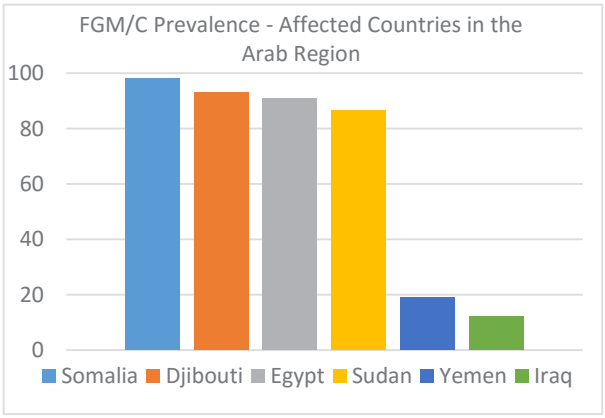
UNFPA arab states

Policy Brief

Stopping Medicalisation of Female Genital Mutilation/ Cutting in the Arab region

Female Genital Mutilation/Cutting in the Arab Region[i]



SOURCES: EGYPT DHS 2014, SUDAN MICS 2010, DJIBOUTI MICS 2006, IRAQ MICS 2011, YEMEN DHS 2013

Of the estimated 125,000,000 girls and women who have undergone Female Genital Mutilation / Cutting[ii] (FGM/C) globally, nearly 45% live in the Arab region. [iii]

FGM/C occurs in social contexts marked by high levels of gender discrimination, maternal and infant mortality, and acceptance of violence against women.[iv] As both a sign of low attainment of sexual and reproductive health and rights (SRHRs) and an impediment to exercising those rights, wherever FGM/C is practised the determinants of gender equality are greatly compromised.

Of the twenty-nine countries where the practice is concentrated globally, six are in the Arab region: Egypt, Djibouti, Iraq (Kurdistan), Somalia, Sudan and Yemen.[v] Four Arab countries are among the eight classified globally as having 'very high prevalence' (above 80%). These include Somalia, with the highest overall prevalence of any country (98%), and Egypt, with the largest number of girls and women affected (27.2 million).[vi]

The practise of FGM/C, which pre-dates both Islam and Christianity, continues to evolve in response to changes in the social environment. A particularly concerning development has been the increasing involvement of trained health-care providers in performing FGM/C. Known as medicalisation of FGM/C, this trend has recently gained significant ground in some Arab countries.

Medicalisation of FGM/C

Recorded cases of health care providers performing FGM/C go back to the middle of the 19th century.[vii] In the Arab region, involvement of trained health-care providers began at least as early as the 1920's. In colonial Sudan, for example, British Christian medical missionaries promoted a medicalised version of FGM/C as safer and less harmful, with

some seeing it as a step toward eradicating the practise altogether.[viii] This same 'harm reduction' rationale persists today as a key driver of the current trend toward medicalisation.[ix]

In countries where Type III FGM/C (infibulation) has been practised, medicalisation has been associated with a shift to Types I and II (partial or total clitoridectomy, with or without excision). The presumed rationale for the shift is harm reduction, however, all types of FGM/C carry risks that cannot be eliminated and cause serious long-term harm to girls' and women's physical and mental health.
FGM/C is almost always performed at the behest of a third party, usually a parent or another relative. When girls and women are treated as mute objects of a transaction between this paying client and an FGM/C practitioner they are effectively stripped of their status as human beings vested with inalienable rights. By the same token, when trained health providers contravene the ethical standards of their profession to perform FGM/C (even if requested by a woman for herself) their behaviour is reduced to that of monetised service suppliers.

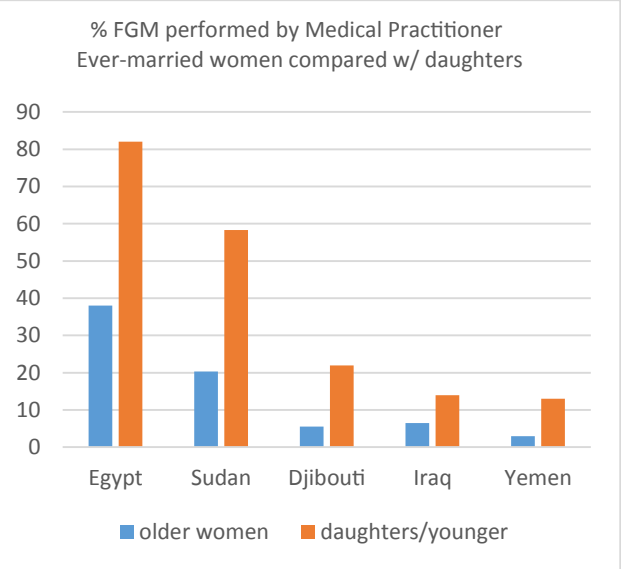
Since the first international meeting to focus significantly on FGM/C, the 1979 Khartoum 'Seminar on Harmful Traditional Practices Affecting the Health of Women and Children,' recommended that efforts should focus on complete abolition, medicalisation of FGM/C has been widely recognised as a key threat to efforts to end the practice.[x]

In 2009, in the face of evidence that in some countries the medicalisation trend was rapidly accelerating,[xi] renewed focus was brought to bear on the issue through WHO-led consultations that culminated in the publication of a joint Global strategy to stop health-care providers from performing female genital mutilation.[xii] Authoritative medical opinion against the involvement of medical providers in carrying out any form of FGM/C is thus firmly established.

UNFPA/Arab States Regional Consultation Addressing FGM/C medicalization in the Arab Region, August 2015

Against this background, in August 2015 UNFPA and the Alexandria Regional Centre for Women's Health and Development (ARC) convened a meeting in Cairo, Egypt on FGM/C medicalisation in the Arab region. The meeting analysed challenges and identified key actions needed to effectively stop health-care providers in the region from performing FGM/C. The present policy brief is an outgrowth of that meeting and reflects the deliberations and contributions of expert participants from Egypt, Sudan, Djibouti, Somalia and Iraq (Kurdistan).

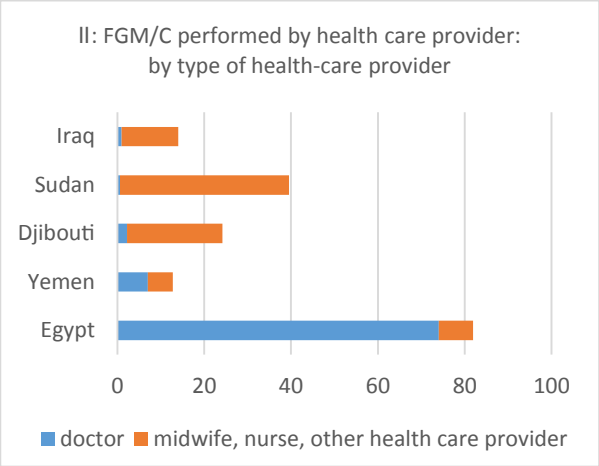
Current situation of FGM/C medicalization in the Arab region



As seen in the chart above, in Egypt and Sudan most women in the older age brackets underwent FGM/C at the hands of traditional practitioners. In sharp contrast, 82%[xiii] of daughters in Egypt and 58% of girls aged 10-14 years in Sudan were subjected to FGM at the hands of trained health-care providers. Replacement of traditional practitioners by trained health-care providers, although accounting for a lesser proportion of cases overall, is likewise occurring in Djibouti, Iraq (Kurdistan) and Yemen.

As shown in the chart below, nearly all girls in Sudan who undergo FGM/C at the hands of a trained health-care provider are subjected to the practice by a trained midwife or nurse, as is also the case in Iraq (Kurdistan) and Djibouti. In Egypt, however, it is medical doctors who carry out 9 out of 10 FGM/C

procedures performed by healthcare workers. Doctors are also the most likely type of health-care provider to perform FGM/C in Yemen.[xiv]



Common factors behind trained health care providers' involvement in FGM/C:

- Claim of reducing harm
- Personal financial gain
- Adherence to social-cultural values that underpin the practice

What is driving the medicalization trend?

Medicalisation is associated with greater public awareness of immediate health risks arising from traditional FGM/C procedures, which are typically carried out with rudimentary tools in unsterile settings: shock, haemorrhage and infection among other health risks. Viewed through this lens the trend toward medicalisation may be seen as an unintended consequence of education efforts that have raised awareness of immediate health risks of FGM/C without effectively communicating the adverse rights implications and the long-term physical and psychosocial risks and harm of the practice. It is also likely that new and emerging patterns of recourse to midwives, nurses, doctors and other trained health cadres are not entirely specific to FGM/C but are part of a larger trend toward medicalisation of an array of services previously performed by traditional health practitioners.

Violating girls' and women's rights, violating medical ethics

Trained health-care providers who perform FGM/C carry out harmful invasive procedures that have no medical indication and no medical benefit to the patient. Three prevailing rationales have been identified to explain their involvement:

Harm reduction:

As a public health construct, 'harm reduction' describes actions deliberately taken by a third party to lessen the harm a person exposes him- or herself to when s/he cannot be persuaded to abandon a self-harming course of action. The illegitimacy of the harm reduction rationale when applied to FGM/C is immediately apparent when one considers that FGM/C is most often carried out by force on children who cannot give informed consent. Furthermore, to justify FGM/C on the basis that its medicalised performance reduces the immediate risks (infection, shock, haemorrhage and death) is to ignore the serious adverse implications of the practice, its infringement on human rights and its long-term physical and psychological consequences.

From a health and human rights perspective the real choice faced by the health-care provider requested to perform FGM/C is not a choice between increased or reduced harm but a choice between causing primary harm to a girl or woman or, alternatively, playing a role to prevent that harm from ever being inflicted.

Personal financial gain:

FGM/C procedures carried out by a non-family member are always performed for a fee regardless of the type of practitioner. In areas where FGM/C is already highly medicalised, performance of FGM/C may constitute a substantial proportion of a health-care provider's professional income. Legal bans may have the unintended effect of making the procedure more lucrative as higher fees are chargeable based on perceived increased risks to the practitioner.

Irrespective of their initial motivation, health-care providers who engage in FGM/C business are likely

to develop a personal financial interest in the continuance of the practise.

Socio-cultural values, a crucial cross-cutting rationale:

Discussions of FGM/C medicalisation typically characterise families, supported or influenced by members of the wider community, as persistent seekers of the practice while health-care providers are described merely as service suppliers. This demand-supply dichotomy misses a crucial dimension of medicalisation: with few exceptions, health-care providers who perform FGM/C are themselves members of the communities they serve and share with their patients important convictions about the practice that are nevertheless at variance with medical ethics and human rights principles. Such shared convictions include the mistaken but widely-held and very influential belief that 'female circumcision' is required or recommended by religion; or that FGM/C benefits girls and women by improving their hygiene, moulding their characters, and/or curbing natural sexual appetite thereby promoting socially-valued chaste behaviour; and above all else, the knowledge that a girl who has not been cut will face stigmatization and may not easily make a good marriage within the community. Significantly, health-care providers who perform FGM/C are also likely to resort to modern medicalised FGM/C services for their own daughters and female family members. Their cultural-insider perspective on FGM/C provides an additional and perhaps particularly salient set of motivations and rewards for carrying out the practice.

Whatever the rationale, by their very participation as FGM/C practitioners health-care providers reinforce a falsely positive association between FGM/C and health and lend credibility to the fallacy that the risks of the practise and the harm it causes can be reduced to acceptable levels.

In the face of persistent demand from community members who interpret FGM/C as a social and religious requirement, lack of appropriate legislation, weak legal monitoring and enforcement, absence of effective professional regulatory bodies and mechanisms all contribute to a legal and professional environment that allows medicalisation of FGM/C to take root and spread.

Key Actions Needed to Stop Medicalisation of FGM/C

At the regional level:

- **Legal:** Increased advocacy for development and enforcement of laws and regulations to prohibit FGM/C
- **Religious:** Increased effective promulgation of the most authoritative religious positions refuting FGM/C
- **Knowledge and Evidence:** Increased generation and use of evidence; improved data harmonisation to facilitate regional analyses

At the national level:

- **Legal:** development and enforcement of laws and regulations to prohibit FGM/C
- **Health System:** Increased and strengthened training of health care providers to promote awareness of FGM/C as a rights violation and health risk; instil personal commitment not to perform FGM/C procedures and to contribute to ending the practice; strengthen technical knowledge and increase effective communication skills.
- **Knowledge and Evidence:** Increased generation and dissemination of reliable evidence relevant to stopping the medicalisation of FGM/C

The way forward

Government policymakers, medical professionals, legal and religious authorities at both national and regional levels have responsibility and important roles to play in stopping medicalisation of FGM/C.

Recommended actions at the regional level

Legal and regulatory dimension: Regional bodies should advocate for national laws and regulations to be issued and enforced and for existing commitments of the African Union, the League of Arab states, the Organisation of Islamic Conference and other regional UN bodies to be implemented and upheld. **WHO, UNICEF, and UNFPA regional offices** jointly share an important responsibility for regional advocacy and awareness creation to end FGM/C medicalisation.

Religious Dimension: While higher ranking religious authorities in the region have condemned the practice of FGM/C contradictory religious opinion persists at the community level and exerts important influence on both families' demand for FGM/C and trained medical providers' willingness to supply it. To more effectively promulgate the most authoritative religious positions refuting FGM/C UNFPA and UNICEF regional offices should support the establishment of a regional network of religious leaders under the auspices of prestigious Muslim institutions such as Al-Azhar University International Islamic Centre for Population Studies and Research (IICPSR) and Al-Azhar Islamic Foundation. Existing regional religious bodies need to continue issuing and promulgating rulings (fatwa) against FGM/C that prompt community members and health professionals to reject the practice and to report any breach or violation of these rulings.

> "By taking a stand in favour of abandonment of the practice and by refraining from performing it, health-care providers will contribute to increased debate and questioning of the practice by communities"
> (WHO 2010, p 5)

Knowledge and Evidence Dimension: UNFPA/ASRO to work closely with national statistics offices and national population councils/committees in those Arab countries where the practice is prevalent and to support inclusion of data gathering modules on the practice in national studies and DHS and/or MICS surveys. National data collection systems need to be harmonised to facilitate regional analyses. New regional research studies should be undertaken to generate evidence and facilitate analyses related to cross-border FGM/C practitioners, particularly those who perform infibulation (type III).

Recommended actions at the national level

Health System Dimension: Within national health systems, training of healthcare providers is a critical area for action to stop medicalisation of FGM/C. There are two related aims of healthcare provider training on FGM/C. First, training is needed to motivate and equip health care providers to conclusively decline requests to perform any kind of FGM/C procedure, including reinfibulation after delivery. Second, training is needed to strengthen the capacity of health care providers to play an effective role in reducing demand for FGM/C among the families and communities they serve.

To achieve these aims, governments and national medical training institutions as well as medical syndicates and associations should ensure that comprehensive training on FGM/C is integrated into pre-service as well as in-service professional training and academic studies for doctors, nurses and midwives. Training must go beyond mere transmission of technical knowledge to instil personal commitment and confer practical skills for effective communication and advocacy with health service users and other community members.

A lesson learnt from decades of activism and advocacy against FGM/C is that training based on transfer of information alone does not automatically lead learners to develop personal commitment to desist from the practice. Recognition that most healthcare providers who perform FGM/C are themselves members of the communities they work with and are shaped by the same social norms and values must inform development of training programmes. New types of training tools and modules that use insights gained from settings where abandonment of FGM/C has occurred need to be developed and put into action to promote the growth of personal

commitment to stopping FGM/C among health care providers. New training strategies and tools must be rigorously pilot-tested and validated before use.

Understanding FGM/C as a human rights violation with irreversible consequences for physical and mental health and well-being is an essential step toward developing commitment to refuse requests to perform any type of FGM/C and to advocate for its abandonment. To ensure incorporation of the human rights perspective in the training curricula, modules that cover both physiological and psychosocial dimensions of human health and sexuality and the impact of FGM/C on women's and girls' sexual and reproductive health and rights should be designed and implemented. Legally binding professional oaths prohibiting performance of FGM/C must be required of all graduating health-care providers.

Training on medical ethics needs to include typical FGM/C scenarios in case studies illustrating conflicts of interest, the principle of non-maleficence and respect for human rights including physical and psychological integrity. Guidance on professional ethics must emphasize that any degree of harm caused to the present or future health or well-being and, especially, any risk whatsoever that death could result is utterly unacceptable for a procedure that has no medical benefit.

In all cases the training of healthcare providers must impart clear information on legal sanctions against FGM/C at all operative levels, from national laws to prohibitions established by medical associations and other professional regulatory bodies, including information on reporting procedures and penalties for providers who carry out FGM/C.

Healthcare providers must be trained to anticipate, recognise and make effective use of opportunities for communicating about FGM/C with families and community groups. In the case of female infants and young girls early and frequent communication on the vital importance of protecting them from FGM/C should be initiated with the parents and families accessing health services, including through pre- and post- natal care services and babies' check-ups.

In countries where Type III FGM/C is practised health care providers must be prepared to face requests for reinfibulation following childbirth, whether initiated by third parties or by adult women acting on their own behalf. The healthcare provider's response should not stop at a simple denial of service. Training should equip healthcare providers with communication skills and tools that enable them to transform the interaction into an opportunity to affirm the importance for the woman of attaining the highest available standard of health despite the previous harm done by infibulation, and to support her in making a healthy psychosocial adjustment without reinfibulation.

Beyond communication in the health service setting, ministries of health and related institutions and partners need to broaden outreach strategies to reach family influencers. To decrease demand for medical providers to perform FGM/C a perception needs to be created and widely promoted that members of the health professions are unequivocally opposed to the practice on grounds that can easily be understood by potential clients.

Because beliefs and uncertainties about implications for religion of stopping FGM/C are so often at the top of people's minds, training should equip health care providers to conduct outreach activities in collaboration with local religious and community leaders. Feeling certain of religious approval will also strengthen the resolve of health care providers themselves to decline requests to perform FGM/C and increase their ability to positively influence families to abandon the practice.

The Legal and regulatory dimension: Advocacy and lobbying efforts must be directed at and within national governments that have not signed and ratified the documents issued by the OIC for protecting women and children, so that national laws that criminalise FGM/C are enacted and legislations and bills to prohibit performance of FGM/C (whether by health care providers or not) are passed.

Monitoring mechanisms to detect performance of

FGM/C by trained medical providers both within and outside the health system also need to be strengthened.

Medical syndicates and health professional bodies can play important roles by instituting their own regulations and systems of sanctions. Where such professional bodies are not in place they should be created to act as licensing bodies and to provide needed regulation.

Awareness of existing laws needs to be raised among health service providers and community members. Where national law is not yet enacted, health professions may choose to institutionalize their own regulations and system of sanctions within their national organizations or syndicates.

Knowledge and evidence dimension: Governments need to ensure that regularly updated reliable evidence on FGM/C is available so that the most effective strategies for stopping medicalisation are identified and progress monitored. This crucially includes allocating adequate resources. Using innovative approaches can help overcome challenges to the quality of data that arise from sensitivities surrounding FGM/C. Narrative and psycho-social research methodologies can offer promising alternatives to established approaches. Another important area for development is research using participatory approaches that position community members as partners in the change process rather than opponents to it, offering opportunities for those most affected by the issue to join in identifying problems and solutions related to FGM/C. Such communities critically include groups and networks of health-care providers facing demand to perform medicalised FGM/C.

[i] 'Arab region' refers to the twenty countries covered by the UNFPA Arab States Regional Office (ASRO): Algeria, Bahrain, Djibouti, Egypt, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Palestine, Qatar, Saudi Arabia, Somalia, Sudan, Syria, Tunisia, United Arab Emirates and Yemen.

[ii] According to WHO female genital mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. FGM is classified into four major types: 1- Clitoridectomy: partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris); 2- Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina); 3- Infibulation: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris and 4- Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

[iii] DHS, MICS, 1996 – 2014; UNICEF 2013 'Female Genital Mutilation / Cutting: a statistical overview and exploration of the dynamics of change

[iv] UNFPA 2015 'Demographic Perspectives on Female Genital Mutilation'

[v] All but Iraq (Kurdistan) are focal countries for the UNFPA-UNICEF Joint Programme on Female Genital Mutilation / Cutting, which provides support to countries' efforts to end the practise in all its forms so that girls and women may enjoy their full rights to the highest attainable standard of sexual and reproductive health, to bodily integrity and to human dignity .

[vi] DHS, MICS, 1996 – 2014; UNICEF 2013 'Female Genital Mutilation / Cutting: a statistical overview and exploration of the dynamics of change

[vii] Female genital mutilation: a contemporary issue, and a Victorian obsession, John Black MD FRCP, JR Soc Med 1997;90:402-405

[viii] Boddy, Janice. 2007. *Civilising Women: British Crusades in Colonial Sudan.* Princeton: Princeton University Press.

[ix] *'The medicalization of female "circumcision": harm reduction or promotion of a dangerous practice?'* Bettina Shell-Duncan, Social Science & Medicine, Volume 52, Issue 7, April 2001; 1013–1028

[x] The International Federation of Gynaecology and Obstetrics (FIGO) has urged member societies to oppose 'any attempt to medicalize the procedure or to allow its performance' under any circumstances, in health establishments or by health professionals (1994). The 1997 joint statement on FGM by WHO, UNFPA and UNICEF commented specifically on medicalisation as a violation of health care ethics, emphasizing that performance by a health-care provider does not eliminate the harm genital mutilation causes to women and girls and that all forms of FGM/C must be stopped.

[xi] In Egypt, for example, the percentage of FGM/C procedures in all surveyed women (age 15 to 49) that were performed by trained medical providers increased from 17% in 1995 to 32% in 2008. Egypt DHS 1995, 2008

[xii] Global Strategy to stop health-care providers from performing female genital mutilation. UNFPA, UNICEF, UNHCR, UNIFEM, WHO, FIGO, ICN, IOM, WCPT, WMA, MWIA. (WHO 2010)

[xiii] Egypt Demographic and Health Survey 2015." *DHS Program.* N.p., Oct. 2015. Web. 29 Nov. 2015. <http://www.dhsprogram.com/pubs/pdf/FR313/FR313.pdf>

[xiv] Yemen 2013 DHS