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Chapter

Reproductive Health and Ethical Problems in Women’s Health

Vasfiye Bayram Değer

Abstract

Development levels of countries are determined by a number of parameters including women’s educational status, women’s active participation in political, indicators of women’s health, mortality of mother and infants, the social status of women in that country, the general level of economic development and the quality of the health services provided. Sexual and reproductive health problems, which occupy an important place among women's health problems both around the world and in our country, are commonly encountered. In addition, rapid changes and medical advances are booming nowadays. While these advances help to overcome many health problems, they also affect social values and engender ethical problems. In particular, these ethical dilemmas emerge in every field influencing women's health and may adversely affect women’s health by causing ethical violations. It is one of the major duties of health care professionals to prevent ethical violations of women who are already disadvantageous in every aspect of social life. In this context, the professionals working in the field of all women’s health should be knowledgeable about ethical rules and adhere to these rules. Prevention and reduction programs for sexual health and reproductive health problems will contribute to promoting women’s health and ultimately the public health.

Keywords: reproductive health, human rights, women's health, female genital mutilation, curettage

1. Introduction

Femininity has certain cultural meanings and images, but they are often combined with motherhood, which is often associated with the basic fostering nature of women. Motherhood is a prestigious and positive identity, but the dominant role of motherhood in many cultures contributes to minimizing the diversity among the women. The major stereotypical discourses about women in the society include being “a good mother”, “bad mother” or “permissive mother”, or “childless mother”, etc. The woman are exposed to stigmatization due to these discourses. For example, the fact that any woman fails to fulfill her socially and personally expected roles, and become a mother due to their choice or infertility is subjected to stigmatization in many societies. Such a stigmatization and accusation may have negative consequences by compelling them to receive endless fertility treatments that can endanger their health, as well as creating insensitivity to the women’s health problems. In addition, the stigmatization
of reproductive decisions or situations is often fused with patriarchal discourses that regard women as weak, ignorant, needing protection or guidance. As a result, there are many dimensions of women's reproductive health and the women's health is experienced in different ways in different parts of the world [1].

The efforts to identify sexual health were greatly influenced by the health definition accepted by the World Health Organization in 1948. A conference titled International Population and Development Conference on International Conference and Development/ICPD was organized in Cairo in 1994, culminating an agreement on an expanded definition of reproductive health including sexual health, and the importance of public access to these services was emphasized [2].

In recent years, the definition of sexual health made by ICPD (International Conference on Population and Development) as a component of reproductive health has been debated. It is widely accepted that sexual health means more than reproductive health and in fact it should be considered as a separate concept. The first part of the report explains that sexual health forms the basis of accessing to reproductive health rather than a component of reproductive health and is a prerequisite for this [2].

Sexuality and sexual relations are placed at the center of both reproductive and sexual health, but most sexual activity is not directly associated with reproduction and affects the whole life of the person. Therefore, sexual health can be considered as a broader concept. Discussions on human rights and sexual health continue to exist and documents related to international human rights are increasingly used to support and advance individual and social initiatives for guaranteeing and fulfillment of governments' respect for sexual and reproductive rights, and to ensure the protection and fulfillment of governments [2].

Conceptually, sexual and reproductive health form a whole. According to WHO, sexual health is a state of physical, mental and social wellbeing related to sexuality. In addition to a positive and respectful approach to sexuality and sexual relations, it requires potentially having pleasant and safe sexual experiences free of all kinds of coercion, discrimination and violence. Reproductive health focuses on all aspects, functions and processes of the reproductive system [2].

There is an increasing consensus that sexual health cannot be achieved and sustained without respecting and protecting certain human rights. In this context, it is necessary to mention sexual rights. The sexual right is a contribution to the ongoing dialog on sexual health-related human rights. The application of existing human rights to sexuality and sexual health constitutes sexual rights. Sexual rights protect the rights of all people to realize, express and benefit from sexual health by respecting for the rights of others and protect their right within the framework of protection against discrimination [2].

“Maintaining sexual health is linked to the extent to which human rights are respected, protected and fulfilled. Sexual rights cover certain human rights that are already recognized in international and regional human rights documents and other relevant agreements and national laws. These critical rights include the folaboring;

Critical rights for the maintenance of sexual health include:

• Rights for maintaining equality and avoiding discrimination.

• Right not to be tortured or exposed to cruelty, inhuman or humiliating treatment or punishment.
• The right to have privacy.

• The highest accessible health standard (including sexual health) and social security rights.

• The right to get married and have a family involving free and full consent of future spouses for marriage contract and the right of equality in divorce.

• The right to decide on the number and the interval of birth of children by the parents.

• The right to obtain information and receive education.

• The rights of freedom of thought and expression and

• The right to apply for an effective legal path for violations of fundamental rights [2].

The responsible use of human rights requires everyone to respect the rights of others.

The biological difference between men and women causes different health problems. The onset of a new life period or menopause that starts with the end of fertility, the pregnancy and birth processes due to the physiology of women and the unique illnesses prevalent among the women are one of the aspects of this difference at first glance. In addition, in the cases caused by female physiology, the diseases seen in the reproductive organs are very severe due to the fact that some diseases and conditions in women form a different risk group that vary according to age. Therefore, it can be said that women-specific health problems should be handled separately and original approaches should be developed in this regard [3].

**Sexual Health (SH) and Reproductive Health (RH) Problems of Women:**

The women spend a significant part of their lives in the period known as “the age of fertility”. This period involves the most frequent complications related to pregnancy and birth for women are most experience and cover the ages between 15 and 49. Undesirable results of pregnancy and birth are considered as the most important cause of illness and death for fertile women in many developing countries of the world [4] (Table 1).

Another important determinant factor in dealing with women’s health problems separately lies in the fact that women are pushed in the background much more than men in accessing health care. Undoubtedly, this discrepancy between men and women is not limited to health services. Most women do not have equal positions and right with men in participating in the decision-making processes in relation to education, social status, income level and development and in their domestic positions [3].

Social gender roles, which are subsequently learned and assumed by both men and women in social structuring, have an essential place on the basis of the inequalities that arise due to gender. The concept of social gender covers all of the situations that involve “being a woman” or “being a man”, which is added to the biological gender gained by birth, taught to the individual by their family and the society in which they live. Moreover, this situation is often reinforced by education and internalized by individuals in the process of socialization [5].

The deprivation of women’s global social and economic rights continues to prevent health improvements for women [6]. The social and political invisibility as a result of
Fetal and Childhood Period (0–9 ages)

• gender choice, female circumcision, early menarch as a result of hormonal imbalances,
• Neglecting the health status of girls and restricting them from health services because of boys being favored or pampered by the family
• Malnutrition in girls as a result of less breastfeeding and insufficient nutrition
• Inadequacy in immunization
• infections (such as pneumonia, diarrhea)
• The rate of morbidity and mortality is higher in the girls aged between 2 and 5 years than boys.
• Sexual abuse, harassment (incest relationship, child pornography etc)

Adolescent period (10–19 ages)

• Physiological Change in the Reproductive System (Development in Menarch, Telarch and Secondary Sexual Characters)
• Failure to benefit from sexual and reproductive health services
• Social gender discrimination and pressure
• Sexual harassment and abuse (such as prostitution, incest relationships, pornography etc)
• Early marriage
• Adolescent pregnancy
• Unhealthy abortion
• Sexually transmitted diseases (STD such as HIV)
• harmful habits (such as alcohol, smoking and drugs)
• Depression, suicide
• Violence
• Anemia, malnutrition as a result of insufficient and unbalanced nutrition
• Eating disorders (such as anorexia neurosis and bulimia neurosis)
• Female genital mutilation

Adulthood/Fertile period (15–49 ages)

• Problems with Pregnancy, Birth and Postpartum Period
• unwanted pregnancy
• deliberate abortion
• Deaths due to pregnancy and mother deaths
• infertility
• Traditional applications harmful to health
• Sexual health problems (vaginusmus, abortion sexual desire and disgust, orgasmic disorders, dysparonia etc)
• Sexual health problems (vaginusmus, sexual desire and disgust, orgasmic disorders, dysparonia)
• Anemia and malnutrition
• Violence
• Sexual harassment and abuse
• harmful habits (alcohol, smoking)
• Sexually transmitted diseases (such as HIV)
the deprivation of the rights of women's health and well-being constitutes an enormous obstacle to the improvements in their health status. In some environments, rejection of the most basic ethical principles and human rights makes the simplest medical ethics axioms (prevention of damage) almost impossible. In particular, the deliberate damage in the form of sexual violence in the military conflict continues to eliminate the rights of women not to suffer physical damage. Elimination of psychological and reproductive health of women's human rights through such war crimes or simply cultural norms will affect the health of women and the families throughout the next generations [7].

There cannot be a more fundamental ethical obligation to secure the health of mothers and future generations for the societies, but this continues to be a distant and inaccessible ideal in many parts of the world. Associating the value of family health status to the abortioner status and value of women around the world has direct effects on governments [8]. The fact that governments are not interested in women's safety and health causes both short and long-term damages to their economic and political stability and health, but still remaining a remarkable abortion priority for many countries. This forms a great obstacle that the medical profession should ultimately overcome. One of the ethical obligations of a learned profession like medicine is to educate and advocate human rights for a better future. In order to make visible this connection between the economic and social conditions of women around the world as well as the health of women and their families is a key to an ethical obligation of the learned medical profession and to improve women's health [7].

Two special health problems, which associate women's cultural roles and status with negative medical consequences, are at the center of global medical ethics and continue to prevent health promotion. The multiple relationships between ethical issues, religious and cultural norms and health rights for women constitute striking examples [7].

The first example is female genital mutilation (FGM) [9]; The second culturally affected health problem is related to the widespread incidence of HIV in women because they cannot refuse sexual intercourse due to sexual violence, abortion social status, poverty, expectations cultural submission, or cannot ensure protected sexual intercourse by demanding the use of condoms [6].

### Table 1.
Sexual health (SH) and reproductive health (RH) problems of women in view of age periods [4].

<table>
<thead>
<tr>
<th>Period</th>
<th>Problems</th>
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<tbody>
<tr>
<td>Menopausal complaints</td>
<td>Pelvic organ prolapse, decreasing sexual desire, postmenopausal bleeding</td>
</tr>
<tr>
<td>Pelvic organ prolapse</td>
<td>Pelvic organ prolapse, decreasing sexual desire, postmenopausal bleeding</td>
</tr>
<tr>
<td>Decrease in sexual desire</td>
<td>Pelvic organ prolapse, decreasing sexual desire, postmenopausal bleeding</td>
</tr>
<tr>
<td>Violence</td>
<td>Pelvic organ prolapse, decreasing sexual desire, postmenopausal bleeding</td>
</tr>
<tr>
<td>Increased incidence of breast</td>
<td>Pelvic organ prolapse, decreasing sexual desire, postmenopausal bleeding</td>
</tr>
<tr>
<td>Cancer, lung and colon cancer</td>
<td>Pelvic organ prolapse, decreasing sexual desire, postmenopausal bleeding</td>
</tr>
<tr>
<td>Postmenopausal bleeding</td>
<td>Pelvic organ prolapse, decreasing sexual desire, postmenopausal bleeding</td>
</tr>
<tr>
<td>Chronic diseases (cardiovascular problems)</td>
<td>Pelvic organ prolapse, decreasing sexual desire, postmenopausal bleeding</td>
</tr>
<tr>
<td>Mental and psychological problems (such as loneliness, decreased self-esteem, depression and dementia)</td>
<td>Pelvic organ prolapse, decreasing sexual desire, postmenopausal bleeding</td>
</tr>
</tbody>
</table>
Midwifery - New Perspectives and Challenges

Among the problems that can be considered as other ethical problems in women's reproductive health issues are virginity test, examination in the case of sexual offenses, uterus evacuation, sterilization. This chapter will focus on FGM, Hymen Examination and uterine evacuation.

2. Hymen examination or virginity testing

Hymen (hymen) is an elastic membrane rich in thin vessels, which partially covers the vaginal entrance and can usually be torn in the first sexual intercourse. Hymen, which is seen as an important element of being a woman and sexuality, has gained cultural importance by influencing the lives of individuals and societies [10]. In some cultural settings, the woman's sexual intercourse can exclude her from being a candidate for marriage, so that a woman who wants to marry and establish a family may have to conceal the truth if she had had sexual intercourse before [11]. While virginity has no cultural importance in today's Western societies, it is still culturally important in Muslim Eastern societies, including our country. For this reason, virginity test is mostly applied especially in Eastern societies [10].

Determining whether a woman has previously had sexual intercourse through gynecological procedures is called virginity test or hymen examination [12]. The virginity test, also called as examination of the hymen, two fingers or per vaginal, involves the examination of the female sexual organ to determine whether the person has had sexual intercourse [13]. The two most common techniques are the examination of the hymen in terms of size or the torn and the vaginal placement with two fingers to measure the size of the entrance or the looseness of the vaginal wall. Both techniques are carried out with the belief that they have a special genital appearance of accustomed sexual intercourse [13, 14]. The social belief that dominates the test lies in the fact that the virginity of an unmarried woman is an indication of her moral character and social value, compliance with marriage, assessment of sexual assault, application for employment or other context [13, 14].

Virginity examinations are mostly performed for non-married women, usually without obtaining consent or when individuals cannot have the right to consent [13]. The person who examines the region may be a medical doctor, police officer or community leader. The countries in which this practice is reported to be used include Afghanistan, Bangladesh, Egypt, India, Indonesia, Iran, Jordan, Palestine, South Africa, Sri Lanka, Swaziland, Turkey and Uganda [15]. The virginity test is performed in various countries due to varying regional reasons. Some communities in the Kwazulu Natal in South Africa and Swaziland have applied virginity tests to school girls in order to deter the sexual activity before marriage and to reduce the prevalence of HIV [16, 17]. In India, the test is part of the assessment made for sexual assault among the victims of rape [18]. In Indonesia, this test has become a part of the application procedure for women to be recruited in Indonesian police force [19, 20]. Due to increasing globalization, virginity test reports emerge in countries without such a history of virginity test, including Canada, Spain, Sweden and the Netherlands [16]. Although it is a long-term tradition in some communities, official assessments of the incidence of virginity tests are abortion. For this reason, although its prevalence is not fully known, the anecdotes of its incidence emerge in various social environments in different countries. Increased interest in eliminating sexual violence has promoted awareness of routine use of virginity test in some settings [21].
According to a systematic study that reviewed 17 studies on the virginity test in the hymen examination [15] studies have shown that the examination of the hymen cannot provide precise evidence about vaginal penetration or any other sexual history [22, 23]. It is possible that normal hymen examination findings will occur in those who have a history of vaginal penetration and in others who do not. A hymen examination with abnormal findings is not certain: abnormal hymen properties such as hymen cutting, tearing, expansion or scars are observed in women with a history of sexual intercourse and those without such a history [24–32].

A hymen feature commonly examined in the virginity test is the size of the hymen opening. It was found that the size of the hymen opening was an unreliable finding for vaginal penetration [27–29]. The size of the hymen opening varies according to the examination method, the position of the person being examined, the cooperation and relaxation of the person being examined and the age, weight and height of the person being examined [27]. Regarding the healing of hymen injuries, it was revealed that most of these injuries rapidly healed and there was no evidence of previous trauma [28, 29].

Another form of virginity test is the insertion of two fingers into the vagina to examine their looseness [18]. The medical community does not accept this examination as a clinical indicator of previous sexual intercourse. The vagina is a dynamic muscular channel with a flexible dimension and shape depending on the person, developmental stage, physical position and various hormonal factors such as sexual arousal and stress [33]. However, there are reports that the so-called finger test ‘is used to evaluate evidence of sexual assault in countries such as India [34].

Research on the effects of the virginity test on the person being examined are also limited. According to the examination of eight studies on the effects of virginity test [17, 32, 34–39], virginity examination causes the person to be physically harmed. These studies are supported by the news that five students from Turkey attempt to commit suicide by consuming mouse poison to avoid the virginity test. The virginity tests are also known to result in psychological trauma with long-term negative effects, though not restricted to these, including anxiety, depression, loss of self-confidence and suicide. Health professionals have also defined violations of privacy and autonomy as negative effects [35, 38]. Finally, the virginity examinations have been reported to have a negative social impact, including social exclusion, perceived dishonor for society and family, discrimination in employment, humiliation and increasing risk of exposure to sexual assault [17, 35, 39]. It was revealed that the virginity testing, also known as two fingers, hymen or vagina head examination, was not a useful clinical tool and could be physically, psychologically and socially destructive for the person being examined. In terms of human rights, the virginity test is a kind of sexual assault when performed without permission and a kind of gender discrimination, as well as violation of fundamental rights [15]. In many countries, virginity examination usually forced to be performed for those women who claim to be raped or are accused of prostitution and as part of public or social policies to control sexuality, in hospitals and other places including detention places. The Independent Forensic Expert Group/IFEG, which consists of thirty-five leading independent Forensic Medicine Specialists from eighteen countries specializing in evaluating and documentation of the physical and psychological effects of torture and mal-treatment, published a declaration about this application in December 2014 [13].

The declaration of IFEG summarizes the physical and psychological effects of forced virginity examinations on women based on collective experiences. Based on these effects, the group discussed the medical interpretation, suitability and ethical results of such examinations by evaluating whether forced virginity examinations
are cruel, inhumane or humiliating treatment or torture [13]. IFEG concluded that virginity examinations are not medically reliable and lack clinical or scientific value. These examinations are discriminatory by nature and in almost all cases, when it is forced, they cause significant physical and mental pain and suffering, and therefore constituting cruel, inhuman and humiliating treatment or torture. In case of forced virginity examinations and vaginal penetration, the examination should be considered as sexual assault and rape. The inclusion of health workers in these examinations violates the basic standards and ethical principles of professions [13]. In October 2018, the World Health Organization (WHO) issued a report that condemns the application of virginity test, which was scientifically unquestionable and seemed to be harmful for victimized women. In February 2019, The Belgian National Council of Physicians Order supported the report by WHO and reminded that the virginity test was not justified or ethical [40]. In some forensic medical textbooks, virginity test is still a standard procedure for the evaluation of sexual assault [41–44].

2.1 Hymen examination in cases of sexual assault

Hymen examination should be performed under adequate illumination. The labiums of the person deposited in the dorsosacral position gently and upwards are pulled up and the entrance of hymen, vestibule and vagina is uncovered. The folaboring questions should be answered in the hymen examination: 1-What is the type of hymen? 2- Is there any rupture in the hymen? 3-Is the rupture new or old? 4-How many ruptures are there? 5 Where are the ruptures? 6- Do the ruptures reach the vagina wall? 7-Are there any findings like ecchymosis around the hymen? The shape and rupture of the hymen should be shown on a chart. The location of the ruptures should be indicated according to the clock dial. Hymen healing varies according to each patient, the number and scope of ruptures, venereal diseases, local diseases and vulva hygiene. In the examination using colposcope, it was stated that the fastest healing in a single partial rupture was 9 days. On the other hand, the healing of more complicated ruptures may extend up to 24 days. The majority of the ruptures (62%) are between 5-7 according to the clock dial. The rupture area is red, swollen, painful and bleeding when touched. They usually heal in 7 days and after 8 to 10 days, the rupture area shrinks. Hymens often have natural notches that can be mixed with old tears. They do not reach the vagina wall and are usually found a priori. The structure of some hymens is elastic and a sexual intercourse is possible without tearing. The opening of such hymen can reach up to 3-3.5 cm. These are called anatomical virgins. The incidence of such cases is about 30 %. The rupture in hymen does not show sexual intercourse without the consent of the person [45].

Consequently, hymen examination is a violation of human rights, regardless of the reason. Governments, medical and healthcare professional organizations in all countries, even those who do not have a history of virginity, should take initiatives to prohibit the use of virginity tests and create national guidelines for health professionals, public officials and community leaders. Further research is needed to understand the regional and cultural reasons of virginity test and to develop more robust and effective educational strategies including communities. Medical faculties and public health specialists should update textbooks, courses and trainings to eliminate all kinds of recommendations related to the virginity test and educate people on the lack of scientific evidence and potential hazards of the use of this test.
3. Female genital mutilation/cutting (FGM/C)

The FGM/C involves the partial or complete removal of the external genital organs or another injury of female genital organs for non-medical reasons. It is accepted as a violation of human rights [46]. There is no known health benefit, but many harmful results have been reported. According to the World Health Organization, more than 200 million women and girls worldwide are influenced by FGM/C [46]. Each year, 3 million girls are at the risk of passing FGM/C before the age of 15 [46].

Female Genital Mutilation (FGM) is an ongoing application in various parts of the world, but especially since the end of the 80s, academic studies on the women’s body and “clitoris” have proliferated, which paved the way for vehement debates. FGM is aimed to be partially or completely banned by many national and international regulations. This application, which has been claimed to have a two-thousand-years of history, is still maintained and the girls and women are often exposed to FGM. It is not merely possible to examine the mutilation expressed in different concepts in the literature by examining and addressing legal regulations only in terms of health. When examining this application, the history of the FGM, the reasons and the permanent and temporary side effects should be handled together. This application, which is performed in order to limit the place of women in society and to control their sexuality, is one of the most prominent and concrete examples of masculine domination [47].

In the joint statement published by the World Health Organization in 1997, the United Nations Children Aid Fund and the United Nations Population Fund, identified female genital mutilation as “all the procedures that do not have therapeutic properties or cultural reasons or damage the female genital organs or a partial or full removal of the external genital region” [48] and this definition has been the focus of many academic studies. In the literature, different concepts such as female genital mutilation, female circumcision, injury, cutting and even torture are used for explaining this practice. In Female Genital Mutilation Report published in 1997, the application was divided into four different types and the World Health Organization updated the FGM types in 2007 with small alterations [49] (Figure 1).

FGM/C is applied in approximately 30 countries, especially in Africa, Middle East and Southeast Asia. It is a strong cultural practice of ethnic origin and carried out for various reasons, including fulfilling a transition ceremony, giving a sense of ethnic identity, providing social acceptance, preserving virginity, and encouraging marriage, loyalty and beliefs. Some groups believe that FGM/C is a religious requirement, yet it is not mentioned in any great sacred text such as Qur’an or the Bible [50].

FGM is carried out by people such as midwives and birth officials without medical education. Knives, scissors, cutting tools or hot objects and similar tools are used during the application [51]. According to the report published by UNICEF in 2013, the application is carried out by traditional practitioners in most of the cases. Health personnel are only involved in FGM application in certain cases [52]. In this context, for example, in Senegal, Niger, Benin, in the United Republic of Tanzania, FGM practices are completely done by traditional practitioners. Moreover, the majority of the procedures are performed at home and a hygienic and sterile environment suitable for the operation cannot be provided most of the time [52].

According to the same report, in half of the afore-mentioned countries, FGM is mostly applied before girls turn five years old and usually completed at fifteen years of age [52]. For example, it was stated that 85% of girls in Yemen were exposed to FGM in the first week after birth [53]. Although UNICEF emphasized that the actual number is not known, at least 200 million children and women were exposed to FGM in
accordance with the survey data provided by 30 states by 2016. It is known that FGM is widespread in all African countries, especially in the Middle East countries such as Iraq and Yemen and in Asia such as in Indonesia [54]. Moreover, although there are great differences between countries and regions in terms of the spread of FGM, it is stated that the frequency of incidence is still over 40% especially in Western, Eastern and North African countries, including Mali, Moritania, Gambia, Guinea, Djibouti and Sudan, [55]. As a result of migrations to Europe, North America, Australia, New Zealand and Japan, it is known that the application among the female immigrant population increased greatly in these countries as well [54]. For the last thirty years, it seems difficult to obtain the total number of children and women affected by the FGM in these countries due to the incomparability of the existing data in the countries that have migrated in the last thirty years and to make comparisons at the national level. However, some concrete data can be obtained as a result of the data provided by international research programs in addition to the national representative data in the originating countries of the application [54]. In line with this, the incidence of FGM among children aged 0–14 years in East Africa was 71.4% in 1995, which decreased to 8% in 2016. It was 57.7% in North Africa in 1990, which decreased to 14.1% in 2015. It was 73.6% in 1996 in West Africa, which decreased to 25.4% in 2017 [55].
It is estimated that 513,000 women and girls, who are born of mothers migrating from countries that apply FGM/C or who come from these countries in the United States, are confronted with the risk and consequences of FGM/C. Approximately 55% of these women and girls come from Egypt, Ethiopia or Somalia [56, 57].

FGM usually occurs between 4 and 12 years of age and causes numerous complications such as bleeding, infection, sepsis, infertility, dysmenorrhea, dysparonia, keloids, cysts/abscesses, psychological outcomes and increased risk of obstetric complications during birth. The application is also dangerous for the newborn. Infibulations (Type III FGM) should be opened during sexual intercourse and in later periods of life for birth (defibulation). Infibulation can lead to abortion and painful menstruation and urine output caused by the almost completely closure of the vagina and urethra. Urinary incontinence and painful sexual intercourse are common complications. The least reported outcomes of female mutilation include psychological and emotional elements. It is important to mention about three important psychological outcomes: the “anxiety” caused by insomnia and hallucinations; “Response Depression” caused by delayed recovery and “psychotic excitement” caused by childlessness and divorce. FGM is the most serious type of sexual abuse and is considered a crime in many countries [58] (Table 2).

In addition, the narrowing of genital scarring or introitus in women with Type III FGM/C may also make speculum examination difficult or impossible. FGM/C can be treated with chronic pelvic pain, sexual dysfunction, genitourinary cysts and neuromers and infertility, surgical or non-surgical approaches. Non-surgical interventions for pelvic pain include use of lubricants, topical lidocaine and behavioral changes such as avoidance of actions that apply pressure to the vaginal region (eg cycling). Sex therapy has been successful in improving sexual function. Defibulation should be recommended for women with Type III FGM/C complications (ie, the removal of the scar of the narrowed vaginal openness) [49].

<table>
<thead>
<tr>
<th>Risk</th>
<th>Remarks</th>
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<tbody>
<tr>
<td>Immediate risks</td>
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<tr>
<td>Hemorrhage</td>
<td></td>
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<tr>
<td>Pain</td>
<td></td>
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<tr>
<td>Shock</td>
<td>Haemorrhagic, neurogenic or septic</td>
</tr>
<tr>
<td>Genital tissue swelling</td>
<td>Due to inflammatory response or local infection</td>
</tr>
<tr>
<td>Infections</td>
<td>Acute local infections; abscess formation; septicemia; genital and reproductive tract infections; urinary tract infections</td>
</tr>
<tr>
<td></td>
<td>The direct association between FGM and HIV remains unclear, although the disruption of genital tissues may increase the risk of HIV transmission.</td>
</tr>
<tr>
<td>Urination problems</td>
<td>Acute urine retention; pain passing urine; injury to the urethra</td>
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<tr>
<td>Wound healing problems</td>
<td></td>
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<tr>
<td>Death</td>
<td>Due to severe bleeding or septicemia</td>
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<td>Obstetric risks</td>
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<tr>
<td>Cesarean section</td>
<td></td>
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<tr>
<td>Postpartum hemorrhage</td>
<td>Postpartum blood loss of 500 ml or more</td>
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<tr>
<td>Episiotomy</td>
<td></td>
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</table>
Despite the increasing need for clear guidance in the treatment and care of women who have undergone genital mutilation to eliminate or abandon the application, the current efforts have not yet effectively reduced the number of women and girls who have been exposed to it, and fail to meet the health needs of millions of women who are still living with mutilation. International efforts to address the FGM have been focused on treating relevant health complications, providing care for survivors and involving health care providers as key stakeholders primarily to prevent the application. Acknowledging this obligation, the WHO developed the 2016 guide on the management of health complications of FGM [50].

<table>
<thead>
<tr>
<th>Risk</th>
<th>Remarks</th>
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<tbody>
<tr>
<td>Prolonged labour</td>
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<tr>
<td>Obstetric tears/lacerations</td>
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<td>Instrumental delivery</td>
<td></td>
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<tr>
<td>Difficult labour/dystocia</td>
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<td>Extended maternal hospital stay</td>
<td></td>
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<tr>
<td>Stillbirth and early neonatal death</td>
<td></td>
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<tr>
<td>Infant resuscitation at delivery</td>
<td></td>
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<tr>
<td><strong>Sexual functioning risks</strong></td>
<td></td>
</tr>
<tr>
<td>Dysspareunia (pain during sexual intercourse)</td>
<td>There is a higher risk of dysspareunia with type III FGM relative to types I and II</td>
</tr>
<tr>
<td>Decreased sexual satisfaction</td>
<td></td>
</tr>
<tr>
<td>Reduced sexual desire and arousal</td>
<td></td>
</tr>
<tr>
<td>Decreased lubrication during sexual intercourse</td>
<td></td>
</tr>
<tr>
<td>Reduced frequency of orgasm or anorgasmia</td>
<td></td>
</tr>
<tr>
<td><strong>Psychological risks</strong></td>
<td></td>
</tr>
<tr>
<td>Post-traumatic stress disorder (PTSD)</td>
<td></td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
</tr>
<tr>
<td><strong>Long-Term-Risks</strong></td>
<td></td>
</tr>
<tr>
<td>Genital tissue damage</td>
<td>With consequent chronic vulvar and clitoral pain</td>
</tr>
<tr>
<td>Vaginal discharge</td>
<td>Due to chronic genital tract infections</td>
</tr>
<tr>
<td>Vaginal itching</td>
<td></td>
</tr>
<tr>
<td>Menstrual problems</td>
<td>Dysmenorrhea, irregular menses and difficulty in passing menstrual blood</td>
</tr>
<tr>
<td>Reproductive tract infections</td>
<td>Can cause chronic pelvic pain</td>
</tr>
<tr>
<td>Chronic genital infections</td>
<td>Including increased risk of bacterial vaginosis</td>
</tr>
<tr>
<td>Urinary tract infections</td>
<td>Often recurrent</td>
</tr>
<tr>
<td>Painful urination</td>
<td>Due to obstruction and recurrent urinary tract infections</td>
</tr>
</tbody>
</table>

Table 2. 
FGM/C is known as a form of gender-based violence (GBV) and is a transnational human rights, gender inequality and public health problem [59]. Since the FGM constitutes a violation of human rights in terms of women and children, the universal declaration of human rights dated 1948, the international contract on civil and political rights of 1966, known as twin contracts, and the international contract on social and cultural rights, are also a reference for FGM. Moreover, considering the group exposed to the application, it should be stated that the Convention on the Prevention of All Discrimination against Women of 1979 and the 1989 Convention on the Rights of the Children's Rights is among the international resource documents [47]. The European Court of Human Rights (the ECHR emphasized that exposing a child or adult to FGM in a verdict will be a malfunction in contradiction with Article 3 of the ECHR [60].

When we look at the legal regulations at the regional level, the African Union Organization attracted attention in 1990 on children's rights and prosperity. In 2005, the African Convention on the Rights of the African Humans and Peoples, the African Women's Rights Protocol or Maputo Protocol, prohibits FGM directly under the title of "eliminating harmful practices" and the medicalization of this practice. Moreover, the African organization announced in 2019 that they launched a campaign to finish Women's Genital Mutilation and aimed to end all gender-based violence forms, including FGM by 2063 [61].

According to the report published by Equality Now in March 2020, 51 of 92 countries, in which FGM is used, prohibited this practice by enacting a direct law at the national level (see Benin, Eritrea, Guinea, Kenya, Italy, etc.) and included it in the laws of punishment, child protection, violence against women or domestic violence (see Egypt, Djibouti, Ghana, France, Germany, Australia, New Zealand, etc.) [62]. Anti-FGM laws, especially applied in 28 African countries, are widely performed by diaspora communities, and there are anti-FGM legal regulations in other states such as America, Canada, Australia, New Zealand [62]. Moreover, it is stated that FGM applications differing between countries constitute an important problem. For example, the East African community has signed the Women's Genital Mutilation Prohibition Agreement in 2016 and made transitions between the countries within the other countries- for example, it is stated that the FGM is prohibited from the age of 18 in Tanzania by changing the boundary from Kenya. In addition, the Convention on the Prevention of All Discrimination Against Women (CEDAW) and the Istanbul Convention imposes a number of obligations to the parties in this regard. First of all, in CEDAW 1st Article 1 proclaims: “According to this agreement, the phrase “distinction against women” is the recognition and use of human rights and fundamental freedoms in political, economic, social, cultural, civilized or other fields based on the equality of women and men. This will mean any discrimination, deprivation or restriction that prevents or eliminates or is based on gender.”. There is no doubt that FGM application is also included in this definition. In addition, the CEDAW Committee proposed a number of measures to take appropriate and effective measures in order to eliminate the "female mutilation in all of the parties in the recommendation decision 14. In the same way, in the recommendation of decision 31, the obligations to prevent and eliminate the harmful practices applied to women and girls to the parties also counted FGM among these practices [47].

FGM is a financial burden for countries. WHO conducted a study on the economic costs of treating FGM's health complications and found that the current costs for 27 countries where data are available cost a total of $1.4 billion for a period of one year (2018). If the prevalence of the FGM remains the same, this amount is expected to increase to 2.3 billion in 30 years (2047), which corresponds to an increase of 68% of
inertia costs. However, if countries give up the FGM, these costs will decrease by 60% in the next 30 years [63].

WHO efforts to eliminate FGM and Medicalization focus on [63]:

- Strengthening of health sector intervention: To develop and implement the guidelines, tools, training and policy in order to provide medical care and counseling to girls and women living with FGM and to communicate in order to prevent implementation;
- Evidence creation: To produce information about the reasons, results and costs of the application, including why health service providers do the application, how to leave the application, and how to look at the FGM;
- Increasing advocacy: Developing publications and advocacy tools for international, regional and local efforts to terminate the FGM (including tools to predict the potential public health benefits and cost savings of FGM and).

As a result; in the wider context of GBV, FGM/C is a transnational human rights and health problem. It is necessary to understand the complex socio-cultural necessities of this practice, to develop policies in the best way to protect women and girls from this practice and to look at them in the best way. There should be political determination to support the education of professionals related to the changes in the health system and the protection and care of children and women. Training and prevention programs that will help communities give up this harmful practice can be coordinated. The campaign to eliminate FGM should be very disciplined and includes women, teachers, school nurses, health professionals and security forces affected by FGM, but includes education and training of groups. Education related to health and well-being should be the core curriculum rather than optional. In addition, there is an urgent need to take into account the psychosocial aspects of FGM and to determine the ways where health professionals can contribute to healthcare. In addition to the effects of intercultural psychology, it is necessary to investigate women’s experiences and attitudes towards FGM. At the same time, the role, views and attitudes of men should not be ignored in our attempt to eliminate FGM within a generation.

4. Uterin evacuation

Rapid population growth is a very important issue for countries due to economic, environmental, rapid urbanization and other social problems it brings with it and is a situation that directly affects “health” as well as due to “excessive fertility” indirectly [64].

The phenomenon of population, which is extremely important in terms of health, is affected by the population policies folaborioned by countries, fertility behaviors of individuals, legal status of family planning services, and the existence, accessibility and acceptability of services even when legal. Calculations show, there will be a decrease of 30–40% of mother and child morbidity and mortality that if risky pregnancies can be prevented by family planning practices. In other words, if family planning services can be provided successfully in developing countries, approximately 30–40% of mother and infant deaths may be prevented from excessive fertility and reduction of risky pregnancies will be possible [64].
More than 500,000 women die every year due to pregnancy and birth complications, only 1% of them occur in developed countries and the remaining 99% in developing countries. Although significant developments in child health have been seen in the last twenty years, the same improvement has not been observed in maternal health. Family planning services, which can prevent at least one third of mother and child deaths, are still unreachable for 300 million couples in the world [64].

In developing countries, the mother mortality rate is 100–200 times higher than developed countries. Again, according to the current statistics information, 13% of maternal deaths are due to unhealthy miscarriage. This information indicates that at least one of every 10 mother’s deaths depends on this cause. 25 percent of the world’s population lives in countries with very strict abortion laws. This inevitably increases the application for illegal and non-secure abortive practices [64].

Undesirable pregnancies and non-secure abortions are one of the important health problems that concern women’s health in developing countries. According to the World Health Organization (WHO) estimates, 46 million women in the world resort to abortion every year, 19 millions of cases are performed under unsafe conditions, and 68,000 women die, while 5.3 million women have temporary or permanent disabilities [65].

The World Health Organization describes the non-secure abortion as the termination of unwanted pregnancy by persons void of the necessary education and skills and/or under conditions that do not comply with minimum medical standards. Unfortunately, in developing countries, women are not as lucky as in developed countries. In the majority of these countries (56%), women are forced to apply to uneducated persons due to laws that prohibit the safe abortion or try to end their pregnancy. The situation is even more grave in many Central and South American countries that apply the prohibitions of the Catholic church and in Africa due to both prohibitions and poverty. Almost all of those who want to end their pregnancy in these regions (97–100%) have to resort to non-secure, dangerous ways [66]. According to a study conducted in Turkey, “undesirable pregnancy” was the most frequent cause of having a curettage (88%) [67].

Although curettage is a fundamental component of reproductive health and sexual health services, many women face obstacles in benefiting from safe curettage services [68]. It is known that only 35 out of 1000 women between the ages of 15–44 every year can access curettage services every year. There are many reasons for social, cultural and legal reasons for women’s failure to receive such services [69]. Access to secure curettage services is considered as the basic human right, while approximately half of all curettage services worldwide are not safe [70]. Insecure curettage service is one of the attempts to end the pregnancy by herself, the absence of sufficient training and experience of the health care worker providing curettage service or the use of appropriate medical protocols [71]. Another problem is that women face the risk of stigmatization when searching for curettage service. The curettage stigmatization is defined as a common understanding that it is morally wrong and/or socially unacceptable [72]. Although curettage stigmatization is common all over the world, it may vary in relation to individual factors such as age, civilized situation and religion as well as social, legal, religious and cultural variables [73]. In the decision of the woman’s curettage, the meaning that society imposes on curettage is very effective. Curettaging women negatively affect women in physical, emotional, social and financial aspects. Curettage stigmatization may cause regret, anger, sadness, guilt and stress [74]. In a study of Shellenberg and TSUI with 4000 women who experienced curettage, 58% of women needed emotional support after the curettage [75].
The World Health Organization (WHO) publishes new directives on abortion care to protect the health of women and girls and to help prevent more than 25 million unauthorized abortions that occur every year. According to WHO, “to get safe abortion is a very important part of health services” [76]. Almost every death and injury caused by non-secure abortion can be completely prevented. WHO therefore recommends that women and girls can access abortion and family planning services when they need them. Based on the latest scientific evidence, these combined guides combine more than 50 recommendations covering clinical practice, health care provision and legal and policy interventions to support quality abortion care. Abortion is a simple and extremely safe process proposed by WHO in accordance with the duration of pregnancy and with the help of someone with the necessary knowledge and skills. However, in a tragic way, only half of all abortions take place under such conditions; Unfailed abortions cause approximately 39,000 deaths each year and cause millions of women to be hospitalized due to complications. Most of these deaths are intensified among those living in abortion-income countries, including more than 60% in Africa and 30% in Asia. The guide contains advice on many simple primary interventions that improve the quality of abortion care provided to women and girls. They include sharing tasks by a wider range of health workers. Access to medical abortion pills means that more women can receive safe abortion services and ensure that anyone who needs can access the right information about care [76].

As of 2011, all of the 189 countries in all parts of the world are provided with legal basis to terminate pregnancy for various reasons with the exception of only five (Dominican Republic, Malta, Al Salvador, Nicaragua and Chile) countries. Only in these five countries, even in order to save the mother's life, a legal abortion is not abortonioned. When we look at the differences between developed and less developed regions in terms of safe abortion services, a consistent picture with the degree of development is seen. In more than 80 percent of developed countries, economic, social reasons, women's mental or physical health conditions, fetal developmental problems, sexual assault, insects or women's life in order to protect the life of women abortion is abortonioned while the access to abortion service without any reason can be reached in 69 percent of these countries. In developing countries, these rates are 62 percent and 41 percent, respectively [77]. From 1996 to 2009, in the last years, 48 countries such as Saudi Arabia, Colombia, Jordan, Portugal, Italy, Australia, Mexico and Swithery liberalizes the abortion laws of 48 countries, while 14 countries including Poland, Dominican Republic, El Salvador, Nicaragua, Argentina, Latvia, Hungary, Hungary Congo, Iraq, Qatar, Japan, Algeria, Belize, and Panama, there are some restrictions on miscarriages. Brazil, Moldova, Vietnam and Uruguay issued new regulations in order to reduce the insecure abortion problem without going to legal arrangements [77, 78]. Although some countries, unfortunately, the latest developments in Turkey, in this direction, women to reach the safety abortion services that make it difficult to walk into the practices, but generally globally, positive developments in reaching services are seen. As a positive end, it is an example of these developments that countries such as France (2001), Denmark (2003), Sweden (2007), which have already liberal laws and have never seen insecure abortions, are an example of these developments. With these applications, the pregnancy period for legal abortion in France was increased from 12 weeks to 14 weeks, and in Denmark and Sweden, the conditions for citizenship and residence were removed. Likewise, Ekvador, who had a very limiting law in the direction of the Catholic Church's policy, put into effect the law in 2006, which enables the safe abortion service in health institutions if the pregnancy was a danger to the health or life of women or if it was
formed as a result of sexual assault. In 2006, in 2006, Colombia and Mexico City state in 2007 also enabled women to reach healthy abortion services by liberalizing their abortion laws. Especially in the laws of law in South America, women consciously played a major role in this issue. In summary, as of October 2011, 60 percent of the world’s population covering 73 countries can reach healthy and safe abortion service only on request without showing any reason; Five countries do not willingly give women the opportunity to willingly. Women in the remaining 185 countries live in countries where laws that abortion to receive healthy abortion service at different levels due to various reasons. However, the situation that needs to be emphasized here is the fact that laws do not reflect the whole truth. Despite liberal laws, women in many poor and developing countries cannot receive safe abortion service due to their conservative views of managers, biased behavior and interpretations of health personnel, economic reasons and health services or difficulties in accessing abortion drugs. Legal restrictions show one aspect of the problem. On the other hand, in spite of the laws, everyone who advocates the safe/willingness of women in terms of human rights and women and reproductive rights, along with various obstacles in front of women, has to deal with the issue in a multi-faceted way. Liberal abortion laws should be gained as indispensable rights, but then efforts should be maintained in order to ensure the conditions of women’s use of these rights. Legalization of curetage has an important role in reducing curettage stigmatization and reducing mortality and morbidity caused by curettage [66].

The view and attitude of the society in which the individual lives in the curettage stigmatization is very important. 6 of the studies in the systematic review by Yilmaz and Şahin deals with the opinion and attitude of the society. In the studies, it was determined that in societies with negative sexual intercourse, the experience of unmarried women was more negative. These people have been seen as embarrassing to their family as deprived of honor, unfaithful, murderer, malicious and individuals not suitable to marry. It has been found that curettage experiences more than once increased stigmatization. In addition, it was determined that women with curettage were exposed to more stigmatization than those who have abortion experiences. Since it is thought that a woman does not have any decisions or judgments at abortions, there are only societies that allow curettage in abortion cases. For this reason, women who want to end their pregnancy can initiate their abortion procedure by applying to non-secure pregnancy termination methods [79]. The religious view of the society is also important in curettage stigmatization. In the study of Loi et al., 89.9% of 1207 participants stated that women who experience curettage have sinned and therefore women who do not want to continue their pregnancies should give birth to their children in order not to commit sin [69, 79].

The perspective of health personnel to curettage also affects the decision to apply care and curettage. In Zorddo’s work, some of the participants described curetages “a dirty job that no one wants to do, and some stated that some of them gave women’s rights and women’s right to speak on their bodies. Italian physicians were found to be more exposed to conscientious discrimination, stigmatization and exclusion compared to physicians in Spain. Since only pregnancy was terminated in the Spanish hospitals for medical reasons, it was found that physicians in Spain did not stigmatize and did not object as much as physicians in Italy. It is stated that physicians in Italy are due to the strong religious aspects [69, 80]. In their study in Uruguay, Cárdenas et al. Reported that the stigmatization of curettage due to the legalization of curettage in Uruguay was reduced. Even after the legal of the curettage, health personnel described curettage as “dirty work, morally questionable practice” [79, 81]. In their study in Ghana, Aniteye and Ark, it was determined that the lack of laws that provide
full protection for curettage law and practitioners caused fear of stamping and legal threats [79, 82]. In the study of Kavanagh et al. In this study, health personnel stated that they did not use the phrase “curettage is against people living in the rural areas where stigmatization is high, and that they used only when the seriousness of the situation should be understood [79, 83].

Consequently, abortion, which is an important issue for women’s health, has been subjected to different interpretations throughout history in political dynamism and has been the subject of legal regulations. The right of abortion of women has developed within the framework of political relations. In the periods of population growth, abortion was encouraged through religion and state. In response to this approach, the same religious and state teachings took prohibitive measures on abortion during the periods when the population growth rate decreased. Women’s organizations started in the process of revolutions in abortion. In this process, it was seen that the understanding of sexual freedom developed with the spread of abortion and the right to have abortion [84].

It has been observed by paying strong costs that women cannot achieve freedom with the development of women’s participation in production activities and the development of sexual freedom. It has emerged that the female body has become a means of sexual exploitation through sexual emancipation. The fact that sexual freedom pose a threat to the family and society order has led to the development of prohibitive policies on abortion. The development of sexual freedom has justified a dangerous understanding aimed at destroying the family institutionally. It has been seen that the right to abortion is taken into consideration on the axis of political interests rather than the development of the understanding of freedom for women [84].

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