

Stunting? What Happens to Children Born to Women with FGM?

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It is one of the many mysteries of female genital mutilation (FGM) that few researchers are curious about whether it has a direct inter-generational impact beyond the obvious harm of the 'cutting' itself.

Daughters of women who have FGM are more likely also to undergo this cruelty - though socio-economic interventions such as more education and better income-generating opportunities mitigate the risk [1]. But the impacts and harm of FGM may be much more than those to the woman or girl alone, long-lasting, sometimes even lethal, though these may be.

Babies, boys as well as girls, born to women (and, even more tragically, to underage girls) with FGM must surely be more vulnerable to problems around health and maybe failure to thrive [2]? Are infants - boys and girls both - born to mothers with FGM more likely than others in similar 'non-FGM' demographic cohorts to experience negative health outcomes such as stunting?

Stunting is a serious medical/health condition which can occur at points in a child's development, or is sometimes permanent. It is associated with [3] inadequate infant and young child feeding, low maternal education, poverty, poor sanitation and water, and frequent illness.

The World Health Organisation (2015) [4] summarises the issues as: *Stunting is the impaired growth and development that children experience from poor nutrition, repeated infection, and inadequate psychosocial stimulation. Children are defined as stunted if their height-for-age is more than two standard deviations below the WHO Child Growth Standards median.*

Stunting in early life -- particularly in the first 1000 days from conception until the age of two...[can give rise to] impaired growth [which] has adverse functional consequences on the child. Some of those consequences include poor cognition and educational performance, low adult wages, lost productivity....

Soliman., et al. (2021) [5] add that ... *[t]he debate continues as to whether children who become stunted before age 24 months can catch up in growth and cognitive functions later in their lives. The potentially irreparable physical and neurocognitive damage that accompanies stunted growth is a major obstacle to human development.*

Child stunting is a very serious matter.

230 million 'cut' women; 150 million stunted children

At least 230 million women and girls [6] alive today have undergone FGM. We know that as of 2016 about 3 in 10 children under age five [7] were 'stunted' in low- and middle-income countries - with a higher number in West Africa and South Asia. Globally the number of stunted children [8] is round 150 million, resulting [7] in an estimated one million deaths, 3.9% of years of life lost, and 3.8% of disability-adjusted life years globally.

Whilst no reliable single figure is available, the incidence of FGM in parts of Africa and Asia is significant (maybe a quarter of all girls in West Africa [9]) compared to other areas of the world. Research also suggests that that larger families or households with more young children [10] are more likely to have stunted children. In parts of Africa family (household) size is around 7 [11] (household size in South Asia is about half [12] that).

In this paper we will consider only West Africa. Whilst there are acknowledged commonalities in causation of stunting between West Africa and South Asia, there is also significant variation, and FGM, which may sometimes be a factor, is more widespread in Africa than Asia. Africa and Asia share broad structural drivers for child stunting [13], while differing in the balance of maternal, environmental, infectious, and demographic determinants.

It may not be simple coincidence that so many infants in West Africa are probably both stunted and born to mothers with FGM. But we do not know for certain; the required data does not seem to be available. Perhaps that omission should be corrected?

Can we make any assumptions about the likely outcomes when stunted mothers with FGM give birth to stunted daughters who themselves give birth to stunting-vulnerable daughters, and so on over generations? Is there any data on how FGM, age of mother and stunting may align? Do we understand how the additional problems around fertility [14] which FGM causes may interface with possible stunting?

Do we know how local economies are impacted by these matters, and/or if they in turn influence family formation?

For instance, the parts of the world where FGM and stunting are both most likely to occur are also the regions where there are most young people. In Sub-Saharan Africa 40+% of the population is now aged below age 15 [15] - more than twice the proportion in Europe - so any future health and developmental impacts of stunting in this part of Africa could be highly significant for local economies as well as for individuals.

Where's the data?

Amongst the issues which make comparable data on stunting and FGM unavailable may be the probability that, even if proper formal clinical records exist (unlikely in e.g. rural Africa) aggregated gynaecological information about mothers is not available to correlate with infants' records. Obstetricians do not routinely share aggregated data about women's FGM status with the paediatricians who may or may not have aggregated data on the care outcomes for these women's infants.

Nor it seems do obstetricians track the impact of possible stunting through generations of women and girls who may all have undergone FGM and then developed sub-optimally, perhaps likewise stunted for life. Do any FGM factors influencing stunting have cumulative impact over generations? This is a public health issue [16]; who can determine it?

Even in formal, accurately recorded, settings, notes on a mother's FGM status are not part of her baby's clinical record except in some countries for safeguarding purposes [17]; and it is unlikely that there will be any formal collated data allowing direct examination of possible correlation between FGM in mothers and stunting in their infants - just as there is precious little evidence enabling consideration of that equally fundamental requirement, the availability of clean water [18] 'vs' incidence of FGM.

We know virtually nothing about possible interplays between FGM, stunting and water.

Studies have shown [8] that changes in maternal characteristics and circumstances - including parity, interpregnancy interval, hygiene and maternal height - may reduce the risk of stunting, but do policy makers, or clinicians, or experts in strategic development even consider whether FGM is similarly a factor in this harm?

Children

Stunting affects girls and boys alike, and can have measurable impact on the individuals concerned, on their families, and on their entire economies. Given the millions of women who experience FGM in Africa, the question of whether FGM correlates with stunting is an important policy matter.

Stunting is a critically fundamental human issue. Anything which influences the risk of babies, boys and girls alike, becoming stunted is of the highest significance socially, morally and economically.

In our (always absolutely essential) focus on the wellbeing and rights of women and girls who have undergone FGM, have we sometimes lost sight of the impact it has also on the welfare and futures of their children?

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