: 9-17 years (9-16 years)
Mean: 13.44 12.81
S.D.: ± 1.47 ±1.58
t. test = 2.81 P value > 0.05 (significant)

Table 11
Frequency Distribution of the Studied Groups According to Dysmenorrhea

Dysmenorrhea	Circumcised		Uncircumcised	
	No.	%	No.	%
Present	137	86.5	52	52.0
Absent	63	31.5	48	48.0
Total	200	100	100	100

Chi. Sq. = 7.09
P <0.05 (significant)

Table 12
Frequency Distribution of the Studied Groups According to Fertility

Fertility	Circumcised		Uncircumcised	
	No.	%	No.	%
Fertile	142	71.0	79	14.0
1ry infertility	21	10.5	8.0	73.0
2ry infertility	37	18.5	13.0	13.0
Total	200	100	100	100

Chi. Square= 2.22
P > 0.05 (i.e. no significant difference).

Table 13
Frequency Distribution of the Studied Groups According to Type & Complications of Delivery

Delivery	Circumcised		Uncircumcised	
	No.	%	No.	%
Home	65	32.5	28	28.0
Hospital & Medical clinic	114	57	64	64.0
Episiotomy	25	12.5	21	21
Vacuum extractor + episiotomy	39	19.5	16	16
Low forceps + episiotomy	14	7	4	4
Caseasarean section	19	9.5	12	12
Spontaneous	17	8.5	11	11
No children	21	10.5	8	8
Total	200	200	100	100

* Delivery of first child only included.
Chi. Sq. = 5.299 P> 0.05

Table 14
Frequency Distribution of the Studied Groups According to Dyspareunia

Dyspareunia	Circumcised		Uncircumcise	
	No.	%	No.	%
Present	183	41.5	29	29.0
Absent	117	58.5	71	71.0
Total	200	100	100	100

Chi. Sq. = 3.90
P <0.05 (significant)

Table 15
Frequency Distribution of the Studied Groups According to Sexual Desire

Desire	Circumcised		Uncircumcised	
	No.	%	No.	%
No	83	41.5	26	26
Sometimes	41	20.5	23	23
Yes	76	38	51	51
Total	200	100	100	100

Chi. Sq. = 7.26
P > 0.05 (significant).

Table 16
Frequency Distribution of the Studied Groups According to Sexual Enjoyment

Enjoyment	Circumcised		Uncircumcised	
	No.	%	No.	%
No	88	44	23	23
Sometimes	48	24	31	31
Yes	64	32	46	46
Total	200	100	100	100

Chi. Sq. = 12.75
P < 0.001 (Highly significant).

Table 17
Frequency Distribution of the Studied Groups According to the Occurance of Orgasm

Orgasm	Circumcised		Uncircumcise	
	No.	%	No.	%
Yes	67	33.5	44	44
Sometimes	50	25.0	27	27
No	83	41.5	29	29
Total	200	100	100	100

Chi. Sq. = 7.6
P < 0.05 (significant).

Table 18
Frequency Distribution of the Studied Groups According to Attitude Towards Their Daughter's Circumcision

Daughter's Circumcision	Circumcised		Uncircumcised	
	No.	%	No.	%
Yes	82	41	22	22
No	118	59	78	78
Total	200	100	100	100

Chi. Sq. = 3.90
P <0.05 (significant)

Discussion

There are many dubious justification for F.G.M. It is however widely held to be religious and cultural obligations. However, a number of religious leaders have condemned the practice and point out that there is no mention of such act in the Holy Koran. F.G.M. is not a cultural issue, it is an abuse of children and women's basic human rights to good health. It is an unnecessary practice that damages women's physical and

psychological well being, it is not a race issue, nor it is practiced for religious reasons. It is a form of brutal young female torture. It should be, therefore, a concern for psychiatrists working with young female children and adolescents, working in the field of psychosexual disorders, and those interested in the psychological health of human beings as a whole. We have found that (table 8) over 60% of circumcised women have what is considered to be F.G.M. rather than simple circumcision (only 38%)

Our findings are closely similar and even a repetition of previous studies and reports of Lotfi and El-Defrawi (1995), Karim (1993) and Mahran (1979 & 1987). Female circumcision appears to be significantly associated with illiteracy and low level of education, more prevalent in rural than urban communities whether a general sequential sampling or randomly selected samples were studied, and also, associated with negative psychosexual and gynecological problems like dysmenorrhea, dyspareunia, reduced sexual desire and less occurrence of orgasm than in uncircumcised women. All these findings are discussed and mechanisms behind which are explained elsewhere (Cunter, 1985, Douglas 1984).

However, there are a number of observations that need attention and elaboration. First, we have noticed that illiteracy was higher among circumcised women (28%) compared with 14% among uncircumcised group. According to Farrag (1995) the high rates of illiteracy (50% for males and 70% for females) have not changed much during the last three decades inspite of continuing campaigns of the high council on the eradication of illiteracy. These rates of illiteracy are even higher in rural communities especially in upper Egypt and remote areas. The poor schooling for girls, particularly in rural areas where enrollment of girls does not exceed 40%, especially in upper Egypt, possibly because of some persisting cultural values that do not encourage girl's education, or do not permit them to attend mixed co-educational schools or schools outside their communities, all are factors leading to negative impact on the status of women and their socialization process.

The second observation is the still high rate of circumcised women among those consulting the health care centers (75%). Apparently these figures have not changed much from those of Ammar and Karim (1965), Karim's (1975), and Mahran (1977) and even in selected samples (Lotfi and El-Defrawi, 1995). These findings suggest that the social belief and traditions have a powerful influence stronger than the efforts of the Ministry of Health which issued a law prohibiting female circumcision in governmental hospitals and health centers. In our view, such adverse health practices could be eradicated by programs transmitted and carried out through Non Governmental National and Local Organizations rather than governmental institutions.

The third observation is the still high & common attitude by circumcised mother that they intend or plan to have their daughters circumcised in the future. Apparently, this phenomena reflects, societal attitudes towards change when a deeply rooted believes in the significance and utility of practicing of such procedures are confronted with the question of how to motivate people to change such negative and passive practices. Integrated work including social, medical, religious and political campaigns to help citizens to understand that such practices are definitely

hazardous to physical and psychological integrity of our culture inspite of its common heritage are needed. Lastly, more studies and research work should be carried out to keep such phenomena under focus and to follow up on the evaluation and outcome of established programs to eradicate female circumcision.

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Une étude descreptive sur la circoncision féminine au Ismailia

Parmi les femmes consultant des centres de maternité et génycologiques deux groupes ont été choisi par hagard (un group avec 200 femmes circonsicées et un autre groupe avec 100 femmes non-circonsice) et ont passé un examen génycologique et un entretien psychiatrique afin d'évaluer des informations psychosexual à l'aide de bilan (sexual behaviour assessment schedul (Adult SEBAS-A).

La résultat a démonstrée que les femmes circonsicées se trouvent en grand, pourcentage aux villages et elles ont beaucoups des problemes génycologiques.

دراسة ختان الإناث فى الإسماعيلية

قام الباحثون بإنتقاء عينتين عشوائيتين من السيدات المترددات على مراكز وعيادات تنظيم الأسرة ومراكز الطفولة والأمومة – بحيث تكون العينة الأولى من السيدات المختنات ويبلغ قوامها مائتين سيدة – والعينة الثانية من غير المختنات وتبلغ مائة سيدة، وقد تم إختيار عينة السيدات المختنات بحيث تمثل التواجد الريفى من القرى والحضرى من ضواحى الإسماعيلية ومدنها – وتم عمل فحص بواسطة إخصائى أمراض النسا، كما تم الحصول علي بيانات حول عملية الختان فى المجموعة الأولى، وأجريت مقابلة شبه مقننة لأجزاء من جدول السلوك الجنسنفسى للبالغين.

وقد أظهرت النتائج وجود أعداد وفيره بنسبة عالية من السيدات المختنات بين المترددات على مراكز الصحة (٧٥٪)– وكانت النسبة أعلى بدرجة ذات دلالة إحصائية فى العينات القروية عن الحضرية، وفي السيدات الأقل تعلماً عن السيدات الأكثر درجة من التعليم – كما أوضحت النتائج وجود إرتباط ذا دلالة إحصائية بين تشخيص ختان الإناث وبين المضاعفات الجنسنفسية ومشاكل الطمث وآلام الجماع والاضطرابات الأخرى المرتبطة بالوظيفة الجنسنفسية.

وقد أظهرت المقابلة النفسية أن نسبة عالية من السيدات المختنات (٤١٪) مازالت تؤمن بضرورة الختان وينوين إجراءه لبناتهن. وتناقش الدراسة الدلالات، وتلقى الأضواء على جذور المشكلة وكيفية الخروج منها.