SOCIO-DEMOGRAPHIC CHARACTERISTICS OF FEMALE GENITAL MUTILATION AND ITS RELATION TO SEXUAL FUNCTION

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SUMMARY

Background: *Female genital mutilation (FGM) is a deeply rooted cultural tradition primarily in Africa and certain communities in the Middle East and Asia. A Greek papyrus, 163 B.C. mentioned that "both boys and girls in Egypt undergoing circumcision at the time of the Pharaohs", also, evidence from mummies has shown both Type I and Type III FGM present.*

Objectives: *To assess some socio-demographic characteristics of females with genital mutilation and to investigate the relationship between female genital mutilation and sexual function.* ***Methods:*** *This cross-sectional study has been performed on 350 married women during their sexual active life in Cairo, Egypt. Personal data of women with and without FGM were collected carefully by interviews, and then physical examination was done for the included women. Each woman asked to answer an Arabic-translated version of the female sexual function index (FSFI) questionnaire.* ***Results:*** *The study revealed that, almost a majority of women (77.4%) reported being subjected to genital mutilation. The group of FGM showed statistical significant differences compared to an equivalent control non mutilated group in arousal, orgasm, and satisfaction.* ***Conclusion:*** *Female genital mutilation is a common and popular practice throughout Egypt. Also, sexual function in women with FGM is adversely altered. Therefore, FGM women with sexual dysfunctions should be cured using sexual therapy.*

INTRODUCTION

Female genital mutilation (FGM) is a deeply rooted cultural tradition primarily in Africa and certain communities in the Middle East and Asia. A Greek papyrus, 163 B.C. mentioned that "both boys and girls in Egypt undergoing circumcision at the time of the Pharaohs", also, evidence from mummies has shown both Type I and Type III FGM present.[1]

It is also known as female genital cutting (FGC), or female circumcision, is any procedure involving the partial or total removal of the external female genitalia or other injury to the female genital organs [2]

According to estimates by WHO (2004), up to 140 million girls and women have undergone FGM, and annually another 4–5 million are thought to be at risk of this human right violation [2]. It is extensively being practiced in Africa and among Muslim populations in Indonesia, Sri Lanka and Malaysia. Countries of the Middle East concerned include: Egypt, Oman, Yemen and the United Arab Emirates. It is

also said to be occurring among immigrant communities in parts of Asia, the Pacific, North and Latin America as well as Europe [3].

FGC consists of several distinct procedures. Their severity is often viewed as dependent on how much genital tissue is cut away. The WHO, 2003; uses the term Female Genital Mutilation (FGM), classified the procedure into four major types [4] Type I is excision of the prepuce, with or without excision of part or all of the clitoris; type II is excision of the clitoris with partial or total excision of the labia minora[5]; type III is excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulations) [6]; and 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 or cutting of the vagina ; 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 FGM given above[7].FGM is associated with cultural ideals of femininity and modesty, which include the notion that girls are “clean” and "beautiful" after removal of body parts that are considered "male" or "unclean" and believed to reduce a woman's libido Religious beliefs are a strong predisposing factor for female genital mutilations. Religious leaders have contradictory opinions with regard to FGM: some promote it, some consider it irrelevant to religion, and others contribute to its elimination [8].

Al-Azhar Supreme Council of Islamic Research, the highest religious authority in Egypt, issued a statement saying FGM/C has no basis in core Islamic law or any of its partial provisions and that it is harmful and should not be practiced [9].

Also, Mohammed Said Tantawi, head of the Al-Azhar Islamic Institute, had stated during the 1990s that the practice is un-Islamic, and the Health Minister of Egypt, Ismail Sallam, announced a ban on FGM in 1996 –Jul. this was uphold by junior administrative court in Cairo. Moreover, Professor Ali Gomaa, the Grand Mufti of Egypt, issued a Fatwa on FGM on 2006-Nov-24, which stated that, "there are no written grounds for this custom in the Qur`an with regard to an authentic tradition of the Prophet [10] .

Coptic Pope Shenouda, the Head of Egypt's Christian community, said that neither the Qur'an nor the Bible demand or mention female circumcision.

For non-medical reasons, the United Nations has also declared 6th February as "International Day of Zero Tolerance to female genital mutilation. The United Nations Population Fund (UNFPA) has stated that "the practice violates the basic rights of women and girls and it is not required by any religion. Among practicing cultures, FGM is most commonly performed between the ages of four and eight, but can take place at any age from infancy to adolescence [11].

Female genital mutilation/cutting has both immediate and long-term consequences for the health of women. The effects of FGM depend on the type performed, the expertise of the practitioner, the conditions under which it is

conducted, the amount of resistance and general health condition of the girl undergoing the procedure. Complications may occur in all types of FGM, but are most frequent with infibulations, which includes stitching or narrowing of the vaginal opening. Immediate complications include severe pain, bleeding, shock, wound infection, fever, and Septicemia, urine retention and even death are possible acute complications [12]. Delayed complications include painful and difficult menstruation, pelvic infections, urinary tract infections, massive hemorrhage after delivery and obstructed and prolonged labor. Anemia, the formation of cysts and abscesses, keloid scar formation, damage to the urethra, resulting in urinary incontinence, painful sexual intercourse and sexual dysfunction, hypersensitivity of the genital area [13]. Moreover, the National baseline Survey on Harmful and Positive Traditional Practices reported that over 114 million women and girls all over the world lost their lives through Female Genital Mutilation [14], So, World Health Organization has made the eradication of female genital mutilation a major goal in Africa, Asia and Australia. Egypt's Ministry of Health and Population has banned all forms of female genital cutting since 2007[15]. The ministry's order declared it is 'prohibited for any doctors, nurses, or any other person to carry out any cutting, flattening or modification of any natural part of the female reproductive system Islamic authorities in the nation also stressed that Islam opposes female circumcision. Laws alone, however, are not enough to end the practice. Governments are far from being able to monitor FGM, which is usually underreported, particularly those cases occurring in remote locations. FGM remains a culturally entrenched procedure and unless a prohibition of the practice is accompanied by educational efforts, the effectiveness of legal action is low [16].

SUBJECTS AND METHODS

This is a cross sectional study, involved 350 women during their sexual active life "with and without FGM" attending gynecology, family planning and dermatology clinics in Al-Zahraa and Al-Maadi hospitals between August 2008 and March 2009. The women were informed about the principles of the study, and they were assured about confidentiality of the obtained information. They were enrolled after obtaining their consent for participation in the study. The Human Ethics Committee of the included hospitals approved the study protocol.

An interview questionnaire was developed by the researchers to fulfill information in the following areas: a) personal/family data; education of subject and their parents; socio-economic status; family history of FGM (sisters and daughters) conditions and characteristics of FGM (age, place, agent, reason, and types); and its effects on their sexual activity through Arabic-translated version of the modified female sexual function index (FSFI) questionnaire.

FSFI [17] was used to investigate sexual dysfunctions during the past 4 weeks. It was originally tested with 19-item of self-report questionnaire, then modified to 15 items that measures six dimensions of female sexual functioning: desire, arousal, lubrication, orgasm, satisfaction, and pain. The 15-item version has been shown to have good reliability and validity as well as to be able to differentiate between

sexually functional and dysfunctional women. Each question is given a score of 1 to 5. Low scores on FSFI indicate more problems with sexual functioning, and high scores indicate fewer problems with sexual functioning. Out of 271 circumcised women; (87.7%) completed the interview and physical examination and only (12.3%) refused examination.

Univariate and multivariate statistical analysis was done using SPSS version 17.

P value < 0.05 considered significant and 95% confidence interval. Logistic regression analysis for factors which assumed to affect circumcision also was analyzed.

RESULTS

The current study revealed that, majority of women (77.4%) subjected to genital mutilations. Their mean ages (30.3±5.7) years, 38.8% of mutilated women were below 30 years age compared to 61.2% whose their ages above 30 years; however, 89.8% of non-mutilated women were less than 30 years compared to only 10.2 whose their ages above 30 and this difference is statistically significant (P<0.05). Also, most female genital mutilation (80.4%) occurred above seven years of age; compared to only 19.6% who was mutilated before seven years, and all genital mutilation occurred before the age of menstruation.

51.7% women characterized their FGM as type I and the remaining 48.3% women characterized their FGM as type II. None of the included females were joined to type III or IV.

More than half of mutilated women (66%) belonged to middle and low socio-economic status (SES) while 33.9% belonged to high social class; compared to no mutilated females who belonged mainly to high social class (86.1%) and this difference is statistically significant (P<0.05). Illiterate and partially educated fathers of circumcised females constituted 9.6% and 22.9% respectively while 67.5% of parents were highly educated; on the other hand all fathers of non-circumcised females were of high school education and college. Also, 39.5% and 43.2% of circumcised females mothers were illiterate and partially educated respectively and only 17.3% were highly educated on the other hand 64.6% of non-circumcised female's mothers were highly educated.

73.4% of circumcised females were from rural regions and only 26.6% from urban area however, 75.9% of non-circumcised females were from urban origin and this difference is significant statistically.

In the present study cultural ideas of femininity are the main reason in 80.4% of circumcised females which responsible for the family's decision to have their daughter's genitals mutilated followed by religious factor 19.6%.

The primary place for genital mutilations was home in 56.1%; while it was 29.2% in private clinics; and the remaining 14.8% was in hospitals.

However, the primary practitioner of the genital mutilations is nurse (38.7%); followed by physicians (36.5%) then the midwife (19.9%); and traditional personnel (barbers & daya) did only (4.8 %).

68.5% of females subjected to genital mutilation have one or more sisters with genital mutilation, compared to only 14.6% of non-mutilated females who have circumcised sisters and this is significant statistically (P<0.05).

77.1% of women who were subjected to genital mutilations have one or more daughter with genital mutilation, they perpetuate the practice and insist that it will be done to their daughters, compared to only 22.9% of females subjected to genital mutilation, refused the practice or will consult doctor before performing this practice to their daughter; however, all non-circumcised women refused to circumcise their daughters and this difference is significant.

31% of circumcised women said that they planned to continue this custom, which involved a ritual incision but no tissue removal, and would perform it for their daughters, compared to nearly all non-circumcised females (96.2%), not planned to do this, and this difference is significant statistically(P<0.05).

These socio-demographic characteristics of FGM in our sample are summarized in (Table 1 & 2) and (Figure: 1, 2 & 3).

Table (1): Socio-demographic characteristics of the studied females (N = 350)

Variable	Circumcised (N=271)		Non-circumcised (N=79)		Chi square	P value
	No.	%	No	%		
Age:						
20-	46	17	55	69.6		
25-	59	21.8	16	20.3		
30-	93	34.3	7	8.9		
35+	73	26.9	1	1.3	91.8	< 0.05
Origin:						
. Urban	72	26.6	60	75.9		
. Rural	199	73.4	19	24.1	63.5	< 0.05
Social class:						
. low	64	23.6	0	0		
. middle	115	42.4	11	13.9		
. high	92	33.9	68	86.1	68.8	< 0.05
Paternal education:						
. Illiterate	26	9.6	0	0		
. partially educated	62	22.9	0	0		
. high school & college	183	67.5	79	100	34.3	< 0.05
Maternal education:						
. Illiterate	107	39.5	3	3.8		
. partially	117	43.2	25	31.6		
. high school & college	47	17.3	51	64.6	75.5	< 0.05

Table (2): Characteristics of females with genital mutilation (N = 271)

Variable	No	%
Age of circumcision:		
. < 7 years	53	19.6
. > 7 years	218	80.4
Type of circumcision:		
. type I	140	51.7
. type II	131	48.3
Reason:		
. cultural	218	80.4
. religious	53	19.6
Place:		
. home	152	56.1
. clinic	79	29.2
. hospital	40	14.8
Agent:		
. physician	99	36.5
. paramedical	105	38.7
. midwife	54	19.9
. Traditional personnel	13	4.8

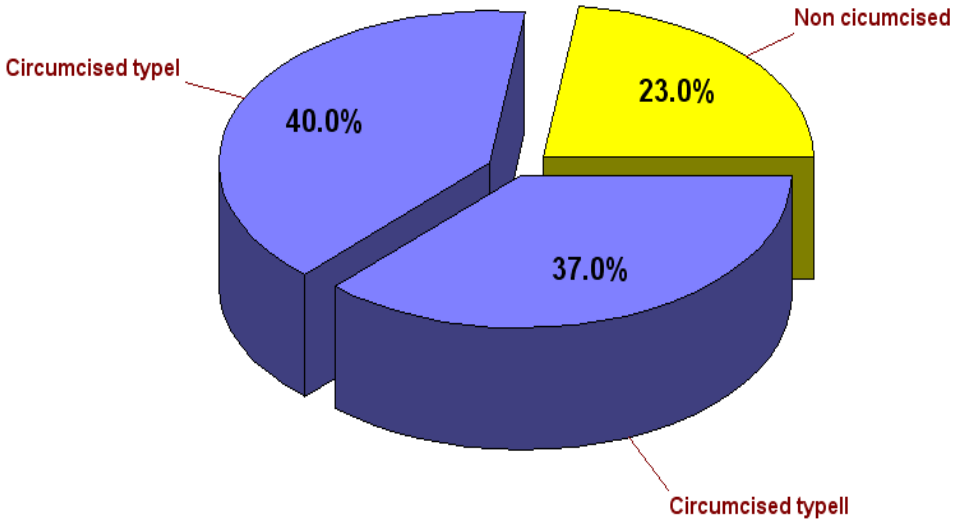

Figure (1) : Circumcision among the studied sample

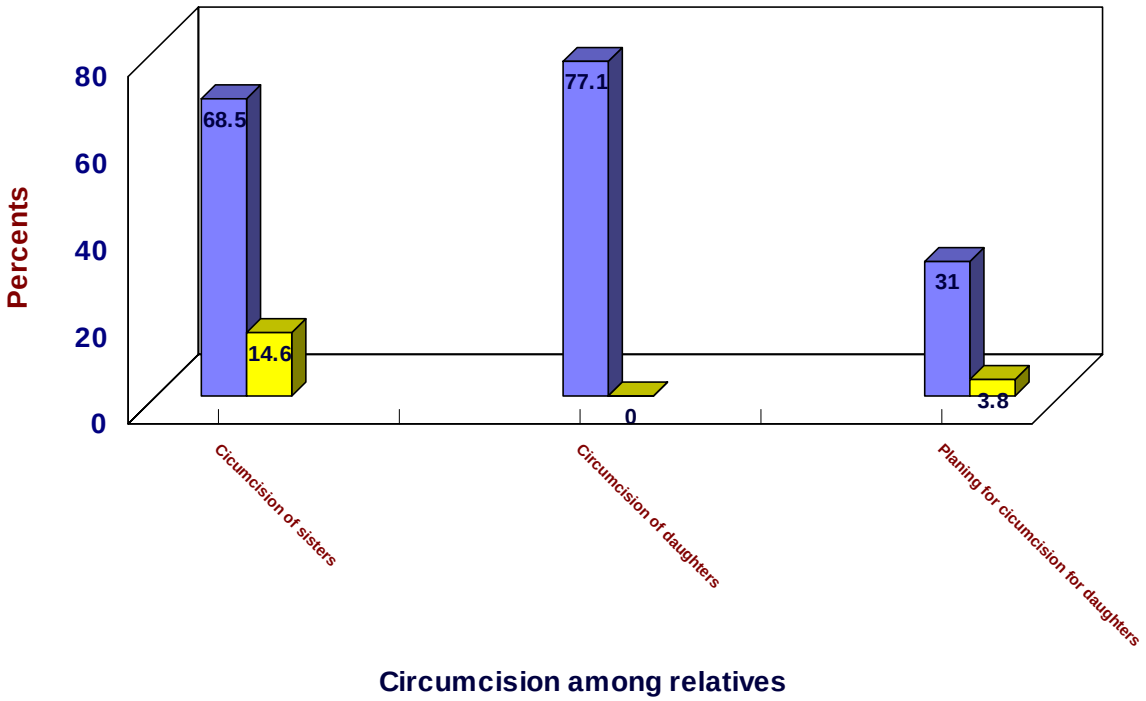

Figure (2): History of circumcision among relatives of the studied group

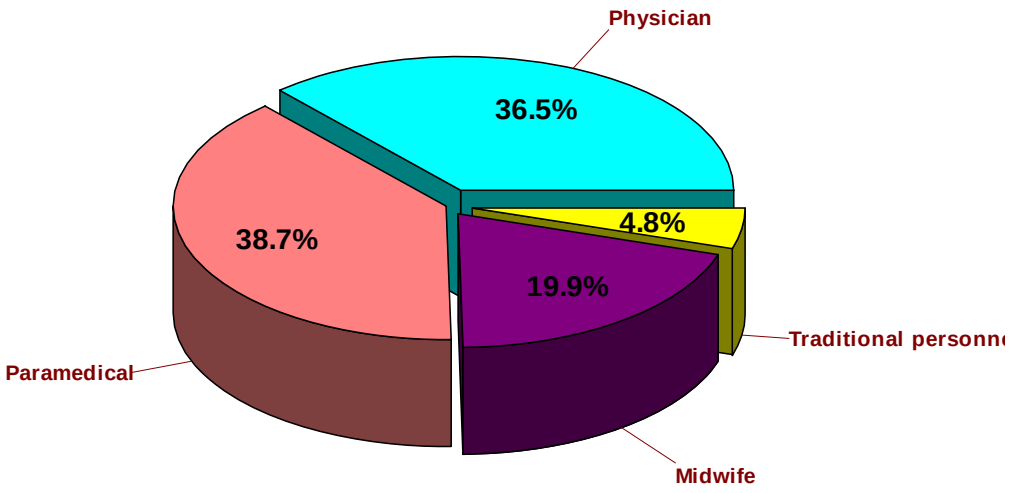

Figure (3): Agents of circumcision among the studied group

In order to assess sexual function of women with and without FGM, there were no statistical significant differences between them regarding desire as 47.9% of mutilated females not having desire compared to 46.9% and 5.2% who have desire for sometimes and always respectively, also; non- mutilated females who moderately or always have desire were 55.7% and 6.3% respectively. However, when comparing orgasm between circumcised and non-circumcised females we found a significant difference as we found that only 14% of circumcised females always having orgasm and nearly half of non-circumcised females always having orgasm. Moreover, regarding arousal we found difference between mutilated and no mutilated women as 10.3% and 39.1% of mutilated females not or sometimes having arousal respectively compared to 65.8% of non-mutilated women who were always having arousal and this difference is significant statistically. Also, we found significant difference regarding satisfaction between the two groups as 51.7% of circumcised females not satisfied with intercourse compared to 54.4% of non-circumcised females who were satisfied. On the contrary, regarding lubrication there were no significant difference between the two groups as; 81.9% and 82.3% of circumcised and non-circumcised females respectively having lubrication most times. Also, regarding pain there is no significant difference between the two groups as 83.4% and 79.7% of mutilated and non-mutilated females respectively not suffering pain after intercourse. Nearly half of the mutilated and non-mutilated females suffering mild pain during intercourse and this are of no significant difference statistically.

By analyzing the factors which assumed to affect FGM by using logistic regression, we found them as follows; origin, age, paternal education, and maternal education.

The relationship between FGM and sexual function and logistic regression analysis were represented in (Table: 3 & 4).

Table (3): Relationship between female genital mutilation and sexual function among the studied sample

Sexual function	**Circumcised**		**Non-circumcised**		**Chi square**	**P value**
	No	%	No	%		
Desire:						
. No	130	47.9	30	38		
.Sometimes	127	46.9	44	55.7		
. Always	14	5.2	5	6.3	2.47	0.29
Arousal:						
. No	28	10.3	1	1.3		
.Sometimes	106	39.1	26	32.9	9.33	0.009
. Always	137	50.6	52	65.8		
Orgasm:						
. No	151	55.7	12	15.2		
.Sometimes	82	30.3	35	44.3		
. Always	38	14	32	40.5	46.64	0.00
Satisfaction:						
. Not satisfied	140	51.7	14	17.8		
.Moderately satisfied	71	26.2	22	27.8		
. Satisfied	60	22.1	43	54.4	37.75	0.00
Lubrication:						
. few time	49	18.1	14	17.7		
. Most time	222	81.9	65	82.3	0.01	0.94
Pain during intercourse:						
. No	130	47.9	30	38		
. Moderate	127	46.9	44	55.7		
. Severe	14	5.2	5	6.4	2.47	0.29
Pain after intercourse:						
. No	226	83.4	63	79.7		
. Moderate	38	14	14	17.8		
. Severe	7	2.6	2	2.5	0.66	0.71

Table (4): Logistic regression analysis of factors affecting female genital mutilation.

Factors	B	P value
. origin	— 1.622	0.00
. age	0.349	0.00
. father education	— 1.342	0.001
. mother education	— 0.573	0.058

DISCUSSION

Female genital mutilation is an inherited practice throughout Egypt where every day thousands of young girls are subjected to this mutilation. It is a culturally accepted practice, the prevalence of FGM in Egypt ranged from 80% to higher [18].

The term Female Genital Mutilation (FGM) as used by WHO, reinforces the idea that this practice is a violation of the human rights of girls and women, and thereby helps promote national and international advocacy towards its abandonment.. The latter terms include female genital cutting, female circumcision, female Sunna circumcision, and Pharaonic circumcision [19]. The term female circumcision does not reflect analogies to male circumcision, a procedure that involves far less alteration in structure and function of the male genital organ. For example, the male equivalent of clitoridectomy would be penectomy. Furthermore, male circumcision carries multiple personal and public health benefits, and when carried out in the neonatal period is very cost-effective. As it reduces the risk for HIV, chancroid, syphilis, neonatal urinary tract infection, penile also cervical cancers, and possibly herpes simplex virus II. Current evidence suggests that some cells found in the male foreskin are especially vulnerable to infection with HIV and that routine circumcision of all men in Africa, for instance, could prevent 2 million new HIV infections and avert 300,000 deaths over the next 10 years [20]. On the other hand, some studies have found increased risk of HIV among women who had undergone FGM [21].

The use of the term ‘Sunnah Circumcision’ is nothing but a form of deceit to misguide people and give the impression that the practice is Islamic. The practice of FGM predates Islamic times and is common in religious and nonreligious groups. This practice is found among all races and many religions, including Islam, Coptic Christianity, Catholicism, and Protestantism [22]. However, it is not included in the Muslim holy book, the Qur'an and Islamic authorities agree that all types of body mutilation including FGM are condemned by Islamic faith ".

We should avoid the use of the word “Sunna” to prevent implying religious support for the procedure. Sunna means following the instructions of the Prophet Mohammed peace be upon him, true female Sunna circumcision does not exist in the real world because the Prophet Mohammed's instructions for the performance of female Sunna circumcision "to remove minimal tissue from the prepuce if essential".

FGM is a culturally accepted practice, and there was a study found that over 95% of Egyptian women have undergone some form of FGM [23]. However, in the current study revealed that, (77.4%) Egyptian women reported being subjected to genital mutilations. Higher rates of FGM were recorded in Cairo at (1977) it was (81.8%), at (1979) it was (90.8%), and at (1985) it was (81.6%)[24]. The different prevalence of FGM in various studies compared to the present study may be attributed to raising community awareness and education, and measures that were taken for prohibition and prevention of FGM by mass media under direction of ministry of health and population also, religious men in both mosques and churches. We have observed that the prevalence of FGM was higher among woman above 30 years than those less than 30 years. This means that there is actual decline in this practice among the new generations.

Regarding type of mutilation the current study revealed that, about half of mutilated women were type I and the remaining were type II, and none of the included females were joined to type III or IV. This explained by the fact that most of this action was done by doctors and paramedical personnel also was done at private clinics and hospitals.

The present study revealed that cultural tradition beliefs are strong predisposing factor for FGM. This is coincided with what was found by other studies in which reasons given for FGM include the psychosexual (maintenance of chastity and virginity before marriage, fidelity during marriage, and promotion of fertility); and sociologic (initiation into womanhood, maintenance of cultural tradition, protection against spells and hygienic) [24].

The current study revealed that FGM occurred among all socioeconomic groups but the majority of women with genital mutilations belonged to middle and low socio-economic family status; and came from rural regions. Girls of urban/rural areas (living in urban areas but raised in rural areas) remain at a higher risk for genital mutilation than urban/urban girls. Mothers are directly responsible for arranging the genital mutilation of their daughters. Daughters of urban and educated women were less likely than others to undergo FGM. Many women especially in rural areas perpetuate the practice and insist that it will be done to their daughters.

As regards, persons who perform FGM, the present study revealed that the primary practitioner of the genital mutilations is nurse, followed by physicians then the midwife, and traditional personnel (barbers & daya). Concerning place of mutilation, our study reported that, around half of FGM was done at home and the remaining was at hospitals and private clinics. So educational programs that are directed to Egyptian families "both male and female must be included"; the agents that perform the genital mutilations (midwives, doctors, nurses), and the social-political and religious leaders on the harmful and devastating effects for these procedures will contribute significantly to the elimination of female genital mutilations. It must be emphasized that physicians who perform these genital mutilations are not follow medical ethics that prohibit unnecessary medical practices.

Specific attention must be given to the effects of genital mutilations upon reproductive processes, the birth of the child and the marital sexual relationships. Also, the involvement of men and boys throughout efforts to end FGM was a critical strategy in making progress. Men need to understand that their marital sexual relationships and happiness will be significantly enhanced when the female genitals are not mutilated.

In order to assess sexual function of women with and without FGM, there were no statistically significant differences between them regarding desire, lubrication, pain, and arousal. However, when comparing orgasm and satisfaction between circumcised and non-circumcised females we found that there were statistically significant difference ($P<0.05$). Our findings will add to the existing literatures an important aspect of the medical complications of FGM as we have demonstrated that even type I and type II are associated with sexual dysfunction [25].

This is coincided to what El-Defrawi et al. (2001), who reported that, circumcision has a negative impact on a woman's psychosexual life, raising common problems; vaginal dryness during intercourse, lack of sexual desire, less pleasure, less orgasm or having difficulty to reach orgasm [26]. Also, Elnashar and Abdelhady (2007) demonstrated that dyspareunia, loss of libido, failure of orgasm and husband's dissatisfaction were commonly encountered among circumcised women [27].

Contradictory to this issue a study done by year 2007 who declared that, FGM in many communities is believed to reduce a woman's libido and thereby is further believed to help her resist "illicit" sexual acts. The Center for Social Studies conducted a survey which showed that 85% of the prostitutes in Egypt were circumcised. So, there is no relation between female circumcision and the girls' behavior [28]. Female genital mutilation in this group of women did not attenuate sexual desire. This is coincided to what we found that; there were no statistically significant differences between females with and without circumcision regarding desire. Therefore, female genital mutilation cannot be justified by arguments that suggest that it reduces sexual desire in women and prevents adverse outcomes of sexuality. So, every woman has the right to have sexual health and to feel sexual pleasure for full psychophysical well-being.

The present study revealed that, FGM does not completely eliminate all sexual pleasure for all women who undergo the procedure "as all mutilated women with type I and II and there is no type III and IV", but it does reduce the likelihood of arousal, satisfaction and orgasm. This can be explained by that, stimulation of the clitoris is not solely responsible for the sexual excitement and arousal of a woman during intercourse; this involves a complex series of nerve endings being activated and stimulated in and around her vagina, vulva (labia minora and majora), cervix, uterus and clitoris, with psychological response [29]

This is coincided with what reported in 2006 that, in some infibulated women, some erectile tissue fundamental to produce pleasure had not been completely excised. Defibulation of subjects revealed that a part of or the whole of the clitoris

was underneath the scar of infibulation. The study found that sexual pleasure and orgasm are still possible even after infibulation, and that they rely heavily on cultural influences, when mutilation is lived as a positive experience, orgasm is more likely. When FGM is experienced as traumatic, its frequency drops. The study suggested that FGM women who did not suffer from long-term health consequences and are in a good and fulfilling relationship may not interrupt their marital relationship, and women who suffered from sexual dysfunction as a result of FGM have a right to proper intervention [30].

Recommendations:

The norm of damage to young girls should be replaced with a norm of strengthening them through improved education with the support of women empowerment in the community. With successful interventions, over time a critical mass of parents who have not undergone FGM will be reached within a community, levels of FGM will fall dramatically, and males will be more likely to prefer women who have not been cut. Also, many non-governmental organizations and a number of intergovernmental and governmental bodies should be actively involved in raising awareness about FGM as well as developing strategies for its eradication.

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دراسة بعض الظواهر الاجتماعية الديموجرافية لختان الاناث و تاثيره على الوظائف الجنسية – القاهره – مصر

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الخلاصة

يمثل ختان الاناث عادة مستحدثه عميقة الجذور فى افريقيا و بعض دول الشرق الاوسط و اسيا. وهناك برديات اغريقية من سنة 163 قبل الميلاد ذكر فيها ان الفراعنه فى مصر كانوا يمارسون هذه العاده للذكور و الاناث. و ذلك بالاضافة الى وجود علامات فى المومياوات تدل على حدوث النوع الاول و الثانى من الختان. و لذلك كان الهدف من هذه الدراسة هو دراسة بعض الظواهر الاجتماعية الديموجرافية لختان الاناث و ايضا دراسة العلاقة بين ختان الاناث و الوظائف الجنسية. و فى هذه الدراسة المستعرضة تم اختيار 350 امراة متزوجة من القاهرة – مصر، و تم المقارنه بين اللاتى تعرضن للختان و اللائى لم يجرين هذا الختان و قد اجريت معهم مقابلة شخصية و فى هذه المقابلة تجيب المريضة عن الاستبيان الذى يقيس تاثير ظاهرة الختان على بعض الوظائف التناسلية و ايضا بعض البيانات الشخصية ثم يتم الكشف على هؤلاء النساء. و فى هذه الدراسة وجد ان نسبه عاليه (77.4%) من النساء تعرضن للختان. و قد تبين وجود اختلاف ذو دلالة احصائية بين النساء المختنات و غير المختنات بالنسبة الى الاستثارة و هزة الجماع و الاشباع الجنسى.

و لذلك تم استنتاج ان ظاهرة الختان هى ظاهرة رائجة و معتادة فى مصر. و ايضا لها تاثير سلبى على العلاقة الجنسية عند النساء المختنات. ولذلك فنحن نوصى بان هؤلاء النساء لديهم الحق فى العلاج النفسى الجنسى.