Female genital mutilation has harmful consequences

Female genital mutilation is associated with a series of health risks and consequences. Almost all those who have undergone female genital mutilation experience pain and bleeding as a consequence of the procedure. The intervention itself is traumatic as girls are usually physically held down during the procedure (Chalmers and Hashi, 2000; Talle, 2007). Those who are infibulated often have their legs bound together for several days or weeks thereafter (Talle, 1993). Other physical and psychological health problems occur with varying frequency. Generally, the risks and complications associated with Types I, II and III are similar, but they tend to be significantly more severe and prevalent the more extensive the procedure. Immediate consequences, such as infections, are usually only documented when women seek hospital treatment. Therefore, the true extent of immediate complications is unknown (Obermeyer, 2005). Long-term consequences can include chronic pain, infections, decreased sexual enjoyment, and psychological consequences, such as post-traumatic stress disorder. (See Annex 5 for details of the main health risks and consequences).

Dangers for childbirth

Findings from a WHO multi-country study in which more than 28,000 women participated, confirm that women who had undergone genital mutilation had significantly increased risks for adverse events during childbirth. Higher incidences of caesarean section and post-partum haemorrhage were found in the women with Type I, II and III genital mutilation compared to those who had not undergone genital mutilation, and the risk increased with the severity of the procedure (WHO Study Group on Female Genital Mutilation and Obstetric Outcome, 2006).

A striking new finding from the study is that genital mutilation of mothers has negative effects on their newborn babies. Most seriously, death rates among babies during and immediately after birth were higher for those born to mothers who had undergone genital mutilation compared to those who had not: 15% higher for those whose mothers had Type I, 32% higher for those with Type II and 55% higher for those with Type III genital mutilation. It was estimated that, at the study sites, an additional one to two babies per 100 deliveries die as a result of female genital mutilation.

The consequences of genital mutilation for most women who deliver outside the hospital setting are expected to be even more severe (WHO Study Group on Female Genital Mutilation and Obstetric Outcome, 2006). The high incidence of post-partum haemorrhage, a life-threatening condition, is of particular concern where health services are weak or women cannot easily access them.

Note

In contrast to female genital mutilation, male circumcision has significant health benefits that outweigh the very low risk of complications when performed by adequately-equipped and well-trained providers in hygienic settings Circumcision has been shown to lower men's risk for HIV acquisition by about 60% (Auvert et al., 2005; Bailey et al., 2007; Gray et al., 2007) and is now recognized as an additional intervention to reduce infection in men in settings where there is a high prevalence of HIV (UNAIDS, 2007).

Health professionals must never perform female genital mutilation

"It is the mission of the physician to safeguard the health of the people."
World Medical Association Declaration of Helsinki, 1964

Trained health professionals who perform female genital mutilation are violating girls' and women's right to life, right to physical integrity, and right to health. They are also violating the fundamental medical ethic to "Do no harm". Yet, medical professionals have performed and continue to perform female genital mutilation (UNICEF, 2005a). Studies have found that, in some countries, one-third or more of women had their daughter subjected to the practice by a trained health professional (Satti et al., 2006). Evidence also shows that the trend is increasing in a number of countries (Yoder et al., 2004). In addition, female genital mutilation in the form of reinfibulation has been documented as being performed as a routine procedure after childbirth in some countries (Almroth-Berggren et al., 2001; Berggren et al., 2004, 2006). Among groups that have immigrated to Europe and North America, reports indicate that reinfibulation is occasionally performed even where it is prohibited by law (Vangen et al., 2004).

A range of factors can motivate medical professionals to perform female genital mutilation, including prospects of economic gain, pressure and a sense of duty to serve community requests (Berggren et al., 2004; Christoffersen-Deb, 2005). In countries where groups that practise female genital mutilation have emigrated, some medical personnel misuse the principles of human rights and perform reinfibulation in the name of upholding what they perceive is the patient's culture and the right of the patient to choose medical procedures, even in cases where the patient did not request it (Vangen et al., 2004; Thierfelder et al., 2005; Johansen, 2006a).

Some medical professionals, nongovernmental organizations, government officials and others consider medicalization as a harm-reduction strategy and support the notion that when the procedure is performed by a trained health professional, some of the immediate risks may be reduced (Shell-Duncan, 2001; Christoffersen-Deb, 2005). However, even when carried out by trained professionals, the procedure is not necessarily less severe, or conditions sanitary. Moreover, there is no evidence that medicalization reduces the documented obstetric or other long-term complications associated with female genital mutilation. Some have argued that medicalization is a useful or necessary first step towards total abandonment, but there is no documented evidence to support this.

There are serious risks associated with medicalization of female genital mutilation. Its performance by medical personnel may wrongly legitimize the practice as medically sound or beneficial for girls and women's health. It can also further institutionalize the procedure as medical personnel often hold power, authority, and respect in society (Budiharsana, 2004).

Medical licensing authorities and professional associations have joined the United Nations organizations in condemning actions to medicalize female genital mutilation. The International Federation of Gynecology and Obstetrics (FIGO) passed a resolution in 1994 at its General Assembly opposing the performance of female genital mutilation by obstetricians and gynaecologists, including a recommendation to "oppose any attempt to medicalize the procedure or to allow its performance, under any circumstances, in health establishments or by health professionals" (International Federation of Gynecology and Obstetrics, 1994).