

# Female Genital Mutilation in Egypt

## Introduction

According to the World Health Organization (WHO), female genital mutilation (FGM) is defined as intentional alteration to female genitals for non-medical reasons (Whitehorn, 2010). FGM has been categorized into four different types, namely Clitoridectomy (Type I), Excision (Type II), Infibulation (Type III), and miscellaneous types, which includes incision of the genitalia, piercing, scraping, or burning (cauterization) (WHO, 2014). Despite the fact that the severity of FGM increases as we shift the practice from type I to type III, the extent of the performed cut dictates the severity of the FGM type (WHO,2014).

Type I is defined as the complete removal of the clitoris and prepuce which is a sensitive erectile portion of female genitalia, and the skin which surrounds the clitoris, respectively (WHO, 2014). This type of FGM has been ranked the least severe among other types of FGM (Yasin, 2013), and prevalence of removal of prepuce is rare ( WHO, 2014). Type I is divided into two subcategories, namely Type Ia, which is associated with the removal of the prepuce or clitoris, and Type Ib which is associated with the removal of both, the prepuce and the clitoris, together (Yasin,2013). Type II, also known as excision is defined as the complete removal of the clitoris and the vaginal lips (labia minora), either with or without removal of labia majora (WHO, 2014). Type II is divided into further three sub-categories, defined as Type IIa, which is associated with just the removal of labia minora, Type IIb, associated with the complete removal of clitoris, as well as labia minora, and Type IIc, associated with either the complete or partial removal of the clitoris, including labia minora and majora (Yasin, 2013).

Type III also known as infibulation is defined as sealing the vaginal opening by performing incisions to the inner or outer vaginal lips (labia), which cause the vaginal

opening to narrow. This procedure may be performed with or without the removal of the clitoris (WHO, 2014). This is considered the most severe type among all types of FGM (Yasin, 2013). Type III is also further sub-divided into two sub-categories. Type IIIa, associated with labia minora rearrangement and removal, and Type IIIb associated with labia majora rearrangement and removal (Yasin, 2013). Infibulation serves as a barrier for childbirth and sexual intercourse due to narrowing of the vaginal opening. As a result, women subjected to infibulations must undergo the process of de-Infibulation to allow child birth and sexual intercourse. Physical complications such as vaginismus and dyspareunia, perennial tears, shock and excessive bleeding may occur as a result of forced penetration. In some cases, re-infibulation is performed in order to narrow the vaginal opening (PROMOTING GENDER EQUALITY: Frequently Asked Questions on Female Genital Mutilation/Cutting, n.d.).

FGM is also referred to as “female circumcision”, and “female genital cutting.” Among these terms, “Female circumcision” is most prominently used when translating from many African languages to English. Usage of the term circumcision for this process may imply that female and male circumcisions are the same; however, in truth, female circumcision is more substantial than the male circumcision. To emphasize and verify the harmful effects of female genital mutilation, the United Nations chose to use the term FGM in its documents in an effort to be more sympathetic towards the victims of this act, as well to appear less provocative towards the proponents of the act. The term female genital cutting is used by many literature reports and community organizations. However, critics argue that usage of this terminology is not inclusive of all types of female genital mutilation (Shaeer, 2013).

Despite the fact that both male and female circumcisions are categorized as ritual practice, the difference lies in anatomical and functional parts that are subjected to amputation. The clitoris is considered a specialized sex organ, as the foreskin acts as a protective sexual part of the female sex organ. In addition, female circumcision results in more health complications in comparison to male circumcisions (Denniston, 1999). Female genital mutilation poses several physical, psychological, and psychosexual complications in women. Infections and hemorrhages are considered to be the main causes behind short and long term morbidity and mortality (Whitehorn, 2010).

Short term physical consequences have been characterized as pain and bleeding. Long term physical health consequences include urinary tract infection, retention of urine, infection, fistula, collection of menstrual blood in the vagina, increased risk in acquiring HIV, infertility, and pelvic infections. In addition to these complications, chronic pain, which derives from the performed procedure or the infections and difficulties during menstrual periods can itself stimulate prevalence of other problems such as, increased chances of depression, decrease in social functioning, as well as feelings of worthlessness, guilt, and even suicidal thoughts, and social isolation (Whitehorn, 2010), formation of benign dermal tumors (keloid). Poor quality in sexual life has also been identified as a complication of female genital mutilation (Yasin, 2013).

Sexual dysfunction is considered a part of physical complications associated with FGM. In a study done on a female population, among which 80% were circumcised, 45% had suffered from a reduction in sexual desires, 49% experiences a reduction in sexual pleasure, and 60.5% reported frailer orgasms. Psychological complications resulting from FGM include post-traumatic stress disorders (PTSD), depression, and anxiety. Infertility leads to isolation of

women as a result of rejection by family and society, due to the high value placed on motherhood (Whitehorn, 2010).

1% of the females who undergo female genital mutilation die during child labor (Whitehorn, 2010). Type III female genital mutilation requires an additional surgical procedure to make childbirth and sexual intercourse possible (Yasin, 2013).

According to Whitehorn et al. (2010), practice of female genital mutilation has a long history of 5,000 years and interestingly, evidence of this practice had been seen in 19<sup>th</sup> century in England. The practice in England prevailed largely due to a belief in the remedying power of this practice for epilepsy, masturbation, and sterility. Additionally, evidence of this practice has been found in Roman slaves, who passed a metal ring through the labia minora to prevent females from conceiving. It is believed that the practice of female genital mutilation dates back prior to the coming of religion. FGM practice has transcended religious beliefs and has prevailed through the ages among Muslims, Christians, Jews, and Animists (Whitehorn, 2010).

In the past, FGM practices were performed by a relative or a traditional birth attendant in the absence of antibiotics, antiseptics, and various other appropriate surgical tools. The tools that have been used include blades, broken glass, and razors. For healing purposes, local herbs such as ash were used for healing wounds (Whitehorn, 2010).

Traditional performance of female genital mutilation poses serious health risks because the procedure is usually performed by a circumciser who has little or no knowledge of human anatomy. Furthermore, the operating equipment is usually non-sterilized; as a consequence, the state took steps in the mid-1990s to regularize the procedures to minimize health risks (Aixelà, 2010). However, based on a study done by Yasin et al. (2013) in contemporary practices of FGM, the settings and the professionals involved in the practice varied across countries, in some

countries female genital mutilation is performed by a traditional birth attendant or circumciser while in some others, it is performed by medical professionals. For instance, in Erbil, where the Kurdish Iraq's exist, FGM procedures are performed by traditional birth attendants because female circumcisers rarely exist in the community, as opposed to a larger number of male circumcisers. Contrarily, in Egypt, where (24-67%) of female genital mutilation practices are performed by healthcare providers. Furthermore, studies show that only 0.9-11.9% of FGM procedures are performed by healthcare professionals in Erbil and Nigeria (Yasin, 2013).

According to the study by Shaeer et al. (2013), the underlying motives for female genitalia circumcision practices vary as a result of different variable such as culture, country of practice, level of education, and religion. These underlying motives then are manifested and categorized as cultural, traditional, and religious beliefs (Shaeer, 2013).

Study done by Whitehorn et al. (2010) show that various regions, where FGM is practiced, explains the motives behind such a practice, for example, female sexuality control, maintenance of marital fidelity, prevention of lesbianism, assuring calmness of female personality, prevention of clitoris growth, and protecting a woman's honor (Whitehorn, 2010).

Prevalence of female genital mutilation from a sexist's point of view, one who views females as second-class citizens, subservient to men, is that the practice may result in improvement of hygiene, sense of community belonging, and fertility enhancement ensuring that based on these factors, it is logical that women will be forced to undergo this procedure. It is inevitable then that in such societies where females are placed in low social rankings, the gateway to a better society includes honoring women through such barbaric practices (Whitehorn, 2010). Additionally, this practice has been seen as a path to adulthood, and maternity (Aixelà, 2010). Furthermore, lack of education on the health consequences of FGM

also formulates an important factor in the prevalence of such practices (Web MD, 2012). It has been shown that mothers who have undergone FGM are willing to perform the procedure on their daughters. Lack of adequate education regarding health consequences of female genital mutilation provokes higher prevalence of such a practice in a region (Yasin, Al-Tawil, & Shabi, 2013).

Estimates indicate that 125 million females have undergone FGM procedures across 29 African and Middle Eastern countries (WHO, 2014). According to the WHO report on FGC that availed information researched between 2000 and 2009, females between ages of 15 to 49 located in Africa and Yemen, prevailed countries with the highest and lowest prevalence of FGM respectively. According to this report, a high prevalence rate of 90% and 91% exists in Sudan and Egypt respectively. Prevalence of FGM, around 75%, exists in Djibouti, Eritrea, Gambia, Guinea, Mali, Serra Leon, and Somalia which are considered countries with high prevalence of FGM. A relatively low prevalence exists in Liberia (58%), Chad and Guinea Bissau (44%), Ivory Coast (36%), Central African Republic of Benin (12%), Kenya (27%), Nigeria (29%), Senegal (28%), and Tanzania (14%). The lowest prevalence of FGM is attributed to countries such as Uganda, Cameroon, Ghana, and Niger. These countries have a low prevalence of around 10% (Shaeer, 2013). The lowest prevalence of FGM has been attributed to Zambia, which has a rate of 1% (Unicef, 2012).

The age at which FGM occurs varies between and within countries, based on differences in ethnic groups and regional locations (Yasin, 2013). According to the World Health Organization, it is most likely that the procedure is performed on females between the time they are born and the age of 15 (WHO, 2014). However, in some cultures the procedure is performed during adolescence or after childbirth (Whitehorn, 2010).

Female genital mutilation has been classified as a violation of human rights (Yasin, 2013), as a result the high prevalence of FGM in such countries as Egypt with prevalence rate of 91% (Shaeer, 2013) should be given attention in order to understand the motivational roots for combating prevalence and to provide adequate care and support for the victims of such acts. This research paper aims to describe a general background of female genital mutilation in Egypt, as well as a general review of literature on Female Genital Mutilation accompanied by public health impacts and current existing recommendations regarding this issue.

## **Background**

Female genital mutilation has been practiced in Egypt for over 5000 years. Evidence of practice has been found in Egyptian Mummies (Whitehorn, 2010). Historically, the performer of the procedure was a traditional birth attendant (Whitehorn, 2010). However, currently 72% of the procedure is performed by medical professionals on girls under the age of 17, and 21% of the procedures are performed by traditional birth attendants, which reveals that most of the procedures are undertaken by medical professions (Fahmy, 2010).

According to the 2008 Demographic and Health Survey (DHS), prevalence of FGM decreased by 6% between 2000~2008. This reveals that future trends of the practice will decrease among younger generation which is a direct result of educating and raising public awareness on the issue (Fahmy, 2010).

The DHS also reports that in 2000, 97% of women reaching puberty underwent this process (Fahmy, 2010). The age at which FGM is practiced, according to studies varies. In some cases, age of practice is estimated to be between 9-11; however, the Egyptian demographic and health survey depicted age as between 10-11. Ethnographic data, however,



suggests the age range between 6-12 years (Aixelà, 2010). According to Yasin (2013), the mean for the practice is defined as 10.1 years of age among Egyptian females (Yasin, 2013). Different countries practice different types of female genital mutilation. The most common type of FGM practice in Egypt is of Types I and II (Aixelà, 2010).

The underlying root for the practice has been verified as ritualistic (Aixelà, 2010), which is considered as Tahara (cleanliness). In addition, according to a study conducted in 2003, the motivational root of the occurrence of FGM in Egypt have been depicted mainly as a tradition with a desire by males for circumcised wives, for the purposes of preventing sexual promiscuity and premarital sex, and issues of marriage (Fahmy, 2010).

In Egypt, the practice of female genital mutilation is more prevalent among Muslim women in comparison to religious groups. According to the data from the Egyptian Demographic and Health Survey conducted in 1995, the percentage of Christian women undergoing FGM was 61%, and that of Muslim women was 87% (Aixelà, 2010).

### **Review of literature**

Various studies have been conducted on this topic. For instance, two studies by Shaeer et al. (2013) and Fahmay et al. (2010) were similar in the fact that they both aimed to investigate the motivational roots behind the occurrence of female genital mutilation in Egypt and arrived at the same conclusion that practice of FGM is rooted in culture, rather than religion, and that this practice is viewed as a necessity for maintenance of female chastity, from Egyptian men's perspective (Shaeer, 2013) and (Fahmy, 2010). However, the approach towards this conclusion differs, as well as the solutions proposed towards the problem. Fahmy et al. (2010) explored female sexuality role in society and the underlying reasons for men being in-favor of female genital mutilation continuation, and for understanding the views that

they hold over sexual consequences of this procedure, a one year study (2008-2009) was conducted in Egypt. This study had been conducted in a large Cairo slum area, as well as two upper rural communities. Needed qualitative information had been gathered through interviews, discussions, and a focus group, consisting of 102 women and 99 men (Fahmy, 2010).

According to the reports in 2003, observing the tradition, as well as, men's preference for circumcised wives in order to prevent sexual promiscuity have been identified as the motivational root of the female genital mutilation in Egypt (Fahmy, 2010). In addition, another underlying cause of FGM has been noted as qualifying for marriage, which is affected negatively when the females in a community are uncircumcised (Fahmy, 2010).

Many Muslim and Christian religious leaders have condemned the practice by speaking out in public. For instance, Grand Sheikh of Al-Azhar has condemned the practice and emphasized the motivational root in culture as opposed to religion (Fahmy, 2010).

According to the findings of this study, public perceptions regarding FGM playing a great role in lessening female sexual desire, not pleasure, had been rejected. Based on the contemporary literature present regarding FGM/C and sexuality, which has been published since 1990, along with extensive research published on FGM/C and sexuality in 1999, declared orgasms as a measure of healthy sexuality and that an intact clitoris serves as a factor for sexual enjoyment.

The study suggests that to investigate sexual consequences of female genital mutilation, the extension of the cut, as well as the measurement indicator of sexual response should be taken into consideration. Chronological studies done on sexual consequences of female genitalia vary in results. In a study published in Egypt in 1996, a majority of the 41 women who had undergone FGM reported no negative consequences in sexual relationships with their husbands. However,

majority of studies done on female genital mutilation during 1965-1988 reported sexual problems among the population. A more informative study conducted in 2003, which was hospital based, revealed that females undergoing Type I FGM reported no sexual function as opposed to females undergoing Types II and III. As a result, the extent of cutting had been marked responsible for sexual problems in women. 16%-46% of females who have undergone the process of FGM experience pain during intercourse. A study done in 2007 on married women in Egypt, revealed that 90% of them had undergone female genital mutilation process and that 70% of them had suffered from some sort of physical complication, however, the underlying factor had been related to socio-economic status, as well as disharmony in marriage (Fahmy, 2010).

In investigation of the view of both, females and males over female sexuality and female genital mutilation revealed that both men and women over the age of 35 believe that female genital mutilation will regulate female sexual desire and prevent the drive for sexual activity. Additionally, males expressed a fear of their wives being more sexually demanding in comparison to uncircumcised wives. Women viewed sexual pleasure as existent in marital harmony while men described it in the sexual relationship within the marriage (Fahmy, 2010). As it has been depicted in this study, the younger men are more concerned about the negative sexual consequences of FGM in females and believe it to be responsible in reduction of female sexual pleasure, which will result to the reduction of females in engaging in sexual activity (Fahmy, 2010).

The study done by Sheer and et al. (2013), investigated the motivational root of female genital mutilation, as well as, the contemporarily prevalence of female genital mutilation in Middle Eastern countries among internet users whom 50.2% of the participant were located in

Egypt (Shaeer, 2013). It was established that the underlying causes of the practice are cultural as opposed to religious (Shaeer, 2013).

According to this study, the average age at which FGM procedure was performed is estimated at 9.6 (+/-3.5) years of age. 31.6% out of a total 992 participants experienced FGM. Muslim women (36.9%) had a higher prevalence of FGM in comparison to Christian women (18.8%). It has also been concluded in the study that prevalence of female genital mutilation is higher in rural areas with 78.7%, in comparison to urban areas with 47.7%. FGM procedures performed by health care professionals were identified as 54.7% by doctors and 9.5% by nurses (Shaeer,2013).

The survey in this study indicates that 22.5 percent of the sample population asserted that FGM was necessary. This view was more among men, in rural areas. Educational levels of respondents had no role in the determinacy of this opinion. Among Muslim people, 55.4% of the population was pro FGM and 44.6% were anti FGM. Furthermore, this study, as well as the research conducted by Fahmy (2010) states that the underlying motives behind female genital mutilation have been identified as the mandate of men for female chastity (Shaeer,2013) and (Fahmy, 2010).

The most important result depicted by this study shows that 74.5% of females would not have undergone FGM if they had a choice, and 15.4% would have it done regardless. 10.1% have no opinion on the issue (Shaeer, 2013).

This study also emphasizes on the fact that female genital mutilation has no roots in Islam. In fact, Quran has banned any harm to the body (Al Quran33:58). However, there are some Muslim leaders who favor this practice despite the fact that there is no direct evidence of the practice in Quran (Shaeer, 2010).

The study done by Dalal and et al., aimed to study the attitude of women in halting the practice based on the level of knowledge they have regarding negative sexual consequences of female genital mutilation and the extent of their belief in practicing the culture in Egypt (Dalal, 2010).

Based on the cross-sectional study on 9159 females across Egypt by disseminating questioners in order to examine their attitude toward the practice of female genital mutilation, it was revealed that people who reside in urban areas (33.3%) who had a higher level of education, were more opposed to this practice than women who reside in rural areas (12.5%) and had lower level of education. In addition, women who had read information through media such as newspaper and radio were more in favor (53.4%) of discontinuation of female genital mutilation in comparison to those that had not (18.4%). Moreover, women who were aware of the negative sexual consequences of female genital mutilation were more prone to support the discontinuation of female genital mutilation in comparison to those who lacked knowledge regarding this issue. Also, this study depicted that females who believed in the cultural aspect of this practice had lower prevalence in accepting the discontinuation of female genital mutilation (Dalal, 2010). Various studies have been conducted to ascertain the implementation of laws against female genital mutilation.

Ethical issues towards FGM had been raised by the obstetrical society for advocates of the procedure regarding the fact that we have no right to remove a woman's clitoris, just like we are not allowed to remove a man's penis. However, proponents of the procedure claim that clitoris sustains a minor role and varies in function and anatomy in comparison to a penis. In addition, advocates of FGM perceive clitoridectomy as a way of preserving a woman's chastity which according to their belief, morality is unable to cope with thereby, making FGM surgery a

necessity. Historically, female masturbation had been viewed as a disease, and subsequently, condemned. In 1889, Dr. Joseph Jones, a medical doctor, researched and concluded that cause of hopeless sanity is masturbation and considered it as a hereditary factor which has the capacity to be passed on to the offspring. In 1984, a U.S. based surgeon named female masturbation as a moral leprosy, the 'cure' to which is clitoridectomy (Whitehorn, Ayonrinde, & Maingay, 2010).

History of combating FGM from the perspective of law enforcement has not been known exactly, however, in 1959, the public ministry resolution passed a law which prohibited the performance of *infibulation*. At that time, Egypt had a legal void regarding this issue. In 1995, the Egyptian government started to perform the practice in hospital settings, and the first occurrence of FGM had been shown as a documentary, broadcast by CNN in 1994, which highlighted the procedures and issues associated with female circumcision. The fight towards halting the practice of FGM continued, however, the most prominent and effective step took place on June 2007, by the Egyptian administration which prohibited the practices of Female Genital Mutilation. The law imposed serious sanctions as of June 2008, where imprisonment of three months to 2 years had been imposed on people who were involved in FGM procedures (Yasin, 2013).

In order to quantify the effectiveness of laws against FGM, a series of studies were carried out. According to the study done by Hassanin et al. (2013), studies in two out-patient clinics in Upper Egypt had been conducted between January 1<sup>st</sup> and November 30<sup>th</sup> 2011 in order to investigate the prevalence of female genital mutilation and the perception of educated mothers towards the performance of FGM, after passage of laws against the practice. According to the results obtained in 2011, among all participants, only 1 case was reported (71.1%-77.6%). In addition, the underlying performance of FGM had been depicted as 43%, resulting from family

pressures. The percentage where physicians operated FGM procedures had been significantly lower in 2011 in comparison to 2006, which had been depicted as 34% and 39.3% respectively. Even though there has been a significant decrease in prevalence of female genital mutilation, in order to achieve better results further educational programs, as well as a change in attitudes of women towards the practice should be focused on (Hassanin, 2013).

In another study, conducted by Rasheed et al. (2011), to understand the effectiveness of the 2007 laws passed against female genital mutilation, from September 15<sup>th</sup> 2008 through to September 15<sup>th</sup> 2010, a series of questionnaires had been provided to both the health care providers as well as patients who had attended the Departments of Gynecology and Obstetrics or Pediatrics at Sohag and Qena, Egypt. Based on the obtained results, there had been a significant decrease in the prevalence of FGM among Egyptian women, the incidents went down from 9.6% in 2000, to 7.7% in 2006 (Rasheed,2011).

In the study by Rasheed et al. (2011), it has been shown that a vast majority of procedures have been performed by practitioners. It has also been shown that 88.2% of nurses, 14.9% of doctors, and 34.3% of young physicians are in favor of the practice in Egypt. A decrease in the number of FGM cases has been witnessed, however, the incidents are still high. More education should be done in order for the practice to completely halt. The *new millennium goals* came into effect to make the practice relatively safer by being performed by physicians and nurses, in an effort to decrease female mortality rates (Rasheed, 2011).

### **Public health impact**

Due to migration of women who have been undergone female genital mutilation to Western countries, it is not far from reality that healthcare professionals will be dealing with physical, psychological or sexual dilemma of this process (Whitehorn, 2010). It is normal for

immigrants and refugees to have a tendency to preserve their cultural beliefs and practices, even in the event of their migration. This implies that the practices of FGM will be continued in some immigrant communities secretly despite the fact of illegalization of the practice by that country. For instance, practice of FGM had been banned in 1985; however, there are immigrants who are still performing this practice. It has been reported that in some cases, to perform the practice, girls have been sent abroad. Medical professionals who perform the procedure in UK may risk their license being cancelled (Whitehorn, 2010).

It is very important for doctors to be sensitive to the identity issue that immigrants experience due to cultural roots. Refugees who traditionally practice this procedure have shared problems of refuge to be often mixed with psychological stress, trauma of conflict, confusion, loss and separation, and persecution. They view the practice as their racial and ethnic identity to be challenged by migration and acculturation; As a result, doctors should handle the issue of identity with care (Whitehorn, 2010).

## **Recommendations**

Various recommendations have been proposed in an effort to combat female genital mutilation and assisting the current victims. These include understanding the motivational roots of FGM specific to the target region (Shaeer, 2010) considering female and male sexuality in the context of social construction (Fahmy, 2010), enactment of laws, training the medical professions, (Fahmy, 2010) and religious leaders advocating for stopping the practice in public (Shaeer, 2013). However, there are several barriers, which limit the effectiveness of the recommendation of interventions as will be explained. These include viewing of the practice as female sexual morality among the public (Fahmy, 2010), higher prevalence of the procedure done by medical professionals (Fahmy, 2010) and mandatory permission of females to undergo



the practice from their husbands before visiting doctors when facing medical complications resulting from female genital mutilation (Whitehorn, 2010).

Shaeer and et al. (2013) recommended that to be able to change traditional norms in a society, one must identify the underlying motivational roots of the practice, which varies among and within countries due to the differences in culture and religion (Shaeer, 2013).

According to Fahmy and et al. (2010), it is asserted that in addition to personal experience, socioeconomic factors should be taken into consideration when investigating the socially constructed concept of sexuality in both females and males in Egypt. Two separate studies by Fahmy and et al. (2010), and one carried out in 2007, revealed that women held responsible socioeconomic factors for their sexual problems. According to these women, their involvement in sexual activities was solely for the purpose of saving their marriage by preventing their husbands from seeking extramarital affairs, religious and most importantly, financial needs. It has also been suggested that educational campaign needed to assist the implemented laws against female genital mutilation as the implemented laws alone are not as effective due the fact that Egyptians perceive this practice as an ultimate solution for female sexual morality. TV shows are recommended to be the channel for dissemination of educational messages towards educating the public in an effort of combating female genital mutilation as most of the Egyptians watch TV on a regular basis. It has been recommended that health care professionals should be trained regarding the negative sexual consequences of female genital mutilation and how to treat females who have undergone the procedure, as well as, not to practice this act in order to reduce the prevalence of the practice in Egypt and to show the support of health care professionals in banning the practice. However, currently as it has been indicated in the study, 72% of the female genital mutilations have been done by doctors (Fahmy,

2010) which indicates the fact that the medical professionals in Egypt are pro FGM and that the process of implementing intervention through combating this practice through medical professionals is almost impossible.

Women believing in submissive roles, as wives and child bearers, their beliefs as well as, the husband interference during the patient-physicians consultation appointment, which results in females being reluctant of discussing any emotional consequences that they face, have created barriers in implementing effective intervention because women who have undergone the procedure want their daughters to undergo the process as well (Whitehorn, 2010). Based on a study done by Aixela (2010), it has been noted that despite governmental efforts in eliminating the practice of FGM through laws, a huge barrier exists that of the importance of motherhood, and the concept of being married among Arabic Muslim women (Aixelà, 2010).

Based on the study done by Dalal and et al., it has been recommended that to change the cultural beliefs, religious leaders should be included as they can influence the attitude of the public towards the discontinuation of female genital mutilation (Dalal,2010). However, it emanates that some religious leaders support FGM as discussed earlier.

### **Solutions to the problem**

After meticulous investigations on various motivational root of female genital mutilation and other aspects surrounding this issue, solutions have been proposed to combat the practice in Egypt such as reconstruction surgery for the female who have undergone the process of female genital mutilation (Whitehorn, 2010). Training doctors on the complications resulting from the practice, as well as, how to assist the female undergoing the process (Whitehorn, 2010).

To reduce the risk of obstetrics, physical, and psychological complications resulting from FGM, some countries now offer reconstruction surgeries. Additionally, it has been mandated that

gynecologists who provide this type of care should be aware of the sources of stress causing factors in women who have undergone FGM which include monitory examinations, as well as taking care that usage of instruments to perform the procedures do not or at least minimize painful flash back memories for the woman (Whitehorn, 2010).

It is important for medical practitioners to familiar with medical, psychological, and obstetric complications resulting from FGM in order to create effective interventions. It has been suggested that to eradicate female genital mutilation practices among the population, a total attitude and belief overhaul of women and men towards female sexuality is required and instead of suppressing female sexuality and independence, it should be celebrated (Whitehorn, 2010).

The practice of FGM is considered a cultural problem that still exists in contemporary society despite human rights awareness, and shifts in female sexuality roles in society. The reason for its prevalence has been associated with a lack of awareness and tendency in preserving cultural norms. As a result, due to increases in immigrant populations in a society, which leads to multiple cultures and diversity of views in the population, it is very common for healthcare professionals to encounter patients who have undergone FGM. Encountering patients with this complication may mostly be seen in primary care services such as pediatrics, gynecology, obstetrics, psychological, and psychosexual services. To achieve a higher rate of success in interventions, increase in awareness of FGM should be among the curriculum of health and social sciences professionals. In order to gain trust among the target population, cultural sensitivity of the issue must be taken into consideration. Preferential referral pathways for physical and psychological advance care such as, traditional health care versus modern health care should be identified and performed accordingly. It has been recommended that the intervention should be done without any judgment. Furthermore, in order to foster change,

attitudes and education regarding the practice of FGM should be influenced; moreover, there should be a close proximity among healthcare professionals, specialized in the areas of pediatric, gynecology, and psychology, as well as immigrant communities. In addition, help of international organizations both, non-governmental and human rights should be sought in educating the public regarding the risks associated with female genital mutilation. Females who have undergone the procedure may also play a greater role in minimizing future occurrence of this procedure (Whitehorn, 2010).

Study conducted by Fahmy et al. (2010) suggests that the main underlying reason of women engaging in sexual relationships and marriage have been identified as that of socio-economic status and fear of their husbands wanting out of marriage or relationship. The study recommends that economic empowerment of women should be taken into account, as well as educational campaigns in educating the public on health consequences of FGM. It has also been suggested that due to high audience for TV programs in Egypt, educational and awareness programs and messages should be displayed during prime time. It has also been suggested that along with educational programs, the political forces should also make efforts towards elimination of this practice (Fahmy,2010).

According to the study done by Dalal and et al., emancipating women educationally and financially plays a great role in changing the females' opinion regarding discontinuation of female genital mutilation in Egypt as opposed to implementing laws against the vice. This derives from the premise that women who were more educated and had occupations were more in favor of discontinuation of female genital mutilation (Dalal, 2010).

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