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MEDICALISATION OF FEMALE GENITAL MUTILATION/CUTTING: ETHICAL DIMENSIONS

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Abstract

The global vision of a world without female genital mutilation/cutting, where women's and girls' sexual and reproductive health rights are fulfilled, cannot be achieved with persistent FGM/C and its medicalisation. The vision is articulated in the global development goals with specific member states domesticating the agenda and enacting international treaties that guarantee women's rights through FGM/C prevention, response and outlawing medicalisation. Medicalisation is FGM/C performed by health professionals perpetuated through harm reduction narrative used for countering the practice by highlighting its health complications. Although medicalisation lessens immediate FGM/C-related complications, it does not eliminate long-term effects, including psychological impacts. Medicalisation also does not address human rights violations, notably sexual and reproductive rights, but negates the 'Hippocratic oath' and 'do no harm' principles that guide the conduct of health professionals. A two-prong strategy involving health and human rights approaches has been used to address medicalisation. The health approach is anchored on harm reduction for mitigation of FGM/C-related complications using medical-surgical expertise and health awareness. The human rights approach

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adopts a zero tolerance stand agreed upon by the global community to guarantee human rights violated by FGM/C. Adopting either of the approaches presents a professional ethical dilemma in prevention and response to medicalisation between harm reduction and total adherence to the 'do no harm'. Conversely, while the human rights approach is critical in protecting women and girls, it compromises the right to bodily autonomy and freedom of choice. At the centre of these contestations are the economic benefits for health professionals as key driver for medicalisation. These dilemmas cannot be addressed through legislations, but rather through professional discourses, engagements and dialogues. This chapter presents a comprehensive narrative of medicalisation adduced through content analyses of the existing evidence. It showcases the magnitude of medicalisations of FGM/C and spotlights approaches for ending it as well as existing ethical considerations and dilemmas.

1 Introduction

Global attention towards female genital mutilation/cutting (FGM/C) has gained momentum because of its persistence and the impediment it poses to the attainment of sexual reproductive health and rights as well as full potential for women and girls. On a bigger scale, the practice of FGM/C is a threat to the achievement of the national development agenda and, notably, the attainment of the Sustainable Development Goals (SDGs). Indeed, SDG 5.3 of the United Nations (UN) spotlights the eradication of all harmful practices, including FGM/C, as a means of achieving sustainable development.[1] This is based on the evidence that FGM/C is implicated with negative social impacts, health complications, human rights violations, gender inequalities and the undermining of the realisation of full potential for women and girls.[2]

1 United Nations Statistical Division '5.3.2 Proportion of girls who have undergone female genital mutilation or cutting' Global SDG Indicator platform, https://sdg.tracking-progress.org/indicator/5-3-2-proportion-of-girls-who-have-undergone-fgmc/ (accessed 17 February 2023).

2 UNICEF 'Female genital mutilation/cutting: A global concern. UNICEF's data work on FGM/C support for data collection data analysis and dissemination' 2016, https://data.unicef.org/resources/female-genital-mutilationcutting-global-concern/ (accessed 17 February 2023).

The practice of FGM/C comprises all procedures that involve the partial or total removal of the female external genitalia and/or injury to the organs for non-therapeutic reasons.[3] The terms 'mutilation', 'cutting' and 'circumcision' are generally used interchangeably to signify the practice of FGM/C. However, mutilation denotes the extent and the extreme to which healthy tissues are severed as well as differentiates the practice of FGM/C from the medically beneficial circumcision performed on males (male circumcision). The term is also used to reinforce the notion that FGM/C is a violation of the human rights of girls and women.[4] Notwithstanding this, at community and individual levels the use of the term 'mutilation' can be problematic, offensive, and may appear judgmental, making terms such as 'cutting' or 'circumcision' more acceptable. Additionally, the correct naming of the practice based on context and environment is crucial because it can serve as a facilitator or barrier to buy-in and partnership building with practising communities for effective FGM/C abandonment strategies. This is based on the notion that the use of acceptable terms is interpreted as respect for the culture of the community and diffuses tension and the idea of foreigners 'undermining our culture'. Moreover, the utility of these terms is dictated by sensitivity with regard to FGM/C issues, the context, environment, the audience, as well as the need to be non-judgmental towards the practising individuals and communities.[5] In this narrative, female genital mutilation/cutting (FGM/C) will suffice.

The practice of FGM/C has been reported in 31 countries that have representative data about the practice. Among these countries are 28 African nations spanning from the West, through Central to East and the Horn of Africa (the so-called FGM/C belt) as well as countries in the Middle East, Latin America and Asia.[6] The practice has also been reported among the diaspora communities residing in Europe, North

3 World Health Organisation 'Guidelines on the management of health complications from female genital mutilation' 2016, http://www.who.int/reproductivehealth/topics/fgm/management-health-complications-fgm/en/ (accessed 17 February 2023).

4 GI Serour 'Medicalisation of female genital mutilation/cutting' (2013) 19 *African Journal of Urology* 145-149.

5 K Monahan 'Cultural beliefs, human rights violations, and female genital cutting: Complication at the crossroad of progress' (2007*) 5 Journal of Immigrant and Refugee Studies* 21.

6 UNICEF 'At least 200 million girls and women alive today living in 31 countries have undergone FGM' Global databases on FGM based on 2004-2021 DHS,

America, Australia and New Zealand, among them migrants and those seeking asylum due to economic reasons as well as socio-political conflicts/instabilities.[7] To date, more than 230 million girls and women are estimated to have undergone some form of FGM/C, with an additional more than 4.3 million girls at risk of being cut annually.[8]

The World Health Organisation (WHO) categorises FGM/C into four types, namely, clitoridectomy (type I); excision (type II); infibulation (type III); and other harmful procedures on female external genitalia (type IV) practised by ethnic groups across countries.[9] Clitoridectomy is the partial or total removal of the clitoris and/or the prepuce (where the glans and/or the body of the clitoris are cut);[10] excision or type II is the partial or total removal of the clitoris and/or the prepuce (where the glans and/or the body of the clitoris are cut) as well as the labia minora, with or without excision of the labia majora; infibulation or type III is the narrowing of the vaginal orifice and the creation of a covering seal by cutting and apposition or sewing together the labia minora and/or the labia majora, with or without excision of the clitoris; and type IV entails all other harmful procedures or injury to the female genitalia for non-medical reasons, which include pulling, pricking, piercing, incising, scraping and cauterisation.[11] The severity of the cut progressively increases from clitoridectomy to excision and infibulation respectively as more tissue is damaged as well as the attendant health complications. The type of FGM/C varies within and between communities and geographies. Furthermore, the practice of FGM/C has undergone considerable changes in form and context across practising communities. Some of these changes include shifting from traditionally performed FGM/C types (infibulation or excision) to less severe forms (type I or IV), the cutting of girls at a younger age and medicalisation of FGM/C.[12]

MICS and other national surveys, 2023, https://data.unicef.org/topic/child-protection/female-genital-mutilation/ (accessed 9 February 2023).

7 A Armelle & M Lesclingand 'Female genital mutilation around the world' (2017) 543 *Population and Societies* 1-4.

8 UNICEF Female genital mutilation statistics, 2024, https://data.unicef.org/topic/child-protection/female-genital-mutilation/ (accessed 15 March 2025).

9 WHO (n 3).

10 A Jasmine and others 'Care of women with female genital mutilation/cutting' (2011) 6 *Swiss Medical Weekly* w13137.

11 WHO (n 3).

12 S Kimani and others 'Female genital mutilation/cutting: Emerging factors sustaining medicalisation related changes in selected Kenyan communities' (2020)

2 Introduction to medicalisation of female genital mutilation/cutting

The WHO defines medicalisation as situations in which FGM/C is practised by any cadre of healthcare providers in a public or private clinic, at home, or elsewhere, at any point in a woman's life (including re-infibulation).[13] It represents a change where the healthcare professional (doctor, nurse, midwife, or other health allied professionals or their trainees) performs FGM/C either in a health facility, at home or a neutral place, often using surgical tools, anesthetics and antiseptics.[14] Medicalisation also includes the practice of re-infibulation which entails re-closing of the external genitalia of a woman who had been de-infibulated (opened) to allow for delivery, sexual intercourse to consummate marriage and/or other specific gynecologic procedures for non-medical reasons by health workers.[15]

The classification of medicalisation of FGM/C as per the WHO definition, which mainly considers the extent of damage to the genital tissue, is problematic.[16] Indeed, there has been no clear evidence of what medicalisation entails in terms of the tissues involved because of a lack of objective clinical examination data on the status of external genitalia. However, findings from interviews reveal that medicalisation is a less severe form of FGM/C, implying that it could be a clitoridectomy or type IV based on the extent of tissue and structures involved. That said, a number of FGM/C sub-types are consistent with the broad definition of less severe types of FGM/C carried out during medicalisation, including rubbing, scraping, stretching, pricking and piercing, incision, and excision. For example, evidence from Indonesia shows that there are FGM/C sub-types that would fit as type I and type IV based on

15 *PLoS ONE* e0228410. See also S Kimani & B Shell-Duncan 'Medicalised female genital mutilation/cutting: Contentious practices and persistent debates' (2018) 10 *Current Sexual Health Reports* 25-34.

13 WHO, UNFPA, UNHCR, UNICEF, UNIFEM, FIGO, ICN, MWIA, WCPA, WMA 'Global strategy to stop health-care providers from performing female genital mutilation' 2010, https://www.who.int/publications/i/item/WHO-RHR-10.9 (accessed 9 February 2023).

14 WHO and others (n 13) 14.

15 WHO and others (n 13) 14-15.

16 WHO and others (n 13).

the WHO typology.[17] However, there also exists a sub-type referred to as symbolic FGM/C that is allegedly less harmful and that does not explicitly fit into the WHO typology – the rubbing of the female genitalia using antiseptic as a way of cleaning.[18]

The definition and naming of medicalisation are problematic and have implications for end FGM/C programming. For example, whereas previous studies have depicted medicalisation to perpetuate less severe type of FGM/C, the opposite is also true. Evidence by Dewi and others[19] showed that 46 per cent of the health professionals cut more tissue by removing the clitoral hood compared to 23 per cent of the traditional cutters. The professionals performed 30 per cent type IV FGM/C compared to 35 per cent performed by the traditional cutters. These findings are consistent with evidence that midwives and other health professionals perform fewer (26 per cent) less invasive cuttings such as incision, compared to traditional cutters who carried out 41 per cent rubbing/scrapping and incision (50 per cent). This evidence refutes harm reduction as a justification for medicalisation and indicates that healthcare professionals may be performing equally or more severe forms of FGM/C.[20]

Although the definition of medicalisation is universally applied, its applicability may be problematic when attempting to address the practice, especially when targeting the performer. This is because it does not preclude non-clinically (skilled) trained practitioners such as messengers, cleaners, traditional cutters and traditional birth attendants who may perform FGM/C using hospital/clinic-based supplies such surgical antiseptics, pain killers and anesthesia. This is because such practitioners, although not categorised as healthcare professionals, may

17 MP Budiharsana, L Amaliah & B Utomo 'Female circumcision in Indonesia. Extent, implications and possible interventions to uphold women's health rights' 2003, https://knowledgecommons.popcouncil.org/cgi/viewcontent.cgi?article=1033&context=departments_sbsr-rh (accessed 18 February 2023). S Dewi and others 'Female-genital mutilation-cutting: Standing between the tradition and modernity' 2017 Centre for Population Studies, Universitas Gadjah Mada, https://cpps.ugm.ac.id/wp-content/uploads/sites/1070/2020/02/Female-Genital-Mutilation-Cutting_English.pdf (accessed 16 February 2023). WHO (n 3).

18 Dewi and others (n 17).

19 As above.

20 WHO and others (n 13). See also S Kimani, H Barrett & J Muteshi-Strachan 'Medicalisation of female genital mutilation is a dangerous development' (2023) 380 *BMJ* 302.

still access the aforementioned supplies from hospitals or pharmacies and use them in performing FGM/C in many countries with high prevalence of FGM/C. Furthermore, the clinically-trained professionals (doctors, nurses, midwives and medical assistants) may feel demeaned or demotivated for being grouped together with non-skilled professionals in committing a non-ethical practice such as the medicalisation of FGM/C.

Moreover, the skilled healthcare workers, including doctors, midwives, nurses and medical assistants, subscribe to vibrant associations and regulatory bodies enabling professional advancement, advocacy and quality control through self-regulation. These institutions are important in addressing ethical and professional actions involving acts of commission and omission, for example, the medicalisation of FGM/C. Their interventions for addressing medicalisation are enshrined in laws and regulatory policies that impose sanctions and disciplinary actions against professional who may perpetrate the practice. This makes the professionals an important facet for the advancement of human rights, fitting into advocacy roles as well as protection and care of the vulnerable and hard to reach girls at risk of FGM/C. These deterrent mechanisms may be difficult to find in non-skilled persons who participate in the performance of FGM/C. This calls for a specific and comprehensive definition of medicalisation of FGM/C for more targeted strategies towards the practice.[21] It also calls for multi-sectoral collaboration to facilitate reconciliation between professional regulatory policies and national laws that address FGM/C in tackling the medicalisation of FGM/C.

2.1 Magnitude of medicalisation of female genital mutilation/cutting

The phenomenon of medicalisation is of great interest because girls (0-14 years of age) are increasingly subjected to the practice. It also presents a new challenge in achieving the total abandonment of FGM/C. Data on magnitude and prevalence of FGM/C, including its medicalisation, is generated from representative data obtained using the FGM/C module incorporated in the Demographic Health Survey

21 Kimani and others (n 20).

(DHS) and Multiple Indicator Cluster Surveys (MICS) implemented across various countries.[22] Emerging evidence from these data sources has been critical for monitoring the prevalence, trends and patterns of FGM/C across countries, while qualitative studies suggest that families in certain communities are increasingly opting for medicalisation for their daughters. The practice has become popular because of its alleged potential to minimise FGM/C-related health risks, the willingness of the health professionals to carry out the procedure, financial incentivisation and social recognition for the performer who is purported to offer 'special services'.[23]

Significantly, the highest proportion of women (15 to 49 years of age) who have undergone medicalised FGM/C have been reported in Sudan where seven in ten (67 per cent) have been cut by healthcare professionals, followed by Egypt with four out of ten (38 per cent), Guinea with two out of ten (15 per cent), Kenya, two out of ten (15 per cent) and Nigeria has one out of ten (13 per cent).[24] Of interest is Nigeria where the prevalence appears small but huge in absolute numbers given the population size of the country. Furthermore, nuanced analyses of medicalisation data show that the risk of FGM/C is higher among daughters (0 to 14 years) compared to their mothers (15 to 49 years). Girls who have FGM/C performed by healthcare professionals amount to 82 per cent in Egypt, 78 per cent in Sudan, 20 per cent in Kenya and 12 per cent in Nigeria.[25] This is an indication that medicalisation is gaining momentum based on geography and ethnicity, a trend more likely to normalise FGM/C, encouraging its continuation rather than its abandonment.[26] This calls for more targeted strategies toward medicalisation, because there is realistic evidence that the practice may

22 UNICEF (n 6).

23 Kimani & Shell-Duncan (n 12) and WHO and others (n 13). B Shell-Duncan, Z Moore & C Njue 'The medicalisation of female genital mutilation/cutting: What do the data reveal?' 2017 Population Council New York, https://www.popcouncil.org/uploads/pdfs/2017RH_MedicalizationFGMC.pdf (accessed 17 February 2023).

24 Kimani & Shell-Duncan (n 12) and Shell-Duncan and others (n 23).

25 As above.

26 Kimani & Shell-Duncan (n 12) and HM Doucet, C Pallitto & D Groleau 'Understanding the motivations of health-care providers in performing female genital mutilation: An integrative review of the literature' (2017) 14 *Reproductive Health* 46.

continue to erode the gains achieved in addressing FGM/C for decades across the globe.

2.2 Reasons why families choose medicalisation of female genital mutilation

Evidence shows that the decision to adopt medicalisation of FGM/C is dependent on community as well as healthcare professional-related factors. These factors include conforming to communities' social norm systems, sustained through rewards and punishment aimed at enforcing adherence over generations. Medicalisation has also been perpetuated through the narrative that it allegedly minimised the risk of immediate complications, such as pain and bleeding, associated with FGM/C. This narrative is based on the notion that in the case of medicalisation there is less severe cutting, FGM/C is done by a healthcare professional, and the use of health facility supplies could help address the expected immediate complications.[27] The practitioners of medicalised FGM/C are known to benefit financially from payments done for the girl as well as the elevated social recognition status for offering 'special services' to the community. This status and consideration help to build trust among community members, promoting the uptake of other healthcare services offered by the professional guaranteeing income for the longest.[28]Of importance is the notion that community members and healthcare professionals from FGM/C-prevalent cultures believe that medicalisation is acceptable, promotes quick recovery and could help evade law enforcement because of a quick turnaround time of healing.[29] The healthcare professionals perform FGM/C to reduce harm as they consider performing it would prevent expected danger that would arise if the procedure was to be carried out by traditional practitioners.[30]

27 WHO and others (n 13).

28 C Njue & I Askew 'Medicalisation of female genital cutting among the Abagusii in Nyanza province' 2004 Population Council, https://knowledgecommons.popcouncil.org/departments_sbsr-rh/32/ (accessed 17 February 2023). AJ Pearce & S Bewley 'medicalisation of female genital mutilation. Harm reduction or unethical' (2014) 24 *Obstetrics, Gynaecology and Reproductive Medicine* 29-30. B Shell-Duncan 'The medicalisation of female "circumcision": Harm reduction or promotion of a dangerous practice?' (2001) 52 *Social Science and Medicine* 1013. Shell-Duncan (n 23).

29 Kimani & Shell-Duncan (n 12).

30 Shell-Duncan (n 23).

However, medicalisation has been condemned and challenged at global and national level as it neither has any medical benefit, nor does it prevent long-term medical, psychological or sexual complications associated with the practice, and it also perpetuates human rights violations.[31] On the contrary, medicalisation is believed to normalise and encourage the continuation of FGM/C among the practising communities. This is because healthcare professionals are respected members of society and are likely to be emulated when they subject their daughters to FGM/C or participate in the cutting of girls.[32] Although laws, policies and strategies for addressing the abandonment of FGM/C including medicalisation have been developed, their effectiveness have not been ascertained because of a paucity of real time data. However, fewer strategies exist for tackling increasing medicalisation, while their effectiveness is unclear. Among the countries that have banned the medicalisation of FGM/C, Burkina Faso is the best case scenario.[33]

3 How has medicalisation of FGM/C been addressed? A health approach

Generally, interventions for addressing FGM/C have largely adopted the health approach model. This approach highlights the negative health effects of FGM/C, including the immediate and long-term physical effects, birth, gynecological, psychosocial and sexual complications that compromise the right to health of women and girls.[34] However, the narrative involving health complications has been attributed to the rise of medicalisation as families figured how they could mitigate these effects. Indeed, persistent medicalisation is shown to have been promoted by heightened awareness about health complications associated with traditionally performed FGM/C. These interventions motivated families to seek FGM/C services from healthcare professionals who

31 WHO and others (n 13).
32 WHO and others (n 13).
33 UNFPA & UNICEF 'Joint evaluation of the UNFPA-UNICEF Joint Programme on the Elimination of Female Genital Mutilation: Accelerating change Phase III (2018-2021), https://www.unfpa.org/joint-evaluation-unfpa-unicef-joint-programme-elimination-female-genital-mutilation-accelerating (accessed 17 February 2023).
34 WHO study group on female genital mutilation and obstetric outcome 'Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries' (2006) 9525 *Lancet* 1835-1841.

were assumed to conduct the procedure safely and could cut less severely while the recovery period was shorter for medicalised girls.[35] The practice was aimed at countering the narrative of FGM/C-related health impacts linked to unhygienic conditions; the use of unclean or non-sterile equipment; alleged poor skills of traditional cutters; extensive cutting and the associated immediate health complications including pain, bleeding and infections associated with traditionally performed FGM/C.[36]

Notwithstanding this, the assertion that medicalisation is safe is not correct. This is because it does not address the long-term health complications such as keloids and psychological effects, for example, psycho-trauma linked to FGM/C.[37] Furthermore, the healthcare professionals lack the expertise for performing FGM/C as no formal training is offered during medical/health training programmes on how to conduct it. Therefore, the professionals may be utilising the general principles learnt in surgical and medical practice, bringing to question their competencies and skills in performing FGM/C procedures involving sensitive female external genitalia. In some cases, extremely young girls in their neonatal period (0 to 28 days) have been subjected to FGM/C. The practice of FGM/C with all its illegality and the extensive damage to healthy tissues is characterised by a lack of curriculum and standard protocols on how to perform it. This fact is quite different from male circumcision – a beneficial practice that is erroneously equated to FGM/C, despite the less severe tissues cut compared to FGM/C. In male circumcision the health professionals undergo specialised training; there is an approved curriculum as well as standard operating procedures on how the procedure should be performed across countries.[38]

35 N Bedri and others 'Shifts in FGM/C practice in Sudan: Communities' perspectives and drivers' (2019) 19 *BMC Women's Health* 168. S Modrek & M Sieverding 'Mother, daughter, doctor: Medical professionals and mothers' decision making about female genital cutting in Egypt' (2016) 42 *International Perspectives on Sexual and Reproductive Health* 81. Kimani & Shell-Duncan (n 12) and Shell-Duncan (n 23).

36 Kimani & Shell-Duncan (n 12), Pearce & Bewley (n 28) and Shell-Duncan (n 40). S Kimani, J Muteshi & C Njue 'Health impacts of female genital mutilation/cutting: A synthesis of the evidence' 2016 Population Council, http://www.popcouncil.org/EvidencetoEndFGM-C (accessed 17 February 2023).

37 Kimani and others (n 36).

38 WHO 'Manual for male circumcision under local anaesthesia and HIV prevention services for adolescent boys and men' Geneva, 2018, World Health Organisation,

The evidence on the lack of protocols for FGM/C is affirmed by interviews with medical professionals from Indonesia, a country with very high rates of medicalisation and where close to 60 million women have been subjected to FGM/C.[39] The findings revealed that no special training was offered to the medical professionals, traditional birth attendants and circumcisers on how to perform FGM/C as opposed to the structured training on male circumcision, performed regularly, and based on clear and standardised protocols.[40] Furthermore, the use of anesthesia which dampen the pain sensation and the fact that FGM/C is performed on very young girls are likely to harm more or extensively damage the external genital tissues because of a large body surface area compared to when the procedure is done on mature girls or adults.[41] For example, in the case of a seven days old girl, how much tissue can the fingers of the health care worker or traditional cutter hold for cutting during the FGM/C procedure. I theorise that there is more extensive cutting during FGM/C for infants than when a mature girl is involved.

Interestingly, the health approach has been used in addressing FGM/C by spotlighting the FGM/C-related health complications in the hope that communities will be motivated to abandon the practice. This is premised on the evidence that all forms of FGM/C have no known health/medical benefits but instead are harmful to girls and women.[42] Moreover, the practice of FGM/C interferes with the natural functioning of girls' and women's bodies, as it removes and/or damages healthy functional genital tissue.[43] This compelling messaging anchored through the health approach might have encouraged health professionals to comply with their clients' requests to perform FGM/C and justified this as a 'less harmful' alternative when compared to the traditionally

https://apps.who.int/iris/bitstream/handle/10665/272387/9789241513593-eng.pdf (accessed 17 February 2023).

39 UNICEF (n 7).

40 R Patel & K Roy 'Female genital cutting in Indonesia' 2016, Islamic Relief Canada, https://had-int.org/e-library/female-genital-cutting-in-indonesia/ (accessed 17 February 2023).

41 Kimani and others (n 20) and DF Huelke 'An overview of anatomical considerations of infants and children in the adult world of automobile safety design' (1998) 42 *Annual Proceedings/Association for the Advancement of Automotive Medicine* 93-113.

42 WHO (n 3).

43 WHO (n 38).

performed cutting.[44] This narrative is supported by regulatory policies issued by governments' ministries' of health in Egypt in the 1990s, and Indonesia in the 2000s, that issued decrees for FGM/C to be performed by a specific cadre of healthcare professionals in designated health facilities to minimise the negative health complications.[45] The policy decrees were criticised by human rights activists leading to their revocation with notable residual professionals and infrastructure that supplied and might have enjoyed financial lucrativeness of the medicalised FGM/C services. This was not difficult to sustain the supply-demand chain of medicalised FGM/C despite its outlawing as facilitative residual loopholes for the practice still existed.[46] No wonder, therefore, that the proportions of medicalisation are extremely high in these two countries partly because of the initial legal/policy decisions made around FGM/C.

Similar moves were observed in Europe and North America during the 1990s because of an influx of immigrants from FGM/C-prevalent countries. The proposals were to allow for pricking and consent for FGM/C instead of the severe cutting in older children as a way of balancing respect for cultural values, host countries laws, medical and ethical principles while minimising health risks. These proposals, however, remained as ideas because of pressure and backlash from human rights activists. From the aforementioned narrative, the health approach has had mixed outcomes with regard to the elimination of FGM/C. The unintended consequences of medicalisation of FGM/C are the most prominent outcomes.

Nevertheless, professional bodies associated with medical doctors, for example, the World Medical Association, the American College of Obstetricians and Gynecologists and the American Medical Association, have unequivocally condemned medicalisation. This is in addition to the global body for obstetricians and gynecologists, the International Federation of Gynecology and Obstetrics (FIGO), which also condemned medicalisation.[47] However, the American Association

44 WHO and others (n 13).
45 Kimani & Shell-Duncan (n 12). See also O El-Gibaly, M Aziz & SA Hussein 'Health care providers' and mothers' perceptions about the medicalisation of female genital mutilation or cutting in Egypt: A cross-sectional qualitative study' (2019) 19 *BMC International Health and Human Rights* 26.
46 Kimani & Shell-Duncan (n 12) and Dewi and others (n 17).
47 WHO and others (n 13).

of Pediatrics in 2010 took a position of supporting medicalisation by issuing a statement calling for permissibility of pediatricians to perform nicking/pricking.[48]

The pronouncement triggered stiff public outcry and condemnation prompting a swift recall of the statement.[49] The pronouncements and actions by the medical regulatory bodies resulted to a singular commitment by medical doctors in condemning the medicalisation of FGM/C globally. These positive actions beg the question of whether this could be part of the reason why the proportions of FGM/C cases performed by medical doctors are fewer compared to other healthcare cadres. Of course, with the exception of Egypt, a country where medicalised FGM/C is predominantly performed by medical doctors. Conversely, could the absence of other healthcare cadres in issuing pronouncements and statements condemning medicalisation be the missing link in addressing this practice globally? These critical questions should be interrogated because inclusivity and equity in policy making and programming can accelerate and scale up the pace of addressing FGM/C.[50] For example, most nurse-midwives and other healthcare allied workers interface with community members, including women and girls at risk of FGM/C within primary healthcare facilities (healthcare centres and dispensaries) presenting a special opportunity to address the practice.

Therefore, this special human resource for health should be targeted for a health approach to succeed in addressing FGM/C and its medicalisation. Recently, in a 2017 summit organised in Egypt, public statements against medicalisation were issued by professional medical associations from Djibouti, Egypt, Somalia, Sudan and Yemen.[51] There is a need for an evaluation to understand the impact of condemnation in regard to the prevalence of medicalisation in countries of which professionals were involved. It should be noted that the health approach tolerates some FGM/C provided harm is minimised. Indeed, the health model triggered debates on how to distinguish acceptable risk from

48 Serour (n 4).
49 Serour (n 4).
50 Government of Canada 'Best practices in equity, diversity and inclusion in research' 2021, https://www.sshrc-crsh.gc.ca/funding-financement/nfrf-fnfr/edi-eng.aspx (accessed 16 February 2023).
51 Kimani & Shell-Duncan (n 12).

intolerable harm, or who has the right to make such distinctions opening up interpretive issues, linked to legal, ethical, medical and human rights claims about the limits of individual autonomy and tolerance of multiculturalism.[52] Generally, interventions for addressing FGM/C through the health approach have permissibility to harm reduction model of addressing FGM/C which may be tolerable to interventions that prevent harms associated with the cutting conducted by traditional practitioners. This presents a dilemma and tension with the do no harm principle as well as zero tolerance stand by the right based model of addressing FGM/C. Clearly, to address medicalization of FGM, intervention should integrate both elements of health as well as rights-based model.

4 How has medicalisation of FGM/C been addressed? A human rights-based approach

The practice of FGM/C has also been addressed from the perspective of a human rights-based approach. The rights-based model is premised on the narrative that FGM/C is a violation of women's and girls' rights, interferes with bodily integrity, damages normal functional genital tissue, compromises the possibility of the highest standard of health and undermines the right to health.[53] The proponents of this model argue on the aforementioned facts encapsulated in the international legal-policy instruments and treaties that member states have ratified and whose accountability is required. The human rights approach in ending FGM/C is anchored on provisions contained in international standards and norms (mechanisms/treaties) that provide important frameworks for clarifying that the practice constitutes a violation of human rights.[54]

Importantly, the international treaties address the impact of FGM/C in hindering women's and girls' agency, their enjoyment of human rights and gender equality. The treaties stipulate governments' obligations to

52 Kimani & Shell-Duncan (n 12).

53 WHO and others (n 13) and R Khosla, S Lale & M Temmerman 'Sexual health, human rights, and law' (2015) 386 *The Lancet* 725-726.

54 R Khosla and others 'Gender equality and human rights approaches to female genital mutilation: A review of international human rights norms and standards' (2017) 14 *Reproductive Health* 322-325.

establish legislative and policy instruments, specify requirements and actions for duty bearers in advancing the actualisation of human rights.[55]

Several international human rights treaties explicitly and implicitly address states' obligations to eliminate FGM/C as explained below. The Universal Declaration of Human Rights (Universal Declaration) is cited to have provisions for ensuring that all people enjoy freedom, equality and dignity. With regard to ending FGM/C, it avers that no one shall be subjected to torture or cruel, inhuman or degrading treatment or punishment.[56] The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) requires states to take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women. It promotes the advancement of women.[57] The Convention on the Rights of the Child (CRC) underscores the importance of ensuing protection and care for children and recognises the responsibility of state parties in this regard. CRC established the 'best interests of the child' standard in addressing the rights of children, as well as autonomy related to their evolving capacity. The practice of FGM/C is recognised as a violation of the best interest standard and a violation of children's rights, and mandates state parties to abolish traditional practices prejudicial to the health of children.[58]

Moreover, the International Covenant on Civil and Political Rights (ICCPR) protects the rights to life, liberty, freedom from torture and slavery with specific end-FGM/C provisions stating that no one shall be subjected to torture or to cruel, inhuman or degrading treatment or

55 UN General Assembly 'Intensifying global efforts for the elimination of female genital mutilations' UNGA, A/C.3/67/L.21/Rev.1, 16 November 2012, https://digitallibrary.un.org/record/746164?ln=en (accessed 17 February 2023).

56 United Nations The Universal Declaration of Human Rights Proclaimed by the United Nations General Assembly in Paris on 10 December 1948 (General Assembly Resolution 217 A, during its 183rd plenary meeting), https://www.un.org/en/about-us/universal-declaration-of-human-rights (accessed 17 February 2023).

57 United Nations Convention on the Elimination of All Forms of Discrimination against Women General Assembly Resolution 34/180 of 18 December 1979, https://www.un.org/womenwatch/daw/cedaw/ (accessed 17 February 2023).

58 UNICEF Convention on the Rights of the Child General Assembly Resolution 44/25 of 20 November 1989, https://www.unicef.org/child-rights-convention/convention-text (accessed 17 February 2023).

punishment.[59] The International Covenant on Economic, Social and Cultural Rights (ICESCR) protects the right to economic, social and cultural rights. With regard to ending FGM/C, it mandates member states to ensure equal rights of men and women to the enjoyment of all economic, social and cultural rights set forth in ICESCR.[60]

Importantly, a number of regional human rights treaties explicitly and implicitly address the elimination of FGM/C as described in the following narrative. The African Charter on Human and Peoples' Rights (African Charter) contains provisions that guarantee fundamental and human rights for the African people. In regard to FGM/C, it prohibits all forms of degradation, particularly torture, cruel, inhuman or degrading punishment and treatment of humans.[61]

Similarly, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol)[62] provides for the protection of the human rights of African women. It mandates state parties to combat all forms of discrimination against women through appropriate legislative, institutional and other measures (article 2).[63] The specific provisions addressing FGM/C include that every woman shall have the right to dignity through the recognition and protection of her human and legal rights (article 3); [64] that all forms of cruel, inhuman or degrading punishment and treatment shall be prohibited (article 4); [65] and that state parties have an obligation

59 United Nations International Covenant on Civil and Political Rights General Assembly Resolution 2200A (XXI) of 16 December 1966, https://treaties.un.org/doc/publication/unts/volume%20999/volume-999-i-14668-english.pdf (accessed 17 February 2023).

60 United Nations International Covenant on Economic, Social and Cultural Rights General Assembly Resolution 2200A (XXI) of 16 December 1966, https://treaties.un.org/doc/treaties/1976/01/19760103%2009-57%20pm/ch_iv_03.pdf (accessed 17 February 2023).

61 African Union African Charter on Human and Peoples' Rights. Decision 115 (XVI) of the Assembly of Heads of State and Government at its 16th ordinary session held in Monrovia, Liberia, 1979, https://au.int/sites/default/files/decisions/9526-assembly_en_17_20_july_1979_assembly_heads_state_government_sixteenth_ordinary_session.pdf (accessed 17 February 2023).

62 African Union Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, adopted by the 2nd ordinary session of the Assembly of the Union 2003, https://au.int/en/treaties/protocol-african-charter-human-and-peoples-rights-rights-women-africa (accessed 17 February 2023).

63 Arts 2(1) & (2) African Women's Protocol.

64 Arts 3(1) & (4) African Women's Protocol.

65 Arts 4(1) & (2) African Women's Protocol.

to prohibit and condemn all forms of harmful practices that negatively affect the human rights of women and that are contrary to recognised international standards (article 5).[66]

The African Charter on the Rights and Welfare of the Child (African Children's Charter) seeks to protect the human rights and welfare of the African child. The treaty contains provisions addressing FGM/C,[67] namely, any custom, tradition, cultural or religious practice that is inconsistent with the rights, duties and obligations for the protection of a child shall be discouraged (article 1);[68] all actions concerning the child undertaken by any person or authority shall be in the best interests of the child as the primary consideration (article 4);[69] state parties are mandated to take specific legislative, administrative, social and educational measures to protect the child from all forms of torture, inhuman or degrading treatment while in the care of a parent, legal guardian or school authority or any other person who has been assigned the care of the child; and state parties are obliged to take all appropriate measures to eliminate harmful social and cultural practices affecting the welfare, dignity, normal growth and development of the child (article 21).[70]

Moreover, the African Youth Charter contains provisions that protect human rights and freedom of the African youth.[71] In regard to addressing FGM/C, the Youth Charter has the following provisions: Every young person shall have the right to enjoy the best attainable state of physical, mental and spiritual health (article 16);[72] state parties shall eliminate all traditional practices that undermine the physical integrity and dignity of women (article 20);[73] state parties shall introduce legislative measures that eliminate all forms of discrimination against girls and

66 Arts 5(a)-(d) African Women's Protocol.
67 African Union African Charter on the Rights and Welfare of the Child (AHG/ST.4 Rev.l) adopted by the Assembly of Heads of State and Government of the Organisation of African Unity at its 16th ordinary session in Monrovia, Liberia, 1979, https://www.achpr.org/public/Document/file/English/achpr_instr_charterchild_eng.pdf (accessed 17th February 2023).
68 Art 1(3) African Children's Charter.
69 Art 4(1) the African Children's Charter.
70 Art 21(1) African Children's Charter.
71 African Union African Youth Charter Resolution of the Heads of State and Government during the 1999 Algiers Summit for the development of the Pan-African Charter, https://au.int/sites/default/files/treaties/7789-treaty-0033_-_african_youth_charter_e.pdf (accessed 17 February 2023).
72 Art 16(1) African Youth Charter.
73 Art 20(a) African Youth Charter.

young women and ensure their human rights and fundamental freedoms (article 23);[74] they shall enact and enforce legislation that protect girls and young women from all forms of violence and FGM/C (article 23);[75] the development of programmes of action that provide legal, physical and psychological support to girls and young women who have been subjected to violence and abuse such that they can fully be re-integrated into social and economic life (article 23);[76] and state parties shall take all appropriate steps to eliminate social and cultural practices that affect the welfare and dignity of youth (article 25).[77]

The adoption and ratification of these treaties reflect a consensus that FGM/C constitutes a violation of human rights, and member states should take actions to end the practice and its medicalisation. The state parties' interventions include taking necessary measures, such as enacting and enforcing legislation to prohibit FGM/C. The adoption of the legal-policy instruments stimulated the end of FGM/C interventions in the member states with over 40 countries having banned the practice of FGM/C through laws or constitutional decrees. Countries have also addressed medicalisation, with some having specific prohibitions on FGM/C laws or provisions in their penal codes that prescribe penalties (imprisonment and/or fine) for medical professionals who perform FGM/C, as well as additional punitive actions such as the suspension of practising licences of those who perform FGM/C.[78]

Importantly, the rights-based model is premised on a 'zero tolerance' approach of which the key principle is intolerance for all forms of FGM/C. The platform for action developed at the 1995 Fourth World Conference on Women laid a blueprint for framing FGM/C as a human rights violation.[79] Drawing on these principles, the UN advanced a zero tolerance approach opposing all forms of FGM/C, a position that reflected a break from the earlier health framework on how health risks

74 Art 23(1)(a) African Youth Charter.
75 Art 23(1l) African Youth Charter.
76 Art 23(1)(m) African Youth Charter.
77 Art 25 African Youth Charter.
78 B Shell-Duncan and others 'Legislating change? Responses to criminalising female genital cutting in Senegal' (2013) 47 *Law and Society Review* 803.
79 UNESCO 'Beijing Declaration and Platform for Action' 1995 Fourth World Conference on Women, https://www.un.org/womenwatch/daw/beijing/pdf/BDPfA%20E.pdf (accessed 17 February 2023).

might be minimised.[80] Strategies that promote and protect these rights have faced the challenge of simultaneously addressing competing rights claims, namely, how the rights of the child, women's rights to freedom from discrimination, freedom from torture, and the right to bodily integrity and health can be reconciled with a right to culture or religious freedom.[8182] The challenges have presented legal, ethical, medical and human rights dilemmas about FGM/C and interventions that need to be implemented, slowing the efforts against FGM/C, including its medicalisation.

The strictest application of the zero tolerance stance prohibits any non-therapeutic procedure involving the female genitalia. However, when prohibition is linked to the concept of harm, as is stipulated in certain penal codes,[83] questions arise as to whether restrictions also apply to nicking, pricking or scraping of the clitoris or clitoral hood (type IV procedures).[84]

The growing consensus on defining FGM/C as a human rights violation underscores that concerns are not limited to minimising health risks, but rather extend to broader concerns on child protection and well-being, consent, bodily integrity, and discrimination against women. Medical ethicists, legal experts and policy makers alike have been forced to confront competing rights claims, including the right to health, the right to bodily integrity, the rights of the child, the right to culture and the right to religious freedom. The lack of clear-cut, definitive answers regarding the priority of the competing claims has stimulated debates surrounding medicalisation, some of which have now become objects of scrutiny in courts of law around the world.[85]

Interestingly, there has been a very thin line between the health and rights-based approaches. While proponents of the right-based approach depict that FGM/C violates the rights of women and girls, those who advance the health-based model highlight pervasiveness of health impacts of FGM/C, an indication of convergence in the two

80 B Shell-Duncan 'From health to human rights: Female genital cutting and the politics of intervention' (2018) 110 *American Anthropologist* 225.
81 Kimani & Shell-Duncan (n 12).
82 Shell-Duncan (n 78).
83 Khosla & others (n 54).
84 WHO & others (n 13).
85 Kimani & Shell-Duncan (n 12).

models. This portends that combining the elements and components of the two models in responding to FGM/C prevention, protection and care has the potential for success as opposed to adopting a singular approach. The strength of a combined approach could be based on the principle of complementarity and synergy with weaknesses in one model being cancelled out by the strengths of the other. The successful implementation of the combined model requires capacity building through training of proponents of the two approaches to help reconcile the approaches for concerted efforts in addressing FGM/C. This could also address the issue of framing of the practice and consistency across actors in ending FGM/C. In sum, there has been a convergence and/or intersection between the health and human rights-based approaches in response to FGM/C, calling for a reconciliation of the two models.

5 Ethical dilemma in the context of medicalisation

The healthcare professionals face a dilemma in handling the medicalisation of FGM/C. This is partly because of the cultural nature of FGM/C, the negative impacts associated with the procedure, systemic and capacity challenges, the need for respect of clients' autonomy, as well as professional and ethical requirements. Some healthcare professionals belong to or identify with the culture of the FGM/C practising communities. However, these professionals are ethically required to adhere to the 'Hippocratic oath' and the 'do no harm principle', as well as the best practices prescribed in the WHO generated tools on FGM/C prevention and response. The emergence of and increasing request by families for the healthcare professionals to perform medicalisation on their daughters present some personal and community contestations that require reconciliation. These tensions can be resolved through professional training, dialogues as well as communication to help them apply professionalism when dealing with clients and communities.

The principle of 'do no harm' was first documented by a Hippocratic writer approximately 2 400 years ago, and has since been the basis and guide for ethical behaviour for the practice and training in medicine education.[86] Doctors have been observing this principle for centuries as

86 M Wallace 'From principle to practice: A user's guide to do no harm 2014 CDA Collaborative Learning Projects, https://cdacollaborative.org/wordpress /wp-

part of the Hippocratic oath upon which they uphold their practice.[87] The basis of this principle is that the well-being of the people being helped must be the focus of efforts or interventions to help them. In other words, the cure must not be worse than the disease and the intervention must not destroy (or harm) that which it is meant to help.[88] The implication of the 'do no harm' principle is the need to have a holistic perspective and focus on both harm and benefit in the actions taken. In other words, if there is the slightest possibility of harm, this should not warrant doing nothing at all because harm cannot be avoided by failing to act. This is because doing nothing when people are in need is clearly doing harm.[89]

Therefore, in the context of FGM/C, harm reduction has been proposed as a key justification for medicalisation and used to depict pacification of mostly the immediate complications compared to traditionally-performed cutting.[90] However, it is well understood that medicalisation address neither long-term complications nor human rights violations associated with the procedure. This is the contention between the context of the 'doing no harm' principle and harm reduction. These terms have been erroneously and interchangeably used to justify medicalisation. However, in no way would medicalisation be a marker of the 'do no harm' principle because of its associated health complications, human right violations, and negation of the Hippocratic oath to which healthcare professionals swore to adhere. Additionally, medicalisation is more delicate given that healthcare professionals are never trained to perform FGM/C and, therefore, their FGM/C skills level could be sub-optimal compared to the traditional cutters. This ethical dilemma and assertion could be reinforced by case studies from Egypt and Indonesia. These two countries have very high prevalence of FGM/C and its nascent medicalisation. In an effort to implement harm reduction, governments in these countries issued a policy directive allowing medicalisation.[91]

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content/uploads/2016/07/2015-CDA-From-Principle-to-Practice.pdf (accessed 17 February 2023). CM Smith 'Origin and uses of primum non nocere: Above all, do no harm!' (2005) 45 *Journal of Clinical Pharmacology* 371-377.

87 AD Giovanni 'A pebble in the shoe: Assessing international uses of do no harm' (2014) 15 *Völkerrechtsblog.*

88 Giovanni (n 87).

89 As above.

90 Shell-Duncan (n 23).

91 Kimani & Shell-Duncan (n 12) and Patel and others (n 40).

However, vehement outcries and protests from anti-FGM activists and the international community resulted in the revocation of the policy decrees. Such a policy directive had an immediate impact as well as residual effects to date, characterised by a high prevalence of medicalisation of FGM/C in these countries. This is because the infrastructure, human resource, demand and possibly professional culture had already been well established and could not be demolished with a policy revocation. The implication has been that medicalisation has gone underground and is mostly performed under the disguise of genital modification surgeries performed by healthcare professionals in their clinics.[92] This brings to the fore instances of violations of the 'do no harm' principle where girls obviously are the most impacted in terms of health and rights.

Conversely, there is the dilemma based on the conviction for harm reduction associated with the notion that if the health professional does not perform the FGM/C procedure, the girl or woman would be cut unprofessionally by a traditional cutter. This would expose the girl to danger because of unsafe equipment, unclean environment, risking the girl's life with resultant health complications and potentially death. Although this may present a compelling reason, it marks another dilemma around harm reduction making the professionals violate the 'do no harm' principle. This contestation is associated with the inadequate capacity of the health sector players to address dilemmas that may affect professional conduct among healthcare workers. This calls for capacity building through training of healthcare providers on the philosophy and principles of ethical conduct and human rights issues around FGM/C while implementing health interventions towards the practice.

The decision to continue with medicalisation is hinged on such benefits as acceptability, elevated status, economic gain and community trust accorded to the healthcare professionals. This has been linked to heightened uptake of non-FGM/C healthcare services offered by the professionals as the singular most important driver for medicalisation as it guarantees a perpetual income for the professionals. Although the income from performing FGM/C on a girl may not seem high,

92 Kimani & Shell-Duncan (n 13). T McCoy 'Female circumcision led to the death of this Egyptian girl. Today, her doctor stands trial in landmark case' *The Washington Post* 11 May 2014, https://www.washingtonpost.com/news/morning-mix/wp/2014/05/22/female-circumcision-led-to-the-death-of-this-egyptian-girl-today-her-doctor-stands-trial-in-landmark-case/ (accessed 17 February 2023).

the dividends lie in the large number of girls that seek services as well as long-term relationships with families as their choice for provision of comprehensive healthcare services. This presents an ethical dilemma based on economic benefits accrued from the practice. The economic reasons are similar to what is taunted to promote the emerging practice of female genital modifications. The genital modification surgeries are increasingly being performed on well-educated and well-to-do women, and such procedures are presumed to be fashionable and modern. Looking at the modifications, these are mostly performed on mature consenting women, while they mimic type IV FGM/C. However, when FGM/C is performed on a woman, it represents a dilemma of violation of self-determination (autonomy) in regard to who should have the liberty to make decisions on what to do with their body. With the debate on genital modifications, there is a need to adopt a zero tolerance attitude for all forms of FGM/C in Africa due to the high prevalence and the negative impacts associated with the practice. This will allow for a substantial decline of the practice until the proportions of girls at risk have drastically reduced, when perhaps the debates on genital modification can be canvassed. This will give FGM/C programmers seeking to eradicate the practice an opportunity to address the challenges of abandoning the practice, before debating on issues around bodily autonomy that are likely to throw FGM/C abandonment in Africa into disarray.

5.1 Issues of informed consent in the context of medicalisation of FGM/C

Ordinarily, surgical procedures such as FGM/C would require the practitioner to obtain informed consent from the client before performing it. However, FGM/C is mostly performed on girls between the ages of 0 to 14 years, under coercion and situations in which they cannot provide informed consent mainly because of being dependent and legally under age. The best practice dictates that children should be provided with information on the what, why and how of the surgical procedure so that they can give assent while their parents or guardians should give the informed consent. Surprisingly, even when FGM/C is performed on adult women, it is under coercion and immense pressure,

and the decision is made by the healthcare professional, female relatives and husband.[93]

The scenario of not consenting to a surgical procedure presents a professional dilemma that needs reconciliation with other professional best practices. Indeed, this undermines the principle of self-determination (autonomy) on the side of the woman that is affected by social and economic disparities, among other factors.[94] The dilemma is linked to powerlessness and a lack of agency for girls and women because the decision-making capability are usurped by the larger family, the husband/partner and healthcare professionals. The healthcare professional has a role to advocate for the patient's right to health instead of being the perpetrator of FGM/C. This is based on the principle of a fiduciary relationship between a healthcare professional and their patients, which requires them to do no harm and ensure the clients are treated with respect and dignity.[95] Of course, a key driver for FGM/C in whatever form, is the lack of women's rights and economic dependence on men which influences decision making for women's bodies, including medicalisation.[96] Furthermore, a woman may undergo FGM/C in situations of the worst state of helplessness incompatible with principles of consenting (self-determination). For example, a woman who has had FGM/C performed during labour or immediately after giving birth or under anesthesia is in an unsuitable condition and environment for informed consent. Under such circumstances, the woman is helpless, in pain, while her judgment may be blurred subjecting her to the mercy of the healthcare professional who may have a vested interest in the practice. Under such circumstances, what are the chances the woman would resist FGM/C? The informed consent around FGM/C and medicalisation are not tenable and should not be contemplated because the practice

93 GI Serour 'The issue of reinfibulationo' (2010) 109 *International Journal of Gynecology and Obstetrics* 93-96.

94 LM Henry 'An overview of sexual and reproductive health in the context of public health ethics' in AC Mastroianni, JP Kahn & NE Kass (eds) *The Oxford handbook of public health ethics* (2019) 370-377, https://academic.oup.com/edited-volume/28138/chapter-abstract/212903388?redirectedFrom=fulltext (accessed 17 February 2023).

95 BR Furrow 'Patient safety and the fiduciary hospital: Sharpening judicial remedies' (2009) 1 *Drexel Law Review* 439.

96 Serour (n 4).

is outlawed in most countries and is not permissible across healthcare professionals' ethical and professional practice.

5.2 Dilemmas amongst healthcare professionals based on economic gain from medicalisation of FGM/C

Evidence reveals that healthcare professionals perform FGM/C for financial gain. Medicalisation of FGM/C is purportedly performed to mitigate the health complications, notably, immediate health risks through cutting less severely and the use of hospital-related supplies to minimise such effects, for example, infections and bleeding through the harm reduction strategy. To the professionals, although they may be cognisant of these harms, the economic benefits is a key driver of medicalisation outweighing the anticipated harms. In addition, because the professionals seem 'committed' to the social norms of the community, accepting to offer medicalisation services guarantees an amplification of their status and trust among community members. This is both advantageous and economically enticing as the professionals are perceived to offer 'special services' that promote confidence among community members towards their professional services. This promotes the uptake of other healthcare services offered by the professionals, guaranteeing the long-term economic survival of their healthcare businesses.

This incentive presents a dilemma as it borders on a conflict of interest where the professionals put economic gain before service to humanity. Indeed, there is evidence related to the fear of loss of clients by professionals because of a refusal to perform medicalisation. Furthermore, through medicalisation of FGM/C the professionals deliberately or selectively refuse to advise women against FGM/C or re-infibulation despite the known risks associated with the practice. This would amount to doing harm in not sharing vital information with clients regarding the disadvantages of medicalisation. The professional's advice should be based on best medical practice and ethics but, instead, the professional performs FGM/C for personal financial gain.[97] This allegedly has been the reason to escalate the medicalisation of FGM/C in parts of Kenya.[98]

97 WHO & others (n 13).
98 Kimani & Shell-Duncan (n 12).

5.3 Respect for client choice of medicalised FGM/C

Healthcare professionals have had a long history of forging and maintaining relationships with patients based on mutual respect and trust allowing for informed choice with regard to matters of reproductive health. Indeed, a relationship could have existed between the professional and the family long before the parents seek FGM/C services for their daughter. The relationship is characterised by trusting environment where the patient is confident to discuss, negotiate and make decisions around sexual and reproductive health. For example, decisions on the number of children one would wish to have or the choice of family planning methods are some examples involving discussion with the healthcare professional. A similar principle ought to be applied on decision making regarding FGM/C services to allow women to discuss, negotiate and make choices around the procedure. However, because of the patriarchal nature of communities where FGM/C is practised, gender inequality and social norms, such opportunities are never available because the *modus operandi* is through coercion, peer pressure and the disempowerment of women, leaving them with no choice but to embrace and comply with the norms. The fact that the healthcare professionals are not trained and competent to perform FGM/C compounded with no medical benefit and illegal nature of the practice substantially compromises the consenting process.

However, there is growing interest in genital modification surgeries that almost mimic the procedure involved in the practice of FGM/C. Focusing on these surgeries, the emanating broader picture is that, some can go through as type IV FGM/C as per the WHO typology. These surgeries appear to seemingly perpetuate the medicalisation of FGM/C. A typical case study is Egypt and Indonesia, where most FGM/C procedures are performed by healthcare professionals some disguised as genital modification surgeries.[99] The notion of consenting in a women undergoing body piercing procedures and body modification surgeries is often used. However, in body piercing and cosmetic surgery the woman is counselled and gives her informed consent, which can be withdrawn at any time before the procedure as it is not absolute. The issue of decision making in relation to FGM/C among adult women has been of critical interest and gaining momentum. An example is the

99 Patel and others (n 40) and Kimani & Shell-Duncan (n 12).

Dr Tatu Kamau case in Kenya, where she argued that women should be accorded the opportunity to make decisions to undergo FGM/C based on the right to culture which is guaranteed in the Constitution. The case was adjudicated with the Court handing down a judgment that FGM/C remains illegal in Kenya. Additionally, the Court proposed amendments to the Prohibition of Female Genital Mutilation Act 32 of 2011 (Act) to address the gaps identified in the law, including how to address/regulate genital modifications as potential procedures that could be used to shift the way FGM/C is performed moving forward.[100]

6 Conclusion

There is a persistent twin challenge of FGM/C and its medicalisation in some countries with a high prevalence of the practice. These challenges imply continued negative long-term health effects and human rights violations of women and girls. Medicalisation and its associated impacts that are poorly understood present an ethical and moral dilemma amongst healthcare professionals as they offer healthcare services in response to communities' cultural needs. Interventions for addressing FGM/C have coalesced around health and human rights-based approaches. The health approach adopts a harm reduction strategy based on the evidence that the professionals could address the negative health complications. The approach is adopted in the hope that communities understand the severe effects of FGM/C, act to protect girls and women from the practice, abandon the practice in solidarity with a clarion call for promoting and protecting human rights. The approach, however, created unintended consequences where communities believed the complications could be resolved by healthcare professionals through medicalisation. This erroneous notion is compounded by the fact that healthcare professionals lacked skills and knowledge to resist medicalisation, while medicalisation itself is not safe from long-term complications and human rights violation. The human rights-based approach adopts a zero tolerance approach to any form of FGM/C based on the fact the practice interferes with the fundamental right to bodily integrity, the right to health, affects normal functional genital tissue and is a violation of the

100 High Court of Kenya 2019 'Republic of Kenya in the High Court of Kenya at Nairobi, Constitutional Petition No. 244 of 2019' (244): 1-81.

human rights of women and girls. Actors advocating either the health or human rights-based approach converge in principle on the need to end FGM/C. However, the stand-alone approach in which the two models have been implemented has not successfully eradicated the practice.

Indeed, the approach has resulted in tensions between the implementers of the health and rights-based approaches that require reconciliation at all levels. This chapter proposes an integrated model of the dual approaches to promote cohesion, speed and a scaling-up of the eradication of the medicalisation of FGM/C, as well as resolving the dilemmas of the unintended consequences. There is a need for policy makers, programmers and implementers to consider training dialogues and engagement to promote intersectionality of a health and human rights-based model in the eradication of medicalisation.

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