

Female Genital mutilation/Circumcision and its effects on sexual Health

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Abstract

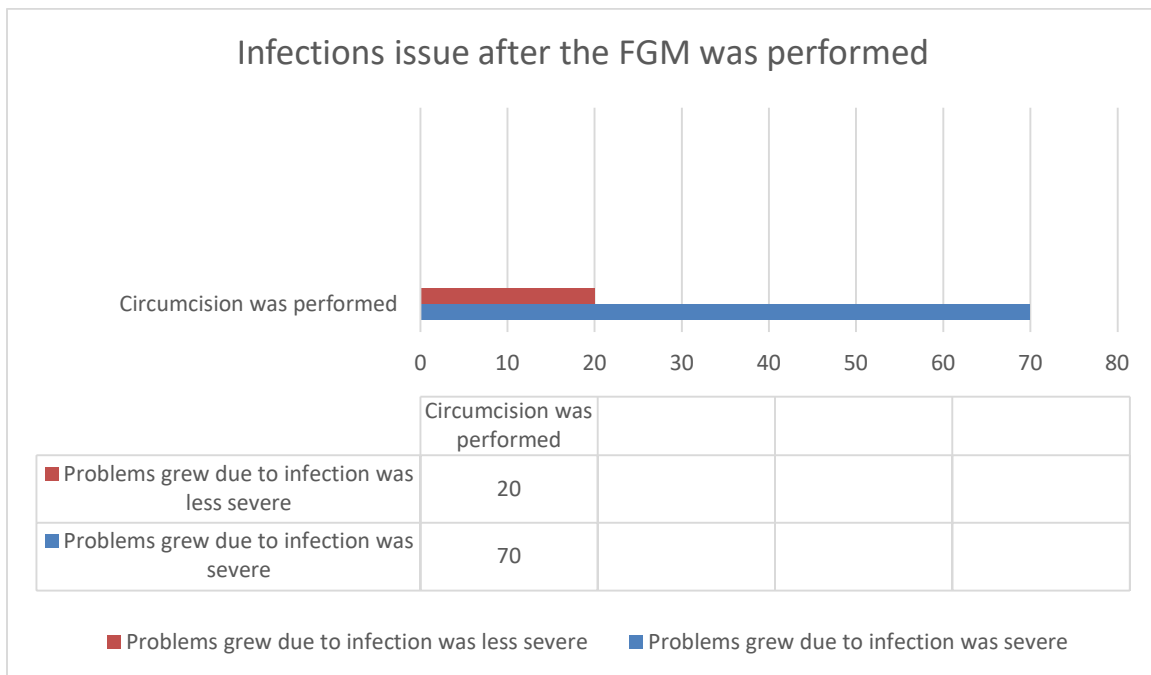
Background: Female genital mutilation (FGM) has been a longstanding tradition in Egypt and gradually it was started practicing in India and many women started agitation against this secret practice since 2017 and until recently the PIL was filed. This study has explained the prevalence of FGM in different parts of India as interviewed by the respondent who told their stories of circumcision. The women empowerment talks about the rights that vested with the women and this practice is in grave violation of it in respect of health.

Methods: This study pooled data from the 2005, 2008 and 2014, 2020, 2024 waves of the UNICEF, UNFPA, WHO Demographic and Health Surveys and also the research done in India on various health aspects of FGC/M.

Empirical research was done based on the hazard that may likely to occur against the women once this practiced is performed.

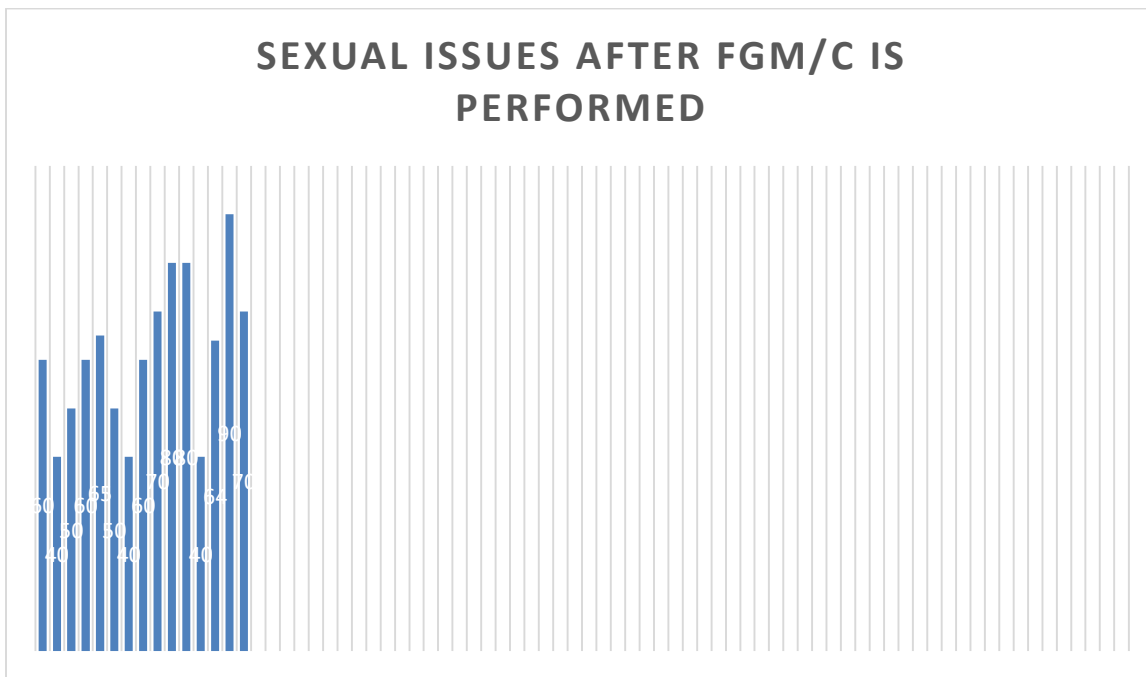
Conclusions: This study confirms that FGM is prevalent in many parts across the country (India) and there is a need of the specific law.

Keywords: Female genital mutilation, Egypt, Reproductive health, women's status, Empowerment



Source: Empirical research survey conducted in some areas of Maharashtra India, in 2023-2024.

The Risk included: There had been recurrent genital infections which had become a serious matter of concern. As a consequence, the individual has ongoing pain, as well as discharge from the vaginal region and itching. It is also possible for vaginal ulcers, cysts, and abscesses to develop with this condition. Chronic infections of the reproductive tract are those that are present. It has the potential to cause ongoing pain in the back and across the pelvis. Does the urinary tract have any infections? In the absence of treatment, infections of this sort have the potential to spread to the kidneys, which might result in renal failure, septicaemia, and even death. This could happen if medical attention is not provided. A significant amount of evidence suggests that female genital mutilation (FGM) is linked to an elevated risk of recurring urinary tract infections in both younger girls and older women. This association has been proven via comprehensive research. Urinating may be an unpleasant experience. The reason for this is that there is a blockage in the urethra, as well as recurrent bouts of urinary tract infections. Concerns have been raised about the vagina. Additionally, it is possible to have infections such as bacterial vaginosis, discharge, and itching¹. Concerns pertaining to the health of relationships. Female genital mutilation (FGM) has a negative influence on the physical structures that are essential to female sexual function, which in turn disrupts the sexual health and well-being of women.



Source: Empirical research conducted in 2023 in Maharashtra India.

Here, majority of the women felt that we have not experienced sexual pleasure the problem grew due to cutting was severe and there was no attraction, the intercourse was done but they didn't felt orgasm. The problem they felt was extraordinary and they felt like dead soul. Sexual sensitivity can be compromised and sexual dysfunctions can occur as a result of the excision or impairment of highly sensitive genital tissue, particularly the clitoris. "These dysfunctions include a decrease in sexual desire and pleasure, dyspareunia, difficulties during penetration, decreased lubrication during coitus, and a decreased frequency or absence of orgasms (anorgasmia). The production of scars, soreness, and traumatic memories associated with the therapy are all

¹ WHO Fact sheet 2024-02-05, available at [https://www.who.int/teams/sexual-and-reproductive-health-and-research-\(srh\)/areas-of-work/female-genital-mutilation/health-risks-of-female-genital-mutilation](https://www.who.int/teams/sexual-and-reproductive-health-and-research-(srh)/areas-of-work/female-genital-mutilation/health-risks-of-female-genital-mutilation)

possible outcomes that might result in such problems. issues that arise throughout the labour and delivery process. Female genital mutilation (FGM) is associated with an increased likelihood of having a caesarean section, postpartum haemorrhage, the need for an episiotomy, obstructed labour, obstetric lacerations, instrumental aid during delivery, prolonged labour, and prolonged maternal hospitalization”². “As the level of female genital mutilation increases, the risks are progressively more severe. The obstetric fistula. The use of female genital mutilation (FGM) and obstetric fistula have not been related in any way. In light of the fact that there is a causal connection between prolonged and obstructed labour and fistula, as well as the fact that female genital mutilation (FGM) is associated with protracted and obstructed labour, it is reasonable to deduce that there may be a connection between the two conditions in women who have been impacted by FGM. There are risks associated with pregnancy. Obstetric complications may result in an increased number of incidents of infant resuscitation during delivery, as well as an increase in the number of stillbirths and deaths that occur during the delivery process.

Psychological health concerns.

According to research, girls who have undergone female genital mutilation (FGM) are at a higher risk of having post-traumatic stress disorder (PTSD), anxiety disorders, depression, and somatic symptoms (such as aches and pains that cannot be explained). A breach of human rights, female genital mutilation (FGM) always represents a violation of human rights, creating risks of trauma and resulting in concerns relating to the mental health and well-being of girls and women, despite the fact that in certain settings it is considered to be normal and culturally important. This study has explained that it very evident that the practice of females Khafd in India is evident in India”³.

Procedural aspect (medical perspective):

“FGM/C is classified into four distinct categories by the World Health Organization (WHO). Type 1 involves the partial or complete excision of the clitoris and/or clitoral hood (Clitoridectomy), whereas Type 2, or Excision, involves the partial or complete removal of the clitoris and labia minora, with or without the labia majora. Type 3, or infibulation, involves the suturing of the vaginal entrance, followed by the excision of the labia minora and labia majora, with or without the excision of the clitoris. Type 4 includes all medically superfluous treatments, including cauterization, piercing, nicking, and pricking of the female genitalia. The topic of FGM/C among Bohras is germane to the WHO's Type 1 and Type 4 categories of FGM/C. Type I: Clitoridectomy, which involves the partial or complete removal of the clitoris and/or the prepuce. In order to effectively distinguish the principal variants of Type I mutilation, the following subgroups are recommended: Excision of the clitoral hood or prepuce is the sole procedure for Type Ia. There is evidence that Bohras in India engage in the practice of female genital mutilation (FGM) of Types 1a, 1b, and Type IV. The operations include cutting the clitoral hood and/or a portion or all of the clitoris, as well as "nicking" the clitoral hood, despite the fact that there is no definitive medical definition of what a "nick" comprises. physicians may be conducting either Type IV or Type 1a female genital mutilation or circumcision (FGM/C) with or without anaesthetic, according to the descriptions of operations carried out by medical physicians or obstetricians and gynaecologists that were provided by mothers of girls who were cut by doctors and one traditional circumciser who was educated by a physician. It is reasonable to assume that traditional circumcisers in India conduct Types 1a and

² UNICEF, *Female Genital Mutilation (FGM): A Global Concern*, UNICEF, February 2016, accessed November 16, 2024, <https://www.unicef.org/protection/female-genital-mutilation>.

³ Ibid.

1b female genital mutilation and circumcision (FGM/C) based on the descriptions of traditional circumcisers, the descriptions of women's own anatomy, and the study of twenty cases as performed by a physician in a small village. Is it submitted that the practice of Khafz/Khatna is a dehumanising practice resulting in the diminution of the human body of the female sex and is intended to reduce or eliminate her sexual pleasure in adult life. It is submitted that the practice mutilates the women body of the female in a very essential manner, namely the ability to enjoy sex and indeed results in experiencing pain during sexual intercourse. It thus makes women, who have undergone FGM/Khafz less than human in that they suffer a loss of human dignity. That any alteration, nicking, pricking, excision, cutting of the clitoral hood or the clitoris amounts to violation of the bodily integrity of a girl and woman"⁴. "97% of women who remembered their FGM/C experience from childhood recalled it as painful. While most women said they suffered immediate pain from the procedure only 2 women said they did not have any immediate or long-term impact from FGM/C. Despite sex being a taboo topic, approximately 33% of women subjected to FGM/C in the study believe it has negatively impacted their sexual life. Low sex drive, inability to feel sexual pleasure, difficulty trusting sexual partners, and over sensitivity in the clitoral area were some of the problems identified by several women. Close to 10% of the women who had undergone the procedure in the current study specifically mentioned urinary problems, recurring UTIs, burning and incontinence. In addition, one of the study participants reported bleeding of the clitoral hood area due to irritation. Many respondents in the study reported feeling fear, anxiety, shame, anger, depression, low-self-esteem, and/or betrayal of trust as some of the fallouts that they associated with their FGM/Khafz. That FGM/C has short-term and long-term ill effects on the health and psychological well-being of the victims. The severity of the cutting/mutilation directly corresponds to the harm suffered. Since anaesthesia is rarely used on the victim during the procedure, there is extreme pain. The other short-term health risks are excessive bleeding, swelling and inflammation in the genital area, infection, urinary problems, and in some extreme cases, even death. The long-term consequences include chronic genital infections, recurring urinary tract infections, painful sexual intercourse, complications during pregnancy, labor and delivery of the child, perinatal risks, and debilitating psychological consequences like Post-traumatic Stress Disorder (PTSD) and depression. FGM/C thus affects the health and social development of girls and women. That FGM/C does not have any beneficial health effects whatsoever. The course of assimilation, modernization and Islamization within the Dawoodi Bohra community is intimately linked to the priorities of the religious leaders. Their fascination with modern ideas and Western customs have opened up the community to outside influences and exposed them to a wide variety of changes. The Islamization program was the product of internal rather than external motivation, including the growth of beards and mandated code of personal appearance"⁵. The Bohra male dress code leaves virtually no room for individual variation and suggests a type of uniform. "The primary designator of rank is the pagri, a turban whose use is strictly limited to graduates of the Jameatus-Saifiya and other respected clerics.

There is no clear division between the clerical hierarchy and the family of the da'i (Syedna) and all of the top clerics are brothers and sons of Syedna (Dawoodi Bohra leader). There are two titles awarded by Syedna: mullah and shaikh. Any man authorized to lead namaz (prayer, offered five times a day) is given the title of mullah. This title is automatically given to male graduates of the Jameatus-Saifiya and teachers in Bohra schools. The higher title of shaikh can be awarded by Syedna after ten years of meritorious clerical services at the Syedna's discretion. Policy is then implemented by a network of amils (Dawoodi Bohra cleric) with similar roles to

⁴ UNFPA, *Female Genital Mutilation (FGM) Frequently Asked Questions*, United Nations Population Fund, 2021, accessed 2024-02-23, available at <https://www.unfpa.org/resources/female-genital-mutilation-fgm-frequently-asked-questions>.

⁵ Ibid.

bishops. In places with relatively small Bohra populations a single amil may have jurisdiction over an entire nation. An amil's primary task is to serve as prayer leader at the local masjid (mosque), and to appoint a surrogate namaz imam when he is out of town. Most Dawoodi Bohras consider themselves lucky merely to catch sight of Syedna, but to meet him face-to-face, to have an actual conversation with him, and to receive du'a (blessing) at his own hand would be considered a once-in-a-lifetime event. The Dawoodi Bohra Education System The Jameatus-Saifiya in Surat is the apex of the Bohra educational system and produces the majority of the clerics who serve in the dawat (Dawoodi Bohra mission). English has been compulsory for all Jamea students since 1965. By providing a first-rate modern education, free for both sexes, the religious education was prevailed, Dawoodi Bohra dawat has avoided the brain drain and insured that the brightest minds of the faith remain grounded in Islamic values throughout.

their intellectually formative years. The dawat's open attitude toward all types of modern learning has enabled it to co-op most aspects Western culture while excluding only those elements directly in conflict with religious values. The student body of the Surat Jamea consists of around 600 men and 300 women from the elite of Bohra youth throughout the world, including students from Britain and the United States. The expectation is that Jamea graduates will repay this free education by entering clerical service and help to educate the next Dawoodi Bohra generation. All of the Jamea's instructors are required to be fully versed in both traditional and modern subjects and there is no conflict between science and faith. It is stressed that science is merely the sum total of observation and common sense. Blank notes the school philosophy concerning English. "Acquiring mastery over the English language is essential for a student of religious knowledge to keep himself abreast of all learning so as to compete and achieve this distinction in all fields". The Jamea does allow students to censored TV but runs its own in-house audio news service, preparing a daily summary of world events of special note to the Bohra community. After graduation almost all students are offered jobs somewhere within the dawat network, but it is the dawat that decides which path any candidate will follow. Some graduates feel the pressure to return home and help run the family company. Those that get posted in Britain or Sweden are inevitably well equipped to fulfil their role as Imam's, having been well educated in English and the local cultural idiosyncrasies. Naturally any new job in a foreign country entails some stress and requires situational meaning. Being well versed in their Dawoodi Bohra religion and educated to western university level their global meaning helps enhance their stability, optimistic bias, and feelings of personal relevance. They are the experts leading a religious congregation towards a global goal"⁶.

"Dawoodi Bohras do not see modern Western education as being antithetical to Islam at all. They have come to the conclusion that a person must be thoroughly grounded in every form of knowledge in order to function in a wider society. They do however try to ensure that their younger members have an Islamic basis to build upon together with others, the girls struggle towards a common goal. It is the participating in the struggle guided by common beliefs that is important. Both global meaning and situational meaning involve the individuals' construction of ways to understand the world and the events that affects them as individuals.

The Dawoodi Bohra illustrated the restricted choice and heavy commitment involved in travelling long distances to community gatherings. They relied on the gathered community tradition which Nonconformist congregations had developed in Britain during the nineteenth century. The Northolt centre became part of an international network which had developed over many centuries through the Dawoodi Bohra involvement in trade and commerce. This far-flung community is tightly organized around its religious leader based in Mumbai. Approximately half of the 6,000 Dawoodi Bohra living in Britain lives in London. The sect's dispersal around the world has threatened the tight, hierarchical leadership structure. They have responded by regularly visiting centred outside of India. They encourage devotees to attend major celebrations in Mumbai and insist on the regular payment of tithes and the tradition of endogamous marriages. Any time the Syedna (the Dawoodi Bohra

al-mullah) makes one of his frequent public appearances, hordes of followers come by train, car, plane, and bus just to be near him. The vast mass of the Bohra population has nothing material to gain by displays of deep piety, and nothing to lose by just staying home”⁷. No attendance is taken, no summonses issued, no points are tallied or prizes awarded to the person who sheds the most copious tears at Ashura. According to Blanks research the outward displays of piety by members of the mainstream Dawoodi Bohra community most commonly reflect a genuine inner belief, which corresponds to Park’s theory of global meaning. This belief that is exhibited is then solidified by these examples of loyalty and orthopraxy leads to orthodoxy. Although this path has been carefully laid out by the dawat, the journey is one most Dawoodi Bohras undertake quite willingly. Having been carried out by several pre-Islamic civilisations in Africa, the Arabian Peninsula, and Egypt, "FGM has roots outside of Islam." In many civilisations, it was connected to rituals of passage, cultural standards of femininity, and sometimes efforts at control of female sexuality. Emerging in the 7th century CE, Islam spread into regions where FGM was already common, and the cultural practice continued with the expansion of the faith. Early Islamic ideas and prophetic sayings (hadiths). The Quran makes no reference whatsoever to FGM. Some proponents of FGM use certain hadiths—sayings attributed to the Prophet Muhammad—to support their practice. “Still, these hadiths are often seen as lacking authenticity or as weak (da’if). One often cited hadith relates that the Prophet came across a woman performing circumcision on a girl and allegedly urged her to "cut lightly and do not overdo it, for it is better for her and more pleasing to her husband". Scholars disagree about this hadith and many do not consider it to be a reliable basis for FGM. Regarding circumcision, another hadith says, "Circumcision is a sunnah for men and a makrumah for women." Though it remains quite vague and does not provide a clear direction, the phrase "makrumah" may be regarded as a "honourable deed," or "noble act." This uncertainty has led to different opinions; some jurists believe it optional while others argue it is not a religious requirement at all. The safety and welfare of female adolescents who are subjected to the practice are a concern that is shared by both supporters of Khafd and those who oppose it, as our research has consistently demonstrated. Opponents of Khafd advocate for the elimination of injury and the complete cessation of the practice; advocates for Khafd seek to mitigate the associated consequences. As a result, numerous proponents of Khafd emphasised the necessity of transitioning from traditional circumcision to medical facilities to enhance hygiene and mitigate risks”⁸. Based on the comments, it is plausible to infer that FGM/C will be medicalised in India in a progressive and rapid manner, starting in larger cities. This process will be primarily conducted in medical hospitals and clinics by medical personnel (doctors and/or nurses).

Conclusion:

‘Sahiyo’ and ‘We Speak Out’ both in Mumbai Maharashtra and SAHAJ, in Gujarat are the non-governmental organizations which have aimed to improve the health and education of girls and women via community-driven initiatives, research, and policy advocacy. SAHAJ partners with coalitions in six Indian states and at the national level to enhance data-for-advocacy competencies with support from EM2030. The initiative aims to enhance discourse and political commitment among government stakeholders about the importance of data-driven implementation of the SDGs for women and girls, particularly focusing on SDG 3 related to health and SDG 5 concerning gender equality. The effort examines empirical information from grassroots organizations and current data to enhance advocacy, focusing specifically on the most marginalized populations of girls and women.

References:

⁷ WHO, *Female Genital Mutilation: Key Facts*, WHO, June 2023, accessed 24-02-14, available at: <https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation>.

⁸ Ibid.

1. UNICEF, *Female Genital Mutilation (FGM): A Global Concern*, UNICEF, February 2016, accessed November 16, 2024, <https://www.unicef.org/protection/female-genital-mutilation>.
2. UNFPA: *Female Genital Mutilation (FGM) Frequently Asked Questions*, United Nations Population Fund, 2021, accessed November 16, 2024, <https://www.unfpa.org/resources/female-genital-mutilation-fgm-frequently-asked-questions>.
3. WHO, *Female Genital Mutilation: Key Facts*, WHO, June 2023, accessed November 16, 2024, <https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation>.
4. Catania L., Abdulcadir O., Puppo V., et al. (2007). Pleasure and orgasm in women with female genitalmutilation/cutting (FGM/C), *Journal of Sexual Medicine*, 4(6): 1666-78.
5. Christoffersen-Deb, A. (2005). "Taming tradition": Medicalized female genital practices in western Kenya, *Medical Anthropology Quarterly*, 19 (4), 402-418.
6. Cook, R. J. (2008). Ethical Concerns in Female Genital Cutting, *African Journal of Reproductive Health*, 12 (1), 7-16.
7. Coren, C. (2003). Genital cutting may alter, rather than eliminate women's sexual sensations,
8. *International Family Planning Perspectives*, 29 (1), 51.
9. Cresswell, J. W. (2003). *Research Design: Qualitative, quantitative and mixed-methods approaches*. Thousand Oaks, CA: Sage Publications.