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POLICY PAPER

Working towards eradicating the medicalisation of female genital mutilation/cutting

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Female genital mutilation/cutting (FGM/C) comprises all procedures that involve the partial or total removal of the external genitalia or other injury to the female genital organs for non-medical reasons. Approximately 200 million women and girls globally are estimated to be survivors of FGM/C. The practice is deeply rooted in sociocultural norms and is considered harmful and a violation of human rights that should be eliminated in all forms.

The medicalisation of FGM/C is practiced in the belief that it is a harm-reduction strategy and as such its prevalence has increased in many countries. However, there is no empirical evidence that medicalisation reduces the negative health consequences associated with FGM/C. Several countries have already legislated to ban the medicalisation of FGM/C, with mixed outcomes and limited success in reducing the practice. Further work needs to be done to eradicate FGM/C, including the medicalisation of FGM/C by challenging the cultural and social factors that support it. With efforts towards the elimination of FGM/C, and in particular its medicalisation, it is essential that a multi-pronged approach is taken when working on solutions, including at policy level. This should include human rights, health and legal perspectives.

What is female genital mutilation/cutting?

According to the World Health Organization (WHO), FGM/C comprises all procedures that involve the partial or total removal of the external genitalia or other injury to the female genital organs for non-medical reasons.

Depending on tradition, FGM/C can be performed on girls and women at any stage of their life, including during childhood, adolescence and even at some point during their reproductive age. However, there is evidence that traditions are changing and that cutting is also taking place on infants and baby girls. But the majority of girls are cut between 8 and 12 years of age. It is estimated that over 200 million women alive today have been subjected to FGM/C and that over three million girls are at risk every year. FGM/C is mainly practised in Africa, the Middle East and Southeast Asia. Nevertheless, it is important to note

that due to immigration from countries where FGM/C is the cultural norm, it has become increasingly present in Europe, Australasia and North America, and thus has become an issue of global concern.

A closer look at the sociocultural reasons under which FGM/C is practised shows how they vary significantly from one region and ethnic group to another, but they are all deeply rooted in patriarchal traditions which are oppressive to women and girls. In general, the reasons for its perpetuation can include the following:

- Conforming to social norms, tradition and as a rite of passage to adulthood and womanhood
- Securing marriageability and controlling female sexuality
- Upholding cultural norms with respect to hygiene and aesthetics
- Believing the practice has religious foundations and merit

FGM/C is a culturally embedded practice, enforced by community sanctions, often involving the discrimination of girls and women who have not been subjected to FGM/C and ostracising them from their families and communities. FGM/C is often carried out by traditional circumcisers or traditional birth attendants, who are highly respected in their communities. Yet, in recent decades, communities have increasingly been turning to health professionals to perform FGM/C, in the belief that medicalisation reduces the health risks for their girls.

IS THE MEDICALISATION OF FGM/C A WAY TO REDUCE HARM OR A HUMAN RIGHTS ABUSE?

Medicalisation creates the impression that FGM/C can be performed safely and is condoned by respected medical professionals, reducing the motivation of parents to abandon the practice. This eventually could lead to the legitimation and institutionalisation of FGM/C. It is believed that medicalisation of FGM/C will have a negative impact on the gains achieved in the campaigns to abandon the practice.

Whilst not empirically proven, medicalised FGM/C is believed to minimise (though, not avoid) some of the short-term physical consequences of FGM/C. However, FGM/C itself has no perceived health benefits, and women have to live with the effects of FGM/C for the rest of their lives. Moreover, some of the long-term effects, such as mental health implications, are poorly understood. Additionally, health professionals performing FGM/C in order to provide a safer setting for the procedure are ignoring the human rights issues associated with FGM/C, including the right to freedom from violence and discrimination, amongst others.

Medicalised FGM/C is often believed to involve less invasive forms of FGM/C and/or have less negative health consequences. If medicalised FGM/C is carried out in a sterile environment, by trained professionals and with anaesthetics, the acute complications can be minimised, although the opposite has also been documented. In Indonesia, for instance, there is anecdotal evidence that midwives are performing more invasive and painful forms of FGM/C than traditional practitioners.

The World Health Organization (WHO) distinguishes four main categories of FGM/C:

- **Type I**: partial or total removal of the clitoris and/or the prepuce.
- **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 by creating a covering seal by cutting and re-positioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation). If performed after giving birth this form of FGM/C is known as reinfibulation.
- **Type IV**: all other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.

FGM/C does not have any health benefits. On the contrary, it results in many adverse health outcomes, and is the cause of many immediate health consequences such as death, pain and bleeding as well as long-term effects, including, but not limited to: urinary difficulties, fistula, menstrual problems, sexual dysfunction, fertility issues, and pregnancy-related complications, including stillbirths and mental health difficulties.

For the reasons presented above, FGM/C is internationally recognised as a form of sexual and gender-based violence and as such is a violation of women's human rights, constituting a severe form of discrimination against women and girls. All forms of FGM/C, including medicalised FGM/C, are classified as a form of torture and an inhumane procedure that is prohibited by international law and conventions.

REFLECTING A SOCIAL NORM AND USED TO JUSTIFY FINANCIAL GAIN

Health professionals who carry out medicalised FGM/C often share the same social norms and beliefs regarding FGM/C as the communities they are working in, and resisting the pressure and demand from the community to carry out the procedure might be challenging. This has been exemplified through a study in Nigeria, which showed that four out of five health professionals who performed FGM/C had also cut their own daughters. Additionally, another study from Sudan concluded that medicalisation is mainly fuelled by the demand from communities that medical professionals serve.

The capacity to make financial gains for both health professionals and the girls' families by performing FGM/C is also relevant, as FGM/C can bring extra income to the health care professional and ensure a higher bride price when the girl gets married. Health professionals' motivation is potentially reinforced by the fact that money obtained by performing FGM/C can become a source of income for themselves.

What is the medicalisation of female genital mutilation/cutting?

The WHO defines FGM/C medicalisation as those situations in which FGM/C is practised by any category of health professionals, whether in a public or a private clinic, at home or elsewhere, at any point in a woman's or girl's life.

Medicalisation of FGM/C is escalating in many countries despite the growing number of states legislating against the practice. It is estimated that around 16 million women between the ages of 15 and 49 living with FGM/C report having been cut by a medical professional. According to UNFPA, medicalisation rates of FGM/C are above 10% in 8 countries amongst girls aged under 14 years (Djibouti, Egypt, Guinea, Iraq, Kenya, Nigeria, Sudan and Yemen). Medicalisation of FGM/C amongst girls aged under 14 years is particularly high in Egypt where 78% of FGM/C on this cohort was performed by a healthcare professional, 77% in Sudan and 31% in Guinea. In Indonesia 62% of girls under the age of 11 years living in urban areas have been subjected to medicalised FGM/C.

This increase in cases of medicalised FGM/C has been mainly attributed to the fact that the early campaigns against FGM/C were centred on stressing the negative health consequences of the practice,

the so-called health approach to ending FGM/C. It is speculated that this approach has unintentionally led to the medicalisation of FGM/C as a means of reducing the harmful effects of FGM/C when performed by a health professional.

United Nations organisations, including the United Nations Population Fund (UNFPA) and the WHO, healthcare professional associations and civil society organisations, such as the END FGM European Network, have taken a clear stance against medicalisation and deemed the practice unacceptable, highlighting the importance of stopping medicalisation if FGM/C is to be eradicated. However, despite strong consensus between global expert bodies, the rise in medicalisation rates shows that it is not a straightforward issue that can easily be resolved.

There are still ongoing debates around FGM/C and its medicalisation that stem from the fact that people want to comply with social norms supporting FGM/C, but want to do so safely. Likewise, health professionals do it because they are part of the community and share these same social norms, and/or for financial gain as health systems in some of these high-prevalence countries are very fragile.

WHEN IS FGM/C DEFINED AS A MEDICALISED FORM OF FGM/C?

Medicalisation is not always defined in the same way. It is sometimes considered to include less invasive types of FGM/C, such as pricking, promoting them as 'harm reduction' procedures and often documented in Africa as well as countries in the global North. There is also some discussion on whether the use of medical instruments, antibiotics and/or anaesthetics by traditional practitioners should be considered as a form of medicalised FGM/C. Data on this is notably lacking, and only anecdotal evidence is available.

Finally, it is also important to note the difficulty of proving medicalised FGM/C in a court of law. A good example of this is a court case in the UK in which a doctor was prosecuted, but not convicted, for the reinfibulation of a woman following the birth of her baby. He stated the operation was necessary to stop the woman from bleeding heavily.

Recommendations for ending the medicalisation of female genital mutilation/cutting Considering the debates surrounding medicalised FGM/C, ANSER is putting forward the following policy recommendations:

- Implement existing human rights legislation to safeguard girls' and women's bodily integrity and protect their human rights. The UN Special Report on Torture (2008), the African Charter on Human and People's Rights (The Banjul Charter), the Protocol on the Rights of Women in Africa (Maputo Protocol), the African Charter on the Rights and Welfare of the Child, the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention), and the European Convention for the Protection of Human Rights and Fundamental Freedoms, can be a basis to start from.
- Include FGM/C and the human rights violations of the practice, even if done by health professionals, in the curricula of health professionals to create awareness of the practice and its consequences as well as to encourage adherence to FGM/C protocols, guidelines and legislation.
- Ensure health professionals are given the tools and training to untangle professional norms from their personal perceptions regarding FGM/C, to understand how performing FGM/C

breaches their Hippocratic Oath and non-maleficence principle, and to uphold the 'do no harm' principle.

- Acknowledge health care providers as role models, respected members of their communities and strong agents of change for ending medicalised and traditional FGM/C, and support them to reach out to legal stakeholders, religious leaders, community leaders and the general public.
- Provide resources and financing to carry out research on the medicalisation of FGM/C. Generating evidence-based information will assist in guiding public policies and programmes that contribute to the ending of FGM/C and its medicalisation.

CULTURAL RIGHTS VERSUS HUMAN RIGHTS?

Because FGM/C is strongly embedded in traditional and cultural norms it poses a serious challenge to the implementation of legislation that aims to protect the human rights of women and girls by criminalising FGM/C. This has been demonstrated in Kenya, where some communities claim that their cultural right to perform FGM/C takes precedence over the law banning FGM/C. FGM/C is considered by many as a cultural right, which makes it resistant to any calls to respect the rights of women and girls, as the rights of females are considered subordinate to the cultural rights of the community in general. Using the argument of the protection of cultural and traditional rights, any legal framework aimed at ending FGM/C gets diluted. This underscores the importance of sensitising and creating awareness among FGM/C-practising communities about the human rights implications of the practice, rather than just relying on a legal approach.

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