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Global strategy to stop health-care providers from performing female genital mutilation

UNFPA, UNHCR, UNICEF, UNIFEM, WHO,
FIGO, ICN, IOM, MWIA, WCPT, WMA

World Health Organization

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Note on terminology

The term “female genital mutilation” is used in this strategy as it was in the two interagency statements on female genital mutilation (WHO 1997 and WHO 2008). The word “mutilation” emphasizes the gravity of the act. Some United Nations agencies use the term “female genital mutilation/cutting” wherein the additional term “cutting” is intended to reflect the importance of using non-judgemental terminology with practising communities. Both terms emphasize the fact that the practice is a violation of girls’ and women’s human rights.

I. Introduction

01

Medical code of ethics

According to the World Medical Association's *Declaration of Helsinki*, 1964, it is the mission of the physician to safeguard the health of the people. Health professionals who perform female genital mutilation (FGM) are violating girls' and women's right to life, right to physical integrity, and right to health. They are also violating the fundamental ethical principle: "do no harm".

02

Definition of female genital mutilation

The term "female genital mutilation" refers to all procedures involving partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.

03

Types of female genital mutilation

Type I: partial or total removal of the clitoris and/or the prepuce (clitoridectomy). Subgroups: type Ia, removal of the clitoral hood or prepuce only; type Ib, removal of the clitoris with the prepuce.

Type II: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision). Subgroups: type IIa, removal of the labia minora only; type IIb, partial or total removal of the clitoris and labia minora; type IIc, partial or total removal of the clitoris, labia minora and labia majora.

Type III: narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation). Subgroups: type IIIa, removal and apposition of the labia minora; type IIIb, removal and apposition of the labia majora. *Reinfibulation* is covered under this definition. This is a procedure to recreate an infibulation, for example after childbirth when defibulation is necessary.

Type IV: unclassified – all other harmful procedures to the female genitalia for non-medical purposes, for example, pricking, piercing, incising, scraping and cauterization.

04
Female genital mutilation as a social norm

FGM functions as a self-enforcing social convention or social norm. In societies where it is practised, it is a socially upheld behavioural rule. Families and individuals continue to perform it because they believe that their community expects them to do so. They further expect that if they do not respect the social rule, they will suffer social consequences such as derision, marginalization and loss of status. While FGM is *de facto* violent, it is not intended as an act of violence. It is considered to be a necessary step to enable girls to become women and to be accepted, together with the rest of the family, by the social group of which they are part.

Where large-scale abandonment of FGM has been achieved, it has been the result of an approach that reinforces the human rights values and social support that are shared by communities. This has enabled the communities to collectively explore and agree on better ways to fulfil these values, and led to sustainable large-scale abandonment of FGM as well as other harmful practices. The health professionals, who typically have status in communities, can play a key role in supporting this process by providing correct information on the consequences of FGM and on the benefits of abandoning the practice.

05
Definition of “medicalization”

“Medicalization” 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 woman’s life. The definitions of FGM and medicalization were first adopted in the document *Female genital mutilation: a joint WHO/UNICEF/UNFPA* [World Health Organization/United Nations Children’s Fund/United Nations Population Fund] *statement (1)* published by WHO in 1997, and reaffirmed in 2008 by 10 United Nations (UN) agencies in *Eliminating female genital mutilation: an interagency statement (2)*.

06

Global scale of the problem of female genital mutilation and medicalization

In African countries, more than 90 million girls and women over the age of 10 years are estimated to have undergone FGM, and some 3 million girls are at risk of undergoing the procedure each year. The practice of FGM has been reported from all parts of the world, but it is most prevalent in 28 countries in Africa and some countries in Asia and the Middle East. As a result of international migration, the practice of FGM and its harmful consequences also concerns a growing number of women and girls in Europe, North America, Australia and New Zealand *(3)*.

FGM of any type is a violation of the human rights of girls and women. FGM is known to be harmful to girls and women in many ways. The removal of or damage to healthy, normal genital tissue interferes with the natural functioning of the body and causes several immediate and long-term physical, psychological and sexual consequences *(2,4)*.

Possibly as a result of the fact that FGM was for years addressed as a health issue, and of the growing awareness of its health consequences, people are increasingly turning to health-care providers to perform the procedure, in the hope that it will reduce the risk of various complications.

A recent analysis of existing data shows that more than 18% of all girls and women who have been subjected to FGM in the countries from which data are available have had the procedure performed on them by a health-care provider. There are large variations between countries, from less than 1% in several countries, to between 9% and 74% in six countries. More research is needed to estimate whether this phenomenon is also observed among migrants, refugees and asylum seekers from FGM practising communities. Available data suggest that in countries with these immigrant populations the involvement of health-care providers in FGM mainly concerns the act of reinfibulation.

The categories of health-care providers that have been found to carry out FGM include physicians, assistant physicians, clinical officers, nurses, midwives, trained traditional birth attendants (TBAs) and other personnel providing health care to the population, in both private and public sectors. Some of the health-care providers are officially retired, but continue to provide FGM as well as other health services.

07
Recognition of the problem by the global health community and national authorities

In 2008, the World Health Assembly adopted the resolution WHA61.16 on the elimination of FGM, in which all member states agreed to work towards the abandonment of FGM, including to ensure that the procedure is not performed by health professionals. WHO first condemned the medicalization of FGM in 1979, in the first international conference on FGM, held in Khartoum, Sudan. Later this was reiterated in a formal statement of WHO's position to the United Nations Commission on Human Rights in 1982 *(5)*. The practice of medicalization was condemned by the World Medical Association in 1993, and later by numerous other medical professional associations, including the International Federation of Gynaecology and Obstetrics (FIGO), as well as by international agencies, nongovernmental organizations (NGOs) and governments. This condemnation was further highlighted and reiterated in the joint WHO/UNICEF/UNFPA statement against FGM in 1997 *(1)*. The condemnation of medicalization was again emphasized in the interagency statement on the elimination of FGM that was co-signed by 10 United Nations agencies in 2008. Furthermore, several United Nations Treaty Monitoring Bodies, inter alia the Committee on Elimination of all forms of Discrimination Against Women, called on countries to eliminate the medicalization of FGM.

Most national governments have recognized the problem of FGM and its medicalization. Several countries have passed a law prohibiting FGM, and some with a special article on penalty if the practice is carried out by a health professional. Many countries have also taken other important steps, including development of national action plans, inclusion of FGM in training of health-care providers and close cooperation with other parties working on the ground, including national and international NGOs and international agencies.

08

Engaging health professionals to support abandonment of female genital mutilation and never to perform it is critical to success in eliminating the practice

Stopping medicalization of FGM is an essential component of the holistic, human rights-based approach for the elimination of FGM, as outlined by 10 UN agencies in *Eliminating female genital mutilation: an interagency statement (2)* and by the Donors' Working Group on Female Genital Mutilation/Cutting in the *Platform for action: towards the abandonment of female genital mutilation/cutting (6)*. 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.

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About the global strategy against medicalization of female genital mutilation

This global strategy against medicalization of FGM has been developed in collaboration with key stakeholders, including UN organizations and health-care professional bodies, national governments and NGOs.

The strategy is intended for a broad audience of policy-makers in governments, parliamentarians, international agencies, professional associations, community leaders, religious leaders, NGOs and other institutions. Part I sets out the issue; Part II relates the issue to global goals and concerns; Part III explains the reasons why medicalization happens, why it should not happen and challenges that needs to be overcome; and Part IV spells out the strategy, which is based on the principles governing international human rights. The adoption and implementation of this strategy is essential to secure the elimination of all forms of FGM.

II. GLOBAL GOALS – GLOBAL REALITIES

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Reaffirming the Millennium Development Goals

The Millennium Development Goals, which grew out of the United Nations Millennium Declaration adopted by 189 Member States in 2000, provide the current international framework for measuring progress towards sustained development and eliminating poverty. To reach five of the eight goals – improve maternal health; reduce child mortality; combat human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), malaria and other diseases; achieve universal primary education; and promote gender equality and empower women – elimination of FGM is a necessary contribution, as FGM affects all these aspects of girls' and women's health, in particular their sexual and reproductive health. For example, an estimated extra one to two perinatal deaths per 100 deliveries occurs among children born to women who have undergone FGM. Another example is that the physical and mental health consequences of FGM can impede women's ability to fully take part in public life, thus having a disempowering effect on them.

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Female genital mutilation and human rights

FGM of any type is a violation of the human rights of girls and women *(7)*, including: the right to non-discrimination on the grounds of sex; the right to life when the procedure results in death; the right to freedom from torture or cruel, inhuman or degrading treatment or punishment; and the rights of the child. FGM is also a violation of a person's right to the highest attainable standard of health, as it damages healthy genital tissue and can lead to severe consequences for girls' and women's physical and mental health. It is on the basis of these human rights violations that many countries have now passed legal sanctions against FGM.

Communities practising FGM generally consider the practice as an important part of their cultural tradition and social requirements, and also part of their religious duty. In migrant populations, these perceptions often remain valid, especially when relocating to a society where women have more freedom of choice, including in their sexuality. While the right to participate in cultural life and to freedom of religion are protected

by international law, the law also stipulates that freedom to practise one's traditions and beliefs may not supersede the protection of fundamental rights and freedoms of people. Therefore, the right to practise religious beliefs and social and cultural traditions cannot be evoked to justify FGM.

III. CHALLENGES TO BE ADDRESSED

Reasons for medicalization of female genital mutilation

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Why there is a demand for medicalized female genital mutilation

While in most cases FGM is performed by traditional practitioners, parents who subject their daughter to FGM often prefer health-care providers to carry out the procedure if they think it might reduce the risks associated with the procedure. The increased demand for health-care providers to perform FGM may therefore be a result of increased information about the harmful health consequences of the practice (8–*11)*. A similar trend can be seen with regard to reinfibulation. Women themselves, or members of their family, may request health-care providers to perform the procedure, believing it to be less risky than if they resort to traditional practitioners.

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Why some health-care providers agree to perform female genital mutilation

Most health-care providers who perform FGM are themselves a part of the FGM-practising community in which they serve. Hence, the reasons why they agree to perform FGM are often the same as those that motivate those requesting it. In addition, studies have documented that in certain countries some health-care providers consider FGM to be medically indicated for most women, while others see the practice as harmless. Some health-care providers, who do not themselves support FGM, still consider it their duty to support the patient's socioculturally motivated request for FGM. Others see medicalization as a form of harm reduction, considering that, by performing it, they help to prevent the expected greater dangers if the procedure were to be carried out by traditional practitioners. Finally, some health-care providers are also motivated by the opportunity for financial gain. *(9,10,12,13)*

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Why some organizations support medicalization

Medicalization of FGM is, or has been, supported by a few professional organizations, international humanitarian organizations, government officials and university professors. These supporters of medicalization of FGM argue that it may help to reduce the risks of the procedure, limit the extent of mutilation, and reduce the pain associated with it. Another common argument is the belief that medicalization could be a first step towards full abandonment of the practice. *(11)*

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Why some health-care providers, individuals and organizations support reinfibulation

In women who have undergone type III FGM, reinfibulation refers to the practice of resuturing and thereby recreating an infibulation following a procedure in which the infibulation has been partially or fully opened, most commonly to facilitate childbirth. Some health-care providers argue that since the woman has already undergone FGM, reinfibulation will not constitute increased harm. Others consider reinfibulation a medical necessity. Another argument that has been used is that although the procedure will recreate a vulva associated with a series of risks and complications, including the need for future surgery, it should be done if expected or requested by the woman, her family or the community. A final argument is that since reinfibulation is most commonly performed on consenting adults, it is as legitimate as any other surgery performed on consenting adults. Furthermore, health providers, although not in favour of FGM, and especially in countries receiving migrants, refugees and asylum seekers, often feel ill-equipped to provide patients with culturally adequate arguments against their request for reinfibulation. *(14,15)*

Reasons why medicalization of female genital mutilation must be stopped

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Why medicalization of female genital mutilation must be stopped

The performance of FGM by health-care providers, despite the global recognition of FGM as a harmful practice and a violation of human rights, constitutes a break in medical professionalism and ethical responsibility. In most countries, it also constitutes a violation of the law.

The involvement of health-care providers in the performance of FGM is likely to create a sense of legitimacy for the practice. It gives the impression that the procedure is good for health, or at least that it is harmless. This can further contribute to institutionalization of the practice, rendering it a routine procedure and even leading to its spread into cultural groups that currently do not practise it. Furthermore, the medicalization of FGM may lead to some health-care providers developing a professional and financial interest in upholding the practice.

Performance of FGM by health-care providers contributes to upholding the practice of FGM. Medicalized FGM is not necessarily safer or less extensive *(13)*. It also ignores the long-term complications of the practice, including sexual, psychological and obstetrical complications that have been found to be associated with FGM, independently of who performs it. Finally, there is no evidence to suggest that medicalization of FGM serves as a first step towards full abandonment.

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Why reinfibulation should be prevented

Reinfibulation recreates, usually several times during a woman's life, the (removed) tight vaginal introitus of the original infibulation. This recreates the same problems of gynaecological, sexual and reproductive health, including difficulties associated with childbirth and the need for further surgeries that the original infibulation had created. This consequently repeats and increases the suffering for girls and women.

Challenges to stopping the medicalization of female genital mutilation

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Lack of protocols, manuals and guidelines to guide the health-care providers

In most countries, the absence of clear policies, protocols, manuals and guidelines for the health-care sector on how to deal with issues related to FGM and its medicalization leave health-care providers ill-equipped to face the request by parents or family members to perform FGM on girls, and those of adult women and their immediate families to perform reinfibulation. This is even more the case among health-care providers in countries receiving migrants, refugees and asylum seekers from FGM practising communities. Guidance is also important in areas where FGM or reinfibulation is performed as a routine procedure.

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Insufficient training and support for health-care providers

Only a handful of institutions that train health-care providers have included comprehensive knowledge about FGM in their curricula. In most countries, health-care providers report that they have insufficient knowledge about FGM and about reasons why it should be stopped, as well as technical knowledge about how to care for girls and women suffering complications of FGM and on how to resist requests for FGM and counsel patients to abandon the practice.

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Lack of involvement of the local health sector in the prevention of female genital mutilation

In most countries where FGM is practised, the health sector has had limited involvement with the prevention of FGM in girls and women. Systematic cooperation between the key players at national, grassroots level and the health sector is insufficient.

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Lack of laws and the will to prosecute

Laws against FGM exist in more than half of the countries in which FGM is a traditional practice, as well as in many of the countries with immigrants from countries where FGM is practised. However, health-care providers are rarely sanctioned for performing FGM, and only rarely are disciplinary measures taken against institutions in which FGM is performed. While legal measures alone often lead to clandestine procedures or initial defiance, a legal framework in support of women's and girls' human rights is an important component. A framework that includes preventive measures to promote abandonment, as well as punitive measures for those who engage in the practice, has been shown to have positive effect when coupled with community-based work (16,17).

IV. STRATEGY TO ACCELERATE PROGRESS

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What health-care providers and national authorities can do

Health-care providers should not perform any type of FGM in any setting – neither should they perform reinfibulation after delivery or in any other situation. They should provide care for girls and women suffering from complications associated with FGM, including special care during childbirth for women who have already undergone FGM. They should counsel women suffering consequences from FGM, and their families, and advise them to seek care for their complications and mental health consequences, advise them against reinfibulation, and counsel them to resist having FGM performed on their daughters or other family members. Health-care providers should also act as advocates for the abandonment of the practice in the community at large. When providing care to migrant women and in cases of limited language skills, health-care providers should have access to cultural interpreters specifically trained on FGM, to ensure counselling to women and families is adequate and done with respect for their cultural beliefs.

Instead of performing procedures that are harmful to girls' and women's health, and that violate their human rights, health-care providers should use their competencies and authority to promote the health and human rights of girls and women, including their rights to information, physical integrity, freedom from violence, and health.

Countries should set priorities and develop specific plans of action according to the country situation, within a consultative process involving all stakeholders. Four overarching activities are recommended:

(a) mobilize political will and funding

(b) strengthen the understanding and knowledge of health-care providers

(c) create supporting legislative and regulatory framework

(d) strengthen monitoring, evaluation and accountability.

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(a) Mobilize political will and funding

Political will and funding are necessary to ensure the development and sustained implementation of policies, guidelines, and laws.

Necessary actions in this area are to:

(1) build strong advocacy support for investment in supporting the abandonment of FGM, engaging political leaders, other leaders, parliamentarians and government ministries;

(2) mobilize and coordinate the efforts of key stakeholders to support a national policy against the medicalization of FGM. This includes parliamentarians, health-care providers, legal experts, human rights groups, government ministries, political leaders and parties, professional organizations, religious and community leaders, including leaders of migrant communities, and other persons of influence;

(3) advocate for sustained and coordinated planning, budgeting and actions for key stakeholders;

(4) advocate for the establishment of a sustainable, co-coordinated public and private partnership in financing FGM-abandonment programmes.

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(b) Strengthen the understanding and knowledge of health-care providers

A prerequisite for preventing the medicalization of FGM is that all health-care providers should be familiar with: factors surrounding the practice of FGM; the reasons why it should not be performed by health-care providers and how to resist requests to do so; how to recognize and manage complications of FGM, including suitable obstetric care; and how to counsel women and families on FGM-related issues. Guidelines should be in place, including medical, ethical and legal information, such as how to counsel and care for girls and women who have undergone FGM, including counselling against reinfibulation. Deeply rooted discriminatory norms and practices that underlie FGM, including sexual concerns and eventual religious

underpinnings, should be addressed, where relevant, when designing training programmes and developing protocols. These aspects are even more relevant when training is aimed at health-care providers in countries receiving migrants, refugees and asylum seekers, as they usually do not belong to the same sociocultural environment as patients from practising communities.

Training should also cover the social conventional nature of the practice to enable health-care providers to appreciate how medicalization will reinforce the social convention and perpetuate the harm, and how they can play a key role in helping practising communities to abandon the practice and permanently remove the risk of future harm.

Necessary actions in this area are:

(1) appropriate national authorities should develop national guidelines for various health-care providers on how to deal with issues related to FGM, including how to care for complications and on how to resist pressure to perform any form of FGM, including reinfibulation;

(2) training modules on FGM for inclusion in pre- and in-service curricula and training, including refresher courses and updates for all health-care providers, should be developed. This includes nurses, midwives, and medical doctors as well as various health outreach workers. Comprehensive training would include information on factors related to the practice, prevalence, motivations and trends of FGM; how to identify and treat complications; and how to counsel individuals, families, and communities on the health risks and possible treatments for complications from FGM and reinfibulation;

(3) training of health-care providers should be integrated at the community level with other community-based activities promoting the abandonment of FGM.

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(c) Create supportive legislative and regulatory frameworks

States should adopt, implement and enforce specific legislation addressing FGM, in order to affirm their commitment to stopping the practice and to ensure women's and

girls' human rights. Alternatively, existing laws should be enforced in the absence of specific legislation on FGM, such as child-protection laws and criminal laws on physical harm. To avoid defiance and the practice going underground, it is important that all legal action takes into account the degree of social acceptance of the practice, and that it is part of a broader initiative that includes direct activities to empower practising communities to abandon the practice.

Necessary actions in this area are:

(1) health-care providers should be informed without delay about human rights and ethical perspectives as well as the harmful consequences of FGM, and that performing FGM, including reinfibulation, would give rise to civil and criminal liability. Appropriate ethical guidelines on FGM should be incorporated into the training curricula of health-care providers;

(2) the Ministry of Health and professional regulatory bodies should issue a joint policy statement against the medicalization of FGM, and laws and policies and/or the application of existing laws and polices should address the role health-care providers play in the elimination of FGM and forbid the performance of any type of FGM, including reinfibulation;

(3) training on how to deal with medicalization of FGM should also be provided to juridical staff and law-enforcement and security personnel;

(4) professional organizations should adopt and disseminate clear standards condemning the practice of any type of FGM and issue firm guidelines for their members not to perform FGM, and not to accept or support its practice. This should be backed up by the application of strict sanctions against practitioners who violate those standards and guidelines;

(5) performing FGM, including reinfibulation, should give rise to legal and professional sanctions. Licensed health-care practitioners must be subject to the maximum available criminal penalties that apply to anyone performing FGM. Offending practitioners may be suspended or their licences withdrawn if they perform FGM;

(6) women and girls should be educated about their human rights and be empowered to access legal remedies specified by law to prevent FGM. Women and girls should have the right to bring civil action suits to seek compensation from practitioners, or to protect themselves from undergoing FGM. Wherever possible, health-care providers should assist by providing evidence supporting the claims of the girl or woman who has undergone FGM.

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(d) Strengthen monitoring, evaluation and accountability

Monitoring and evaluation are essential for improving health-care providers' approaches to FGM and for refining plans to promote abandonment of the practice. Government participation is critical for gathering data and broadening national monitoring mechanisms.

Necessary actions in this area are to:

(1) monitor health-sector training and implement the lessons learned;

(2) develop mechanisms to increase accountability at facility and district levels;

(3) routinely collect data on FGM (e.g. antenatal records);

(4) monitor providers of FGM, including legislative measures taken against them;

(5) integrate FGM, including reinfibulation, into existing monitoring and evaluation systems in the country (sexual and reproductive health, HIV/AIDS, gender-based violence, demographic and health surveys data collection, etc);

(6) report to UN human rights treaty bodies and other international and regional human rights bodies;

(7) institutionalize feedback mechanisms to the communities.

V. CALL TO ACTION

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All health-care providers take an oath of practice in line with the Hippocratic Oath and other relevant statements of ensuring no harm against any patient. Health-care providers should know and respect the health and human rights aspects of FGM and refrain from supporting or performing any form of the practice.

Governments must create a supportive legal and educational framework with corresponding national guidelines and policies that can guide the work of all categories of health-care providers, including reporting and monitoring routines and providing the necessary budget to discourage medicalization of FGM within the overall framework of total elimination of the practice. They should also ensure that health-care providers are given comprehensive training and acquire the necessary knowledge and competencies to provide care for girls and women suffering from complications caused by FGM and strengthen their capacity to act as advocates for abandonment of the practice.

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