

TOPICS

ENDING FEMALE GENITAL MUTILATION



Female Genital Mutilation and HIV

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.

In the efforts to overcome genital mutilation, the question of whether or not this practice increases the risk of HIV infection

for women and girls is frequently raised. Below we will look firstly at the general risk factors for women and girls, before we go on to examine FGM as a potential additional risk factor.

BIOLOGICAL AND ANATOMICAL RISK FACTORS ■ Biological and anatomical factors mean that women run a significantly higher risk of HIV infection than men as a result of unprotected vaginal sexual intercourse. A larger area of the surface of a woman's body (the mucous membrane) is exposed to potentially infected body fluids than is the case for men, and the mucous membrane is thinner in women. The sperm of a man infected with HIV also contains a higher concentration of the human immunodeficiency virus than the sexual secretion of an infected woman, and more semen than vaginal secretion is exchanged during sexual intercourse. This explains why women are more likely to become infected.

SOCIOECONOMIC RISK FACTORS ■ Worldwide the disadvantaged position of women in society, gender-specific roles and norms, and economic factors contribute to the spread of HIV infection among women and girls.

Gender-specific roles, which for instance give women little control over their own body, can lead women to become passive and can result in them knowing too little about their sex life, the control of which is then placed in the hands of men. In numerous studies, women report that they do not dare to refuse to have sexual intercourse or to insist on safer sex. Teenage or arranged marriages prevent young women from selecting their own partners. For anatomical reasons, young girls are more at risk from HIV than older women as they are more likely to be injured during intercourse. The same applies to women and girls who are forced into sexual intercourse with the use of violence. Economic dependence and the fear of violence make it more difficult for women to assert control over their own bodies and to lay down conditions for sexual relations. Economic considerations are often the reason why young girls enter into high-risk relations with older men. Their lack of education and the generally lower level of education among girls and women than among boys and men correlate closely with their inability to protect themselves from HIV.

WORLD HEALTH ORGANIZATION CLASSIFICATION:

Type I: Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).

Type II: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).

Type III: Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).

Type IV: All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.

FGM AND HIV ■ In addition to the risk factors already listed, female genital mutilation can further raise the risk of HIV infection. The World Health Organization (WHO) states that although no direct link has yet been documented, FGM can be a risk factor in the transmission of HIV:

■ The cutting is often performed using non-sterile instruments, which can bring women into contact with infected blood. This can, under certain circumstances, increase the risk of HIV infection (WHO 2008).

■ Serious haemorrhaging immediately after the intervention but also during and after childbirth (WHO 2008) is a very common complication of FGM, which can make blood transfusions necessary. The lack of safe blood for transfusions in sub-Saharan Africa, in particular outside larger towns and cities, can also increase the risk of HIV infection.

■ Studies reveal a higher rate of genital herpes among women subjected to FGM. This can increase the risk of HIV infection since genital herpes is known to facilitate transmission of HIV (WHO 2008).

Other assumptions which would appear to point to a correlation between FGM and HIV are laid out below:

■ Injuries during sexual intercourse are one of the medium-term complications of FGM and depend on the extent of the mutilation. In the case of Type III FGM or where scarring seriously narrows the vagina, sexual intercourse can result in injuries and bleeding, which in turn increase the risk of infection. Some couples resort to anal intercourse, but unprotected anal intercourse is considered to carry a particularly high risk of infection, since the virus can penetrate the intestinal mucous membrane directly.

■ FGM can also injure glands which secrete fluids during sexual stimulation; these are essential to make the vagina moist during intercourse. If the vagina remains dry during sexual intercourse there is a higher risk of injury and HIV transmission.

MALE CIRCUMCISION AND HIV ■ Various studies demonstrate that circumcised men are up to 60% less likely to be infected by HIV than uncircumcised men. Voluntary, safe male circumcision can thus be used as part of comprehensive prevention programmes. It must, however, be used in conjunction with other methods of prevention such as education and condom use. It cannot replace these. It should be noted that the risk for women and girls of becoming infected with HIV during unprotected vaginal intercourse is not reduced because their partner is circumcised. If it were to be proven that circumcised men are more likely to indulge in high-risk behaviour, and that they use condoms less frequently, this would in fact increase the risk of infection for women.

APPROACHES ■ Education on both HIV prevention and FGM are good ways of improving knowledge about sexuality and encouraging healthy behaviour and attitudes. Moreover, information on the ways that harmful practices such as FGM can increase the risk of infection for women and girls can effectively complement information on HIV prevention. Initiatives to eradicate FGM should then also take into account the overlaps with the issue of HIV. Practical examples already exist. GIZ's HIV/AIDS mainstreaming components in Mali and Burkina Faso, for instance, already successfully integrate FGM awareness activities into their work.

CONCLUSION ■ FGM is subject to complex social, cultural and gender-specific factors, which also determine the risks of HIV infection and other sexually transmitted infections. So far the hypothesis that FGM increases the risk of HIV infection is based mainly on assumptions and on limited research results. In conjunction with biological, anatomical and socioeconomic factors, though, they appear to indicate a correlation between FGM and HIV transmission.

Sources:

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