

Female genital mutilation's effects on women's physical, mental, and social health

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Abstract

The non-medical cutting or removal of some or all of the external female genitalia is known as female genital mutilation, or FGM. Physical health issues such as scarring or keloids formation, infertility, infections, and irregular menstruation are reported to result from it. In addition, it causes perineal tears, protracted labor, and postpartum hemorrhage, among other difficulties during labor and delivery. Depression, low self-esteem, and post-traumatic stress disorder are possible psychological outcomes. Sexual dysfunction, including arousal, orgasm, lubrication, and satisfaction, can lead to a loss of connection for sufferers and, indirectly, for significant others. The purpose of this study was to ascertain the impact of female genital mutilation on the body, society, and mind. There were 200 FGM and 200 non-genital mutilation participants in this study. The impacts of female genital mutilation (FGM) on the victims' social, psychological, and physical well-being were assessed. The family of FGM group (N = 129) had a monthly family income of 50000 Naira or less, compared to 46 families (23%) earning 50000-100000 and 25 families (12.9%) having an income above 100000 naira. With regard to employment, 63 fathers (31.5%) described themselves as Traders. 55 (27.5%) of them were farmers, 18 (26.6%) of them were skilled workers, Civil Servants 42 (21%), and Self-employed 32 (16%). 8 (4%) fathers were retired. There are no differences between this group and the other. The findings showed that female with genital mutilation, had greater rates of somatic disturbance, anxiety disorder, and depression than those without female without genital mutilation. Therefore, this study offers additional proof to medical professionals so they may start providing FGM patients with high-quality care right away.

Key Words: physical, psychological, social health genital mutilation

Introduction

Female genital mutilation (FGM), comprises none medical removal of some parts or the complete external female genitalia. This simply means that it is a traditional practice in which the female genital organs are partly or completely removed for cultural or other non-therapeutic reasons (Berg and Dennison). It is practiced in many Africa and in some countries in the Middle East and Asia. However, there is limited data, it is speculated that female circumcision is practiced by immigrant communities in a number of countries. It is forbidden by law in various African and Western countries [1].

The current WHO classification describes four types of female circumcision: Type I known as *clitoridectomy*, consist of partial or complete removal of the clitoris and/or the prepuce. Type II also refers to as *excision*, comprises partial or complete removal of the clitoris and the labia minora, with or without excision of the labia majora. Type III known as *infibulation*, involves narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris. Type IV, *other*, involves all other harmful procedures to the female genitalia for non-medical purposes, for instance: pricking,

piercing, incising, scraping and cauterization. There is differences in prevalence, reflecting ethnicity, tradition and sociodemographic factors [2,3]

This practice of female circumcision is based on social conventions with regards to psycho-sexual and social reasons including control of women's sexuality and family honor which is implemented by the community [4]. This is known to result to physical health problems such as scaring or formation of keloids, infertility, infections as well as menstrual abnormalities. It equally causes complications during labor and delivery, which involves a long period of labor, perineal tears and hemorrhage after delivery [5]. Psychological disorders are major effects such as depression, low self-esteem and indeed post-traumatic stress syndrome. Social health problems to victims of FGM and indirectly to others may include lack of intimacy related to sexual disorders like arousal, orgasm, lubrication and satisfaction [6,7] The practice of FGM is common in some African countries. The effects of this FGM have global impacts. Some frantic efforts are being made to try and reduce the suffering of the victims as well as trying to stop the practice by educating communities. This has been done through their leaders, men involvement

and coming up with strategies and policies that protect the rights of women against such gender based violence [8,9]

Female genital mutilation is recognized as a harmful practice which abrogates human rights. It is linked to various health problems such as intensive pain, bleeding, shock, infections, and difficulty in passing urine and faeces. Caesarean section, blood loss, and increased perinatal mortality are associated birth risks. This in other words results in psychological, social and physical consequences [10,11].

Indeed, some works have been carried out on female circumcision but still there is literature gap on the global physical, social and psychological effects of Female genital mutilation. The effects of Female genital mutilation need to be studied particularly on the victims as the study group and the survivors as the control group. Such studies may provide some significant evidence to healthcare providers to effectively commence high standard medical care to both the victims and the survivors of female genital mutilation.

Materials and Methods

Study area

The study area was in [south East Nigeria](#)

Population

The estimated population is 25.8 million and the population density varies from 230-1,400 people per square kilometer.

Study design

Descriptive and analytical study designs were used in this study. This included and knowledge, attitude and perception studies. Descriptive design was used to investigate the distribution of FGM. Women who had female genital mutilation aged between 12 and 14 were involved and non FGM served as control

Method of data collection

Research instrument for data collection were questionnaires, Personal Interview and Telephonic Surveys

Questionnaires

Well structured questionnaires will be used to obtain data from respondents; the questionnaires were arranged in the following order:

Questionnaire 1

This was used to elicit information from the general populace. It will be organized into the following sections:

Section A: Demographic data

Section B: Knowledge of female genital mutilation

Section C: Social impact of female genital mutilation

Section D: Physical impact of female genital mutilation

Section E: Physiological impact of female genital mutilation

Validity of research instrument

The questionnaires was well structured according to the two categories of respondents: namely; those with FGN and those without FGN

Reliability of research instrument

In order to make the research instruments reliable, pilot or test studies was carried out using five copies of each of the two different categories of questionnaires which were administered to the respective groups of respondents. After an interval of two weeks, another set of five copies of the same instruments was administered on different sets of respondents. At the end of these preliminary studies, the questionnaires were then fine tuned and structured to attain the highest reliability standard.

Ethical consideration

Letters of approval/permission to administer questionnaires on respondents were presented to management of health institutions for approval before they were administered to respondents. Also, the consent of those with FGM were sought for before they were presented with questionnaires. Similar consent were sought from those without FGM.

Statistical analysis

Generated data will be put into Tables and Charts. The data were analyzed using the Statistical Package for the Social Sciences, SPSS version 11.0 for Windows. Descriptive statistics was used to present the characteristics of the sample.

Results

Parameters	FGM		Non FGM	
	N	%	N	%
Age (Years)	13.1±1.5		13.0±1.2	
No of Siblings	5.7±3.2		5.3±3.6	
Family's income	N	%	N	%
<50000	129	64	126	63
50000-100000	46	23	48	24
>100000	25	12.5	26	13
Employment/Father's profession				
Traders	63	31.5	68	34
Farmer	55	27.5	53	26.5
Civil Servant	42	21	44	22
Self employed	32	16	30	15
Retired	8	4	5	2.5

Table 1. Comparison of FGM and non FGM with respect to demographic variables

Parameters	FGM		non FGM	
	N	%	N	%
Anxiety disorders	90	45	61	30.5
Personality disorder	28	14	0	0
Somatic disturbance	41	20.5	32	16

Table 2: Psychological disorders in FGM and Non FGM

Groups	Depression	Self esteem
FGM	34.10±3.8	24.23±4.21
Non FGM	11.53±2.1	8.41±2.80

Table 3: Sociological disorders in FGM and Non FGM

Groups	Scars	Pains
FGM	14.26±3.7	11.53 ±4.1
Non FGM	2.11±3.1	3.0±2.6

Table 4: Physical impact in FGM and Non FGM

Discussion

According to the study's findings, female genital mutilation is probably going to lead to a range of emotional problems, which could lead to psychological diseases. It was discovered that the high rate of depression was higher than average. These results are consistent with earlier research on abused and traumatized youngsters. The study's findings also shown that self-esteem and depressive symptoms together formed an index with statistical significance that could be used to distinguish between the two groups [12,13]

The findings suggest that cultural embedding does not prevent the onset of depression, even though female genital mutilation is a part of the individuals' ethnic heritage [14]. While the study's findings lend credence to the idea that female genital mutilation has a significant detrimental effect on mental health that extends beyond physical issues, care should be taken when interpreting the findings [15,16]

Furthermore, there is a growing movement against female genital mutilation in public spaces like schools where people are taught about its harmful effects [17,18]. Because of this, the way the trauma is assimilated may alter depending on whether or not circumcision is more common. Of course, there are a plethora of additional variables that could also have a significant impact on the mental health outcome, including coping mechanisms, past traumatic experiences, information before to circumcision, and sexual encounters [19,20].

However, this study offers yet another compelling reason in favor of disseminating culturally grounded knowledge that may aid in the elimination of female genital mutilation. In keeping with psychology's growing contribution to the documentation of violations of human rights, it is critical to support women experiencing mental distress and to carry out additional study [21]. Researchers and doctors should focus more on the urgent needs of FGM girls and women, as demonstrated by the startlingly high prevalence of psychological disorders among this population of FGM girls.

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