The Health Effects of FGM among young Muslim women

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Author Note

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Globally, the issue of Female Genital Mutilation (FGM) is one that is rife with controversy. Generally, the western world strongly holds it to be a violation of individual rights, and have led global campaigns to condemn and end what is seen as a non-human and unethical practice. However, in many parts of the world, in particular Africa, it is considered a general norm and is natural to many of the cultures in certain regions. Emerging evidence has led it to be recognized as a form of violence and a health hazard, which has led the UN to place it on top of their women's rights and health agendas. The paper will explore the health, social and economic effects of FGM, and the factors associated with it, in light of recent and earlier literature on the subject. 133

In the discussion by Ofor and Ofole (2015), a summary of current understanding with regards to FGM is presented in light of various studies on the subject. Generally, FGM has 4 key types determined by the degree of impact on the female genitalia. These include: Type I, that involves partially removing the clitoris, Type II involving a more significant removal of the labia minora or the clitoris, Type III is infibulation that is a severe practice which narrows the vaginal opening and Type IV, in which harmful non-medical procedures such as piercing, pricking or incising are done. The history of FGM is traced to Egypt followed by Sub-Saharan and North Africa, which subsequently spread to Britain, EU, and the U.S. through immigration. Currently, prevalence is very high in nearly 30 African countries, in the West, East as well as the South (Ofor & Ofole, 2015). Some of the key causes summarized by Ofor and Ofole (2015) include performing FGM for marital prospects, controlling a woman's sexual desires, enhancing their fertility or as a coming of age ritual. Moreover, in some regions, FGM is a source of cultural identity and seen as a means of enhancing femininity. It is suggested that besides sanctions and law enforcement, awareness campaigns and education is necessary to gradually eradicate the will to practice FGM and bring about cultural change.

Recent studies have attempted to research pregnancy-associated outcomes in women with FGM to establish the harmful nature of the practice. Owing to a large number of immigrant women in the West who practice FGM, Wuest, and colleagues (2009) examined the wishes of pregnant women with FGM with regards to delivery and antenatal care, and to determine whether their maternal and fetal outcomes were different form non-mutilated women. Data with regards to postpartum outcome and fetal health were collected alongside FGM-related wishes against a control group. Wuest and Colleagues (2009) found no differences between the control group and FGM patients in terms of fetal or maternal outcomes, but some patients experienced third-degree vaginal tears, demonstrating that managed care provided to FGM patients achieves nearly the same outcomes as non-mutilated women.

A number of studies have reported inadequate data to establish the physical health risks linked to FGM. In this regard, Berg, Underland, Odgaard-Jensen, Fretheim, and Vist (2014) attempted to systematically review multiple studies to find conclusive evidence demonstrating significant consequences and risks from FGM. For this purpose, empirical studies were selected irrespective of nationality, religion, age, and ethnicity. The findings demonstrated a positive link between physical health and FGM in terms of harms to the child undergoing the procedure and in childbirth and sexual function and found significant consistency in the results.

Similar findings were reported by Reisel and Creighton (2015) who attempted to research the long-term health consequences, complications, and risks associated with FGM. Like Wuest and colleagues (2009), Reisel and Creighton (2015) also discuss rising concerns in the Western world due to the increasing prevalence of the practice, as a result of immigration. From the studies, It can be conclusively claimed that there are no significant health benefits to be achieved from FGM, while the potential for its psychological and physical impacts exist. However, Reisel and Creighton (2015) report inconsistencies and limitations in studies indicating these harmful impacts in certain areas. In case of mental health problems such as PTSD or memory problems, studies indicate a statistically significant risk, however, in the case of physical problems such as prolonged or painful periods and urinary flow, data is limited and inclusive, except in the case of increased risks to acquiring urethral strictures and fistula.

A cross-sectional and qualitative study to observe FGM’s effects and the perception of women, of reproductive age, who had undergone it was conducted by Karmaker, Kandala, Chung, and Clarke (2011) who evaluated the prevalence, contributing factors and health consequences of the practice among the sample groups in Ethiopia's Bale Zone. Analyzing the collected data, it was found that nearly 78% of the women in the sample group had underwent a certain type of FGM, who reported reasons ranging from suppression of sexual desires, social acceptance, religious recommendations or to safeguard their virginity. Complications with regards to urine retention, infection, swelling and discomfort besides severe bleeding at time of cutting. Chung, and Clarke (2011) stressed tackling the strongly held personal beliefs and deep cultural issues that encourage women to tolerate and perpetuate the practice.

A study of a similar nature was conducted in Burkina Faso by Bogale, Markos, and Kaso (2014) who made use of the Demographic Health Survey (DHS) in 2003 in case of women of reproductive age to study links between FGM prevalence and health risks. In the study, 9267 women (77%) women reported having FGM among whom 7336 women also had daughters that had FGM, and a further 4.5% reported intentions to let their daughters undergo the procedure. Bogale, Markos, and Kaso (2014) also reported higher tendencies among women belonging to the Muslim faith and certain other groups to be more accepting of the practice. The results agreed with earlier findings from Chung, and Clarke (2011) and Ofor and Ofole (2015) that deeper held beliefs and cultural issues are involved, that required awareness campaigns led by religious and cultural leaders. However, Ismail and Colleagues (2017) disagreed and found that FGM has no links in religious in particular Muslim practice, predating it. Yet, based upon earlier findings regarding the impact on women's sexual health, Ismail and Colleagues (2017) used a self-reporting FSFI index that indicates sexual function in women to study whether FGM impacted it. It was confirmed that self-reported sexual dysfunction existed in over 83% of women that had either Type II and Type I FGM which was significantly different from the control group in terms of FSFI scores.

Another comprehensive study was performed by Berg, Denison, & Fretheim (2010) in women living in western countries such as the U.S., UK, Australia, France, Switzerland and Sweden to study the physical and mental health consequences of FGM through reviewing a range of literature on the subject that spanned over 3,669 different studies, which included cross-sectional, cohort, and case-control studies. Berg, Denison, & Fretheim (2010) confirmed other findings from Chung, and Clarke (2011) among women living the west also that community mechanisms that have to do with family honor, control over sexuality or other social and psycho-sexual reasons lead to the practice. Moreover, like the recent systematic review based study by Reisel and Creighton (2015), it was similarly found that the quality of evidence is not significant enough to establish a causal relationship between FGM and most physical health associated risks. However, correlations are statistically significant, whereas psychological consequences or disturbances are more likely in women with FGM except in the case of hostility or depression (Berg, Denison, & Fretheim, 2010; Reisel & Creighton, 2015). They are more likely to have sexual dysfunction such as intercourse associated pain, reduced libido, and frequency, as also found by Ismail and Colleagues (2017) in middle-eastern women. However, the overall body of evidence remains of lower quality that lead Berg, Denison, & Fretheim (2010) to likewise conclude that it is difficult to establish causality, yet the evidence is sufficient to warrant a policy response.

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