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Contending with Health Outcomes of Sanctioned Rituals: The Case of Puberty Rites †

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Abstract: This paper explores the rites of passage rituals as the loci of health outcomes. It highlights how religiously sanctioned practices play a central role in healthcare in defiance of the perceived private and public dichotomy that dominates the modern secular mindset. Highlighted in the chapter are African rites of passage, specifically breast "ironing", female genital mutilation/cutting (FGM/C), and child marriage. Drawing from findings of a survey of 50 respondents, the chapter illustrates how these practices exemplify how rituals invoke health concerns in Africa and amongst Africans in the diaspora. The elevation of scientific knowledge and the privatization and categorization of religious knowledge as non-scientific in the mid-19th century resulted in the separation of the cure for the physical body from the spiritual factors, thus eliciting statements like "medicine is secular" and "religion is sacred and private." In reality, however, medicine and religion have been interwoven for centuries and ancient holistic paradigms of healthcare have been present in many cultures even as society has modernized.

Keywords: religion; sexuality rituals

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1. Introduction

Cathy AbahFouda was 10 years old when her breasts began to show. Her mother who was worried that her breasts were growing too fast and that she would begin to attract boys, arranged for the breast "ironing" ritual with the hope that she would protect her daughter from early pregnancy and from shaming her family. Breast "ironing", also known as "breast flattening", is a cultural practice that is commonly found in Cameroon and it involves the massaging and pounding of young girls' breasts as soon as they develop using heated objects such as rocks, hammers, spatulas, pestles, or tight elastic bandage. Even after performing the first ritual of breast "ironing" numerous times, Cathy's breasts grew a year later. Ashamed, she began to "iron" her breasts herself. Ironically, this ritual that was intended to protect her from early pregnancy did not work as planned. She got pregnant at 16 years old and dropped out of school. However, because her breasts were badly damaged, she was unable to breastfeed her baby. She had to undergo surgery to restore her breasts. Cathy is one of the estimated thousands of girls in African diaspora communities in London, Birmingham, Manchester, Luton, Nottingham, Leicester, Sheffield, and Leeds who are or may be exposed to this ritual (Akwei 2018). Even with some arrests made in London and Birmingham, no one has been charged so far.

Meanwhile, Safi Abdullahi, a 20-year-old Ethiopian woman who currently lives in the United States, was expecting a baby. Although she visited her prenatal doctor where she was reassured that her baby was developing well, she found herself preoccupied with questions about the delivery process. "Will it hurt?" she wondered. "Will there be medicine to ease the pain?" Although she did not ask her doctor how the birth or her body would be affected by what was done to her as a child, the thought lingered in her mind (Holden 2015). As a child, Safi was circumcised. Sections of her vagina were cut away and the

whole of it sewn nearly entirely shut. She underwent the severe form of FGM/C known as infibulation. Infibulation is a procedure that is also known as *fir-oo-ni* or pharaonic *sunna* and this procedure is repeated, with infibulation often followed by defibulation.

The next time she was cut was just after her wedding day. Her new husband had been present, as required by tradition, to survey her body to ensure that she was pure and untouched. After that, she went to a doctor to open the sutures slightly so she could consummate the marriage. At her apartment in Minneapolis, Safi planned her birth and how she would ensure that the process was successful. She also planned on asking her doctor to open her up once more so she could give birth safely. What was not clear in her mind was whether the doctor would agree to perform the procedure known as defibulation after she delivered her baby, as per her desires. She was also worried that her vagina would not be sewn up again after she gave birth, as her tradition demands.

Infibulation and defibulation are known amongst the African immigrant community who lived in the Twin City of Minneapolis where she resided. Twin cities refer to the two large cities and suburbs of saint Paul's major metropolitan area, which surrounds the Mississippi, Minnesota, and St. Croix rivers in the East-central Minnesota region. As an immigrant from a country that embraces FGM/C, Safi was aware of the fact that this practice was illegal in the United States and that is why she was worried that her doctor may decline to honor her request. As will be discussed later in the paper, some doctors yield to the demands of their patients while others decline because of the existing laws against the procedure. Despite existing laws, many immigrants boldly request the procedure while others opt to return to their homeland where re-infibulation would be guaranteed. As previous findings have demonstrated, most immigrant communities in the U.S. and other diasporic communities in Europe have expressed similar experiences (Nyangweso 2014).

What is common about Cathy and Safi is the fact that they are daughters of African immigrants from Ethiopia and Cameroon and that their parents hail from communities where puberty rites are central to social status. In this paper, I explore the rites of passage as the loci of health discourse to highlight how religion and healthcare intersect. I specifically focus on how expectations related to the rites of passage define the experience of Africans and Africans in the diaspora. Specifically, puberty rites that are highlighted include breast "ironing", FGM/C, and child marriage, as they invoke both local and international discourse on health. Drawing from the social, feminist, and intersectional theoretical frameworks, the paper argues that 1. Social-cultural beliefs and practices such as puberty rites have significant health outcomes and can have a profound impact on care. 2. For a deep understanding of the health outcomes of puberty rites, one ought to explore the efficacy of health models geared towards a holistic, intersectional, and integrative approach to healing. 3. Familiarity with the cultural and religious context that informs puberty rites necessitates the adoption of a holistic, collaborative approach to health and healing amongst Africans in Africa and the diaspora. 4. For efficacy, medical training in a holistic, integrative approach is necessary.

2. Religion and Health Intersect

Often categorized as traditional or indigenous, the African sense of health and healing is informed by an indigenous holistic worldview. As described by the World Health organization, the holistic health approach refers to "the total of knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to African cultures that are used to maintain health as well as to prevent diagnose, improve or treat physical and mental illness" (WHO n.d.) It is an approach that is also called complementary or alternative medicine. Holism, a Greek word meaning all, whole, entire, and total, references the interconnectedness of factors that influence health. As an approach, holism seeks to implement a multifaceted approach to health and healing by perceiving the patient as a whole. The holistic approach takes into account the individual's psychological, sociological, and mental dimensions. It acknowledges the fact that the individual consists of body, mind, and soul as a unified total. Change in any of these affects the body equilibrium and may

result in a healthy outcome. In essence, the holistic concept of health and healing is not unique as it is intrinsically central to the theoretical foundations of nursing as articulated by Florence Nightingale who discouraged patient care that was one-dimensional. The holistic approach summarizes the psychosomatic approach to disease that contextualizes the patient's situation with specific attention to time and the cultural context. It highlights two important dimensions of health and healing—the biological and social. Understanding the intersection of these two dimensions in health and healing is crucial not just in inpatient care interaction but also in the interpretation of health outcomes (Papathanasiou et al. 2013). The African sense of health and healing recognizes this reality.

When you think about it, this approach seemed to embed an original understanding of medicine. The physician's job was to identify this imbalance and to treat the patient by restoring their body's state of equilibrium. Hippocrates' view that disease is caused by the imbalance was not unique to the Greco-Roman culture. The description of health and healing as "a disturbance in relationships" is an affirmation of health as beyond the physical, "intrapersonal" diagnosis and the treatment of body parts and organs to restore physiological functioning and biochemical processes. As argued by Sulmasy, health is a restoration of relationships that include the physical environment, family, social networks, and spiritual well-being (Sulmasy 2002, p. 29). This view has existed in medical traditions throughout the Ancient Middle East, Asia, and Africa, such as in Ayurveda, Unani, Siddha Medicine, Tibetan medicine, and traditional Chinese Medicine which view health holistically.

In Africa, illness is perceived as a sign of community imbalance resulting from sin or misdeeds. Rituals are a significant component of restoring and sustaining social harmony and communal balance. Non-adherence to prescribed rituals is perceived to trigger this social and cosmological imbalance that can result in misfortune and social and physical illness (Mbiti 1969, pp. 162–67; Olumwullah 2002, p. 68). The World Health Organization's (WHO's) definition of health captures this reality. According to WHO, health is a "state of complete physical, mental, and social well-being and not merely the absence of disease, or infirmity" and includes "the . . . total of the knowledge, skill, and practices on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health" (WHO 1946)[1].

To account for the health outcomes of any ritual, this paper argues for the return to a holistic model of medicine; a model that acknowledges the interconnectivity and the interdependence of social determinants of health. By recognizing that the whole is greater than the sum of its parts, this model accounts for optimal health in the sense that the whole person, the body, the mind, the spirit, and the emotions, is viewed as being central to health and healing. This model, which is informed by Smuts' view of the world as interconnected and interrelated, acknowledges the ritual as a symbolic interaction with health outcomes in line with naturalistic theories of disease causation (Smuts 1926). A similar model that recognizes how complex reality and behavior intersect to influence health outcomes is intersectionality as articulated by Kimberlé Crenshaw. Crenshaw argues that intersectionality as a tool of analysis helps in understanding and responding to how social issues intersect with other identities (Crenshaw 1991, p. 1299; AWID 2004). Although intersectionality does not address health specifically, by extension, it provides a framework through which health outcomes and disparities are perceived. By highlighting the complicated forms of marginalization and privileges, it presents a framework for understanding how social determinants such as culture and religion inform health outcomes. It not only helps illuminate how power structures and processes of gender and race give rise to health vulnerabilities, but it also helps in determining the drivers of specific health outcomes (Bauer 2014). The need for holistic and intersectionality approaches to health is highlighted in growing evidence in reports that suggest the need to promote health by reducing health disparities by addressing social determinants of health (WHO 2006; Hankivsky and Christoffersen 2008). The heightened attention to understanding how social determinants of health are defined by a reciprocal and complex web of social reality was acknowledged in the commission

on the social determinants of health to promote attention to the overlapping effects and simultaneity of intersecting inequities and implications (Kapilashrami and Hankivsky 2018; Holman et al. 2021). The reality of health and healing as social variables with multiple identities that are constructed and defined by social norms is fundamental in addressing health outcomes. As C. Lopez explains, intersectional and holistic knowledge provides a framework that decontextualizes biomedical frameworks that are unlikely to capture social nuances of health and healing (Lopez and Gadsden 2016). In other words, health and healing are social variables that are constructed and defined by social norms.

A deep understanding of health outcomes of puberty rites needs to examine how health models, namely the medical, the social, and the biopsychosocial, account for the varied dimensions of healthcare. The medical model that is typically embraced in modern healthcare views health as constituting the freedom from disease, pain, or defect in terms of the physical or mental impairment of the individual. Its flaws lie in the primary emphasis on the biological determinants of health at the expense of social and other determinants of health. The social model acknowledges health as a social construct. In recognizing health outcomes of social interactions, this model acknowledges the significance of social practices such as rites of passage in public health, even though on its own, it is inadequate (Armstrong and Maureen 1996; Ingstad and Whyte 1995; Susman 1994, p. 15). The biopsychosocial model that emerges as a compromise between the medical and the social model calls into question the failure of the medical and the social approaches to capture the intersection between the psychosocial components of wellness. As Imtiaz Ahmed Dogar argues, a biopsychosocial model offers a broader and more integrated approach to human behavior in addition to recognizing that "there may be important issues beyond purely biological factors" (Dogor 2007). It recognizes health as a social construct of intricate variables; the interaction of biological factors (genetic, biochemical, etc.) and psychological factors (mood, personality, behavior, etc.), and the social factors (cultural familial, socioeconomic, and medical, etc.). Recognizing this complexity is fundamental to appreciating how health outcomes are influenced by a matrix of intersecting variables. As a model, the biopsychosocial model was first articulated by the psychiatrist George L. Engel, who argued that psychological factors can cause a biological effect (Engel 1977). Despite criticism from psychiatrists like Hamid Tavakoli (2009) and sociologists like David Pilgrim (2002), this method offers a scientific method that recognizes the significance of religious values in full comprehension of health as a social reality. As Marcia Carteret validly explains, patients' health beliefs can have a profound impact on care and may impede preventive efforts, delay, or complicate medical care (Carteret 2011).

3. Research Design and Methods

The study employed a cross-sectional intersectionality methodology that drew upon a mixed research investigative approach, namely a qualitative and quantitative research design. The quantitative and qualitative research design was perceived to complement the other in providing both demographic and narrative data, which were acquired through primary and secondary sources. Investigative tools comprised in-depth interviews, questionnaires, and focused group discussion sessions involving a population sample of 60 respondents in Kenya and the African diaspora. Primary data were drawn from interviews of key informants knowledgeable in health outcomes associated with puberty rites. These comprised five doctors, specifically obstetrician-gynecologists, and five social workers who interact with survivors of puberty rites and the communities that embrace the procedure. Three of the doctors were male and two were female. Four of the social workers were female and one was male. Moreover, 30 select respondents determined through snowballing as having experiences FGM/C and breast ironing were also interviewed. Two focused group discussions (FGD) were conducted, one with five women, a second with four men, and a third with doctors and social workers who encounter survivors of these practices. Eighty percent of those interviewed expressed knowledge of FGM/C as a rite of passage embraced in some communities in Kenya. None of them expressed knowledge of breast

ironing. Eighty percent of the survivors of FGM/C interviewed did not understand the health outcomes associated with these practices.

Primary findings were supplemented with existing secondary data on the experiences of women across Africa and the diaspora. Secondary sources provided the necessary background, context, policies, legal frameworks, and guidelines upon which data were discussed. Such findings were drawn upon findings from a 2002 survey of African immigrant communities living in the United States where it was reported that 228,000 women from FGM/C communities had been exposed to this procedure or lived with the risk of exposure (Nyangweso 2014; Lopez 2013). Table 1 below illustrates the findings.

Table 1. Responses about FGM/C in the West.

Statements	*n* = 113	
	Yes (%)	No (%)
Aware of the practice of FGM/C in Industrialized countries	60	40
Know a girl/woman at risk of FGM/C	56	44
Knowledge of illegality of FGM/C amongst immigrants	70	30
Consider FGM/C a human rights violation	81	19
Believe that religion recommends FGC	25	45
Advocate eradication of FGM/C	81	19
Religious leaders can help in intervention programs	89	11
As a cultural practice, FGM/C should not be judged	30	70

Adapted from (Nyangweso 2014).

The sampling design employed was a snowball, which involved the recruitment of participants via a referral process. The inclusion criteria for the sample included specialists in reproductive health specifically concerning matters of child early marriage and female genital cutting. These included those who have experienced child or early marriage, breast ironing female genital cutting, obstetrics, and gynecology, midwives, social workers, and family practice or clinics that encounter patients with female genital cutting and child marriage. The exclusion criteria were for anyone under 18 years old and that has not experienced or encountered these reproductive health concerns. The study samples were drawn from the population in three central regions of Kenya, namely: Kilifi, Nairobi, and Eldoret. These cities offered the opportunity for fruitful cross-regional learning since the WHO has identified them as the most vulnerable to reproductive health concerns, especially fistula. The study was conducted in Kilifi, Mombasa, Nairobi, Eldoret, Elgeyo Marakwet, and Kapenguria. These regions were purposefully selected based on norms and practices that legitimize child marriage or female genital cutting. Data on breast ironing were based primarily on secondary sources describing healthcare specialists' experience with survivors of breast ironing (Pemunta 2016; Ngunshi 2011; Ndonko and Ngo'o 2006). The discussion and analysis drew upon experiences with puberty rites, specifically FGM/C, breast ironing, and child marriage as discussed in the primary and secondary data. While local cultures may differ, the selected communities share similar social, cultural, and economic experiences that informed the findings of the study. Collected data were recorded via tape and video recording, transcribed, coded, and analyzed to determine emerging patterns in the link between gender-based norms and practices and reproductive health outcomes. Symbolisms of these rituals were examined within specific contexts utilizing Arnold Van Gennep's (1960) and Victor Turner's (1964) analysis of social meanings that are conveyed. It is specifically noted that rites of passage serve to mark stages of social transitions for the individual within their social structures and that they involve acts of separating, transitioning, and incorporating the individual into a community (Van Gennep 1960). The symbolism is what Janice Boddy describes as a network of interlocking idioms and metaphors because they bring into focus social concerns such as the place of sexuality

and fertility as in the case of FGMC. The ultimate goal of practices such as these is communal harmony (Boddy 1989, pp. 49–52). Proper critique of social determinants of health should interrogate symbolisms and how they define social reality.

4. Rites of Passage in Social Context

As illustrated by the two case studies described above, puberty rites play a significant role in the African mindset. Although breast "ironing" is common in Cameroon, with 200 ethnic communities embracing the practice, it has also been reported across Africa in countries such as Benin, Chad, Ivory Coast, Guinea-Bissau, Guinea-Conakry, Kenya, Togo, and Zimbabwe. In South Africa, the practice is known as breast "sweeping" (Ngunshi 2011; Nabueze 2018). Even though the origin of breast "ironing" is unclear, some studies trace it to an ancient practice of breast massaging; a practice that was intended to help even out different breast sizes and reduce the pain of nursing mothers. After a while, it evolved into a repetitive practice with a new unique goal associated with puberty norms (Ngunshi 2011). The practice is performed mainly by mothers to protect their daughters from sexual harassment and rape and to help prevent early pregnancy that would tarnish and shame the family name. Today, the practice is justified as a way to ensure that girls pursue education rather than be forced into early marriage due to pregnancy. The rationale behind breast ironing is that, by removing the breast tissues, the young girls' bodies will be less attractive to men, thereby postponing sexual relationships and pregnancy at a young age. One anonymous British woman who went through this ritual explains how it works. "They put the spatula on the fire then they press it on the breast, and yes it hurts . . . then it goes weak, it's like melting, melting fat and you can feel the breast going back" (Bond 2016).

In Cameroon, it is estimated that around four million girls have been affected by this practice with four in ten schoolgirls affected. The practice is said to be on the increase due to the early onset of puberty. While common in Africa, the practice is drawing international concern after British parents were reported to be practicing it on their daughters. Came Women's and Girls Development Organization (CAWOGID), a community-based organization based in London, raised concerns about the practice and is currently working with London's Metropolitan Police and Service and Social Services Department to raise awareness of the practice (Pare 2016; Bond 2016). In the United States, the State Department's Human Report on Cameroon referenced reports of breast "ironing" in 2010. According to the report, the practice has resulted in burns, deformities, and psychological problems for numerous girls in the Cameroon Africans in the diaspora (Mabuse 2011).

Although Safi faced health challenges after exposure to FGM/C as described earlier, her experience is not unique and she was lucky to survive unlike Fatmata Turay, a Sierra Leonian teenager who died after she was exposed to FGM/C in an initiation ceremony in the village of Mabolleh. Her death came just days after a 10-year-old girl in Makpozou, a forested area in the south of Guinea, died in a camp where young girls are confined to perform FGM/C (Agence France—Press (AFP) 2016; Guilbert 2016). While some young women escape this practice without serious health effects, several live with the health consequences of the procedure. FGM/C, also commonly referred to as female circumcision (FC) or female genital cutting (FGC), refers generally to all procedures involving partial or total removal of part of the female genitalia or some form of injury caused to these organs for non-medical reasons. The variation in terminologies references perspectives and the medical and human rights indications of the procedure. While the term FC is preferred by communities that embrace this practice to highlight the cultural and religious values associated with the practice, WHO and healthcare specialists prefer the term female genital mutilation (FGM) to highlight health indications associated with this procedure. This term is, however, resisted in practicing communities because it implies that the procedure is savage and practiced by savage people whose intention is to harm children, a claim that is far from the truth. By emphasizing the health concerns, the term FGM overlooks or downplays the cultural and religious norms and symbolisms that are central to the practice.

The term female genital cutting (FGC) evolved, as a result, to present a more nuanced and neutral sensitivity to the values associated with the practice and to avoid judgmental overtones in discourses on the subject. Later on, the term FGM/C was preferred for the same reasons. In this work, the terminology FGM/C is adopted in recognition of the medical indications of the practice even as the cultural norms are acknowledged.

WHO classifies FGM/C procedures into four types. Type I refers to genital cutting that consists of partial or total removal of the clitoris and/or the prepuce (clitoridectomy). Type II refers to procedures that involve partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision). Type III also known as "infibulations" refer to procedures that involve excision of the clitoris as well as the narrowing of the vaginal orifice to create a covering seal by sewing together cut raw edges of the labia minora and/or the labia majora. Type IV describes all other procedures including pricking, piercing, incising, scraping, and cauterization (2018). The procedures are commonly found in 30 countries in Africa and some Asian and Middle East communities. Traditional experts, usually older women, midwives, or healers who are known as circumcisers or excises, are trained in the skill of excising and are assigned the responsibility of performing FGM/C. When undertaken according to traditional requirements, often no steps are taken to reduce the pain because the intention is to socialize the initiate to endure pain and suffering, which is a part of real life. Where practiced as a rite of passage, FGM/C serves as an initiation rite into womanhood. The age at which it is performed varies from community to community even though age specifications are no longer enforced due to criticism, community outcry against the practice, and criminalization by various governments. There are cases where toddlers and babies are exposed to this practice worldwide to evade complications related to this outcry or law enforcement. As some findings indicate, some parents have turned to hospitals or medical experts' clinics to reduce the risk associated with the procedure (Spencer 2002, p. 2; Rahman and Nahid 2001, p. 8; Wangila 2007; Nyangweso 2014).

Since young girls are given a sense that after the procedure is performed, they assume that they are ready for womanhood and marriage. Most end up in early marriage. The desire for dowry or bride motivates early marriage leading to some young girls being forced out of school so they can undergo FGM/C and be married off (Otieno 2016). Marriage as a rite of passage is celebrated because it is a step toward procreation and continuity of lineage and the survival of the entire community. FGM/C is an expression of patriarchal norms in most communities where chastity and early marriage/child marriage are allowed. Opponents of the practice tend to view it as embedded in a patriarchal social structure that sanctions male dominance. They consider it a cultural practice that is designed to control and oppress women as it is informed by patriarchal values that view women as incapable of restraining their sexual desires. Because the removal of the clitoris is associated with the control of women's sexual pleasure, feminists have described this practice as a practice that is designed to "police the womb," to ensure that a woman remains chaste to her husband in the name of honor (Daly 1978; Bonvillain 2001). It is often linked to other cultural practices such as virginity, polygamy, early and arranged marriage of girls, and widow inheritance, all of which are designed to limit women's self-realization and enhancement in life in the name of chastity and family honor (Gruenbaum 2001, p. 133). Nancy Bonvillain explains the rationale behind female genital mutilation as men's fear of and, therefore, wish to control women's sexual behavior. Women who are subjected to the procedure not only suffer from reduced sexual desire and the loss of part of their sexual organs, but they also avoid sexual intercourse for fear of the pain involved with intercourse. They are unlikely to engage in premarital or extramarital sexual activity that seems to threaten the patriarchal social systems that male-dominated ideologies legitimate (Bonvillain 2001, p. 277). Barbara S. Morrison's explanation is significant. "The female body is a symbolic construct upon which power is inscribed. While the procedure may not compromise the reproductive ability of the female, it exposes the female body to pain that permanently obliterates the sites of pleasure that constitute that female body" (Morrison 2008, p. 126). Female genital cutting is intended to protect women from a presumed

"promiscuous" lifestyle by diminishing their freedom to embrace sexual desire, enjoyment, and eventually sexual health.

Because it is rooted in patriarchal societies that assign gender roles based on the perceived superiority of men and inferiority of women, it is a violation of social equality as stipulated in the *United Nations Charter* articles 1 and 55; UDHR articles 2 and 7; ICCPR article 2; ICESCR article 2; ECHR article 14; CEDAW articles 1 and 5(a); *African (Banjul) Charter on Human and Peoples' Rights on the Rights of Women in Africa* article 2; *African Charter on the Rights and the Welfare of the Child* article 26; *American Convention on Human Rights* Article 1. In particular, it violates their right to be free from discrimination (Article 2), the right to be protected from all forms of mental and physical violence and maltreatment (Article 19(1), the right to the highest attainable standard of health (Article 24), and freedom from torture or other Cruel, Inhuman or Degrading Treatment or Punishment (Article 37). According to the United Nations Committee on CRC, discrimination against girl children is a serious violation of rights, affecting their survival and all areas of their young lives as well as restricting their capacity to contribute positively to society. Article 5(a) of CEDAW specifically states that States Parties shall take all appropriate measures:

> (a) To modify the social and cultural patterns of conduct of men and women to achieve the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or superiority of either of the sexes or stereotyped roles for men and women.

Understanding FGM/C as a patriarchal norm that poses serious health outcomes is important since these children as not mature for marriage and childbirth. Speaking on the prevalence of child marriage in Kenya, Samson Michira of Action Aid Kenya, a non-profit organization that advocates against child marriage explain how girls are perceived as a source of wealth through dowry and how FGM/C licenses marriage readiness (Otieno 2016). Among the Kuria of Kenya, for instance, parents and young girls look forward to FGM/C with passion and eagerness because the rite grants them the desired "maturity" status. Education is secondary to FGM/C and marriage celebrations. The fact that 62% of girls do not make it to high school even after enrolling fairly well in elementary school is evidence of how strong this practice is (Otieno 2016).

The social status guaranteed to the initiate is so important that some girls have forcefully sought FGM/C procedures on their own against their parents' advice. In February of 2019, for instance, Sylvia Yeko of Uganda decided to get circumcised at age 26, violating the 2010 government law, which outlawed the practice. Ms. Yeko and her anonymous friend decided to have the procedure done in public because they could not continue to bear the insult of being called a child. "During this day I felt so proud, I just felt so excited . . . Before I was circumcised, I was taken as any other child, but now I'm someone respected," she explains (BBC News 2019). Even though she knew she would face up to five years in prison for being circumcised, her identity meant so much more to her than prison. Among the Sebei community of Uganda from where she hails, a woman who has not been cut cannot go to the community granary or pick cow dung from the kraal. Cow dung, which is often used to plaster houses, is one of the tasks expected of women. In fact, "a husband can marry another wife when he realizes that his wife is not circumcised" (Byaruhanga 2019). It is because of the value placed on these practices that the prevalence of FGM/C and child marriage in Africa has persisted. According to UNICEF data, 38% of the girls in sub-Saharan Africa are married off before age 18 (Otieno 2016; UNICEF 2013). With 62% of young girls dropping out of school due to early marriage, the cultural challenge for Africa is beyond health outcomes.

Although FGM/C is illegal in most countries in the West, the practice is reported in African immigrant communities, especially in the Somali communities, like in the Twin Cities in the United States. According to the Population Reference Bureau (PRB), a nonprofit that collects data on the health variable, the Twin Cities in the United States is one of the top metropolitan areas where women and girls live with the risk of being exposed to FGM/C and its consequences. It is estimated that more than 37,000 Twin Cities women were at risk

in 2013 and the number rises to over 44,000 throughout the state. As countries in the West become culturally and religiously diverse, foreign values and practices have increasingly exerted their influence. Studies indicate that FGM/C is not only on the increase amongst African immigrants but also, women in these communities have and intend to continue the practice in their new countries (Keaton 2010; Bashir 1996). Some have sought doctors from FGM/C communities to perform the procedure while others take their children abroad to Africa where they can perform the procedure without fear of prosecution (Nyangweso 2014, pp. 2–5; Wescott 2015). In 2002, a survey of African immigrant communities living in the United States reported that 228,000 women from FGM/C had been exposed to this procedure or lived with the risk of exposure (Nyangweso 2014; Lopez 2013).

Terry Dunn, an obstetrician-gynecologist in Denver Colorado explains how parents approach physicians by saying, "I want to have the procedure that makes my daughter like me" (Odigie 2012). Carol Horowitz of Seattle Washington testified to having treated more than 20 Somali refugees, most of whom had been exposed to the more severe forms of FGM/C (Nyangweso 2014). In the Harbor Medical Center of Seattle Washington Hospital, Somali immigrants' request for symbolic forms of FGM/C known as *sunna* led to a serious discussion about cultural sensitivity. Coleman describes this exchange between a patient and her obstetrician:

> Obstetrician to a pregnant woman: "If it's a boy, do you want him circumcised?"
>
> Pregnant woman: "Yes, and also if it is a girl."

Dr. Miller explains how some patients expressed confusion about how "Americans encourage the circumcision of their sons but refuse a less invasive symbolic *sunna* for their daughters" (Coleman 1998, pp. 717–49). In Europe, it is estimated that 7 million women have been subjected to FGM/C with about 500,000 girls living with the risk. In the United Kingdom, 279,500 women had been exposed by the year 2004 with about 33,000 believed to live with the risk. The list of countries affected is long, an indicator of how serious this issue is for Africans in the diaspora (Nyangweso 2014). From the cultural perspective, it is important to appreciate the role of FGM/C in the communities where the practice is embraced. It is important to acknowledge that most mothers allow their daughters to undergo FGM/C for fear that they would not get married. They also fear the social isolation that uncircumcised girls and women endure. The discussion about health concerns of FGM/C must be interrogated within the cultural milieu of the norms behind the practice. It is even more important than the discussion should emerge within the communities that embrace the practice. Efforts to change the procedure should fall within the cultural evaluation processes that various communities experience.

While recognizing the health outcomes associated with rites of passage, this article emphasizes the need for a social-cultural analysis of these rituals in the context to appreciate their significance in the identity formation process. As Kwame Gyekye rightly observes, every society's structure defines goals, hopes, and potential for the individual (Gyekye 1997). In most African communities, individual actions are perceived in holistic and corporate understanding. John S. Mbiti, a scholar of African religions, explains how "an individual does not and cannot exist alone except corporately." He/she owes existence to other relations in the community including those of the past generation, the family, and the clan (Mbiti 1969, p. 106). Therefore, the individual's attitude and behavior are perceived to have effects on the corporate existence that is cultivated through rites of incorporation. It is society's responsibility to "make, create or produce" the individual. Rites of passage offer the individual transition processed from one stage of corporate existence to another, a process that Mbiti describes as "I am because we are, and since we are, therefore I am" (Mbiti 1969, p. 106). Kenyatta reiterates this role when he describes rites of passage as a way to instill "the moral code of the community that symbolizes" the unification of the whole community" (Kenyatta 1938/1962, p. 87). It can be argued that practices such as FGM/C, breast ironing, and marriage are symbolic systems reflecting on the communities that

embrace them. Where they are legitimized by religion, they acquire a sacred authentication for the individual.

In several communities in Africa, FGM/C is not only a cultural practice but is also legitimized by religious notions associated with natural endogeneity, bisexuality, and hermaphroditism. Some communities believe that these extraordinary characteristics are associated with the gods and that they are perceived to be expressed in the perceived bisexual nature of all humans at birth. The Dogon and Bambara of Mali, West Africa, believe that FGM/C is a necessary ritual for perfecting the sex and gender of a child. They argue that a child is born with two souls, which are inhabited by an evil power known as *wanzo*. This spirit, which is believed to cause infertility, is feared by these communities. To destroy the power of *wanzo*, the prepuce must be cut off during male circumcision and the clitoris must be cut off during female circumcision (Griaule 1965, pp. 16–29). As other findings indicate, this narrative is told in various versions in the various communities across Africa that embrace circumcision, and this is illustrative of the possible origin of mythology about FGM/C (Nyangweso 2014). Thus, male genital cutting is perceived as a ritual that is necessary for defining the masculinity of the boys by shedding away their feminine soul that is represented by a prepuce. The femininity of girls is perfected by shedding away their masculinity, which is represented by the clitoris. It is believed that if one is not cut, he/she would encounter misfortunes arising from curses and the wrath of the ancestors and the gods. Perceived misfortunes include infertility, stillbirths, the death of siblings or a spouse, incurable diseases, insanity, and even death. Since these cultural and religious beliefs have persisted in some communities, it can be argued that cultural norms contribute to the persistence of these practices.

As Africans have embraced new religions, they have referenced new forms of justifications for this practice. For instance, even though FGM/C is not mentioned in the Bible, this has found legitimacy in the Judeo-Christian values. References have been made to the practice found in around 1000 Eastern Jewish communities that are said to practice FGM/C as a way to reduce sexual sensitivity. Strabo, a Greek philosopher of the first century BCE, mentions FGM/C as a practice of Creophagi Jews. As Abu-Sahlieh explains, the Bible is also referenced in the narrative about the Virgin Mary. It is argued that she must have been exposed to FGM/C since rituals associated with this procedure include the establishment of a girl's virginity. As argued by Abu-Sahlieh, the term "Virgin Mary" means "an unmarried woman who is initiated, and therefore circumcised" (Abu-Sahlieh 2001, p. 219). In the Judeo-Christian context, therefore, virginity and chastity values not only reinforce perceptions about these practices as sanctioned by God but also imply the practice of FGM/C in those communities. Even in cases where FGM/C is not mentioned in the scripture as in the Islamic Qur'an, the practice is associated with religious values. FGM/C was a common practice in pre-Islamic Arabia, in Middle Eastern countries such as Egypt, Sudan, Yemen, and even in Arabia before Islam and has persisted in countries such as Oman, South Yemen, Libya, Algeria, Lebanon, Iraq, and Palestine (Abu-Sahlieh 2001, pp. 176–177). It is often referred to as *tathir* or *Tahara,* an Arabic word for purification. Muslim communities that embraced the practice believed that it helps to rid the woman of the "dirty surpluses that if left would hide the demon" (Abu-Sahlieh 2001, p. 143). In some communities, it is referred to as *Khitan al Sunna or al-Sunna*, which means "compliant with the tradition of Muhammad" (Abu-Sahlieh 2001, p. 11). While FGM/C is a cultural practice that precedes Islam, over time, it acquired Islamic justifications as some Muslim leaders embraced it (Nyangweso 2014). While culture and religion are factors in the persistence of the practice, other reasons include patriarchal ideals of power and reaction to the imperialistic threat to community identity concerns. Both communities in Africa and the African diaspora encounter these challenges that are worth exploring further.

5. Health Implications of Rites of Passage

Health implications associated with rites of passage are best understood within the framework described above. Studies that have been done on breast ironing describe this

condition as extremely painful and traumatic. The procedure, which is often associated with the destruction of breast glands, is said to lead to the development of cysts and abscesses, itching, infection, milk or fluid discharge, and cancer. As reported by Mabuse, some cases have resulted in burns, deformities, and psychological problems (Mabuse 2011). Cases of breast cancer caused by breast ironing have been reported by medical personnel in Cameroon (Tchoukou 2014; Ndonko and Ngo'o 2006; Pemunta 2016). In some cases, the procedure has led to the complete disappearance of breasts (Barns 2015; Pemunta 2016). Medical experts have warned that this procedure can also lead to depression and may interfere with breastfeeding (Tetchiada 2006). As Ngambouk V. Pemunta explains, some victims have suffered from personality disorders, anxiety problems, depression, and other psychiatric disorders. Emanuelle, a 23-year-old, explains how difficult it was for her to breastfeed her babies even after reverting to driver ants that she believed would inflate her breasts with their sting (Barns 2015). James, one of the male respondents, explains how his relationship with his girlfriend Lucy ended because she was ashamed of what the procedure did to her body. Her chest was completely flattened, James explains to Pemunta. "I felt like I was making love to a boy and we could not stay together," he adds (Pemunta 2016). Dr. Sinou Tchana, a gynecologist in Cameroon explains how she has seen breast glands that were destroyed due to breast ironing. One of the patients, 23 years old, had scars that remained painful fourteen years after the procedure (Tapscott 2012).

Although FGM/C is not the most dangerous of the practices affecting women's health globally, some women who are exposed to these procedures have suffered adverse and undeniable health effects. Health effects, which vary according to the type, severity, and cleanliness of the tools used, are both immediate and long-term. Immediate consequences include severe pain, urine retention, shock, hemorrhage, and infection. Hemorrhage is caused by the amputation of the clitoris, which is extremely painful due to the dense concentration of the nerves in the clitoral and the vulva areas. Most girls are routinely cut without anesthesia. In cases where there is limited access to immediate medical attention, especially in rural areas, death may result from hemorrhage. The situation is made worse when there is a reluctance to refer cases to hospitals for fear of prosecution. In most countries of origin, FGM/C is performed in unclean conditions and traditional practitioners may use scissors, razor blades, knives, broken glasses, tin lids, thorns, sharp stones, or pieces of glass, which pose high health risks.

Long-term consequences include damage to the genitalia, cysts, abscesses, Keloid, scarring, damage to the urethra, dyspareunia, difficulties with childbirth, and sexual dysfunction. Due to unclean conditions and the use of unsterilized tools, the chance of spreading life-threatening infections, such as tetanus, and sexually transmitted infections (STIs), including hepatitis B and C and HIV/AIDS is increased. Since most genital cuttings take place in group settings, where unsterilized instruments are often used on more than one person, the risk of infection is increased. Untreated lower urinary tract infections may lead to bladder and kidney infections, resulting in renal failure, septicemia, and sometimes death. In some cases, the urethra, anal sphincter, vaginal walls, or Bartholin glands may be permanently damaged during the procedure, leading to dangerous urine retention. Scars tissues (cysts or abscesses, keloids) are not only uncomfortable, but they also often lead to a slow or strained flow of urine. Tumors in the scarred vulva tissue can cause severe pain during intercourse.

Women who are exposed to type I and II of the procedures are at a lesser risk for obstetric complications than those that have undergone type III (infibulation). Infibulation is particularly harmful because it is designed to prevent vaginal intercourse (Dorkenoo 1994, p. 14). Where it is performed, sexual organs may be damaged further when the vulva is reopened after marriage and re-infibulated after the birth of each child or during separations in case of long travels. A woman who has been exposed to infibulation is left with a narrow vulva, resulting in a condition that is medically referred to as "neointroitus." This condition often leads to a strained and slowed urinary stream that may eventually cause stagnant urine and chronic ascendance of bacteria into the urinary tract, causing infections and

re-infections. Further, the small opening often inhibits gynecological examinations like pap tests and pelvic exams. Often, reproductive tract infections result from vaginal fluid and menstrual blood retention. In some cases, pelvic infections have led to sterility. Childbirth is especially difficult since it is prolonged, thus inhibiting fetal descent, which exposes most women to greater risk during vaginal deliveries. Reports indicate that these women have increased incidences of perineal tears, wound infections, episiotomy separations, postpartum hemorrhage, and sepsis. Prolonged labor increases the risk of fetal brain damage and fetal death, back pain, and painful menstruation. Some women have been reported to get severe or extensive third-degree tears involving the whole perineum of the rectum and the sphincter, resulting in vesicovaginal and rector-vaginal fistulae (openings between the vagina and the urethra or rectum) (Shell-Duncan and Hernlund 2002, p. 14). The Table 2 below outlines these health effects.

Table 2. Effects of Female Genital Mutilation/Cutting.

Short-Term Effects	Long-Term Effects
Hemorrhage Severe pain Urinary tract infection Injury to adjacent tissues Death Damage to other organs Fractures or dislocation due to restraint during the procedure	Haematocolpos Keloid formation Vulval abscess Sexual dysfunction Pregnancy and childbirth complications Psychological damage fear, anxiety flashbacks phobia depression Penetration Problems Lack of sexual response

List of effects were adapted from (Momoh 2010).

Recent studies associate obstructed labor with FGM/C and immature uterine formation in child marriages. Obstructed labor can cause fetal brain damage, the reason for many stillbirths in these women. Consequently, patients brought in with this condition end up turning to cesarean sections during childbirth, and may experience dangerous bleeding after childbirth, episiotomy, and extended hospitalization following birth. In some cases, there is infant resuscitation and maternal illness, and sometimes death after childbirth is reported. Findings from a study by Africans and international researchers verify this fact (WHO 2006). Professor Emily Banks of the National Center of Epidemiology and Population Health at Australian National University described the Community findings of a study that involved 28,393 women in 28 Obstetric centers in six African countries—-Burkina Faso, Ghana, Kenya, Nigeria, Senegal, and Sudan—-as significant since it provides the first reliable evidence on the impact of FGM/C on childbirth complications (Science Daily 2022).

Other findings associate FGM/C with serious psychological trauma, perinatal death, and economic implications. As argued by Adams et al., the economic burden of FGM/C on a nation's health systems is significant (Adam et al. 2010). Psychological effects, including anxiety and phobic behavior, have been reported in some women with recurring pain and trauma flashbacks of the procedure, especially during intercourse. Personal accounts of FGM/C reveal feelings of anxiety, terror, humiliation, betrayal, and in some cases sleeping problems. The effects have been equated to post-traumatic stress disorder (PTSD) (Buggio et al. 2019). The psychological and emotional stress is typical because the procedure is performed on very young girls, who often do not understand what the procedure involves and why it is needed in the first place. To highlight these medical complications, the WHO adopted the term female genital mutilation (FGM/C) that communicates the harm that is associated with the procedure. According to WHO, a procedure that maims any part of the female genital organ, especially the clitoris, which is an equivalent in anatomy

and physiology to the male penis, is maiming (WHO 2018). By this description, the WHO opposes any medical intervention or modification to the practice for any reason. Medicalization undermines WHO's key position on this practice as a violation of female sexual health.

Despite efforts by WHO, FGM/C has persisted both in Africa and amongst the African immigrants in the diaspora. Due to the secrecy that shrouds the practice, many serious injuries go unreported, often with tragic results. With the rising numbers of young immigrant women in the diaspora getting exposed to the procedure, medical experts are faced with the challenge of how to address outcomes of FGM/C and child marriage in these communities. As discussed in *Female Genital Cutting in Industrialized Countries: Mutilation or Cultural Tradition* (Nyangweso 2014), the challenges that medical experts in the West face are due to ignorance of the procedure and lack of training on this subject. Most medical experts find themselves in a state of bewilderment when they encounter a patient with this condition. Katherine Rausch explains how medical care for women with FGM/C in countries such as the United States is lagging and how most women do not trust doctors who appear to frown on their condition. Chances of finding a knowledgeable physician or talking about her condition are not good, she explains (Rausch 2011). With training in this area, medical doctors in the diaspora can familiarize themselves with the subject of FGM/C and child marriage as rites of passage. They will be equipped with tools for responding to women such as Safi Abdullah. Clinics such as the African Women's Healthcare in Boston in the United States founded by Dr. Nawal Nour and the Refugee Women's Health Clinic founded by Crista Johnson in Arizona, also in the United States, must be recognized for their initiatives in establishing culturally sensitive centers to address this issue. Other clinics in Trinidad, Colorado, San Manteo, California, and Seattle, Washington, and those in other countries such as Australia and the United Kingdom need to be applauded for their work (Nyangweso 2014).

6. Conclusions

In this article, I have discussed the relationship between religious practices and health outcomes. Specifically, I have argued that puberty rites not only have significant health outcomes but can also have a profound impact on care. Drawing examples from breast "ironing", FGM/C, and child marriage, the article describes how sanctioned cultural and religious practices can trigger health concerns. The article acknowledges how the dualist public and private mindset that elevated the scientific health method over spiritual health models led to the medical demarcations that have overlooked how social determinants of health and healing can have a profound impact on care. It is argued that nuanced discussion about health outcomes should take seriously the contexts within which health occurs. Familiarity with the cultural and religious values of a community is central to effective address of health. The article demonstrates the benefits of collaborative, holistic, and integrative efforts in promoting health and healing in a changing society. The need for medical training towards increasing medical experts in health outcomes of rites of passage is emphasized. Humans as agents of change ought to adapt to reality. As a sociologist, Margaret Archer argues that humans as social agents can adapt to new situations since they are the products of their agency (Archer 1988). As compelling as academic arguments are, the most appealing position is informed by ethical values that are central to promoting individual and communal welfare. These values acknowledge that the sanctity of humanity should transcend socially constructed values that hinder human flourishing.

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Note

[1] See also the Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York: World Health Organization, 19–22 June 1946 accessed at https://www.who.int/about/who-we-are/frequently-asked-questions on 30 August 2019.

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