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RESEARCH ARTICLE

Prevalence psychological impact, challenges and coping strategies of female genital mutilation among female workers in Somalia

Hodan Hassan Kahin[1*], Maymuna Sheikhs Abdullahi Abdirahman[2], Shukri Cisman Cabdi[3], Mohamud Hassan Kahin[4], Abdiladif Sheikh Abdullahi[5]

[1] *Hodan Hassan Kahin, Daffodil International University, Bangladesh*

[2] *Maymuna Sheikhs Abdullahi Abdirahman, Jazeera University, Somalia*

[3] *Shukri Cisman Cabdi, Shifa Health Sciences University, Somalia*

[4] *Mohamud Hassan Kahin, Madina Hospital, Somalia*

[5] *Abdiladif Sheikh Abdullahi, HMIS unit, Ministry of Health, Somalia*

***Corresponding author:** Hodan Hassan Kahin, hothanhassan91@gmail.com

ABSTRACT

Background: Female Genital Mutilation (FGM) is a harmful cultural practice affecting millions of women and girls worldwide, particularly in Africa, the Middle East, and Asia. Although often associated with cultural beliefs related to purity and marriageability, FGM has no medical benefits and is linked to serious physical and long-term psychological consequences. This study aimed to assess the prevalence, psychological impact, challenges, and coping strategies of FGM among female workers in Somalia. **Methods:** A mixed-methods approach was employed to provide a comprehensive understanding of the issue. The quantitative component involved a cross-sectional survey of 384 female workers to determine the prevalence and associated factors of FGM. The qualitative component included in-depth interviews with 15 participants to explore personal experiences, psychological impacts, and coping mechanisms. **Results:** The findings revealed that a large proportion of participants had undergone FGM, most commonly during early childhood, with Type II being the predominant form. Parents were identified as the primary decision-makers, and strong community influence played a significant role in sustaining the practice. A substantial number of participants reported experiencing emotional distress, and many sought psychological or emotional support. Qualitative findings highlighted that FGM is deeply rooted in cultural traditions and reinforced by social pressure. Participants described enduring physical complications, psychological trauma, and social challenges. Coping strategies included reliance on social support, religious beliefs, and personal resilience. Participants also emphasized the importance of community education and awareness in preventing the practice. **Conclusion:** FGM remains highly prevalent among female workers in Somalia and continues to impose significant physical, psychological, and social burdens. Addressing this issue requires comprehensive interventions, including community education, mental health support, and active involvement of families, community leaders, and healthcare professionals to prevent FGM and support affected women.

Keywords: Somalia, Female genital mutilation, post-traumatic stress, cultural traditions, prevention strategies, female worker

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1. Introduction

Female Genital Mutilation (FGM) is a harmful traditional practice that involves the partial or total removal of external female genitalia for non-medical reasons. It is widely recognized as a violation of human rights and a serious public health concern affecting millions of women and girls worldwide[1]. The practice is deeply rooted in cultural, social, and, in some contexts, perceived religious beliefs, where it is often associated with notions of purity, modesty, and marriageability. Despite increasing global awareness and efforts toward eradication, FGM remains highly prevalent in many parts of Africa, the Middle East, and Asia, continuing to expose women and girls to lifelong health risks and psychological trauma[2].

In Africa, FGM persists as a socially enforced norm, particularly in communities where it is considered a prerequisite for social acceptance and marital eligibility. Somalia represents one of the most affected countries globally, where the practice is nearly universal among women[3]. The most severe forms of FGM are commonly performed during early childhood, often without the consent of the individual. Deeply entrenched cultural traditions, combined with strong community pressure, continue to sustain the practice despite growing advocacy and intervention efforts[4]. As a result, many women live with long-term consequences that extend beyond physical health, affecting their emotional well-being and social functioning[5].

While the physical complications of FGM, such as infections, childbirth difficulties, and chronic pain, are well documented, the psychological impact remains less explored, particularly among adult women in the workforce[6]. Women who have undergone FGM may experience a range of psychological challenges, including anxiety, depression, post-traumatic stress symptoms, low self-esteem, and emotional distress. These psychological effects can significantly influence their quality of life, interpersonal relationships, and work performance. Female workers, in particular, may face unique challenges as they attempt to balance professional responsibilities with the lingering effects of trauma, often in environments where mental health support is limited or stigmatized[7].

In addition to psychological distress, women affected by FGM encounter various social and structural challenges, including limited access to healthcare services, lack of awareness regarding mental health, and cultural barriers that discourage open discussion of their experiences[8,9]. Many women remain silent about their suffering due to fear of stigma, social exclusion, or cultural expectations. In response, survivors often develop coping strategies to manage their experiences, such as relying on religious beliefs, seeking social support, or adopting personal resilience mechanisms. However, these coping approaches may not always be sufficient in addressing the deeper psychological consequences of FGM[10].

Despite the high prevalence of FGM in Somalia, there is a significant gap in research focusing specifically on female workers and their lived experiences, particularly in relation to psychological impact, workplace challenges, and coping mechanisms. Understanding these dimensions is essential for developing effective, culturally sensitive interventions and support systems that address both the mental health needs and social realities of affected women[11]. This study aims to assess the prevalence and psychological impact of Female Genital Mutilation among female workers in Somalia, along with associated challenges and coping strategies.

2. Methodology

2.1. Study Design

This study employed a mixed-methods approach, integrating both quantitative and qualitative techniques to comprehensively examine Female Genital Mutilation (FGM) among female workers in Somalia. The quantitative component assessed the prevalence and associated factors of FGM, while the qualitative

component explored participants' lived experiences, psychological impacts, challenges, and coping strategies in depth.

2.2. Study Area and Population

The study was conducted among female workers in Somalia aged 18 years and above, representing diverse professional sectors including healthcare, education, business, and administration. The population included women who had undergone FGM as well as those with awareness of its psychological and social impacts, allowing for a broader understanding of the issue within workplace contexts.

2.3. Sample Size and Sampling Technique

For the quantitative component, a sample size of 384 participants was determined using Cochran's formula for prevalence studies, assuming a 95% confidence level, 5% margin of error, and an estimated prevalence of 50%. Simple random sampling was employed to ensure equal probability of selection and to minimize selection bias. Participants were recruited through online survey distribution across female workers in Somalia. For the qualitative component, 15 participants were purposively selected based on their ability to provide rich and relevant insights. Interviews were conducted until data saturation was achieved, ensuring that no new themes emerged.

2.4. Data Collection Procedures

Quantitative data were collected using a structured questionnaire administered through online platforms. The questionnaire included sections on socio-demographic characteristics, FGM experience, psychological effects, challenges, and coping strategies. Participation was voluntary, and informed consent was obtained prior to data collection. Qualitative data were collected through in-depth, one-on-one interviews conducted via online communication platforms. These interviews allowed participants to freely share their personal experiences and perspectives regarding FGM.

2.5. Eligibility Criteria

Participants were selected based on predefined inclusion and exclusion criteria. Eligible participants included female workers residing in Somalia who were aged 18 years or older and willing to provide informed consent. Participants were required to have either direct experience with Female Genital Mutilation (FGM) or sufficient knowledge of its psychological and social impacts. Additionally, all participants needed to be able to communicate effectively in either Somali or English.

Individuals were excluded from the study if they were not currently working in Somalia, were below 18 years of age, or were unwilling to participate or provide informed consent.

2.6. Data Analysis

Quantitative data were analyzed using Statistical Package for the Social Sciences (SPSS). Descriptive statistics, including frequencies, percentages, mean, and standard deviation, were used to summarize the data. Findings were presented using tables, charts, and graphs. Qualitative data were analyzed using thematic analysis. Interview transcripts were reviewed multiple times to ensure familiarity with the data. Meaningful statements were coded and organized into themes reflecting psychological impacts, challenges, and coping strategies. Patterns and variations across participants were identified to provide a comprehensive understanding of their experiences.

2.7. Ethical Considerations

Ethical approval for the study was obtained from the Research Ethics Committee (REC) of the Faculty of Health and Life Sciences at Daffodil International University. Informed consent was obtained from all participants prior to data collection. Confidentiality and anonymity were strictly maintained, and participation was entirely voluntary.

3. Results

A total of 384 female workers participated in the quantitative study, along with 15 participants in the qualitative interviews. The findings are presented in tables with concise explanations highlighting key outcomes related to prevalence, characteristics, psychological impact, and support needs.

Table 1. Socio-demographic characteristics of participants (n = 384)

Variable	Category	Frequency	Percentage (%)
Age	18–25 years	127	33.1
	26–35 years	116	30.2
	36–45 years	114	29.7
	≥46 years	27	7.0
Marital status	Single	145	37.8
	Married	193	50.3
	Divorced/Widowed	46	12.0
Education	Bachelor's degree	220	57.3
	Master's degree	67	17.4
	No formal education	58	15.1
	Primary/Secondary	39	10.2
Occupation	Employee	245	63.8
	Businesswoman	139	36.2

Table 1 shows that most participants were young adults, particularly aged 18–25 years (33.1%) and 26–35 years (30.2%). The majority were married (50.3%) and highly educated, with 57.3% holding a bachelor's degree. Most respondents were employees (63.8%), indicating active workforce participation.

Table 2. Prevalence and characteristics of FGM (n = 384)

Variable	Category	Frequency	Percentage (%)
FGM status	Yes	355	92.4
	No	29	7.6
Age at FGM	Below 5 years	210	54.7
	6–10 years	135	35.2
	11–15 years	27	7.0
	Above 15 years	12	3.1
Type of FGM	Type I	125	32.6
	Type II	156	40.6
	Type III	61	15.9
	Don't know	42	10.9
Decision-maker	Parents	300	78.1
	Relatives	41	10.7
	Community pressure	34	8.9
	Others	9	2.3

Table 2 indicates a very high prevalence of FGM (92.4%) among participants. Most procedures were performed at an early age, particularly below five years (54.7%). Type II FGM was the most common (40.6%), followed by Type I (32.6%). Parents were the primary decision-makers in the majority of cases (78.1%), highlighting strong family influence.

Table 3. Attitudes and psychological impact of FGM (n = 384)

Variable	Category	Frequency	Percentage (%)
Support continuation of FGM	No	260	67.7
	Yes	98	25.5
	Not sure	26	6.8
Emotional distress	Yes	358	93.2
	No	26	6.8
Sought support	Yes	348	90.6
	No	36	9.4

Table 3 shows that the majority of participants (67.7%) did not support the continuation of FGM, indicating growing awareness. However, a considerable proportion (25.5%) still supported it. A very high percentage (93.2%) experienced emotional distress, and 90.6% sought psychological or emotional support, demonstrating the significant psychological burden.

Table 4. Perceived support needs for FGM (n = 384)

Support type	Frequency	Percentage (%)
Community awareness and education	230	59.9
Mental health counselling	92	24.0
Medical treatment	32	8.3
Legal protection	23	6.0
Others	7	1.8

Table 4 indicates that community awareness and education (59.9%) were considered the most important interventions, followed by mental health counselling (24.0%). This highlights the need for both preventive and supportive strategies.

4. Discussion

The findings of this study indicate that Female Genital Mutilation (FGM) remains highly prevalent among female workers in Somalia, with the majority of participants reporting that they had undergone the practice. This highlights the persistence of FGM despite increasing awareness, education, and workforce participation among women. Notably, a large proportion of participants had attained higher education and were actively engaged in professional roles, yet this did not significantly reduce the prevalence of FGM. This suggests that deeply rooted cultural and social norms continue to override educational and economic advancement in influencing the continuation of the practice.

The study further revealed that FGM is predominantly performed during early childhood, with most participants undergoing the procedure before the age of five. This early exposure indicates that the practice is often imposed before individuals are capable of informed consent, reinforcing its normalization within families

and communities. The findings also show that parents are the primary decision-makers, emphasizing the central role of family influence and intergenerational transmission in sustaining FGM[12].

Psychological impact emerged as one of the most significant findings of this study. A very high proportion of participants reported experiencing emotional distress related to FGM. Qualitative insights further demonstrated that women continue to experience long-term psychological consequences, including trauma, anxiety, low self-esteem, and a persistent sense of incompleteness. These findings indicate that the effects of FGM extend far beyond physical harm, deeply affecting mental health and overall well-being. The persistence of such psychological distress highlights the need for increased attention to mental health support for affected women[13].

Cultural and social pressures were identified as key drivers of the continuation of FGM. Participants described strong expectations from family members and the wider community, often linked to preserving honor, ensuring marriageability, and maintaining social acceptance. Even among those who opposed the practice, many felt unable to challenge it due to fear of rejection or social isolation. This demonstrates how FGM is sustained not only through tradition but also through powerful social enforcement mechanisms[14].

Despite these challenges, the study found evidence of a growing shift in attitudes. A majority of participants expressed opposition to the continuation of FGM, indicating increasing awareness of its harmful consequences. This shift may reflect the influence of education, exposure to global health and human rights perspectives, and increased access to information. However, the persistence of support for FGM among a portion of participants suggests that change remains gradual and uneven[15].

The findings also highlight a significant gap in institutional and healthcare support systems. Although many participants reported seeking psychological or emotional support, access to formal mental health services remains limited. As a result, many women rely on informal coping mechanisms, such as religious faith, social support, and personal resilience, to manage their experiences. While these strategies provide some level of relief, they may not adequately address the deeper psychological impacts of FGM[16].

In addition, participants identified community education and awareness as the most important strategies for addressing FGM. Increasing knowledge about the health risks and human rights implications of the practice was seen as essential for changing attitudes and behaviors. Participants also emphasized the importance of involving key stakeholders, including families, community leaders, healthcare professionals, and policymakers, in efforts to prevent FGM and support affected individuals[17].

Overall, the findings of this study demonstrate that FGM remains a complex issue influenced by cultural, social, and psychological factors. It is not only a public health concern but also a significant mental health and social issue affecting women's lives and well-being. Addressing FGM requires a comprehensive and multi-sectoral approach that includes community education, strengthened healthcare systems, legal enforcement, and the empowerment of women to challenge harmful practices.

5. Conclusion

Female Genital Mutilation (FGM) remains highly prevalent among female workers in Somalia despite education and workforce participation, reflecting the strong influence of cultural and social norms. The practice is typically performed in early childhood and is largely driven by family decisions, reinforcing its continuation across generations. FGM has profound psychological consequences, including emotional distress, trauma, and reduced self-esteem, highlighting its impact beyond physical health. Although there is a growing opposition to the practice, awareness alone is insufficient to eliminate it. Addressing FGM requires comprehensive

strategies, including community education, improved mental health support, and coordinated efforts from families, communities, and policymakers to both prevent the practice and support affected women.

6. Recommendations

Efforts to address Female Genital Mutilation (FGM) in Somalia should focus on a comprehensive and multi-sectoral approach. Community-based awareness campaigns are essential to improve understanding of the harmful physical and psychological consequences of FGM and to challenge deeply rooted cultural beliefs. There is also a need for the development and effective enforcement of legal frameworks aimed at preventing the practice. Strong policy implementation, supported by community engagement, can play a critical role in reducing its prevalence. In addition, accessible and culturally sensitive mental health services should be provided for women affected by FGM. Integrating psychological support into healthcare systems is essential to address the long-term emotional and psychological consequences experienced by survivors.

7. Strengths

This study employed a mixed-methods approach, combining quantitative and qualitative data to provide a comprehensive understanding of FGM among female workers. This design allowed for both statistical analysis and in-depth exploration of personal experiences, enhancing the overall validity of the findings. A key strength of the study is its focus on educated and working women, a group that is often underrepresented in FGM research. By examining this population, the study provides valuable insights into how FGM persists even among women with higher education and professional engagement. The qualitative component offered rich and detailed insights into participants' lived experiences, revealing important themes such as cultural pressure, intergenerational influence, and psychological distress. These findings add depth and context to the quantitative results. Furthermore, the study highlights the significant psychological impact of FGM, an area that is frequently overlooked. By emphasizing mental health outcomes, the research contributes to a more holistic understanding of the consequences of the practice.

8. Limitations

Despite its contributions, the study has several limitations. Some participants had limited knowledge about the different types of FGM, which required additional clarification during data collection and may have influenced responses. The sensitive nature of the topic also led to hesitation among some participants, potentially affecting the depth and openness of responses, particularly in the qualitative interviews. Additionally, the qualitative sample size was relatively small, which may limit the generalizability of the findings. However, efforts were made to ensure data saturation and capture diverse perspectives.

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