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Impact of Female Genital Mutilation (FGM) on sexual health: A comprehensive interdisciplinary review

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Abstract

Female Genital Mutilation (FGM) remains a critical global health and human rights issue, with more than 200 million women and girls affected worldwide. Despite increased awareness and international efforts to eradicate the practice, FGM persists across various cultural and geographic contexts, particularly in parts of Africa, the Middle East, and Asia. This review examines the multifaceted impact of FGM on female sexual health, drawing from clinical, psychological, and sociocultural perspectives to provide a comprehensive analysis of its consequences. FGM encompasses a range of procedures involving partial or total removal of external female genitalia or injury to the female genital organs for non-medical reasons. The practice has profound and lasting implications on sexual function, including diminished libido, dyspareunia (pain during intercourse), anorgasmia, and reduced genital sensitivity. These outcomes stem from both anatomical alterations and psychological trauma, leading to a complex interplay of physical and emotional dysfunction. Further, FGM is associated with complications such as chronic infections, scarring, and obstetric trauma, which exacerbate sexual discomfort and reproductive challenges. Psychologically, women with FGM may experience anxiety, depression, body image disorders, and post-traumatic stress, all of which further impair sexual well-being. Cultural taboos and stigma surrounding sexuality often silence affected women, impeding access to medical and psychological support. This review highlights the urgent need for culturally sensitive healthcare services, trauma-informed counselling, and legal frameworks to support survivors. It also emphasizes the importance of comprehensive sex education and community-driven advocacy to combat FGM. Addressing the sexual health repercussions of FGM is essential to promoting bodily autonomy, gender equity, and holistic well-being.

Keywords: Female Genital Mutilation; Sexual Dysfunction; Women's Health; Psychological Trauma; Reproductive Rights; Dyspareunia

1. Introduction

1.1. Background and Global Burden of FGM

Female Genital Mutilation (FGM) constitutes a grave violation of human rights and a significant public health concern affecting millions of women and girls worldwide. Defined as all procedures involving the partial or total removal of external female genitalia or other injury to the female genital organs for non-medical reasons, FGM is deeply rooted in cultural, religious, and social norms [1]. Despite international advocacy and legal reforms, FGM remains prevalent in at least 30 countries, primarily in Africa, the Middle East, and parts of Asia, with growing evidence of its practice in diaspora communities across Europe, North America, and Australia [2].

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According to UNICEF, over 200 million women and girls alive today have undergone FGM, with an estimated 3 million girls at risk annually [3]. The practice is typically performed on minors, often under unsanitary conditions and without anesthesia, increasing the risk of immediate complications such as hemorrhage, infection, and even death [4]. Long-term consequences include chronic pelvic infections, childbirth complications, and psychological trauma.

FGM also reinforces gender inequality by controlling female sexuality and perpetuating male dominance within patriarchal structures [5]. Despite growing resistance from activists, survivors, and global health organizations, deeply embedded traditions continue to sustain the practice in many communities. Comprehensive efforts involving education, legal enforcement, and health system reform are essential to eradicate FGM and mitigate its extensive harm [6].

1.2. WHO Classification and Typology of FGM

The World Health Organization (WHO) classifies FGM into four distinct types based on the extent and nature of the genital alterations. Type I involves the partial or total removal of the clitoris and/or the prepuce, known as clitoridectomy. Type II, refers to the partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora [7].

Type III, the most severe form, is termed infibulation. It involves narrowing of the vaginal opening by creating a covering seal formed by cutting and repositioning the labia, sometimes including removal of the clitoris. Type IV includes all other harmful procedures to the female genitalia for non-medical purposes, such as pricking, piercing, incising, scraping, or cauterizing [8].

Each type presents varying degrees of health risk and long-term sexual dysfunction. Understanding this typology is critical for healthcare providers and researchers when assessing clinical outcomes and tailoring intervention strategies [9].

1.3. Rationale for Focusing on Sexual Health Outcomes

Although much of the research on FGM has historically focused on physical and obstetric complications, there is a growing recognition of the significant toll it takes on women's sexual health and psychosocial well-being. Survivors of FGM frequently report diminished sexual desire, arousal difficulties, painful intercourse, and an inability to achieve orgasm—all of which can profoundly impact quality of life and intimate relationships [10].

Sexual dysfunction resulting from FGM is not merely physiological but also rooted in psychological trauma, fear, and misinformation propagated through cultural narratives about female sexuality [11]. Moreover, limited access to sexual health education and support services exacerbates the silence and stigma surrounding these experiences.

Focusing on sexual health outcomes not only validates the lived realities of survivors but also expands the framework for understanding FGM's multidimensional impact. It aligns with global health goals that emphasize comprehensive sexual and reproductive rights as central to women's autonomy and dignity [12].

1.4. Objectives and Structure of the Paper

This paper aims to explore the sexual health consequences of FGM by analyzing available clinical and psychosocial evidence, with particular emphasis on survivors 'lived experiences and access to supportive services. It seeks to bridge the gap between biomedical findings and human rights discourses to provide a holistic perspective on FGM's impact.

Following this introduction, Section 2 provides an overview of sexual dysfunction associated with FGM. Section 3 reviews clinical and qualitative evidence, while Section 4 discusses intervention strategies and healthcare challenges. Section 5 offers recommendations for research, policy, and practice to improve survivor-centered care and promote sexual health equity [13].

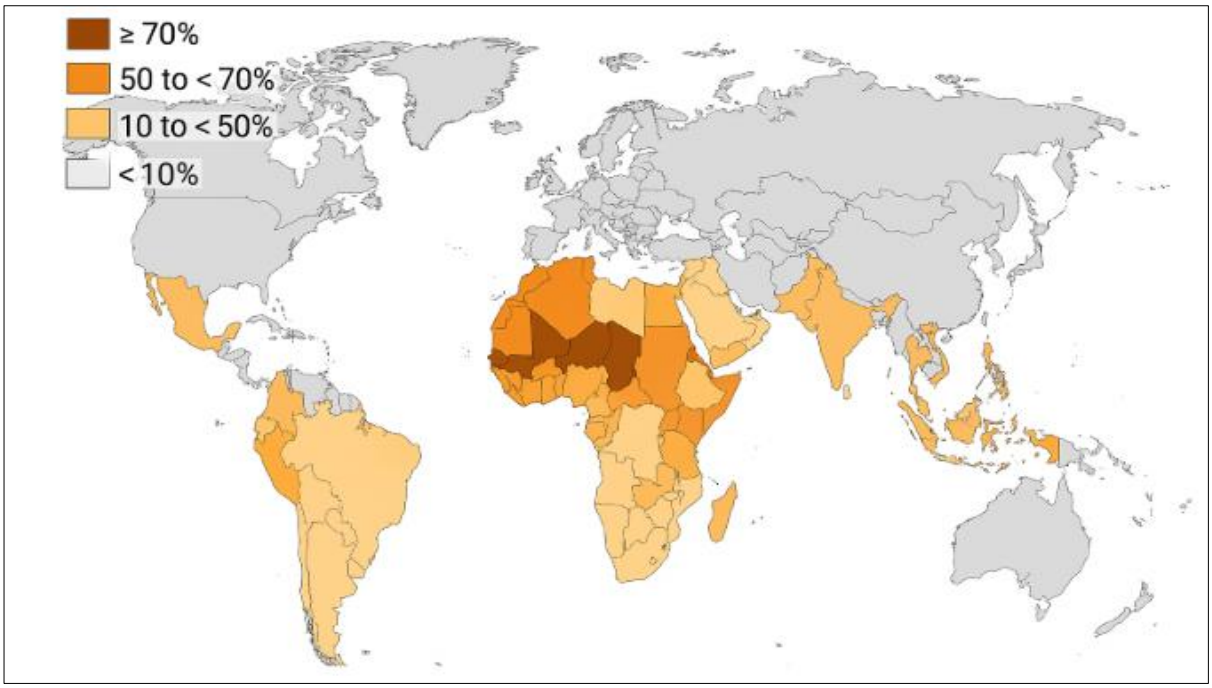

Figure 1 Global map showing prevalence of FGM by region

2. Historical, cultural, and societal dimensions of FGM

2.1. Cultural and Traditional Justifications

Female Genital Mutilation (FGM) is sustained by a complex web of cultural, traditional, and pseudo-religious beliefs that vary across regions and communities. One of the most frequently cited justifications is its perceived alignment with religious values, although no major religious text mandates or explicitly endorses the practice [5]. In many contexts, FGM is erroneously associated with Islamic teachings, despite strong condemnation by various Islamic scholars and religious authorities [6].

The practice is also embedded in rites of passage ceremonies, marking the transition from girlhood to womanhood. Within these traditions, FGM is often celebrated through elaborate community rituals and storytelling, framing it as a necessary step toward social acceptance and maturity [7]. As such, it is viewed not merely as a medical act but as a cultural performance that reinforces communal identity.

Furthermore, FGM is widely believed to promote cleanliness, femininity, and aesthetic appeal. In several societies, uncut female genitalia are perceived as dirty, shameful, or masculine, and the act of cutting is framed as essential for hygiene and beauty [8]. These beliefs are perpetuated by older women, midwives, and community elders, creating a cycle of generational transmission.

Despite growing awareness campaigns, these cultural narratives remain deeply entrenched and resistant to change, particularly where education and healthcare infrastructure are limited [9]. Understanding these justifications is essential for developing culturally sensitive interventions that challenge harmful norms while respecting the communities' need for identity and belonging [10].

2.2. Social Norms, Gender Roles, and Community Pressures

FGM operates within a broader framework of gendered social norms that prioritize female chastity, obedience, and family honor. In many communities, a girl's virginity and fidelity are directly linked to her genital status, and FGM is promoted as a method of controlling female sexuality and preserving moral behavior [11]. This belief not only diminishes women’s autonomy but also reinforces patriarchal expectations about women’s roles within marriage and society.

The social pressure to conform is immense. Girls and families who resist FGM risk ostracization, shame, and diminished marriage prospects. In several cultures, uncut women are considered impure or unfit for marriage, reducing their value in the eyes of potential suitors and undermining the family's social standing [12]. This connection between FGM and marriageability makes it a deeply gendered institution, upheld not only by men but also by women who fear social exclusion.

Community honor is often cited as justification for continuing the practice. Families comply with FGM not out of personal conviction but due to the fear of reputational damage if seen as transgressing tradition [13]. This collective enforcement is compounded by silence and taboo surrounding sexual health discussions, making open dissent difficult.

Although some communities have begun to question and abandon the practice, change is often uneven and contested. Peer pressure, misinformation, and generational loyalty continue to reinforce adherence to FGM, especially in rural or isolated regions [14]. Addressing these social dynamics requires community-driven strategies that engage local influencers, challenge harmful gender norms, and create safe spaces for dialogue and resistance [15].

2.3. Legal Frameworks and Policy Interventions

Table 1 Summary of National and International Laws on FGM

Country	Anti-FGM Law (Year Enacted)	Key Legal Provisions	Penalties for Violation	Ratified International Treaties
Kenya	Prohibition of FGM Act (2011)	Criminalizes FGM, bans medicalization, extraterritorial application	Up to life imprisonment and/or fines	CEDAW, Maputo Protocol, CRC
Egypt	Penal Code Amendment (2008, 2016)	Criminalizes all forms of FGM including medicalized procedures	5–15 years imprisonment for practitioners	CEDAW, CRC
Nigeria	Violence Against Persons (Prohibition) Act (2015)	Prohibits FGM nationwide, overrides state law	Up to 4 years imprisonment and/or fines	CEDAW, Maputo Protocol
United Kingdom	FGM Act (2003); Serious Crime Act (2015)	Criminalizes FGM, travel for cutting, failure to protect child	Up to 14 years imprisonment	CEDAW, CRC
France	Penal Code Articles 222-9 to 222-10	Recognizes FGM as a form of violence, extraterritorial jurisdiction	Up to 20 years imprisonment	CEDAW, CRC
Somalia	No national ban; some regional laws	Legal ambiguity, traditional norms dominate	Not consistently enforced	CRC (ratified); CEDAW (not ratified)
United States	Federal Prohibition Act (1996, revised 2021)	Criminalizes FGM and transport of minors for cutting	Up to 10 years imprisonment	CEDAW (not ratified); CRC (signed, not ratified)
Australia	State and territory laws; Model Criminal Code	Prohibits FGM nationally and abroad	7–21 years imprisonment depending on jurisdiction	CEDAW, CRC

Over the past two decades, legal and policy measures have played an increasingly prominent role in global efforts to combat FGM. Many countries where the practice is prevalent have enacted national laws criminalizing FGM, often supplemented by penalties for medicalization and cross-border cutting [16]. For instance, Kenya, Egypt, and Burkina Faso have implemented explicit criminal provisions with varying degrees of enforcement [17].

On the international level, instruments such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the Maputo Protocol explicitly condemn FGM and obligate member states to take legislative and preventive action [18]. The Sustainable Development Goals (SDG 5.3) further reinforce the global mandate to eliminate harmful practices, including FGM, by 2030.

However, significant gaps remain between law and practice. In many countries, enforcement is weak due to limited resources, corruption, or reluctance among local authorities who view FGM as a cultural issue rather than a legal one [19]. Additionally, victims and witnesses are often unwilling to report due to fear of retaliation or loyalty to community members. Legal ambiguity also persists in countries with pluralistic legal systems where customary law may contradict statutory provisions.

Diaspora countries have introduced extraterritorial laws enabling prosecution of citizens or residents who take girls abroad for FGM. The UK, France, and Sweden are notable for taking legal action against FGM within immigrant communities [20]. Still, prosecutions are rare, and prevention remains a priority over punishment.

Effective policy interventions require a multi-sectoral approach that includes education, community sensitization, and healthcare support alongside legal mechanisms. Integrating anti-FGM education into school curricula, training frontline health workers, and creating anonymous reporting channels are crucial to bridging the gap between legislation and meaningful impact [21].

3. Medical and Anatomical Consequences of FGM

3.1. Overview of FGM Classifications and Surgical Methods

FGM is medically classified into four types, each associated with varying degrees of anatomical alteration and health risk. Type I, also known as clitoridectomy, involves the partial or complete removal of the clitoris and/or the prepuce. This is the least extensive form but still results in pain, bleeding, and long-term dysfunction [22].

Type II, or excision, includes partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora. This type is more invasive than Type I and is commonly practiced in several African and Middle Eastern countries [23].

Type III, referred to as infibulation, is the most severe. It involves narrowing of the vaginal orifice by cutting and repositioning the labia minora or labia majora, sometimes accompanied by clitoral removal. A small opening is left for urine and menstrual flow, and the vaginal opening is often cut open at marriage or childbirth [24].

Type IV includes all other non-medical modifications such as pricking, piercing, scraping, or cauterizing the genital area. Although often perceived as “minor,” Type IV still poses significant medical and psychological risks [25].

The tools used are frequently non-sterile, including razor blades, knives, or broken glass, and procedures are typically conducted without anesthesia by traditional practitioners. Understanding these classifications is critical for clinical diagnosis, patient care, and designing appropriate intervention strategies [26].

3.2. Short-Term Medical Complications

FGM can lead to a range of immediate medical complications, many of which are life-threatening. Severe pain is universal due to the lack of anesthesia, often causing trauma and shock. The pain response is heightened by the rudimentary tools used and the absence of antiseptic measures [27].

Hemorrhage is a major concern, especially in Type II and III procedures where extensive tissue is excised. Excessive bleeding can result in hypovolemic shock, requiring emergency intervention—unavailable in many rural settings [28]. Infection is another frequent complication. The use of unsterilized instruments introduces bacteria that can cause tetanus, sepsis, and localized abscesses, often progressing to systemic illness [29].

Urinary retention is also common due to swelling, inflammation, or the fear of urinating through a painful wound. This can lead to urinary tract infections (UTIs), which are recurrent in many survivors. Fever, vomiting, and acute genital trauma may follow, particularly among younger girls with lower body mass and immune capacity [30].

In rare but critical cases, girls die from uncontrolled bleeding or sepsis. These outcomes often go unrecorded due to social silence, misreporting, or burial customs that conceal the cause of death. The psychological aftermath begins immediately, with girls experiencing fear, confusion, and dissociation from their bodies [31].

Due to the stigma and secrecy surrounding FGM, many girls receive no follow-up care. Early complications can progress to long-term health issues if untreated, including chronic infections and menstrual problems. The short-term risks of FGM thus underscore the urgency for preventive strategies and early clinical intervention [32].

3.3. Long-Term Physical and Anatomical Sequelae

Survivors of FGM face a lifetime of physical complications that significantly impact their sexual, reproductive, and overall health. Vulvar damage and scarring are among the most common outcomes, with extensive fibrosis leading to painful intercourse (dyspareunia), narrowed vaginal openings, and reduced sexual sensation [33]. In Type III infibulation, the vaginal orifice is often so constricted that menstruation and urination become painful and prolonged, increasing the risk of infections and reproductive tract damage.

Neuroma formation, resulting from severed nerve endings during clitoral excision, can cause chronic pain and hypersensitivity. This discomfort persists throughout life and is often misunderstood by both patients and clinicians unfamiliar with FGM-specific pathologies [34].

Menstrual complications, including dysmenorrhea and hematocolpos, occur when blood flow is obstructed by scar tissue. These issues can result in abdominal swelling, anemia, and in some cases, require surgical correction. Obstetric risks are particularly concerning. Women with FGM are significantly more likely to experience obstructed labor, perineal tearing, postpartum hemorrhage, and the need for cesarean sections [35].

Urinary and vaginal infections are recurrent due to poor drainage and altered anatomy. The absence of normal genital structures also affects lubrication, leading to increased friction and tissue tearing during intercourse, which may predispose survivors to HIV and other sexually transmitted infections [36].

The anatomical damage is often compounded by psychological trauma. Many women associate their genital pain with shame and secrecy, leading to body image issues and avoidance of intimate relationships. This compounded trauma contributes to anxiety, depression, and sexual dysfunction, often in silence due to fear of stigmatization [37].

Recognizing these long-term sequelae is critical for developing trauma-informed care and tailored surgical or psychosexual interventions. Interdisciplinary healthcare teams must be trained to identify and address FGM-related complications across the patient's lifespan to promote healing and restore dignity [38].

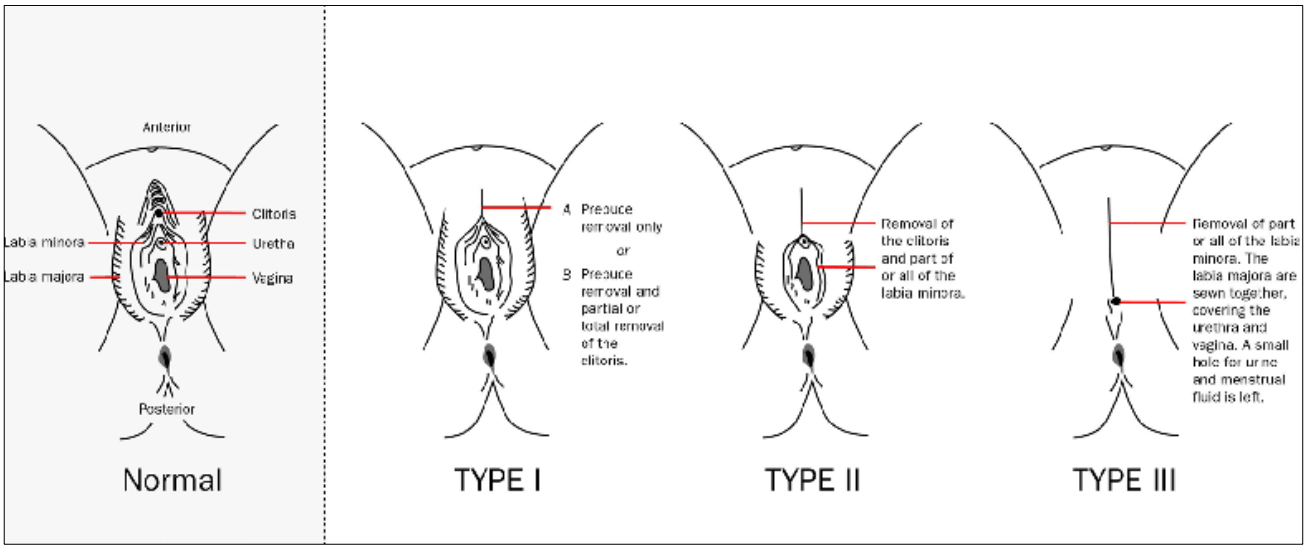

Figure 2 Illustration of genital alterations by FGM type

This figure provides a visual comparison between a normal female genital anatomy and the alterations associated with Female Genital Mutilation (FGM) Types I, II, and III as classified by the World Health Organization (WHO):

- Normal Anatomy: This illustration shows the unaltered female genitalia, including the clitoris, urethral opening, labia minora, labia majora, and vaginal orifice, demonstrating natural anatomical orientation from anterior to posterior.

- FGM Type I (Clitoridectomy): This type involves partial or total removal of the clitoral glans and/or the prepuce (clitoral hood).

    - Type Ia: Removal of the prepuce only.

    - Type Ib: Removal of the prepuce and the glans of the clitoris, either partially or totally.

- FGM Type II (Excision): In this more extensive form, there is partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora. This results in a broader range of tissue loss compared to Type I and significantly impacts sexual sensation and anatomical integrity.

- FGM Type III (Infibulation): This most severe form involves the removal of part or all of the labia minora, and the labia majora are then sewn together to narrow the vaginal opening. A small opening is left for urine and menstrual blood to pass through. This closure can lead to chronic pain, infections, and severe obstetric complications unless surgically reversed (defibulation).

4. Impact of FGM on sexual function and experience

4.1. Neuroanatomical Disruption and Sensory Loss

Female Genital Mutilation (FGM), particularly Types I and II, involves the excision of the clitoris and surrounding tissue, which results in significant neuroanatomical disruption. The clitoris contains over 8,000 nerve endings—more than any other part of the human anatomy—making it central to female sexual arousal and pleasure [39]. When these nerve endings are severed, there is not only a physical loss of sensation but also permanent damage to the pudendal nerve and associated sensory pathways, impeding neural transmission of sexual stimuli.

The dorsal nerve of the clitoris, which plays a major role in sensory perception, is frequently injured or destroyed during the cutting process [40]. This damage significantly reduces the ability to perceive tactile stimulation, leading to anorgasmia and general loss of sexual sensation. In many women, this sensory loss is irreversible, even when surgical interventions attempt to reconstruct the clitoral area [41].

Additionally, scar tissue formation over damaged nerve endings may create neuromas, causing chronic pain or hypersensitivity. This condition is often misinterpreted or untreated due to limited awareness among healthcare providers. Neuroimaging studies also suggest that genital cutting may lead to reorganization in brain regions responsible for processing sexual pleasure, although further research is needed to substantiate these findings [42].

The extent of sensory loss depends on the type and extent of FGM, the age at which it was performed, and the skill of the practitioner. Regardless, the procedure invariably results in partial or complete elimination of the structures necessary for sexual sensory perception. Understanding these neurological consequences is crucial for informing clinical assessments, developing interventions, and validating survivors 'experiences of long-term dysfunction [43].

4.2. Sexual Dysfunction and Dyspareunia

Sexual dysfunction is among the most reported consequences of FGM, with dyspareunia (pain during intercourse) constituting a prevalent symptom across all forms of genital cutting. The removal or alteration of genital tissues—particularly the clitoris, labia minora, and vaginal opening—leads to anatomical changes that impair sexual activity and pleasure [44]. Women with infibulation (Type III) often experience narrowed vaginal introitus, which makes penetration painful or mechanically difficult, often necessitating defibulation surgery prior to sexual intercourse or childbirth [45].

In addition to physical alterations, the scarring and rigidity of remaining tissue reduce elasticity and lubrication, increasing the risk of tissue tears and further pain during intercourse. The reduction in lubrication is partly due to the removal of glands that contribute to vaginal moistening and partly due to autonomic nervous system suppression caused by emotional distress or trauma recall during intimacy [46]. Hormonal influences—such as stress-induced cortisol elevation—may further suppress arousal mechanisms, exacerbating dryness and pain [47].

Psychological factors also play a major role in sexual dysfunction post-FGM. Many women report feelings of shame, fear, or emotional disconnection from their genitals, which affect libido and sexual receptivity. Cultural silence around sexuality can intensify this disconnection, making it difficult to seek help or discuss symptoms with healthcare providers or partners [48].

Studies indicate that the prevalence of sexual dysfunction among women with FGM ranges from 60% to 80%, depending on the population and assessment criteria used [49]. Many women adapt to these changes by limiting sexual activity or enduring pain in silence, often driven by social obligations around marriage and procreation.

Effective intervention requires both medical and psychosexual support, including physical rehabilitation, lubrication aids, trauma counseling, and sexual education. Multidisciplinary care teams that address both physical and emotional dimensions of dyspareunia are essential for improving sexual well-being among survivors [50].

4.3. Orgasmic Disorders and Anorgasmia

One of the most devastating consequences of FGM is the development of orgasmic disorders, particularly anorgasmia—the inability to achieve orgasm despite adequate stimulation and arousal. Orgasmic disorders are especially prevalent among women who have undergone Types I and II FGM, where partial or total clitoridectomy is common [51]. The clitoris is a critical organ for orgasm due to its high concentration of nerve endings and its role in the female sexual response cycle.

When the clitoris is removed or extensively damaged, the neural circuits involved in generating and processing sexual pleasure are disrupted. Even in cases where some clitoral tissue remains, surrounding fibrosis, altered blood flow, and compromised nerve endings reduce the intensity and likelihood of orgasmic response [52]. Additionally, anatomical barriers, such as scar tissue or altered vulvar geometry, can obstruct stimulation of erogenous zones.

Psychological contributors also exacerbate orgasmic difficulties. Survivors of FGM may associate sex with pain or violation, creating mental blocks that inhibit relaxation and pleasure. Moreover, a lack of sexual education in many practicing communities prevents women from understanding their bodies or seeking sexual fulfilment, reinforcing beliefs that female pleasure is unnecessary or immoral [53].

Prevalence studies across FGM-practicing countries show that 40% to 70% of cut women report difficulties achieving orgasm. In Western diaspora populations, the rates remain high despite access to more liberal sexual environments, indicating that physical damage is not the only determinant—cultural, emotional, and relational factors also play significant roles [54].

Medical interventions, such as clitoral reconstruction surgery, have shown some success in restoring sexual sensation and orgasmic function. However, outcomes vary and depend heavily on the extent of original damage, the timing of the procedure, and postoperative psychosexual support [31]. Therapy combining surgical, emotional, and educational components remains the most effective pathway for addressing FGM-related orgasmic disorders.

4.4. Psychosexual Sequelae and Intimacy Issues

Beyond physical complications, FGM has profound psychosexual consequences that affect intimacy, body image, and personal identity. Many survivors report a diminished sense of sexual self-worth and an altered perception of femininity following the procedure. This disruption stems not only from the loss of erogenous tissue but also from the symbolic violation of their bodily autonomy [32].

The ritualistic framing of FGM—often accompanied by secrecy, coercion, or celebration—can create deep psychological conflict, particularly when girls grow older and understand the full implications of what was done to them. Feelings of betrayal, loss, and powerlessness are common, especially when trusted family members facilitated the act [33]. These experiences contribute to long-term emotional distress, including depression, anxiety, and post-traumatic stress disorder (PTSD).

Sexual encounters often trigger emotional flashbacks, causing women to dissociate or avoid intimacy altogether. The fear of pain, judgment, or failure can inhibit arousal and closeness, creating tension in intimate relationships. Some women develop aversion to sexual activity entirely, while others participate out of obligation, suppressing their discomfort to fulfil marital or reproductive expectations [34].

FGM can also interfere with relationship dynamics. Partners may be unaware of the trauma or lack the language to discuss sexual difficulties, leading to misunderstandings and emotional distancing. In certain cases, FGM can contribute to marital conflict, infidelity, or even gender-based violence, particularly when male partners expect sexual performance without understanding the limitations imposed by cutting [35].

Addressing these sequelae requires trauma-informed care that respects cultural sensitivity while prioritizing survivors 'autonomy and well-being. Psychosexual counselling, peer support groups, and survivor-led education initiatives are essential tools in the healing process. Ultimately, restoring intimacy and self-confidence for FGM survivors involves not only physical recovery but also the reclamation of their identity, sexuality, and personal agency [36].

Table 2 Summary of Reported Sexual Dysfunctions by FGM Type

FGM Type	Anatomical Alteration	Common Sexual Dysfunctions	Prevalence Estimates	Clinical Observations
Type I	Partial/total removal of clitoris and/or prepuce	Reduced sexual desire, decreased clitoral sensation, delayed orgasm	50%–70%	Moderate loss of erogenous stimulation
Type II	Removal of clitoris and labia minora (± labia majora)	Dyspareunia, anorgasmia, reduced lubrication, sexual aversion	60%–85%	Greater nerve damage, increased emotional trauma
Type III	Infibulation: removal of clitoris and labia, narrowing of vagina	Severe dyspareunia, anorgasmia, penetration difficulties, low libido	75%–95%	Most restrictive; often requires defibulation for intercourse
Type IV	Pricking, piercing, cauterization, or scraping	Variable: sexual anxiety, fear, occasional dyspareunia	Unknown; fewer studies available	Psychological trauma often significant despite minimal cutting

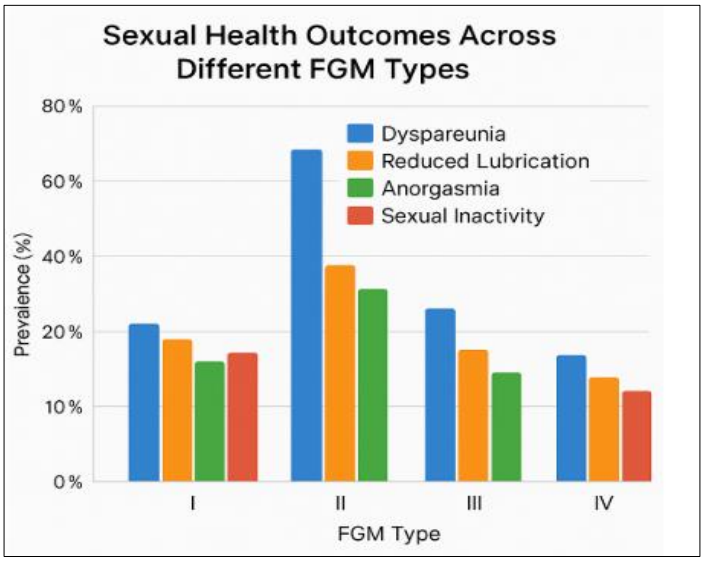

Figure 3 Graph of sexual health outcomes across different FGM types

5.Psychological and emotional impact of FGM

5.1. Post-Traumatic Stress and Anxiety Disorders

Female Genital Mutilation (FGM) is increasingly recognized not only as a physical violation but also as a traumatic psychological event that may lead to serious mental health disorders. Among the most reported conditions is Post-Traumatic Stress Disorder (PTSD), particularly in women who underwent the procedure during childhood without anesthesia or prior understanding of what was to occur [18]. The sudden, invasive nature of FGM—often coupled with familial betrayal—can create deep emotional wounds that persist into adulthood.

Survivors frequently experience flashbacks, particularly during medical examinations or sexual activity, where sensations or contexts trigger re-experiencing of the event. These flashbacks are accompanied by physiological symptoms such as sweating, palpitations, or tremors, indicating ongoing hyperarousal of the nervous system [19]. Even years after the procedure, survivors may avoid specific situations or stimuli associated with the trauma, including touch, intimacy, or clinical visits.

Another common response is dissociation, where the individual mentally detaches from the body or emotions during stress, creating a survival mechanism that can become maladaptive over time. Dissociation during sexual contact or gynecological procedures often leads to feelings of numbness, confusion, and relational difficulties [20].

Compounding the trauma is the silence surrounding FGM, especially in conservative communities where discussing sexuality or emotional distress is taboo. This isolation may delay diagnosis and exacerbate symptoms. Women may internalize the experience, blaming themselves or normalizing their distress, which obstructs healing [21].

To address PTSD and anxiety, culturally sensitive mental health services must be incorporated into primary care. Trauma-informed therapy models—such as Eye Movement Desensitization and Reprocessing (EMDR) or Cognitive Behavioral Therapy (CBT)—have shown promising outcomes in reducing symptoms and restoring psychological resilience in FGM survivors [22].

5.2. Depression and Body Image Distortion

FGM often leads to depressive symptoms, which manifest through persistent sadness, feelings of worthlessness, low energy, and loss of interest in daily activities. Many survivors struggle with body image distortion, perceiving themselves as incomplete, damaged, or unattractive due to the anatomical alterations inflicted upon them [23]. This negative self-perception can become entrenched over time, particularly in societies where female worth is linked to sexual desirability or maternal capacity.

Feelings of shame and fear are common. The secrecy surrounding FGM prevents open discussion, causing many women to internalize their suffering. Shame may be directed toward their own bodies, their families, or cultural expectations that normalized the procedure [24]. For women living in diaspora or more liberal societies, these feelings are compounded by exposure to alternative narratives about bodily autonomy and sexual freedom, which can provoke confusion, regret, and cultural dissonance.

Rejection, whether perceived or real, significantly impacts emotional stability. Some survivors report difficulty forming or maintaining relationships, fearing that a partner will react negatively upon learning about their genital status. In communities where FGM is not practiced, fear of stigma can deter women from pursuing intimate or romantic interactions, further contributing to isolation [25].

In severe cases, these compounded emotional burdens result in clinical depression, characterized by suicidal ideation, insomnia, and appetite changes. Depression may also coexist with PTSD or anxiety, complicating diagnosis and treatment. Effective care must include psychotherapeutic interventions and, where needed, pharmacologic support tailored to the individual's cultural context and psychological needs [26].

Peer-led support groups and survivor storytelling initiatives have shown significant impact in helping women reclaim self-esteem and reconstruct a positive body image following FGM [27].

5.3. Impact on Relationship Dynamics and Intimacy

The psychological and physical consequences of FGM often extend into relationship dynamics, fundamentally affecting trust, communication, and sexual intimacy. Many survivors report difficulties in initiating or maintaining romantic relationships due to anxiety, body shame, and fear of sexual pain [28]. These issues are compounded when partners lack understanding or sensitivity regarding the implications of FGM, leading to communication breakdown and emotional distance.

One of the most significant barriers to intimacy is the fear of sexual contact, rooted in earlier painful experiences or anticipation of discomfort. This fear frequently results in avoidance behaviour, reluctance to engage in physical affection, or complete withdrawal from intimate encounters [29]. When sexual activity is attempted, survivors may endure pain silently, driven by cultural or marital obligations, which further erodes emotional intimacy and self-worth.

The inability to experience sexual pleasure or orgasm may also provoke feelings of inadequacy or guilt, especially in marital relationships where sexual fulfilment is expected. Women may internalize the notion that they are defective or unworthy, while partners may misinterpret avoidance as rejection, creating a cycle of misunderstanding and resentment [30].

Open dialogue about sexual needs and trauma history is often limited, particularly in cultures where sex is a taboo subject. Without communication, misconceptions persist, and neither partner is empowered to seek or offer appropriate support. Some women report being pressured into intercourse or facing emotional abuse when they cannot meet perceived expectations, further exacerbating mental health distress [31].

Conversely, when partners are supportive, educated, and willing to adapt, survivors report greater resilience and improved relational outcomes. Relationship counselling, when delivered with cultural sensitivity and trauma-awareness, can help couples navigate these challenges, rebuild trust, and restore emotional closeness [32].

Programs that engage men and partners in FGM-related education are essential. These initiatives encourage empathy, reduce stigmatization, and equip couples to develop healthier, more affirming sexual relationships. In all cases, integrated approaches that address both individual trauma and relational dynamics are vital for restoring agency, intimacy, and relational satisfaction among FGM survivors [33].

Table 3 Psychological Assessment Outcomes in FGM-Affected Populations

Psychological Domain	Reported Outcomes	Assessment Tools Used	Prevalence Rates	Sources
Post-Traumatic Stress Disorder (PTSD)	Intrusive thoughts, nightmares, avoidance, hyperarousal	PCL-5, IES-R	30%–50% (Type II & III)	[18], [19], [22]
Anxiety Disorders	Panic attacks, phobias, social withdrawal	GAD-7, STAI	35%–60%	[19], [20], [30]
Depression	Low mood, fatigue, suicidal ideation, hopelessness	PHQ-9, BDI-II	40%–70%	[23], [26], [27]
Dissociation	Detachment from body/emotions, memory gaps, numbness	DES-II, MID	20%–40%	[20], [21], [30]
Body Image Distortion	Shame, self-loathing, perception of mutilation	BIS, Self-Image Scales	Qualitative evidence in >60% of cases	[23], [24], [31]
Sexual Dysfunction	Dyspareunia, anorgasmia, reduced desire/arousal	FSFI, DSM-5 Sexual Disorders Criteria	60%–90% depending on FGM type	[25], [26], [27]

Psychosexual Trauma	Intimacy avoidance, loss of sexual identity, sexual phobia	Clinical interviews, Trauma History Questionnaires	High incidence in Type III and infibulated survivors	[28], [29], [32]

6. Reproductive and obstetric outcomes

6.1. Menstrual Complications and Infections

Female Genital Mutilation (FGM), particularly Type III infibulation, significantly impairs normal menstrual function, leading to menstrual complications and recurring infections. The narrowing of the vaginal opening restricts the outflow of menstrual blood, resulting in prolonged menstruation, dysmenorrhea, and accumulation of clotted blood in the vaginal canal or uterus [22]. This obstruction can cause hematocolpos, pelvic pain, and secondary infections if not managed promptly.

Scarring and poor hygiene due to restricted genital access increase the risk of vaginal and urinary tract infections (UTIs). The pooling of menstrual blood creates a favourable environment for bacterial growth, often resulting in chronic vaginal discharge, foul odour, and recurrent inflammation [23]. Many survivors report difficulties with personal hygiene during menstruation, exacerbating their risk of reproductive tract infections and subsequent fertility issues.

Additionally, these complications are frequently ignored due to sociocultural taboos surrounding menstruation and FGM. Women may not seek medical help due to embarrassment, shame, or lack of awareness, leading to untreated conditions that worsen over time [24]. Medical professionals must be trained to identify FGM-related menstrual issues early and offer appropriate care, including surgical defibulation where necessary to restore normal outflow and prevent chronic complications [25].

6.2. Fertility and Conception Challenges

FGM is closely associated with fertility challenges, affecting both natural conception and reproductive health. Physical trauma from the procedure can lead to scarring and adhesions that block the vaginal opening or disrupt cervical mucus flow, hindering sperm motility and vaginal penetration [26]. These mechanical barriers reduce the likelihood of conception, particularly in Type III cases.

More significantly, FGM increases the risk of tubal blockages and pelvic inflammatory disease (PID), often arising from untreated infections. Bacteria introduced during or after the cutting procedure can ascend to the upper reproductive tract, leading to inflammation, tubal scarring, and impaired ovum transport [27]. These conditions are major contributors to secondary infertility, particularly among women in rural or under-resourced settings.

FGM can also result in uterine infections that compromise the endometrial environment, affecting embryo implantation and increasing miscarriage risks. Chronic infections may go unnoticed for years due to the normalization of abnormal discharge and pelvic pain, and women may only discover the extent of damage when undergoing fertility evaluation [28].

Additionally, hormonal responses to trauma and persistent psychological stress can interfere with ovulation and reproductive hormone regulation. Depression, PTSD, and body image issues further reduce sexual activity frequency, indirectly contributing to fertility struggles [29].

Comprehensive fertility care for survivors must include not only gynaecology assessments but also psychosocial support and access to reconstructive services where needed. Addressing both physical and emotional contributors is critical to restoring reproductive potential and empowering survivors with informed reproductive choices [30].

6.3. Labor, Delivery, and Neonatal Complications

FGM has severe implications for labor, childbirth, and neonatal health, especially among women who have undergone infibulation (Type III). The scar tissue and narrowed vaginal opening created by the procedure reduce tissue elasticity and can lead to obstructed labor, a life-threatening condition requiring emergency intervention [31]. Infibulated women often require defibulation—surgical reopening of the vaginal orifice—during labor, which increases the risk of hemorrhage and infection if not performed in sterile, skilled settings [32].

Prolonged and obstructed labor also elevates the likelihood of perineal tears, uterine rupture, and postpartum hemorrhage. The absence of flexible genital tissues can hinder fetal descent and necessitate cesarean sections, which may not be readily available in low-resource settings. Studies indicate that women with FGM are significantly more likely to undergo emergency cesareans compared to uncut women [33].

The neonate is also placed at risk. Prolonged labor and compromised maternal health increase the chances of fetal distress, birth asphyxia, and stillbirth. WHO research estimates that FGM contributes to a 15% to 55% increased risk of perinatal death, depending on the extent of the cutting and available medical care [34]. Additionally, infants born to mothers with FGM face higher rates of low birth weight and neonatal resuscitation needs.

Further complications may arise in postpartum recovery. Women with FGM often experience delayed wound healing, higher infection rates, and difficulty with breastfeeding due to pain or psychological stress. These challenges can interfere with maternal-infant bonding and postpartum mental health [35].

Addressing these outcomes requires that obstetric care providers are trained to recognize and manage FGM-related risks. Antenatal counselling, birth planning, and timely access to defibulation or surgical intervention are essential to ensuring safer labor and better maternal and neonatal outcomes [36].

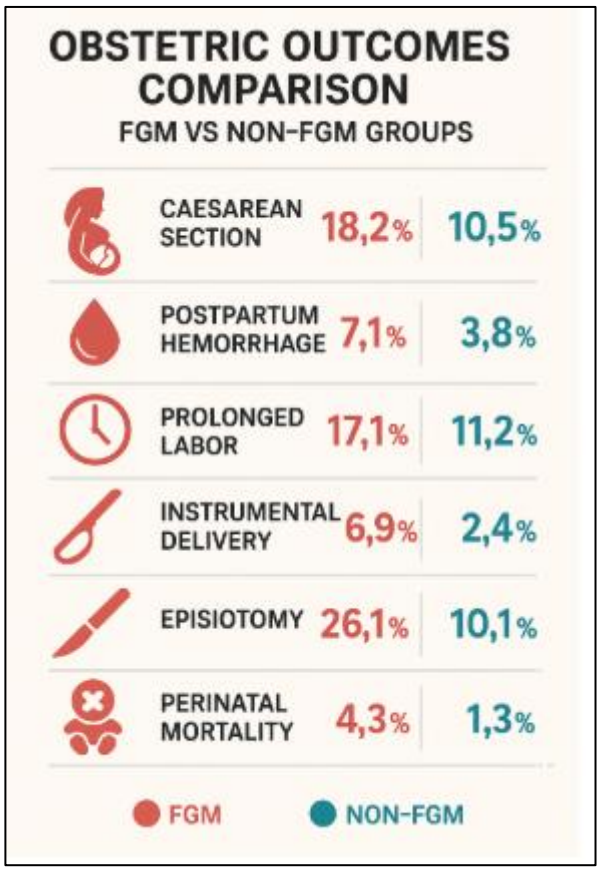

Figure 4 Obstetric outcomes comparison: FGM vs non-FGM groups

7. Survivors 'voices and lived experiences

7.1. Narrative-Based Insights into Sexual and Emotional Pain

Narratives from survivors of Female Genital Mutilation (FGM) offer invaluable insights into the deep sexual and emotional pain endured long after the procedure. These first-hand accounts illustrate the lived consequences that extend beyond clinical symptoms, encompassing complex emotions such as betrayal, confusion, loss, and grief [26]. Many women recount their initial experience of FGM as one of intense fear and physical agony, followed by a lifetime of unresolved trauma that continues to affect their well-being.

Survivors frequently describe an enduring disconnect from their bodies, explaining that the procedure caused them to feel "cut off" not only physically but also emotionally from their sexuality. Some express anger at having been denied the chance to experience sexual pleasure or make informed choices about their bodies. Others convey a profound sense of mourning for what they perceive as a lost part of their identity [27].

Sexual encounters are often described as physically painful and emotionally alienating. Women detail experiences of dyspareunia, numbness, or fear, and many report engaging in sex out of obligation rather than desire. These narratives emphasize the limitations of purely medical assessments, as they fail to capture the internalized suffering, silence, and conflict that often define survivors 'sexual lives [28].

The narratives also underscore the ambivalence survivors often feel—grateful to have survived, yet burdened by enduring harm. Some seek clitoral reconstruction or psychosexual therapy, while others turn to activism or storytelling as forms of healing. These stories reveal that recovery is not linear and that healing often begins when women are allowed to speak freely, reclaim ownership of their bodies, and receive compassionate, trauma-informed care from professionals who understand the profound emotional legacy of FGM [29].

7.2. The Role of Stigma and Silence

Stigma and silence remain formidable barriers that prevent many FGM survivors from accessing support, treatment, or even acknowledging their pain. In communities where FGM is normalized or ritualized, speaking against the practice is often perceived as betrayal of tradition, family, or religion. Survivors may fear social exclusion, blame, or ridicule, particularly if they live in close-knit or conservative settings [30].

The cultural taboo surrounding female sexuality further compounds the problem. Discussions of sex, pleasure, or genital health are often off-limits, especially for unmarried women. As a result, many survivors suffer in silence, unaware that their pain is neither unique nor unavoidable. This enforced silence reinforces shame, prevents diagnosis, and delays access to psychological and medical care [31].

In diaspora communities, the challenges are twofold. While survivors may live in countries with stronger healthcare infrastructure and legal protections, they often experience cultural dissonance, isolation, or fear of being judged by both their communities and the host society. Some worry about being seen as "broken" or unworthy, not only by prospective partners but also by healthcare providers unfamiliar with the emotional toll of FGM [32].

The stigma also infiltrates healthcare spaces. Many women report dismissive or uninformed responses from clinicians, deterring them from seeking follow-up care. In worst-case scenarios, FGM-related concerns are misdiagnosed or ignored altogether, leaving survivors feeling invalidated or retraumatized [33].

Overcoming stigma requires culturally responsive education, public dialogue, and safe spaces where survivors can share their stories without fear. Support networks—both peer-led and clinical—are essential for breaking the silence. Ultimately, dismantling stigma empowers survivors to reclaim their narratives, assert their needs, and seek healing with dignity and agency [34].

8. Clinical and therapeutic interventions

8.1. Surgical Reconstruction and Defibulation

Surgical interventions have emerged as critical tools in mitigating the physical and functional consequences of Female Genital Mutilation (FGM), with two main approaches being defibulation and clitoral reconstruction. Defibulation involves the surgical opening of the sealed vaginal introitus, most commonly required for Type III infibulation. It is typically performed to restore vaginal patency before sexual intercourse, childbirth, or menstruation and has been shown to reduce complications such as obstructed labor, chronic infections, and dyspareunia [26].

The procedure is relatively simple and can be carried out under local anesthesia in outpatient settings, although access is limited in many low-resource or rural areas. Risks include bleeding, infection, and psychological distress if not coupled with trauma-informed counselling. Despite these concerns, defibulation has proven effective in improving urinary flow, menstrual regulation, and sexual function, especially when conducted with cultural sensitivity and appropriate follow-up care [27].

Clitoral reconstruction is a more complex and controversial procedure aimed at restoring clitoral structure and potentially improving sexual sensation. Techniques vary but often involve removing scar tissue and repositioning preserved clitoral tissue. Outcomes differ widely; while some women report enhanced self-esteem and orgasmic response, others experience persistent pain or dissatisfaction. Research on long-term efficacy remains limited, though demand for the surgery is increasing globally [28].

Both procedures should be offered as informed choices, with adequate preoperative education and psychological assessment. When paired with holistic support services, surgical reconstruction offers survivors a tangible means to reclaim bodily integrity, reduce pain, and restore aspects of their sexual and reproductive health [29].

8.2. Psychosexual Therapy and Counselling

Psychosexual therapy is central to addressing the emotional and relational dimensions of FGM, offering survivors a structured and empathetic space to process trauma, rebuild trust, and reclaim sexual agency. At the core of effective intervention are trauma-informed care models that prioritize safety, empowerment, and cultural sensitivity. These approaches recognize that survivors often carry complex psychological wounds, including shame, grief, and dissociation, which must be addressed gently and holistically [30].

Therapy typically begins with building rapport and stabilizing emotional distress. Techniques such as Cognitive Behavioral Therapy (CBT) and Eye Movement Desensitization and Reprocessing (EMDR) are frequently employed to help individuals confront flashbacks, restructure negative beliefs, and reduce avoidance behaviours. Incorporating body-based therapies such as somatic experiencing can also assist survivors in reconnecting with their bodies in non-threatening, affirming ways [31].

Sex therapy helps address sexual dysfunctions including low libido, dyspareunia, and anorgasmia by encouraging open communication, sensate focus exercises, and education about anatomy and arousal. For partnered women, couples therapy may be introduced to improve intimacy, reduce fear, and foster supportive dialogue. This is especially important where partners are unaware of the physical and emotional toll of FGM or unsure how to respond with empathy [32].

Importantly, therapy must be adapted to the survivor's cultural background, language, and belief systems to ensure comfort and relevance. Survivors should never be pathologized for their experiences but supported in defining their own healing goals. When integrated with medical care, psychosexual therapy empowers survivors to reclaim their sense of identity, worth, and wholeness [33].

8.3. Role of Multidisciplinary Teams in Rehabilitation

Figure 5 Multidisciplinary intervention framework for FGM recovery

Rehabilitative care for FGM survivors is most effective when delivered through multidisciplinary teams that coordinate across clinical, psychological, and social domains. These teams typically include gynaecologists, surgeons, psychologists, midwives, social workers, and interpreters, each bringing specialized expertise to address the layered consequences of FGM [34].

A well-functioning team ensures that survivors receive coordinated and continuous care, beginning with needs assessments and extending to follow-up and community reintegration. For example, gynaecologists and surgeons handle defibulation or reconstruction, while psychotherapists address trauma, and social workers assist with legal, housing, or immigration concerns. Midwives and nurses play a key role in reproductive counselling and childbirth planning, ensuring that survivors receive culturally competent prenatal care and respectful delivery services [35].

Collaboration among disciplines enhances care quality, reduces gaps in service delivery, and supports comprehensive healing. Regular case reviews, shared electronic health records, and patient navigators help maintain alignment and accountability across the care continuum. Multidisciplinary teams also support advocacy, research, and training initiatives to improve system-wide responses to FGM.

Ultimately, this integrated approach not only addresses immediate clinical needs but also promotes long-term resilience, dignity, and empowerment for survivors navigating the aftermath of FGM [36].

9. Strategies for prevention and global health advocacy

9.1. Community Education and Empowerment

Sustainable eradication of Female Genital Mutilation (FGM) requires community-centered education and empowerment initiatives that confront deeply rooted beliefs while promoting informed decision-making. Education programs targeting parents, adolescents, and caregivers can shift attitudes by highlighting the health risks and human rights violations associated with FGM [30]. Interactive workshops, school-based curricula, and multimedia campaigns that use local languages and culturally relevant narratives have proven effective in changing perceptions.

Crucially, these initiatives must move beyond awareness to foster empowerment, especially among women and girls. Programs that promote girls 'education, delay marriage, and support economic independence increase the likelihood that they will resist FGM and advocate for others in their community [31]. Empowerment also involves creating safe spaces for dialogue, storytelling, and peer support, where survivors and at-risk individuals can share experiences without fear of judgment or retaliation.

Evidence from successful interventions in countries like Senegal and Ethiopia shows that when communities are actively involved in designing and delivering education campaigns, abandonment of FGM becomes more sustainable [32]. These grassroots approaches are most impactful when combined with access to healthcare, counselling, and legal protection, reinforcing the message that abandoning FGM is both safe and socially acceptable.

9.2. Engagement of Religious and Traditional Leaders

Religious and traditional leaders hold significant influence in many FGM-practicing communities and are therefore essential allies in the fight against the practice. Misconceptions that FGM is a religious obligation are widespread, despite the absence of scriptural justification in both Islam and Christianity [33]. Engaging faith leaders to publicly denounce FGM helps to dispel these myths and reassures followers that abandoning the practice does not conflict with spiritual beliefs.

Traditional leaders, including elders, chiefs, and circumcisers, also shape cultural norms and practices. Involving them in dialogue and alternative rites of passage programs has been successful in reinterpreting tradition without perpetuating harm [34]. Community declarations made in partnership with these leaders carry significant weight and can catalyze collective abandonment.

Importantly, engagement efforts must be framed as collaborative and respectful, rather than accusatory or external. Leaders are more likely to participate when they are included in solution-building, acknowledged for their authority, and equipped with accurate health information and theological guidance [35]. Successful programs often provide capacity-building for leaders, empowering them to act as champions for change within their own communities.

This approach not only accelerates behavioural change but also lends legitimacy to anti-FGM efforts, fostering trust and cooperation at the grassroots level.

9.3. Policy Advocacy, Law Enforcement, and Global Coalitions

Policy reform, legal enforcement, and international collaboration are integral to the global strategy for eliminating FGM. National legislation criminalizing FGM exists in over 30 countries, yet enforcement remains inconsistent due to

corruption, limited resources, and social resistance [36]. Advocacy efforts are essential to strengthen legal frameworks, ensure protection for at-risk girls, and hold perpetrators accountable through fair and transparent judicial systems.

Global coalitions—led by organizations such as UNFPA, UNICEF, and the World Health Organization (WHO)—have united stakeholders through multi-sectoral initiatives like the Joint Programme on the Elimination of FGM. These coalitions support national governments by funding education, healthcare infrastructure, legal reform, and data collection to monitor progress [37].

International instruments such as the Convention on the Rights of the Child, CEDAW, and the Sustainable Development Goals (Target 5.3) provide the normative basis for global action. Policy advocacy should align national strategies with these international obligations, encouraging governments to implement cross-cutting interventions that span health, education, and justice sectors [38].

Furthermore, civil society organizations play a critical role in monitoring implementation, engaging communities, and holding states accountable. When supported by strong legal frameworks and international cooperation, policy advocacy becomes a powerful driver of lasting change in the global fight to end FGM.

10. Conclusion and future directions

10.1. Key Findings and Interdisciplinary Implications

This paper has critically examined the multifaceted impact of Female Genital Mutilation (FGM), emphasizing its devastating consequences on sexual health, psychological well-being, reproductive outcomes, and relational dynamics. The evidence demonstrates that FGM leads to a wide range of chronic physical and psychosexual dysfunctions, including pain during intercourse, anorgasmia, infections, infertility, and trauma-induced aversion to intimacy. Beyond its physiological toll, FGM undermines women's autonomy, self-perception, and access to equitable healthcare.

A central finding is the need for interdisciplinary collaboration in managing FGM-related outcomes. Effective care requires integration of medical, surgical, psychological, and social services tailored to the survivor's specific type of cutting, cultural background, and lived experience. Gynaecologists, psychotherapists, social workers, community health educators, and policy advocates must work together to ensure that clinical interventions are paired with trauma-informed therapy, legal protection, and culturally responsive outreach.

Moreover, prevention and eradication strategies are most successful when rooted in community engagement and supported by religious and traditional leaders. Global health coalitions, legal institutions, and grassroots movements must operate in unison to dismantle harmful norms and uphold the rights of women and girls. FGM is not only a medical or legal issue—it is a deeply social, emotional, and ethical challenge that demands holistic, interdisciplinary responses.

10.2. Recommendations for Research, Policy, and Clinical Practice

To enhance survivor support and accelerate the eradication of FGM, future efforts should prioritize survivor-centered research that captures long-term physical, psychological, and sexual health outcomes across diverse cultural settings. Rigorous, longitudinal studies are needed to evaluate the effectiveness of surgical and therapeutic interventions, including clitoral reconstruction and trauma-informed psychosexual therapy.

On the policy front, national governments should strengthen legal enforcement mechanisms while expanding access to education and social protection for girls at risk. Policies must bridge the gap between legislation and practice by investing in capacity-building for frontline workers and community leaders. Legal reforms should also include provisions for confidential reporting and safe shelters for survivors and at-risk individuals.

Clinically, all health professionals should receive training on identifying and managing FGM-related complications using culturally sensitive and patient-centered approaches. Multidisciplinary teams must be embedded into health systems to ensure seamless coordination between surgical care, counseling services, reproductive health, and advocacy support.

Ultimately, the eradication of FGM and the healing of survivors require a united effort across disciplines—blending science, compassion, policy, and grassroots empowerment to uphold dignity, restore health, and protect future generations from harm.

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