INTRODUCTION

It is estimated that some 140 million women, girls and babies throughout the world have been genitally mutilated. Another three million girls are at risk of such mutilation each year. Female genital mutilation (FGM) is primarily practised in 28 African countries, to a lesser extent in certain countries in Asia and the Middle East and also, as a result of migration, in Western host countries.

Although the elimination of FGM was originally regarded as a mere question of health education and information, today FGM is recognised as a socio-cultural problem that is deeply rooted within the societies in which it is practised. Thus social change is indispensable if the practice is to be ended permanently. Commitment to ending FGM is symbolic of the effort to strengthen the position of women and women's rights generally, because FGM is a serious violation of human rights, and its elimination would serve to advance virtually every one of the UN Millennium Development Goals.

CLASSIFICATION

The World Health Organization (WHO) has divided the various forms of female genital mutilation into four categories (see box). Although this lends the terminology greater uniformity and consistency, definitive classification is not always possible.

RISKS AND COMPLICATIONS OF FGM

FGM can be linked to a whole series of physical and psychological injuries, some of which arise immediately following the procedure, some later on. A 2008 WHO publication concluded that the risks and complications associated with the practice increase in proportion to the severity of the intervention. However, since health complications are only documented when those affected seek hospital treatment, which they rarely do (particularly when health problems occur immediately following the procedure), the actual extent of complications caused by FGM is not known.

IMMEDIATE HEALTH RISKS

During the procedure itself, incisions into the nerve endings and sensitive tissues of the genital region cause extreme pain, which may continue throughout the period of recovery. Anaesthesia is seldom used. Pain and/or heavy bleeding and haemorrhaging may induce shock. Swelling, oedema and pain may lead to difficulty with urination and bowel movement. Studies show that Type II FGM can result in such extreme scarring that the vaginal opening is narrowed to a degree comparable with infibulation. Non-sterilised instruments may cause infection, which in turn can result in septicemia and death. The use of the same non-sterilised instrument could increase the risk for transmission of HIV between girls who undergo female genital mutilation together.

LONG-TERM HEALTH RISKS

When nerve endings are pinched or laid bare, FGM can result in chronic pain. Further side effects are repeated urinary and bacterial vaginal infections. Several studies note increased susceptibility to genital herpes due to FGM. Bleeding during sexual intercourse, particularly in the case of women who have been infibulated, increases the risk of HIV transmission as does genital herpes, too.

FGM can reduce sexual sensitivity, diminish sexual desire and result in pain during sexual intercourse. Complications during
childbirth are documented as being more common among women who have been genitaly mutilated than among women who have not been cut. Such complications include Caesarean section, haemorrhaging following birth, and episiotomy (cutting of the vulva to facilitate childbirth). A 2006 WHO study also confirms that FGM contributes to higher rates of infant and child mortality. Of 100 newborn babies, one or two die during or shortly after childbirth due to maternal complications resulting from FGM.

FGM is a traumatic experience for many women. Among the long-term psychological consequences are fear of sexual intercourse, post-traumatic stress disorder, and depression. Women subjected to FGM may suffer psychologically despite the cultural significance and traditional roots of the practice.

In addition to the complications already named, further negative impacts on health caused by infibulation may include: surgical defibulation (reopening of the vulval orifice) to make possible sexual intercourse and/or childbirth; re-infibulation following childbirth to close the vaginal opening once more; urinary and menstrual problems caused by closing of the vaginal opening, so that surgical reopening may be required; painful sexual intercourse; and infertility due to the increased risk of infection.

FGM AS A HEALTH ISSUE For many years, negative impacts on health were at the forefront of information campaigns against FGM. The argument was that FGM was harmful to health and that it must be abandoned for this reason. This approach was based on the assumption that this sensitive issue would best be addressed without reference to religious and cultural factors.

However, the result of this approach was a ‘medicalisation’ of the practice, that is, the performance of the procedure by trained medical personnel under comparatively hygienic conditions - often a welcome source of additional income for medical staff. The authority and social status that medical personnel enjoy within the society can thus lend FGM greater respectability and permanence. In some regions, an increase in medicalisation has been observed.

Along with WHO, GIZ rejects the medicalisation of FGM, since such ‘medical’ methods in no way alter the fact that FGM is damaging to female health and a violation of human rights.

THE ROLE OF HEALTH PERSONNEL Medical personnel play a key role in efforts to end FGM, since they are well placed and qualified to inform patients and their families about the risks the practice involves. On the community level, medical staff enjoy considerable respect and act as opinion-shapers and role models. Thus they are well placed to train multipliers, participate in information and education activities and act as change agents to help bring about social change.

At the same time, medical personnel can come into conflict with their communities if their role contradicts the values and norms of the society as a whole. Further, they are often not well informed themselves about FGM and seldom have the necessary knowledge and skills to advise parents or to care for or treat women with serious complications.

This is also true in European countries, where repeated demands have been made that the issue of FGM be incorporated in medical training. In its policy guidelines for nurses and midwives, WHO specifically demands of medical personnel that they support the drive to eliminate FGM.

CONCLUSION Genital mutilation has grave consequences for the health of those affected. Years of experience have shown, however, that measures to end FGM ought not to take place in the health sector alone, since social change is needed to end the practice sustainably.

For this reason, effective information campaigns today go beyond health considerations and include the social, economic, cultural and historical aspects of the tradition. These can be taken up with the local population in a culturally sensitive manner, for example, through dialogue approaches.

Sources: