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A scientific approach to the health and obstetrical problems of female genital mutilation of Somali women living in Türkiye

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Abstract

Mutilation is a general name given to the partial or complete injury and mutilation of the female genital organ under the name of tradition and culture. It is quite common in Africa. It is estimated that it is applied to more than 200 million women, especially in the Middle East and the Far East. Different applications continue in each country. After mutilation, anatomical tissue loss occurs in the female genital area. Therefore, lifelong physiological, psychiatric and obstetric problems arise. In this study, the mutilation status of Somali women living in Türkiye was investigated. The effects of mutilation on birth and the attitudes of women towards this practice were revealed.

For this purpose, the status of 190 women in 15 provinces where Somali citizens are most present were examined. For this purpose, a face-to-face survey was conducted with 174 participants. The results were evaluated using statistical chi-square tests and continuous quantitative variables. The data were given as parametric and non-parametric results of the tests. As a result, it was determined that almost all of the Somali women living in Türkiye were circumcised, although slightly below the world average. It was proven that economic status, education, cultural traditions and family structure are closely related to mutilation. It has been observed that female circumcision causes many obstetric and psychiatric problems. It has been determined that the attitude of Somali women living in Türkiye towards female circumcision has changed significantly with the increase in education level, household income, awareness and communication opportunities. Education, cultural change, financial status, level of health services and midwifery services have been proven to reduce female circumcision effectively.

Keywords: health care, midwifery, obstetrics, Somali women living in Türkiye, genital mutilation

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Türkiye'de yaşayan Somalili kadınların kadın sünnetinin sağlık ve doğum sorunlarına bilimsel bir yaklaşım

Özet

Mutilasyon; gelenek ve kültür adı altında kadın cinsel organın kısmen veya tümüyle yaralanmasıyla sakatlanmasına verilen genel bir isimdir. Afrika'da oldukça yaygındır. Orta doğu ve Uzak Doğu başta olmak üzere 200 milyondan fazla kadına uygulandığı tahmin edilmektedir. Her ülkede değişik uygulamaları sürmektedir. Sakatlama sonrası kadın genital bölgesindeki anatomik doku kaybı oluşur. Bu nedenle yaşam boyu süren fizyolojik, psikiyatrik ve obstetrik sorunlar ortaya çıkar. Bu çalışmada Türkiye'de yaşayan Somalili kadınların mutilasyon durumları araştırıldı. Mutilasyonun doğuma etkileri, kadınların bu uygulamaya karşı tutumları ortaya konuldu. Bunun için Somalili

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vatandaşların en çok bulundukları 15 ilde 190 kadının durumu incelendi. Bunun için 174 katılımcı ile yüz yüze bir anket yapıldı. Sonuçlar istatistiksel ki-kare testleri ve sürekli niceliksel değişkenler kullanılarak değerlendirildi. Veriler testlerin parametrik ve non-parametrik sonuçları olarak verildi. Sonuçta; Türkiye'de yaşayan Somalili kadınların dünya ortalamasının biraz altında olsa da neredeyse tamamının sünnetli olduğu tespit edildi. Ekonomik durum, eğitim, kültürel gelenekler ve aile yapısının mutilasyonla yakından ilişkili olduğu kanıtlandı. Kadın sünnetinin birçok obstetrik ve psikiyatrik soruna neden olduğu görüldü. Türkiye'de yaşayan Somalili kadınların kadın sünnetine yönelik tutumunun, eğitim düzeyi, hane geliri, farkındalık ve iletişim olanaklarının artmasıyla önemli ölçüde değiştiği tespit edildi. Eğitim, kültürel değişim, mali durum, sağlık hizmetleri düzeyi ve ebelik hizmetleri kadın sünnetini etkili bir şekilde azalttığı kanıtlandı.

Anahtar kelimeler: sağlık hizmetleri, ebelik, obstetrik, Türkiye'de yaşayan Somalili kadınlar, kadın sünneti

1. Introduction

Female circumcision (FGM) is a procedure that involves cutting, piercing, or otherwise damaging the genitals of girls and has no medical benefit. Every year, 3-4 million girls are subjected to this primitive cruelty and torture. It has decreased in the last 50 years thanks to information and communication opportunities. However, it is still practised under the guise of "tradition-culture". FGM is a clear violation of fundamental human rights [1]. This disgusting practice, which has no place in any divine religion, has been practised since the 5th millennium BC. Unfortunately, more than 200 million girls and women in more than 30 countries are subjected to this practice. It is expected to be eliminated by 2030. However, if FGM is not prevented through education, communication and health services in FGM regions, it can lead to significant disasters [2]. FGM is a substantial violation of women's rights in Sub-Saharan Africa. Somalia is a country that practices its most severe form (type-3) by more than 97%. The exact number and amount are unknown. The surveys are based on unreliable data from underdeveloped countries [3]. It has traditionally become a strong social norm. This power must be motivated by the myth that religions support it. In fact, in the geographies where FGM is practised, there are tribes and communities of different faiths, such as Muslims, Christians and Animists. Each tribe has found a religious cover for this brutal tradition. Over time, FGM myths have been fabricated and have become a cultural tradition [4].The countries where FGM is most common are Somalia (97.9%), Egypt (95.8%), Guinea (95.6%), Sierra Leone (94%), Djibouti (93.1%), Mali (91.6%) and Eritrea (88.7%). The rate of infibulation (cutting the lips of the vagina and sewing the vulva) is highest in Somalia, Ethiopia and Eritrea. FGM is also performed among immigrant communities in Europe, Canada, the United States, Australia and New Zealand [5]. In 2001, 72% of the 10,501 African women who came to Switzerland from countries where FGM is performed were over the age of 15, and approximately 6,000 had FGM [6]. United Nations reports indicate that FGM has decreased since 2012 [7]. Strengthening the information infrastructure, expanding the means of communication and universalizing people's access to information may, over time, develop a severe resistance to mutilation in new generations. On the other hand, the real danger is that immigrants will resist their attachment to their origins [8]. FGM is practised in four different ways around the world. In Ethiopia, Kenya [7], and Eritrea, the clitoris is partially or wholly removed (type 1). In West Africa, the clitoris and labia vaginalis are partially or wholly removed (type II). Benin, Sierra Leone, Gambia and Guinea. In addition to types 1 and 2, the labia minora are also cut. In Sub-Saharan African countries such as Somalia, Djibouti, Northern Sudan, and the surrounding areas, the tissues are repositioned by stitching in addition to these cuts. This type of FGM is a horror and nightmare for girls. The vaginal opening is narrowed with a gasket (type III). In Northern Nigeria, abrasive substances that penetrate the vagina are inserted, scraped and injured. It is known and practised in the region as "gishiri" (type-IV) [9]. The health risks of FGM are assessed in several categories: acute life risks, inflammatory, obstetric, chronic risks and psychiatric risks [10]. Post-traumatic stress disorder (PTSD), anxiety, depression, neuroses and psychoses are common delayed complications associated with FGM. It is complex to realistically define and monitor these conditions in countries where FGM is practised. Failure to treat these psychological traumas can lead to mental anxiety and even permanent damage later in life [11]. This study aims to evaluate the health and birth problems of Somali women living in Türkiye. In light of the information received from institutions, 15 provinces with the highest density of Somali citizens living in Türkiye were selected. Somali women over the age of 18 living in these provinces were included in the study cross-sectionally. Those living in Türkiye for education, work, civil service, and more than six months were included.

2. Materials and methods

An informed consent form was prepared. Data collection was carried out between January 1 and March 31, 2022. To scan Türkiye in general and to obtain a more precise estimate, 15 provinces where Somali individuals live were selected as the research area from official sources. Surveys were shared with 209 universities (131 State, 78 Private and Foundation Universities) through our university with official letters. Somali women were also reached through Google Forms (hhttps://forms.gle/SrUypLyy FPHFTUL18) https://mail.google.com/mail/u/1/#inbox). Women under the age of 18 were excluded. The surveys were collected in the Excel data pool [12]. Two-sample T-Test Power

Analysis was used. At least 190 women aged 18 and over were accepted as the lower limit with 99% statistical accuracy. Estimated group standard deviations of 1.9 and 1.6 to 2.2 were considered significant. A two-sample t-test was used in the study. The 0.05000 level was accepted as the reference. Statistically, 99.99% accuracy was accepted for n=174 [13]. In our research, n=190 was made. The chi-square test was used for analysis. Continuous quantitative variables were evaluated in normality tests. Data were presented with parametric or non-parametric tests by looking at the Kolmogorov-Smirnov and Shapiro-Wilk results. Permission was obtained from the Karabük University Presidency Non-Interventional Clinical Research Ethics Committee on 15.12.2021 with the number E-77192459-050.99-88241 (2021/777). This scientific research is a cross-sectional descriptive study.

Selection criteria: Qualified healthcare personnel, visually and hearing impaired, learning and mentally disabled were excluded from the study. Those with advanced orthopaedic problems, personal care, speech or self-expression and mental-psychological disabilities were excluded from the study. Severely chronic patients, people with epilepsy, diabetics and individuals with acute inflammation were not included in the study.

3. Results

The survey results were obtained regarding the participants' characteristics such as place of birth, education level, occupation, spouse's occupation, age at first marriage, age at spouse, age at first menstruation and age at conception (Table 1). It was observed that even if the place of birth was not in a rural area, it traditionally affected FGM. Education level was highly determinant to FGM. It was determined that occupation and work status could not overcome the rigid cultures of tradition.

Table 1. Individual characteristics of the participants

	n	**%**	**% of total**
Place of birth			
City Center	99	53,80	52,11
District	49	26,63	25,79
Town center	13	7,07	6,84
Village	23	12,50	12,11
Total	184	100,00	96,84
Educational status			
İlliterate	11	5,98	5,79
Primary school	25	13,59	13,16
Middle school	15	8,15	7,89
High school	55	29,89	28,95
University	58	31,52	30,53
Degree	20	10,87	10,53
Total	184	100,00	96,84
Job			
Own workplace	22	12,57	11,58
Officer-worker	22	12,50	11,58
Student	54	30,68	28,42
No Profession	26	14,77	13,68
Doesn't have a job	29	16,48	15,26
Other	22	12,50	11,58
Total	175	99,43	92,11
Spouse profession			
Not working	5	5	2,63
Own working place	11	11	5,79
Officer-worker	42	42	22,11
Student	7	7	3,68
Busy with trade	35	35	18,42
Total	100	100	52,63
First marriage age			

Table 1. Continued

Before age 18	21	19,63	11,05
18-22	34	31,78	17,89
23-27	45	42,06	23,68
28--32	7	6,54	3,68
Total	107	100,00	56,32
Spouse age			
27-35	36	37,89	18,95
36-45	30	31,58	15,79
46-55	17	17,89	8,95
56-76	12	12,63	6,32
Total	95	100	50,00
First menstrual age			
9--11	47	25,13	24,74
12--14	131	70,05	68,95
Over 15	9	4,81	4,74
Total	187	100,00	98,42
Age at conception			
<18	20	21,05	10,53
18-23	36	37,89	18,95
24-29	38	40,00	20,00
30-35	1	1,05	0,53
Total	95	100,00	50,00
First Birth			
Normal birth	72	73,47	37,89
Caesarean section	21	21,43	11,05
Total	98	100,00	51,58

Marriage, monthly income, purchasing power, social security, insurance, education, and age at first marriage of Somali women living in Türkiye were influential in the traditional continuation of FGM. Figure 1, which shows the FGM situation, is indicated.

Figure 1. The situation of Somali women living in Türkiye

The FGM status, living and health conditions and attitudes towards this issue of Somali women living in Türkiye were investigated (Table 2). The women were questioned about their knowledge of FGM and whether they had received training on the subject. It was learned whether they had had FGM themselves. It was determined which type of FGM they had and under what conditions. This situation is presented in Table 2. Almost all of them have had FGM. Since they had FGM at a young age, family pressure is at the forefront. When they had Vaginal Circumcision, they had no knowledge about FGM. Legends were fabricated under the name of culture and told to the children. Regardless of whether they were convinced or not, FGM was forced to be done by their families and relatives.

Table 2. FGM Status, conditions and attitudes of Somali women living in Türkiye

	n	**%**	**% of total**
Do you know about female circumcision?			
Yes	190	100,00	100
No	0	0,00	0,00
Total	190	100,00	100,00
Information or training on FGM			
Yes	136	73,51	71,58
No	49	26,49	25,79
Total	185	100,00	97,37
Why is FGM done?			
Tradition	102	55,74	53,68
Religion	23	12,57	12,11
Required for marriage	2	1,09	1,05
Provides genital beauty	1	0,55	0,53
It is a violation of women's rights	4	2,19	2,11
A false tradition	51	27,87	26,84
Total	183	100,00	96,32
Infringement + False Tradition	55	30,05	28,95
Tradition + religion + Marriage + Genital beauty	128	69,95	67,37
Have you become FGM?			
Yes	183	97,34	96,32
No	5	2,66	2,63
Total	188	100,00	98,95
Where was circumcision done?			
Birth house	9	4,89	4,74
At home	163	88,59	85,79
Hospital	12	6,52	6,32
Total	184	100,00	96,84
Who practiced circumcision?			
Traditional circumcision woman	143	77,72	75,26
Village midwife	24	13,04	12,63
Health employee	17	9,24	8,95
Total	184	100,00	96,84
Which type of FGM was practiced			
Pharaoh	77	41,40	40,53
Sunni	109	58,60	57,37
Total	186	100,00	97,89
Is anesthesia used in FGM?			
Yes	168	90,32	88,42
No	18	9,68	9,47
Total	186	100,00	97,89
Are your feet cross-linked after FGM?			

Table 2. Continued

Yes	112	60,87	58,95
No	72	39,13	37,89
Total	184	100,00	96,84
FGM age			
0-5 Years	16	8,74	8,42
6-10 Years	156	85,25	82,11
11-14 Years	11	6,01	5,79
Total	183	100,00	96,32
Are you aware of the laws regarding FGM?			
İllegal	104	55,91	54,74
Normal in Africa	42	22,58	22,11
Normal in some countries	14	7,53	7,37
Legal	26	13,98	13,68
Total	186	100,00	97,89
How do you agree with the WHO's views on FGM?			
Yes	132	71,35	69,47
No	34	18,38	17,89
No idea	19	10,27	10,00
Total	185	100,00	97,37
Who has a say in ending FGM?			
Dr and paramedic	112	59,89	58,95
Traditional midwives	18	9,63	9,47
Religious leaders	57	30,48	30,00
Total	187	100,00	98,42
Have you received training on stopping FGM?			
Yes	46	24,73	24,21
No	140	75,27	73,68
Total	186	100,00	97,89
Is FGM a religious obligation?			
Yes	31	16,67	16,32
No	155	83,33	81,58
Total	186	100,00	97,89
Is virginity possible with FGM?			
Yes	42	22,46	22,11
No	145	77,54	76,32
Total	187	100,00	98,42
Would you circumcise your daughter?			
Yes	55	29,73	28,95
No	130	70,27	68,42
Total	185	100,00	97,37
What is your spouse's opinion about FGM?			
Supports	16	14,81	8,42
No idea	40	37,04	21,05
Opposed	52	48,15	27,37
Total	108	100,00	56,84
Have you changed your mind about FGM after coming to Türkiye?			
Yes, it has changed	45	24,46	23,68
No, it has not changed	129	70,11	67,89
Other	10	5,43	5,26

Table 2. Continued

Total	184	100,00	96,84
Should FGM be stopped?			
Yes	141	75,40	74,21
No	46	24,60	24,21
Total	187	100,00	98,42
Would you marry a girl who was not female circumcised?			
Yes	145	79,23	76,32
No	38	20,77	20,00
Total	183	100,00	96,32
Does female circumcision have adverse effects?			
Yeah I think	118	71,52	62,11
No, I do not think	47	28,48	24,74
Total	165	100,00	86,84
What are the adverse effects?			
Maternal gynecological diseases increase	41	33,06	21,58
Mother's psychology suffers	53	42,74	27,89
A woman cannot enjoy sexual intercourse	12	9,68	6,32
A woman cannot please her husband	18	14,52	9,47
Total	124	100,00	65,26
Does FGM affect saturation quality?			
Yes	106	66,25	55,79
No	50	31,25	26,32
I do not know	4	2,50	2,11
Total	160	100,00	84,21
How does FGM affect sexual satisfaction?			
Reduces	97	52,43	51,05
Constant	27	14,59	14,21
No idea	61	32,97	32,11
Total	185	100,00	97,37
Reduces + No Idea	158	85,41	83,16

Fear, pain and anxiety during FGM were investigated. It was determined how the participants' life and health status changed after FGM. What kind of obstetric-health problems developed the problems of adolescence were revealed. It was observed that the effects of FGM on women's health, birth and postpartum care could be life-threatening. The pain of the first menstrual bleeding and the first sexual intercourse were questioned. It was determined whether infibulation was performed and whether deinfibulation was applied at birth. The results are clearly given in Table 3.

Table 3. FGM effects and attitudes of women

	n	**%**	**% of total**
Severe pain at first menstrual bleeding after FGM?			
No	82	46,33	43,16
Yes	95	53,67	50,00
Total	177	100,00	93,16
Was the first sex after FGM painful?			
Yes	95	86,36	50,00
No	15	13,64	7,89
Total	110	100,00	57,89

Table 3. Continued

Did you have a normal birth after FGM?			
Yes	77	73,33	40,53
No	28	26,67	14,74
Unanswered	85		44,74
Total	105	100,00	55,26
Has the incision been made?			
Yes	69	92,00	36,32
No	6	8,00	3,16
Unanswered	115		60,53
Total	75	100,00	39,47
Abortion (miscarriage)			
Yes	12	13,48	6,32
No	77	86,52	40,53
Total	89	100,00	46,84
How many curettage?			
1 time	10	83,33	5,26
2 times	2	16,67	1,05
Total	12	100,00	6,32
How many miscarriages did you have?			
1 time	21	58,33	11,05
2 times	12	33,33	6,32
3 times	3	8,33	1,58
Total	36	100,00	18,95
How many children do you have?			
1--2	31	34,83	16,32
3--5	29	32,58	15,26
6--8	21	23,60	11,05
9 and up	8	8,99	4,21
Total	89	100,00	46,84
Insurance			
Available	28	15,30	14,74
None	155	84,70	81,58
Total	183	100,00	96,32
Monthly income			
200--300	66	35,68	34,74
300-500	45	24,32	23,68
500-1000	59	31,89	31,05
1000-3000	14	7,57	7,37
5000 and above	1	0,54	0,53
Total	185	100,00	97,37
Residential Property			
Homeowner	24	12,83	12,63
Rent	155	82,89	81,58
Dormitory	8	4,28	4,21
Total	187	100,00	98,42

4. Conclusions and discussion

Our research revealed that FGM is common in infants and children aged 0-6. FGM was performed by first-degree relatives such as mothers, grandmothers, aunts, and paternal aunts by holding or tying their hands and feet. No medical intervention was performed for acute pain and bleeding after FGM. It was stated that the bleeding could not be

stopped, so the legs were cross-tied for hours, sometimes days (60.87%). No anaesthetic drugs or hemostatic agents were used during FGM. The clitoris, which is the most sensitive tissue, including the pudendal nerve, was removed together with the vaginal lips. Then, the wound lips were stitched, leaving a tiny opening. Severe pain was felt during FGM. Tissue swelling, inflammation and infection are common in FGM. The WHO reports that pain shock and deaths occurred in infants aged 0-2. Tissue healing took months. There are cases where the cutting of the pudendal nerve arms caused spinal cord injury and gait disturbance. Almost all women who had FGM could not experience a normal adolescence. Births were difficult. It usually requires surgical intervention. Women's first bleeding was mostly very painful (53.67%) and severe. It was determined that their first intercourse with their partners was extremely painful (86.36%) and like a nightmare. It was determined that all married women could not enjoy sexual intercourse (66.25%) [14]. On the other hand, it was determined that FGM, which is mythologized in traditional culture, has a severe place in women's minds. Adherence to FGM has become an unconditional and unquestioned belief. Despite all the violence experienced during and after FGM, a significant number of women believe that this tradition is necessary. The rate of those who stated that it reduces sexual power is 56.43%, and the rate of those who think that it should not be discussed traditionally is 32.97%. Those who did not express the opinion that it dulls sexuality and reduces power is 85.41%. They were made to believe that women do not have sexual power and should only perform the function of reproduction. In a similar study, it was reported that the probability of dyspareunia in women exposed to FGM is more than 52%. It has been shown that sexual desire decreases more than two-fold due to pain and complications, and sexual satisfaction cannot be achieved. [15].

15.46% of women lost at least one baby during childbirth. Although the reasons are not explained, FGM is one of the leading causes of obstetric complications. FGM is a risk factor due to genitourinary infections, abscess formation, septicemia and HIV. In our study, FGM complications were higher than 1/3. 3/5 of the complications were found to be chronic[16]. Similarly, the long-term complications of FGM were investigated in 28,000 women. It was shown that postpartum haemorrhage, perineal trauma tears and cesarean section tendency increased. It was reported to cause perinatal death in 1-2%. Chronic complications of women with FGM are remarkable. They are listed as prolonged labour, perineal rupture, cesarean section, episiotomy, birth requiring surgery, bleeding and difficulty in birth.[4]. Most Somali women in Türkiye (97.5%) have undergone FGM. This rate is similar to studies conducted by the WHO and other international civil or official organizations. The acute effects of FGM, which are pain, excessive menstrual bleeding, painful intercourse and lack of pleasure from sexual intercourse, are evident. Post-traumatic psychological problems, back pain, shame and hatred of parents or relatives who perform FGM are evident. Post-traumatic psychological state disorder from childhood is present. Recurrent, persistent and challenging to-treat groin infections are evident.

In this scientific study, the rate of women who got married as children and got pregnant before the age of 18 was determined as 21.05%. One in every 5 Somali women encountered in Türkiye got married as children and got pregnant. Women got pregnant more than five times. This situation is clear evidence of the population density of 7 and above. 17.7% of women had at least one abortion. Although these abortions are not the subject of our scientific research, it is clear that FGM plays an active role here. Stillbirth is 5.1%, and abortion is 6.6%. These rates are not definitive in FGM studies. Women have experienced long-term painful complications in FGM tissues and other limbs. It is definite that FGM reduces sexual performance, creates sexual reluctance and reduces sexual potency. Long-term effects of FGM, such as depression, anxiety and post-traumatic stress disorder, are not the subject of this scientific study. However, there are similar results in previous scientific studies [17]. Somali women think that FGM has adverse effects on their family members by 71.52%. 83.33% of women know that FGM is not a religious obligation. 77.54% stated that their virginity cannot be protected with FGM. They believe that FGM is a crime and violence against women (67.60%). 75.40% of women demand the abolition of circumcision. It can be said that women in Somali families in Türkiye are proportionally ahead of men in terms of education [18]. In our analysis, the prevalence of women who have undergone FGM is 96.32%, while only 2.63% have not undergone FGM. The countries with the highest practice rates are Somalia, Egypt, Sudan, Mali, Djibouti, Eritrea, Sierra Leone and Guinea. The prevalence of FGM in these countries is over 70%. [19]. The most common type of FGM in Somalia is type-3. This is the most harmful type of practice. 99.7% of women have been subjected to this practice [20]. In a scientific study conducted by Abdulcadir et al. on Somali women who migrated to Switzerland, this rate was stated as 60.7%. This difference is probably due to the comparison with those living in Somalia. This rate was different for Somali women living in Türkiye.[21]. Type 3 was found to be in 41.53% of Somali women living in Türkiye ($p<0.05$). In a study conducted in 2002 on FGM practices in maternity hospitals in Mogadishu, the capital of Somalia, mostly type-2 and type-3 were detected. This result supports our scientific research. [11]. This scientific research is very close to other research (97.89%), but a significant difference was found. Somalia has a very sharp culture of traditional blunts. Therefore, a 1% difference can be considered very important. A decrease of 0.908% was clearly detected in this scientific research.

Type-3, Pharaoh circumcision is expressed as 60.7% in studies. It is obvious that Somali society gradually reduced this practice in favour of type-1-2 due to severe physiological problems experienced during or after the Pharaoh circumcision practice. In addition, most of the families of women who come to Türkiye for education purposes are university graduates. They probably have a good awareness of FGM. Although no distinction was made between type 1 and type 3 in our research, Pharaoh circumcision, namely type-3, is proportionally 41.40%. Sunni type circumcision

(type-1-2) is 58.60%. The increase in type 1-2 circumcision is the main reason for the decrease in Pharaoh-type circumcision. Social change, communication, cultural change and integration seem to have been effective in this change. Most participants (84.24%) had this practice between the ages of 6-10. The age of the practice is usually not clearly stated in the literature. The WHO reports that girls are mostly subjected to FGM at any time from birth to age 15. In the Somali tradition, FGM is applied to girls between the ages of 4-8. Some studies state the age range as 6-10 or 4-8 [22]. In our scientific research, the FGM rate between the ages of 0-5 is 8.7%. In contrast, the FGM rate between the ages of 6-10 is 84.78%. The FGM rate is low in the 11-14 age group (5.98%) [23] Although the age range for FGM is 4-8 years, the FGM rate between the ages of 6-10 is high and statistically highly significant (p=0.01). 90% of Somali women living in Türkiye have had FGM between the ages of 4-10. During FGM, the tissues innervating the clitoris are injured or cut. The pudendal nerve, dorsal artery of the clitoris, superficial dorsal veins, clitorial fascia and venules are seriously damaged. The subcutaneous membrane layer of the labia minora, the arteriole, venule, pudendal, perineal nerve and surrounding tissues are injured. Pudendal and perineal nerve damage causes severe and shock pain. Cutting the small arteries causes severe bleeding. Venules and tissue damage causes serous leakage, prolonged bleeding, inflammation and necrosis. In this scientific study, more than half of the participants stated that their feet were crossed after FGM. It was stated that the first menstrual bleeding was severely painful and that there was pain during sexual intercourse. During FGM (cutting the head of the clitoris), the pudendal nerve and its branches come out. Regeneration occurs with the bleeding in the tissue. This regeneration forms a neuroma in the form of a solid and rough tumour. Neuroma puts severe pressure on the spinal cord. As a result, it causes chronic pain that lasts a lifetime. This pain causes gait disorders and deformities due to the pressure [3]. As a result, severe psychiatric conditions such as post-traumatic stress disorder, anxiety, panic, nightmares, insecurity, IQ deficiency and memory loss occur. [18].

When acute problems resulting from FGM are combined with chronic pain and psychiatric problems, maternal function is compromised. Since FGM is seen as a family and private matter, it will probably never be possible to obtain accurate data. Apart from acute and chronic health problems that occur after obstetric examinations, FGM continues to remain a mystery. There is no precise official data from any country regarding FGM. There are laws related to the prohibition and restriction of FGM. These legal texts are more legal texts than the health problems of FGM. Difficulties in childbirth, prolonged birth, cesarean section, episiotomy, recto-vaginal fistulas, difficulty in defecation and urination problems are common in women who have FGM. Although a connection between sexually transmitted diseases and mutilation has not been established, FGM increases the tendency to sexually transmitted diseases because there is no mention of hygiene or medical precautions in FGM practice. FGM is less common in urban areas. It is more common in rural and nomadic populations. Mortality rates resulting from FGM performed in rural areas are unknown. In this uncertainty, it can be understood that babies circumcised during infancy died from blood loss and pain shock.

In this scientific study, the rate of severe pain (86.36%) during the first menstrual period and the first sexual intercourse in those exposed to FGM is high. Acute emergencies and post-traumatic chronic disorders are covered with the introverted steel armour of social tradition and culture. In Somali women in Türkiye, almost one in every five women got married when they were children. According to traditional culture, having children as soon as marriage is desired. Therefore, this 1/5 rate of women gave birth or had an abortion at an early age. 15.46% of those exposed to FGM lost a baby during birth. The infant mortality rate in Somalia decreased from 44.9% to 36.8% between 2001 and 2020. However, FGM is one of the leading causes of infant deaths at birth. Risks such as blood loss, episiotomy, perineal tear risk, prolonged birth, cesarean section, stillbirth, need for resuscitation, and neonatal death in FGM are known anonymous facts.[24].

In conclusion, in this scientific research, 92% of the participants had an episiotomy at birth. The infant mortality rate is 15.46%. 63.68% of the participants believe that circumcision is not a correct traditional culture but cruelty-torture. Unfortunately, 28.94% think that FGM is reasonable and necessary for the future of their daughters. The main reasons for continuing circumcision are customs, culture 53.68%, religion 12.11%, marriage obligation 1.05% and tradition (26.84%). In some studies, [22] 81% of women do not want their daughters to be circumcised. 18% reported that they wish to FGM for their daughters. This scientific study has proven that the demand for FGM for their daughters is higher. Women believe that it is tough to end the practice. Instead, they agree that type 3 should be abandoned. They tend to have their daughters undergo type 1 and type 2 FGM. In this scientific study, Somali women support the continuation of type 1-2 FGM instead of abandoning the practice of FGM. They believe that their daughters' virginity will be secured and their future will be positively affected. Because a significant portion of them (58.60%) think that the tendency of Somali society towards FGM has surpassed traditional culture. İt has been determined that the FGM tradition has become a norm of belief among Somali women. Young women think differently than older adults in terms of belief in FGM. Women over the age of 45 (20.77%) believe that FGM is a feminine requirement that should be implemented. The younger generation (<45) believes this tradition infringes on personal rights in the modern world. It is widely accepted that it is possible to marry a girl who has not undergone FGM (79.23%). However, unfortunately, traditions are stabbing individual freedoms like a double-edged dagger in Somali women. The effectiveness of WHO's studies on the abandonment of FGM has been 71.36% effective. The rate of those who oppose is 18.38%. It is clear that WHO's studies on Africa are meaningful and productive. It has undoubtedly provided a sociological orientation towards integration with the Universal Culture. Protecting new generations from FGM, which is done secretly, can be possible with education and communication. The severe humiliation, shame, and parents' attention to the most valuable body

parts in FGM are remembered as a lifelong psychiatric syndrome. The crossing of the feet for a few hours to 8-10 days to stop the bleeding is the most crucial cause of psychiatric trauma (60.87%). The painful-frightening nightmare of FGM causes extremely painful menstruation after menarche (73.33%). It causes sexual intercourse in marriage to turn into a terrible trauma (86.36%). The situation is awful and more severe in <18 marriages. According to the literature, a proportional decrease is seen. However, this decreasing change is not statistically significant ($p>0.05$). The truth is that 6-7 out of every 10 Somali women we see probably have obstetric-based severe psychiatric problems. 83.33% of Somali women living in Türkiye do not see FGM as a religious requirement ($p<0.05$). The rate of those who think it is a religious requirement is insufficient. Traditional culture surrounds privacy with sharp boundaries. Therefore, it can be concluded that there is a cultural blindness within the family. They believe that female circumcision does not protect the virginity of girls (77.54%). Even more interestingly, the rate of those who define FGM as violence is 67.60%. When combined with those who silently approve this but are hesitant to express it, this rate increases to 69.74% ($p<0.05$).

Dissemination of health information through voluntary midwifery services is essential for the reduction of FGM. Perhaps if it were taught as an introductory course or curriculum in schools, it could be foreseen that this tragic trauma would end.

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Ethical approved

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