Female Genital Mutilation & Medicalisation

End FGM European Network

Position Paper

1. Introduction

This position statement outlines the importance of reflecting on medicalised female genital mutilation (FGM) and other related medical practices carried out within Europe. This statement was developed by the End FGM EU secretariat in cooperation with the members part of the Network's 2018 Medicalisation Working Group. This paper seeks to deepen such reflection and open new paths of work and partnerships that will ensure our movement has a renewed legitimacy when tackling FGM.

2. Background

FGM involves all non-medical female genital cutting practices ranging from nicking or pricking a part of the vulva (commonly the clitoral hood), to removing parts of the external female genitalia (clitoris, labia majora or labia minora), to infibulation (narrowing of the vaginal opening) *(1)*.
According to the official definition adopted for the first time in 1997 by the WHO and other UN agencies, the '"medicalisation" of FGM refers to situations in which FGM is practised by any category of health-care provider, whether in a public or a private clinic, at home or elsewhere. It also includes the procedure of reinfibulation at any point in time in a Survivor's life' *(2)*.
Aware of the issue since the end of the 1990s, in 2010 several UN agencies and international medical bodies developed a joint "Global strategy to stop health-care providers from performing female genital mutilation" *(3)*, unequivocally advising that FGM in any form should not be practiced by health professionals in any settings. Moreover, in the last couple of years, several professional bodies adopted clear public positions condemning the medicalisation of the practice *(4)*. The UN Human Rights Council resolution of 2020 on the elimination of FGM also recognises medicalisation as a main challenge and warns against this practice *(5)*.

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(1) Types I, II, III, IV of the World Health Organisation (WHO) definition, available here.
(2) Global strategy to stop health-care providers from performing female genital mutilation UNAIDS, UNDP, UNFPA, UNICEF, UNHCR, UNIFEM, WHO, FIGO, ICN, WCPA, WMA, MWIA, available here.
(3) Available here
(4) World Medical Association, 2016 (here); FIGO, 2017 (here); pledge of health professionals from the Arab Region in UNFPA, 2017; UNFPA Policy Brief on Medicalization of FGM, 2018 (here); Leye, E., Van Eekert, N., Shamu, S. et al. Debating medicalization of Female Genital Mutilation/Cutting (FGM/C): learning from (policy) experiences across countries, 2019 (here)
(5) UN Resolution adopted by the Human Rights Council on 17 July 2020 (here)

3. Contextualisation of medicalisation

According to an estimation from 2018, out of the 200 million FGM Survivors, at least 20 million have been subjected to the practice by a health care provider *(6)*.

Europe

Although prevalence rates of medicalisation in Europe are unknown, anecdotal evidence indicates that health professionals are confronted with demands for cutting girls' genitals and suggests that some of them are performing FGM. All European countries criminalise FGM. However, beyond this, there is **no homogenous framework** prohibiting the performance of FGM in a medical setting.

Africa & Middle East

According to the 2017 Population Council report *(7)* on medicalisation, 27 countries where FGM is practised have criminalised it, and some of them foresee increased penalty for healthcare personnel who perform FGM, in addition to the possibility of suspending their licenses. According to the same report, **26% of FGM Survivors – nearly 15 million women – have been cut by a medical professional.** Moreover, in 2021, UNICEF published a report highlighting the fact that in Eastern Africa, FGM and medicalisation need to be tackled together *(8)*.

South-East Asia & The U.S.

Concerning **Indonesia**, 2018 research from UNICEF revealed that **62% of girls** who underwent the procedure were **cut by a trained medical professional** *(9)*. FGM is usually provided as part of the child delivery package by birth clinics. Moreover, there are also specialised clinics performing FGM and advertising such services on public boards. Another study conducted in **Malaysia** in 2020, shows that **20% medical professional are still performing FGM**, type I for most of them and sometimes type IV *(10)*.

In the United States, the recent Michigan court case against two doctors from the Dawoodi Bohra community, accused of subjecting at least nine minor girls to the cutting procedure, shows that cases of medicalisation are also present in the US *(11)*.

(6) UNFPA, UNICEF, WHO, Calling for the end of the medicalization of female genital mutilation, 15 June 2018, available here
(7) Population Council, The Medicalization of Female Genital Mutilation/Cutting: What Do the Data Reveal?, Available here
(8) UNICEF, The medicalization of FGM in Kenya, Somalia, Ethiopia and Eritrea, February 2021, available here
(9) UNICEF, Statistical Profile on Female Genital Mutilation: Indonesia, Updated January 2019, available here
(10) Rashid A, Iguchi Y, Afiqah SN (2020) Medicalization of female genital cutting in Malaysia: A mixed methods study. PLoS Med 17(10): e1003303. https://doi.org/10.1371/journal.pmed.1003303, available here

4. Main reasons behind medicalisation of FGM

To tackle the growing practice of medicalisation, one must first understand why healthcare professionals accept to perform such a practice:

Personal Beliefs:

an important number of healthcare professionals accepting to perform FGM belong themselves to FGM-practising communities, and thus adhere to the beliefs and system of thought supporting the practice.

Economic Benefits:

as numerous governments have enacted laws prohibiting the practice of FGM by professionals of the medical sphere, individuals accepting to defy the law to practice such acts may receive an attractive financial compensation from the families.

Harm- & Risk-Reduction:

the use of sterile material as well as the possibility to anaesthetize the girl appears to guarantee, according to them, a reduction of the harm and risks associated with the practice.

Lesser/symbolic forms of FGM:

a medicalised exercise would minimise the type of mutilation perpetrated (from infibulation to clitoridectomy for example, or acts such as « pricking » or « nicking »).

lack of Knowledge:

a high percentage of FGM-practising healthcare professionals claim not to know any possible negative effects of FGM when practised by a physician, neither of physical, psychological or sexual nature.

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(11) United States District court Eastern District of Michigan Southern division, United States of America v D-1 Jumana Nagarwala, D-2 Fakhruddin Attar, D-3 Farida Attar, Case 2:17-cr-20274, 26 April 2017, available here

5. Criticism around the medicalisation of FGM

The medicalisation of FGM has been the subject of strong criticism emerging from the vast majority of actors involved in the fight against FGM's persistency:

Medical ethics principle of "Do no harm":

The patient's well-being is a medical professional's primary consideration, and it appears profoundly incoherent and in breach of their professional oath to contribute to damaging one's health condition with no solid medical justifications behind it.

FGM is a human rights violation:

Even if medicalised and performed under sterile conditions, FGM violates multiple fundamental human rights such as right to the highest attainable standard of health, right to life, freedom from torture and ill treatment, freedom from violence, etc.

FGM is a form of gender-based violence:

Healthcare professionals should not engage and contribute to the cycles of violence in which women and girls are forced in for patriarchal reasons

Short- and long-term consequences not prevented:

No mutilation is ever « safe » and the participation of health-care professionals does not prevent the short-term tragic consequences of such practice, as can be demonstrated by the numerous cases of deaths following medicalised FGM, nor does it hinder any of the long-term consequences on physical health. Besides, the participation of healthcare professionals does not prevent any of the psychological sufferings that may arise for the survivors of FGM.

Possibility of more serious and deeper cutting:

The utilisation of professional medical tools, the highly trained and skilled professionals and the performance of the operation under anaesthesia might even worsen the consequences on girls and women's health, and lead to an increased amount of genitalia removed.

Legitimization of the practice

By involving health-care professionals, respected among their communities for their status, medicalisation appears to legitimize and institutionalise the practice. The medicalisation of FGM also legitimizes the logic behind FGM, because it doesn't question that it is done in order to control women's sexuality and thus normalises the practice.

Medicalisation does not contribute to FGM abandonment:

If some may have suggested that medicalisation is a temporary transition towards the total abandonment of the practice, it has, in fact, not been demonstrated. On the contrary, its institutionalisation and normalisation might make the latter even harder.

6. Link between FGM and other medical practices (12)

A position against the medical performance of FGM, particularly by a Network working in a Western context, would not be complete - or at least would be perceived as ethnocentric and lacking a deeper critical reflection - without addressing other forms of similar medical practices happening in our region.

Other medical practices aimed at controlling the female body

In European society girls and women are exposed to numerous images of "how to be a woman”. Social norms include expectations about the looks of genital organs, which do not always correspond to real/natural anatomy. In order to be able to live up to this, women and girls subject themselves to interventions of cosmetic genital surgery, that can be vaginoplasty or hymenoplasty, respectively to conform with the image of the “ideal vulva” or the obligation to be a virgin before marriage. Such operations, such as FGM, are generally performed for non-medical reasons, influenced by societal pressure, and can lead to complications. In some European countries, these surgeries are accessible to minors (with their parental consent) and fall within the WHO definition of “all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons”. Why are these practices acceptable for Western women and girls, but considered as mutilation for women and girls coming from other parts of the world?

In a pregnancy context, around delivery, other medical practices are widely performed in Europe without medical necessity. This is the case of episiotomy, which, when carried out routinely and systematically when not medically necessary, is considered as a form of obstetric abuse and has similar physical and psychological consequences to FGM *(13)*. Another delivery-related practice can be considered as a form of post-partum cosmetic surgery: the “husband stitch” *(14)*, involving making an extra stitch while closing the vaginal tears (or episiotomy cut) after delivery, to tighten the vaginal opening and thus (supposedly) increase the sexual pleasure for a male partner.

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(12) On this topic see also GAMS Belgium & End FGM EU, ‘Genital mutilation- Addressing common myths and misconceptions’ (2018).
(13) WHO Recommendation on episiotomyy policy https://bestdoulas.com/wp-content/uploads/2020/06/epiguidelines.pdf
(14) The Husband-Stitch: Could it be Female Genital Mutilation? https://www.durham.ac.uk/research/institutes-and-centres/ethics-law-life-sciences/about-us/news/obstetric-violence-blog/the-husband-stitch/

Other non-consensual Medical Practices on Children

Medical non-consensual operations on genitalia do not only affect girls but can also affect male and intersex children. End FGM EU deems it important to reflect on linkages between all operations involving children's genitalia without children's consent, regardless of their sex.

Male circumcision is an operation that involves the removal of the skin that covers the tip of the penis, called the foreskin. The practice of male circumcision is different from that of FGM; for example, in terms of the extent of tissues cut and the consequent health impact. It is to be noted that the reasons justifying the two practices have different natures and outcomes: while male circumcision as a rite of passage perpetuates the notion of "dominant men", FGM, as a practice that seeks to control women's bodies and sexualities maintains the idea of "docile women". However, both practices exist in patriarchal societies and support harmful gender and social norms and stereotypes. The End FGM European Network has not taken any position on the medical practice regarding male circumcision on children.

Intersex genital mutilation (IGM) is an intervention, including operations, of medical sex assignment to ensure "sexual normalisation" of children born with sex characteristics which do not fit the culturally accepted norms for women or men, despite most intersex children being in good health. Since this practice can involve the partial or total removal of genitalia, it is performed to conform bodies to gender norms and become socially acceptable, and has similar negative impact in terms of trauma, physical pain and psychological consequences, it shows great similarities with FGM. The UN Child's Rights Committee condemns both FGM and intersex genital surgery as child rights violations. It can also be argued that there may be cases where FGM and IGM are concurrently performed in the case of some intersex girls undergoing e.g. clitoridectomy with the purpose of marriageability or social inclusion.

7. End FGM EU Position statement

End FGM EU affirms its strongest opposition to the medicalisation of female genital mutilation as a dangerous form of institutionalisation and legitimisation of a human rights violation and a form of violence against women and girls, and as a serious breach of the core medical ethics principle of "do no harm". FGM is a form of gender-based violence and no improved hygienic conditions nor highly skilled professional can change this.

At the same time, End FGM EU affirms that there is the need undergo a deeper reflection in our region on other medical practices carried out in our Western society, which are to some extent related to FGM as ways of controlling the female body and as other non-consensual medical practices performed on children, regardless of their sex.

End FGM EU affirms the need to commonly address the patriarchal stereotypes and gender inequality underlying any form of medical practice performed on female genitalia.

Within the context of it Strategic Plan 2018-2022 and 2023-2027 End FGM EU commits to incorporating these issues in its work and opening channels of cooperation with other actors to explore new partnerships.

8. Recommendations

To European States

- **Ensure** to clearly mention in legal or policy framework the **prohibition of performing FGM in the medical setting**, including through the use of medical guidelines and protocols;

- **Ensure** that healthcare professionals (particularly, gynaecologists, midwives and paediatricians) receive **comprehensive training** (including clinical where possible) on FGM and are aware of its criminalisation and of the prohibition to perform it in medical settings;

- **Ensure** that medical professionals (particularly gynaecologists, andrologists, midwives, aesthetic surgeons and paediatricians) receive **training on gender norms**, stereotypes and human rights as part of their curricula;

- **Ensure** that healthcare professionals who perform FGM are speedily **reported** and face adequate legal and professional consequences;

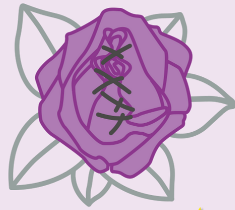
- **Ensure** that teachers/children in school receive mandatory training/education on gender stereotypes, gender inequality and gender-based violence, within a comprehensive sexual education curriculum.

To Medical Professionals

- **Do not perform** FGM in medical settings;
- **Do not perform** IGM in medical settings;
- **Refrain** from systematically suggesting or performing episiotomy to women during delivery, unless a case-by-case assessment proves it strictly medically necessary;

To End FGM EU and its members

- **Continue** the internal reflection around FGM and other related medical practices in terms of controlling the female body and performing non-consensual procedures on children, regardless of their sex;
- **Start** incorporating more and more these issues in their work against FGM and open channels of cooperation with other actors to explore new partnerships at European and national levels.



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