



The Medicalisation of FGM

Authors: Louise Robertson and Michelle Szaraz

Lead Editor: Danica Issell

Contributors: Emma Lightowlers, Dr Brad K Mazon, Dr Ann-Marie Wilson

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A counsellor tries to convince a group of women that they should not have Female Genital Mutilation performed on their daughters in Minia, Egypt. (Reuters 2007)



Executive Summary

Female Genital Mutilation (FGM) is an extreme form of gender-based violence that affects at least 200 million women and girls worldwide¹. Four main types of FGM are recognised by the World Health Organization (WHO), with Types I and II accounting for approximately 80% of all cases².

One of the challenges of the current worldwide campaign against FGM is the trend of medicalisation; that is, attempting to minimise health risks associated with the FGM

¹ UNICEF, 2016

² WHO, 2008, p.4

procedure by having it performed by healthcare providers or medically trained traditional cutters, either within or outside a health facility. An argument for the medicalisation of FGM is that it provides a safer procedure in areas where complete eradication of FGM has not yet been achieved. However, although medicalisation can contribute to the reduction of immediate risks such as infection and pain, it fails to eliminate long-term gynaecological and obstetric complications, as well as life-long emotional, psychological and sexual problems. The death of Soheir Al Bataa in Egypt in 2013 shows that even when carried out by medical professionals, FGM can still result in fatalities. What is more, carrying out FGM violates the principles of professional health ethics 'to do no harm', and constitutes a violation of girls' and women's rights.

The increasing incidence of medicalised FGM in many countries is a great concern. Consequently, it has been addressed through global intergovernmental cooperation alongside non-governmental organisations, including the WHO and UNICEF. However, more needs to be done to ensure that laws and programmes against FGM are based on zero tolerance of all forms of the practice. A more sustainable approach to eliminating FGM needs to be adopted, that takes into account not only the medical concerns, but also the human-rights aspects of FGM. Additionally, NGO staff and healthcare professionals need to be educated in relation to the problems associated with medicalised FGM, and given clear guidelines on how to act in situations which may arise.

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Abbreviations List

AIDS	Acquired Immunodeficiency Syndrome
FGM	Female Genital Mutilation
HIV	Human Immunodeficiency Virus
NGO(s)	Non-governmental organisation(s)
UK	United Kingdom
UNICEF	United Nations Children's Fund
USA	United States of America
WHO	World Health Organisation

What is FGM?

According to the World Health Organization (WHO), female genital mutilation (FGM) refers to any procedure involving total or partial removal of the external female genitalia or other injury to the female genitals for non-therapeutic reasons, such as custom and cultural, religious, social or other beliefs³. By inducing ‘an irreversible reduction of human capacity’⁴, FGM constitutes an extreme form of gender-based violence and an abuse of the rights of women and girls⁵.

It is estimated that at least 200 million women and girls currently live with the consequences of this practice⁶. Carried out on females of various ages, from newborns to women about to be married, FGM is prevalent in 28 countries in Africa, alongside some communities in the Middle East and Asia, as well as within certain ethnic groups in Central and South America⁷. As many as 80 to 90% of girls and women undergo FGM in some of these countries; for example, in Egypt, Eritrea, Ethiopia, The Gambia, Mali, Sierra Leone, Somalia and Sudan⁸. However, FGM is not a phenomenon that is limited to the above-mentioned geographical regions. Increasingly, other countries are faced with the challenge of FGM within diasporas in Europe, the USA, Canada, Australia and New Zealand⁹.

Four main types of FGM are recognised by the WHO, based on the extent to which female genitalia is altered during the procedure (See Table 1). The type of FGM performed and its prevalence among the female population are country specific and vary according to context. It is estimated that the majority of FGM procedures consists of Types I and II, accounting for approximately 80% of all cases. In contrast, the most extreme form, infibulation, represents around 15% of all cases¹⁰.

³ WHO, 2014

⁴ Refaat, 2009, p.1379

⁵ WHO, 2014

⁶ UNICEF, 2016

⁷ Serour, 2013; WHO, 2016

⁸ Krása, 2010

⁹ Human Rights Watch, 2010

¹⁰ Leye et al, 2008

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). Note also that the term 'excision' is sometimes used as a general term covering all types of FGM.
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

Table 1: Types of FGM¹¹

Various reasonings exist within communities performing FGM and among its defenders, usually reflecting a mix of cultural, religious and social arguments¹². In many societies FGM is a deeply-rooted custom or tradition, considered to be a part of the cultural heritage of a community. Commonly, a girl cannot be considered an adult and get married without undergoing FGM, which is performed to define her gender and/or ethnic identity¹³. By being cut, a girl becomes a woman and demonstrates her transition into adulthood along with her readiness to take on the roles of wife and mother¹⁴. Another reason why parents might expose their daughter to such a painful and dangerous procedure is the belief that it will protect her virginity and chastity, thus ensuring her marriageability and the family's honour¹⁵. Furthermore, FGM is used to control women's sexuality and to enhance men's sexual pleasure, although aesthetics, cleanliness and hygiene are also reasons regularly given to justify this practice¹⁶.

¹¹ WHO, 2008, p.4

¹² Krása, 2010

¹³ Jones, Ehiri and Anyanwu, 2004; Ruderman, 2013, p.97

¹⁴ Jones, Ehiri and Anyanwu, 2004

¹⁵ Serour, 2013; Boseley, 2014

¹⁶ Serour, 2013

FGM can cause:
Severe pain
Haemorrhage/bleeding
Infection
Shock
Death

FGM increases
the risk of:
Infertility
Miscarriage
Obstructed labour
Child and maternal
mortality

Psychologically FGM
causes:
Depression
Anxiety,
PTSD and flashbacks,
Sex and relationship
problems

Longer term
FGM can lead to:
Tissue scarring
Cysts
Difficult & painful
sexual intercourse

FGM can also cause:
Fistula and incontinence
Painful menstruation
Difficulty passing
urine/menstrual blood
Urinary tract infections

What is the Medicalisation of FGM?

One of the main challenges of the current worldwide campaign against FGM is the trend of medicalisation. Medicalised FGM has been defined by the WHO as FGM carried out by a member of any category of healthcare provider, regardless of the setting in which the procedure takes place¹⁷. This report adopts a less-restricted definition; accordingly, the medicalisation of FGM also refers to situations where only the health risks associated with FGM are addressed, in order to minimise them, and the other issues surrounding the practice are ignored or downplayed. Therefore, medicalisation includes, but is not limited to:

- facilitating access to sterile medical equipment and products that are used in an attempt to perform the cutting in a more hygienic and less painful way;
- providing medical training to traditional cutters or any other persons who carry out the procedure;
- having healthcare personnel, such as doctors, midwives or nurses (Healthcare Providers) perform the FGM procedure, whether within or outside of a clinical facility; and
- replacing severe forms of FGM, such as infibulation, with more symbolic types of cutting to reduce the health complications associated with Type III cutting.

To a certain extent, the growing trend of practising medicalised FGM has, paradoxically, its origins in the global campaigns against FGM and HIV/AIDS. To be precise, emphasising the immediate and long-term health risks of FGM unintentionally led numerous parents and relatives to seek safer procedures, rather than abandoning the practice altogether¹⁸. As a result of such campaigns, diverse communities around the world now believe that performing medicalised FGM is an appropriate and sufficient

¹⁷ WHO, 2010, p.2

¹⁸ UNICEF, 2013; Njue and Askew, 2004, p.2).

response to the health risks associated with the practice¹⁹. Consequently, in recent years, the medicalisation of FGM has taken place in multiple countries, particularly in Egypt, Indonesia, Kenya, Malaysia, Mali, Nigeria, Northern Sudan, and Yemen, and in many of these countries one-third or more of women had their daughters cut by trained medical staff²⁰.

Distribution of medical equipment and products

One of the ways FGM is medicalised is through the provision of access to sterile tools, anaesthetics and antibiotics²¹. In certain situations, this is facilitated by international non-governmental organisation (NGO) employees who seek to eliminate unnecessary suffering, often without the knowledge or approval of their organisation. For instance, in 1999 a humanitarian NGO, Doctors Without Borders, publicly distanced itself from the individual actions of a number of its field-based staff, who assisted with an FGM procedure, intending to eliminate the immediate health risks²².

By strongly opposing any form of FGM and recognising it as a human-rights violation, Doctors Without Borders joined the majority of international NGOs, which promote a zero-tolerance policy on FGM, insisting that all forms of cutting must be eradicated without any intermediate measures²³.

Although the distribution of tools and drugs by some NGO staff stems from compassion and good intentions, such actions undermine international efforts to terminate the practice.

¹⁹ Njue and Askew, 2004, p.22

²⁰ Serour, 2013, p.147

²¹ Shell-Duncan, 2001, p.1014

²² Serour, 2013, p.147

²³ Shell-Duncan, 2001, p.1021

Medically trained traditional cutters using sterile tools and anaesthetics

One of the options available to family members wishing to have their female relative undergo FGM is to seek a traditional cutter who has been trained to deliver a safer and more hygienic cutting. Njue and Askew²⁴ note that, in certain communities, traditional healers or circumcisers have been provided with basic medical training and now increasingly use clean razor blades, scalpels or scissors. In order to prevent infections and the spread of AIDS/HIV, they dispose of the tools after each cutting rather than using them repeatedly. Also, when FGM is carried out in the traditional way, without anaesthetics and sterile equipment, medically trained personnel are increasingly approached to provide anti-tetanus injections or post-operative care.

Healthcare professionals performing the FGM procedure

Some parents nowadays prefer medical staff to carry out the procedure²⁵. They believe there is less risk involved because the Healthcare Providers guarantee the use of sterile equipment, which helps to prevent infection, and anaesthetics to mitigate immediate pain and reduce the amount of cut tissue²⁶.

Contrary to common assumptions, Healthcare Providers performing FGM is not a modern phenomenon. Midwives in Sudan and Somalia have been trained to make cutting safer at least since the 1970s²⁷. However, recently there has been an increase in the number of cases of doctors, midwives and nurses carrying out the procedure²⁸. In spite of the illegality of the procedure, some Healthcare Providers are willing to perform the cutting for economic or material gain, and families are often willing to pay for a safer

²⁴ 2004, pp.3&14

²⁵ Urwin, 2015

²⁶ Njue and Askew, 2004, p.3; Pearce and Bewley, 2014

²⁷ Shell-Duncan, 2001, p.1018

²⁸ Njue and Askew, 2004, p.11

procedure²⁹. Healthcare Providers may also carry out the procedure as a result of pressure from their community to show respect for tradition, culture and custom³⁰.

Substitution of severe types of FGM with more symbolic forms of cutting

The medicalisation of FGM also manifests as more symbolic procedures, instead of the severe forms of cutting such as infibulation³¹. In the 1990s, efforts were made by governments and medical bodies in certain countries, such as the Netherlands and the USA, to promote painless and safe 'psychological circumcision'. Precisely, it was suggested that nicking or pricking of the clitoris's tip, without removing any tissue, would serve as an alternative to infibulation and thus would help to reduce health risks³². Despite domestic and international campaigns against this approach, more symbolic forms of cutting are still taking place in certain communities³³ and some medical professionals continue to argue that less severe forms of FGM can help to protect girls and women from greater harm³⁴.

²⁹ Njue and Askew, 2004, p.13

³⁰ Njue and Askew, 2004, p.13

³¹ Pearce and Bewley, 2014

³² Shell-Duncan, 2001, p.1018; Njue and Askew, 2004, p.3; Urwin, 2015

³³ Shell-Duncan, 2001, p.1019

³⁴ Arora and Jacobs, 2016

The Medicalisation of FGM in Practice

A study of the trends associated with FGM within the Abagusii community in Nyanza Province in Kenya³⁵ provides a valuable insight into one of the ways in which medicalised FGM is carried out. Multiple interviews with members of the Abagusii community and Healthcare Providers from Nyanza Province confirmed that when a family decides to have their daughter cut, they usually negotiate directly with a member of medical staff for a girl to be admitted to hospital under the pretext of a disease such as malaria. The patient's stay lasts between a few hours and several days, depending on what type of FGM is carried out. The study also revealed instances of nurses carrying out the procedure without the knowledge of other health personnel or management staff. However, it is more common to have a Healthcare Provider carry out the procedure, often during their annual leave, at a girl's home at night, in order to keep the practice secret due to its illegal status³⁶.

Within Western countries, where it might be more difficult to have the procedure performed, parents from diasporas have the option of taking their daughters abroad in order to have them cut in their country of origin or where FGM is more likely to go unnoticed by authorities³⁷. In the past few years, experts have been warning that girls residing in Western countries such as the UK are being taken to Dubai and Singapore to undergo the procedure³⁸.

³⁵ Njue and Askew, 2004

³⁶ Shell-Duncan, 2001, p.1018; Njue and Askew, 2004, p.13

³⁷ Topping, 2014; Njue and Askew, 2004, p.13

³⁸ Urwin, 2015

Arguments Used to Support Medicalisation

One of the main reasons given in support of the medicalisation of FGM is that it is a ‘harm-reduction strategy’ – a concept that the promotion of safer alternatives can help to reduce health risks associated with risky behaviours. For example, in order to minimise the risk of becoming infected with HIV/AIDS, intravenous drug users can be provided with sterile needles³⁹. In the context of FGM, harm-reduction reflects a belief that, since FGM cannot be immediately eliminated in certain areas, it is essential and humane to ensure that the procedure is as painless and medically safe as possible, until its complete eradication takes place⁴⁰. In other words, the ‘compassionate approach’ is to improve the situation of affected girls and women where the abandonment of FGM is not currently achievable⁴¹.

Defenders of this strategy argue that medicalised FGM decreases the risk of complications by ensuring that the procedure is carried out in a more hygienic setting, by a trained cutter who uses anaesthetics to reduce pain and the amount of tissue cut due to swelling. Furthermore, the medicalisation of FGM arguably increases the likelihood of milder versions of cutting being performed instead of infibulation, which is related to more severe and life-long gynaecological and obstetric complications⁴².

As the following section demonstrates, in spite of its perceived positive impacts, the medicalisation of FGM is not an appropriate response to the health risks associated with FGM. All FGM still causes a variety of negative outcomes for the health and psychological well-being of women and girls, as well as for the international efforts to empower women around the world.

³⁹ Shell-Duncan, 2001, p.1013; Ruderman, 2013

⁴⁰ Shell-Duncan, 2001, p.1013; Krása, 2010; Pearce and Bewley, 2014

⁴¹ Shell-Duncan, 2001, p.1013

⁴² Shell-Duncan, 2001, p.1014; Pearce and Bewley, 2014

Arguments Against the Medicalisation of FGM

Threat to the health and well-being of women and girls

FGM is a traumatic experience that may lead to a variety of physical and psychological complications⁴³. In many cases, it not only causes short-term, but also long-term health issues that may threaten the lives of a woman and her unborn child⁴⁴. While the health risks may vary for each type of performed procedure, the WHO⁴⁵ states that all types of FGM are responsible for the following immediate complications: haemorrhaging (bleeding), infection, severe pain, shock, urine retention and death. Long-term health risks related to Types I and II include tissue scarring and cysts, while Type III can also cause fistula, incontinence, dysmenorrhea (painful menstruation), difficulty passing urine and menstrual blood, urinary tract infections, infertility, painful intercourse and obstructed labour⁴⁶. Additionally, among women who have undergone FGM, there is an increased risk of miscarriage and birth defects, as well as a greater likelihood of child and maternal mortality⁴⁷.

While the medicalisation of FGM can contribute to the reduction of acute risks such as pain or the spread of infections, it fails to eliminate long-term gynaecological and obstetric problems. Therefore, if the procedure is carried out by Healthcare Professionals, the incidence of complications may be reduced, but not completely avoided⁴⁸. What is more, medicalising FGM does not result in a diminished risk of long-term emotional, psychological and sexual problems triggered by the traumatic experience

⁴³ Serour, 2013, p.146

⁴⁴ Serour, 2013, p.146

⁴⁵ cited in Jones, Ehiri and Anyanwu, 2004

⁴⁶ Serour, 2013, p.146; Boseley, 2014; 28 Too Many, 2013, pp.13-14; Jones, Ehiri and Anyanwu, 2004; Shell-Duncan, 2001, p.1016

⁴⁷ Derby, 2004

⁴⁸ Serour, 2013, pp.146-147

of being cut⁴⁹. In other words, while the medicalisation of FGM might help to minimise immediate pain and infections, it does little to prevent the feelings of anxiety, betrayal, depression, low self-esteem, panic, phobia and other psychological issues that the cutting may trigger⁵⁰.

Furthermore, even if the medicalisation of FGM could guarantee a risk-free cutting carried out under controlled and sterile conditions, it is unlikely that women and girls living in poor rural communities, where the practice is the most prevalent, would have access to medicalised FGM⁵¹.

Human rights violation

The FGM procedure creates an irreversible violation of girls' and women's bodies⁵². That is why it has been recognised internationally as an extreme form of gender-based violence, reflecting attempts to control women's sexuality and behaviour⁵³. The United Nations views FGM as a form of torture and a cruel, inhumane and degrading treatment of girls and women, as well as a violation of their rights to health, security, physical integrity and, when the procedure results in death, their right to life⁵⁴.

Additionally, FGM is, in certain communities, linked to other forms of gender inequality and abuses of women's and girls' rights, such as early marriage. FGM can either be a prerequisite for marriage or may follow soon after a wedding⁵⁵. Therefore, girls that undergo the FGM procedure at an early age may be at greater risk of being subsequently married. Additionally, both FGM and early marriage not only stem from gender inequality and attempts to control female sexuality, but they also hamper the future educational, social and economic opportunities of affected women and girls⁵⁶.

⁴⁹ Derby, 2004; Njue and Askew, 2004, p.3

⁵⁰ Derby, 2004; NHS, 2014

⁵¹ Derby, 2004

⁵² WHO, 2014

⁵³ Serour, 2013, p.146

⁵⁴ WHO, 2014; RCM *et al*, 2013; Serour, 2013, p.148

⁵⁵ World Vision, 2014, p.4

⁵⁶ World Vision, 2014, p.4

The medicalisation of FGM does not address the human-rights aspect of the practice. Rather than helping to abolish FGM, responding to the medical threats related to the cutting and minimising them helps to keep the practice in place. Nonetheless, cultural norms or customs can be abandoned or modified over time to adopt new beliefs and practices. This is well demonstrated by the pre-20th-century Western medical practice of carrying out FGM to address certain pathologies, until the belief in its efficacy vanished and this ‘medical treatment’ was abandoned⁵⁷.

An example of a more sustainable approach to tackling FGM that can be effective where FGM is regarded as a rite of passage into adulthood is not medicalising the practice, but implementing an alternative ceremony/ritual that eliminates harmful customs while preserving the positive cultural and traditional elements. To illustrate, in one Maasai community in Kenya, some girls now have their heads shaved and milk poured on their thighs to symbolise their transformation from girls into women, rather than undergoing FGM for the same purpose⁵⁸. To support the move away from FGM, many alternative-rite-of-passage approaches are combined with community education on FGM and an emphasis on girls’ education⁵⁹.

Breach of professional health ethics

Over the past few decades, it has been repeatedly argued that Healthcare Providers carrying out FGM contradicts the basics of health ethics. Since FGM has no proven medical benefits for women and girls, if Healthcare Providers carry out the procedure, they violate the principles of professional health ethics forbidding them to harm healthy, functioning bodily organs unless they carry life-threatening diseases⁶⁰. According to one study of 250 Nigerian doctors⁶¹, 80% of doctors interviewed believed that performing FGM could equate to malpractice, because of the absence of benefits to women’s well-being.

⁵⁷ Brusa and Barilan, 2009, p.473

⁵⁸ Tenoj, 2014

⁵⁹ 28 Too Many, 2015

⁶⁰ Shell-Duncan, 2001, p.1019; Serour, 2013, p.148

⁶¹ Derby, 2004

Another concern related to medicalised FGM is the level of medical training undergone by Healthcare Providers who carry out the procedure. Healthcare Providers might lack sufficient surgical training and skills to perform the cutting. Therefore, engaging a Healthcare Provider to carry out the cutting within a clinical setting does not guarantee that the procedure will be delivered safely and without any complications⁶².

Absence of informed consent to carry out FGM

Within a Western context, in recent years, the prevalence of cosmetic surgery and body piercing for the female genitals (for non-therapeutic, aesthetic reasons) has risen steeply and has been linked to the pervasive nature of online pornography and of its impact on culture⁶³. There are also reports of an increased demand for cosmetic genital surgery in Kenya and other African countries⁶⁴.

While there are similarities between female genital mutilation and female genital cosmetic surgery, there are significant differences: Western cosmetic surgery continues to be a niche issue affecting few women and girls; cosmetic surgery is usually only available to those over 18 years old (although procedures on girls under 18 is growing significantly); and, while cultural expectations and ideals are still the motivation for cosmetic surgery, there is no surgery requirement in order for girls or women to participate fully within their community or family.

International and domestic laws remain unclear about distinguishing between FGM and cosmetic surgery (reducing labia, restoring hymen or narrowing vaginal orifices)⁶⁵. However, academic and clinician G. I. Serour⁶⁶ notes that, unlike FGM, in the case of cosmetic surgery a woman is more likely to be of an age when she can give informed consent, be counselled about health risks and have a chance to withdraw at any time before the operation takes place. In contrast, social and economic dependence on family and husbands, pressure from relatives and a lack of information about FGM may

⁶² Njue and Askew, 2004, p.12

⁶³ Caterucci, 2016, Davis 2011

⁶⁴ Murrage 2013, BBC News 2003

⁶⁵ Leye et al, 2008, p.187

⁶⁶ 2013, p.147

prevent women from freely consenting to cutting or reinfibulation. Furthermore, for some Healthcare Providers the motivation of financial or material rewards may be great enough to cause them to persuade women or girls to undergo cutting or provide them with false information about the safety of the procedure.

As concerns increase about both medicalized FGM and female genital cosmetic surgery, experts and campaigners are emphasising that it should be a priority for health service providers, legislators and NGOs to have a clear theory and practice about female genital cosmetic surgery/piercing and the similarities and differences between them and FGM⁶⁷.

A modern trend rejected by traditional communities

Certain communities oppose medicalised FGM because it is regarded as modern and not reflective of their custom or cultural practice, as do the Abagusii in Nyanza Province, Kenya⁶⁸. Consequently, a more effective approach to ensure the eradication of FGM is to offer communities safer alternatives that preserve their culture while ensuring the well-being and upholding the rights of women and girls⁶⁹.

⁶⁷ RCOG 2013, Hussein 2013

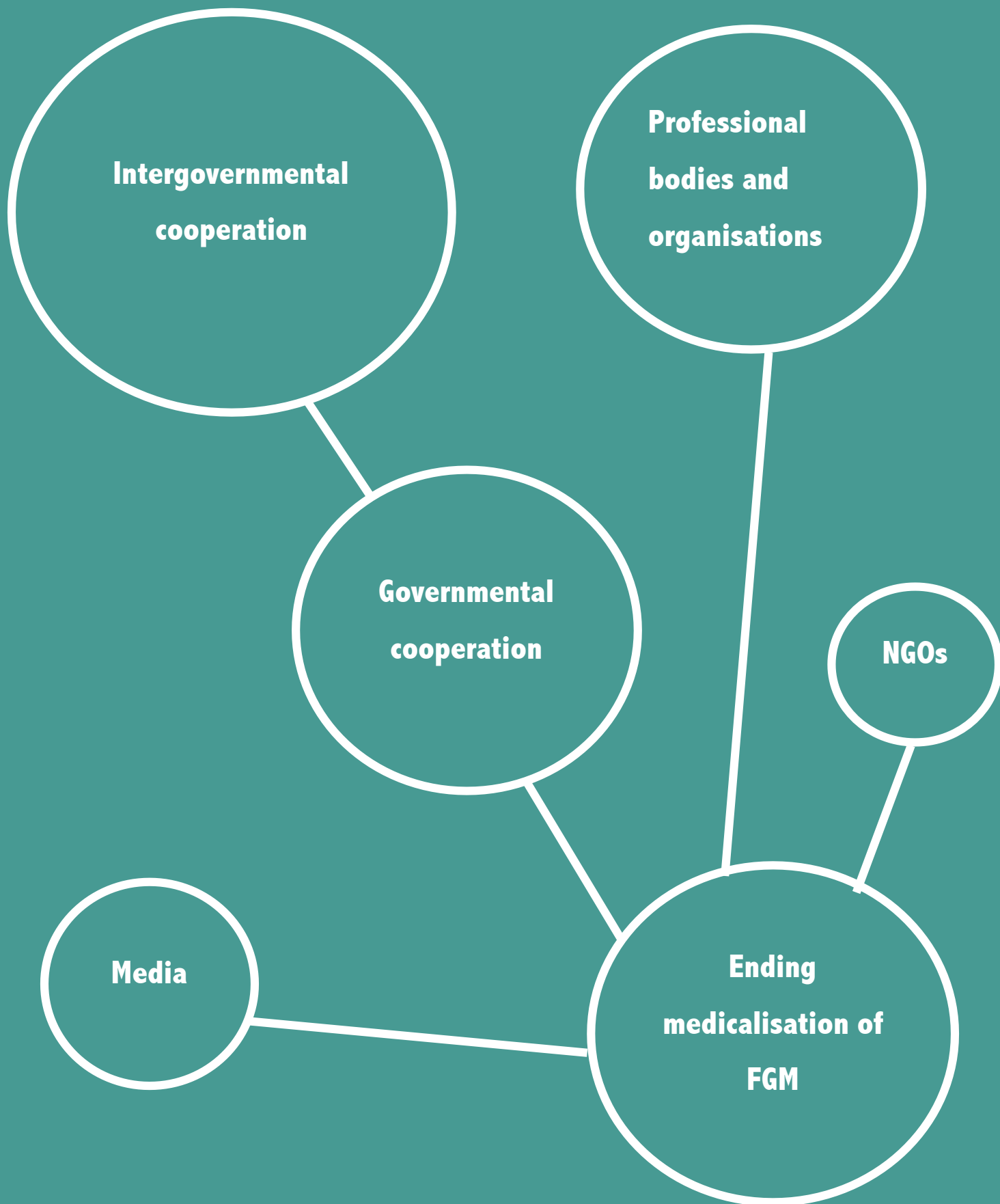
⁶⁸ Njue and Askew, 2004

⁶⁹ Jones, Ehiri and Anyanwu, 2004, p.144

“It is impossible and categorically wrong to compare a child being forced to undergo FGM to a grown woman deciding to have a boob job. But is there a case to be argued that, at completely opposite ends of the scale, they represent a woman’s desire or pressures to live up to the perception of what men want? They are females adapting themselves – or in the case of children, females adapting one another – for the male ideal, to be more socially acceptable and therefore a more attractive prospect to men.”

Hibo Wardere

Activist, Author and Survivor of FGM



**Intergovernmental
cooperation**

**Professional
bodies and
organisations**

**Governmental
cooperation**

NGOs

Media

**Ending
medicalisation of
FGM**

Where and How is the Medicalisation of FGM Tackled?

NGOs

The WHO issued a statement in 1982 declaring that it is unethical for Healthcare Providers to perform the procedure in any setting, including hospitals and clinics, and banned them from carrying it out⁷⁰. Since then, UNICEF and the WHO have led international efforts to eliminate the practice of FGM and to oppose its medicalisation. They have been joined by diverse NGOs from various countries. NGOs have progressively become fundamental actors, assisting and educating local communities, conducting research and leading international, regional and local campaigns to ensure the drafting and implementation of relevant laws. Going beyond researching and campaigning for the eradication of FGM, NGOs help to bring attention to particular cases of abuse and pressure governments for action. To illustrate, a particularly successful outcome of strong campaigns by NGOs, including Equality Now, was the prosecution of an Egyptian doctor who performed FGM on a 13-year-old girl, resulting in her death⁷¹. Although the Egyptian authorities have thus far failed to practically execute the sentence, this conviction might help to deter other Healthcare Providers from carrying out FGM procedures in the future⁷². In early 2016, an Egyptian court ordered that the licence of the doctor concerned be revoked, and the Egyptian health ministry launched the Doctors Against FGM initiative, to urge Healthcare Providers to stop the practice.⁷³

However, the activism of NGOs to eradicate FGM has not always brought about only positive outcomes. As discussed above, humanitarian efforts by international NGOs have indirectly and unintentionally contributed to the trend of medicalised FGM by predominantly highlighting FGM's medical concerns. Therefore, it is necessary for NGOs

⁷⁰ Shell-Duncan, 2001, p.1014; Jaeger et al, 2009, p.29; Njue and Askew, 2004, p.3

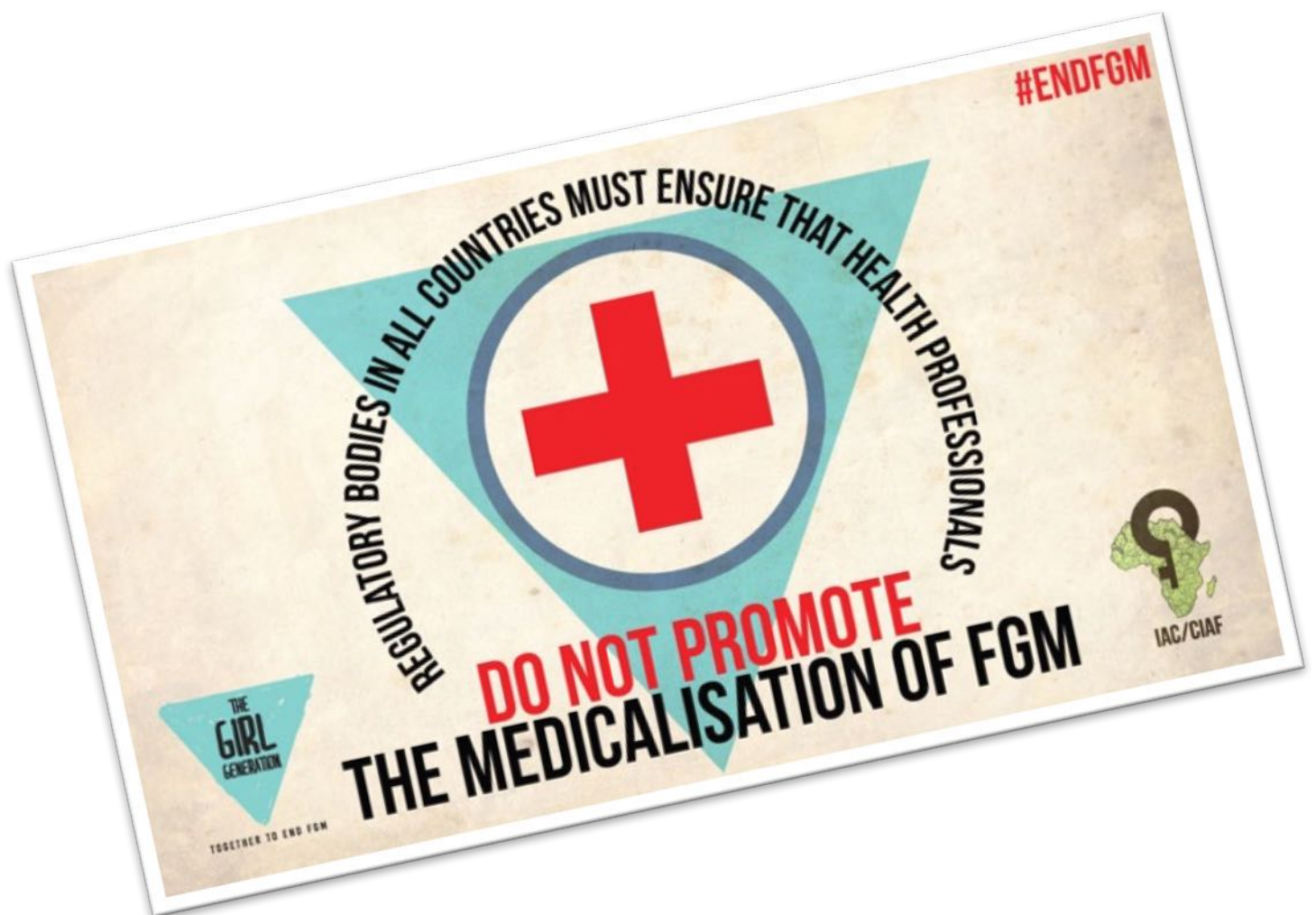
⁷¹ BBC, 2015a

⁷² BBC, 2015a; Fadel, 2015

⁷³ BBC, 2016

to be careful in their attempts to eradicate FGM and to focus their efforts on stressing the human-rights aspect as well as potential health complications.

International NGO “The Girl Generation” include messages addressing the medicalisation of FGM in their anti-FGM campaign⁷⁴.



⁷⁴ Source: Girl Generation Facebook Page

Intergovernmental cooperation

Various efforts have been made as a part of intergovernmental cooperation to tackle the medicalisation of FGM. For instance, representatives from numerous countries and NGOs, including the WHO and UNICEF, participated in a conference in London in 1992 and adopted a declaration that, among other goals, called for health ministers and governments not to support the medicalisation of FGM⁷⁵. Another influential intergovernmental meeting took place in Nairobi, Kenya in 2009⁷⁶. This technical consultation sought clearer strategies to support medical personnel working towards the abandonment of FGM⁷⁷. The participants included representatives of relevant ministries from Egypt, Guinea, Kenya, Nigeria, Sudan, Yemen and several UN agencies, as well as international professional organisations and NGOs such as Amnesty International⁷⁸. The European Union has also recognised the importance of tackling medicalisation in order to eradicate all forms of FGM, and contributed to the UNFPA-UNICEF 'Joint Programme on Female Genital Mutilation (FGM)'. One of the Joint Programme's objectives, among others, is to support countries' efforts to prevent the medicalisation of FGM by closely collaborating with relevant international organisations and national ministries of health⁷⁹.

Governmental efforts

Certain governments, for example in Austria, Belgium, France, Spain, Sweden and Switzerland, have thus far successfully strengthened the legislation to protect girls and women from FGM⁸⁰. These countries enabled the prosecution of those who perpetrate the crime of FGM, even if it takes place abroad, since some girls are taken out of country under the auspices of holidays to undergo FGM abroad⁸¹. Alongside the illegalisation of FGM in numerous states, a greater number of arrests and prosecutions have been

⁷⁵ Krása, 2010, p.277

⁷⁶ Serour, 2013, p.147

⁷⁷ UNFPA, 2009

⁷⁸ UNFPA, 2009

⁷⁹ European Commission, 2015, pp.8-9

⁸⁰ Jaeger et al, 2009, p.32

⁸¹ Ibid.

registered in several countries; for instance, in Burkina Faso, Egypt and Kenya⁸². In France, there were at least 40 FGM criminal cases open in 2012⁸³.

It is estimated that 137,000 women and girls affected by FGM currently live in the UK⁸⁴, where FGM has been illegal since 1985. In order to improve the protection of women and girls from FGM, relevant domestic law was further enhanced in 2003 through the adoption of the Female Genital Mutilation Act (which was further amended by the Serious Crime Act 2015). The 2003 Act prohibits all forms of FGM and raised the punishment for offences to 5-14 years' imprisonment⁸⁵. What is more, similarly to other governments, the UK has recently acknowledged the risk of FGM perpetrated on girls and women taken abroad and addressed the loopholes in its law, which now makes such practices illegal and enables the prosecution of those who breach said law⁸⁶.

Last year, the law began to be practically implemented within the UK. To illustrate, the Bedfordshire Police secured one of the first court protection orders, which allows the authorities to seize passports from those suspected of taking girls abroad to undergo the FGM procedure⁸⁷. This tends to occur especially at the beginning of summer holidays because performing FGM during that period allows sufficient time for girls to heal before returning to school⁸⁸. Additionally, teachers, doctors, midwives and nurses in the UK are now legally required to report FGM cases, otherwise they face the possibility of disciplinary measures and even being barred from work⁸⁹. In the first three months since their introduction only 18 FGM protection orders were issued, prompting campaigners to call for more support for professionals who needed to be braver in taking action⁹⁰.

⁸² UNICEF, 2013

⁸³ Harris, 2015

⁸⁴ Gander, 2015

⁸⁵ Krása, 2010, p.274

⁸⁶ Topping, 2014

⁸⁷ BBC, 2015b

⁸⁸ BBC, 2015b

⁸⁹ Gallagher, 2015

⁹⁰ The Guardian, 2015)

Professional bodies and organisations

The international efforts by governments and NGOs to address the medicalisation of FGM have been joined by those of diverse professional organisations, both domestic and international. For instance, the International Federation of Gynecology and Obstetrics, the Inter-African Committee, the US Agency for International Development and others have explicitly expressed their opposition to medicalised FGM⁹¹. The 1994 International Federation of Gynecology and Obstetrics' resolution, calling upon all doctors to refuse to carry out FGM, was joined by the American College of Obstetricians and Gynecologists, the American Medical Association and others⁹². Also, as a result of international and local anti-FGM lobbying, the health ministries of numerous African countries took a similar stand⁹³.

In the United Kingdom, multiple professional organisations, including the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives and the Royal College of Nursing, have declared FGM a child abuse. Furthermore, these professional organisations promoted the importance of collecting and sharing information on FGM, and recommended the education of health professionals and the strengthening of reporting mechanisms to help girls at risk and those already affected by FGM⁹⁴.

Media

The media has played a fundamental role in disseminating information about FGM and its medicalisation. Various international, national and local news sites and newspapers now provide regular updates about FGM. To illustrate, within the UK, multiple news portals such as the BBC, the *Evening Standard* and *The Independent* now cover FGM cases in a thorough and professional manner. What is more, *The Guardian* offers access to advice on where and how to report FGM, and advice on where to seek help if a person is in danger of being cut or has undergone the procedure. With the intent to amplify the

⁹¹ Njue and Askew, 2004, p.3

⁹² Shell-Duncan, 2001, p.1014

⁹³ Shell-Duncan, 2001, p.1014

⁹⁴ The Royal College of Midwives, 2015

work of campaigners against FGM, *The Guardian* has also initiated the ‘End FGM Guardian Global Media Campaign’, thus demonstrating the importance of the media in leading campaigns to abolish FGM⁹⁵.

⁹⁵ The Guardian, 2016

Conclusions and Recommendations

As this report has demonstrated, the medicalisation of FGM is not an appropriate response to FGM. Not only does medicalised FGM still constitute a threat to the health and well-being of women and girls, it also enables a practice that represents a deeply-rooted form of gender inequality. Furthermore, medicalisation hampers international efforts to eradicate FGM once and for all.

28 Too Many take the position that all female genital mutilation is a violation of the rights of women and girls and a severe form of gender-based violence. There are no health benefits related to FGM and even when medicalised the practice causes physical and psychological harm to women and girls. As the abovementioned Egyptian case clearly proved, FGM performed by a Healthcare Provider is still a risky procedure that can lead to death. Consequently, more must be done to ensure that all women and girls are protected from the complications associated with FGM, whether performed by traditional cutters or medical personnel. In order to achieve this, government and civil-society organisations should make sure that laws and programmes against FGM are based on zero tolerance of all forms of the practice, including where it is carried out in a clinical setting or by trained Healthcare Providers.

Specifically, it is recommended that action should be taken in the following areas:

Government, Policy Makers and Professional Medical Organisations

- Condemn all forms of medicalised FGM at local, national and international level.
- Involve professional organisations and bodies in advising medical personnel against carrying out FGM and in holding Healthcare Providers accountable for

unethical practice. This must include all forms of FGM, including the reinfibulation of women who have previously had FGM, after they give birth.

- Provide medical staff with relevant training to help them understand the practice and the motivations behind it, so that they can offer appropriate counselling and assistance and advocate against FGM.
- Provide specific guidelines for Healthcare Providers on procedures for suturing wounds resulting from emergency reversals during labour.
- Support Healthcare Providers in learning about the clinical management of FGM survivors and recognising when girls and women are at risk of FGM.
- Ensure that medical staff, social workers, school nurses and other relevant actors are trained in relation to the laws applicable to FGM and about cultural sensitivity, as well as preventing, detecting and reporting FGM.
- Provide greater supervision over hospitals in affected areas to deter medical staff from performing the procedure.
- Enhance punitive law and its enforcement for those who perform FGM, including medical professionals.
- Draft and implement clear legislation that distinguishes between FGM and cosmetic vaginal surgery.

International Community and NGOs

- Promote clear statements against all forms of FGM and a zero-tolerance approach to medicalisation of the practice.
- Develop programmes to tackle FGM that take into account local issues, including addressing the medicalisation of FGM, where this is occurring.

- Include Healthcare Providers in the development and implementation of programmes.
- Ensure health education on the harm of FGM is within the wider context of FGM as a human-rights issue and a form of gender discrimination.
- Call upon governments to strengthen their legal protection, reporting and punitive mechanisms to enable effective prosecution of all those including Healthcare Providers who perform, facilitate or permit any form of FGM at home or abroad.

Local Community Organisations

- Assist communities, including immigrants and diasporas, with education on FGM, including medicalisation.
- Disseminate information about the illegality of the practice as well as the health risks associated with medicalised FGM.
- Highlight the practice not only as a health issue, but as a human-rights violation that disempowers women.

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28 Too Many is an anti-FGM charity, created to end FGM in the 28 African countries where it is practised and in other countries across the world where members of those communities have migrated. Founded in 2010 and registered as a charity in 2012, 28 Too Many aims to provide a strategic framework where knowledge and tools enable in-country anti-FGM campaigners and organisations to be successful and make a sustainable change to end FGM. We are building an information base, which includes detailed Country Profiles for each country practising FGM in Africa and the diaspora. Our objective is to develop networks of anti-FGM organisations, to share knowledge, skills and resources. We also campaign and advocate locally and internationally to bring change and support community programmes to end FGM.

www.28toomany.org | info@28toomany.org