



THE MEDICALIZATION OF FGM IN KENYA, SOMALIA, ETHIOPIA AND ERITREA

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Introduction

Female genital mutilation (FGM), also referred to as female genital cutting or female circumcision, involves altering or injuring the female external genitalia for non-medical reasons. The term encompasses a broad range of practices that are classified into four main types, based on specific anatomical descriptions;^a the type performed and its prevalence are context-dependent and can vary within and between communities and countries. It is estimated that the majority of FGM procedures consists of Types I (clitoridectomy) and II (excision), accounting for approximately 80 percent of all cases. In contrast, Type III (infibulation), the most severe form, represents around 15 percent of all cases globally. Type IV procedures (all those not included in Types I-III) comprise the remaining 5 percent.¹

[a] Type I involves the partial or total removal of the clitoris and/or the prepuce (clitoridectomy); Type II involves the partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision); Type III involves infibulation; Type IV includes all other harmful procedures to the female genitalia for non-medical purposes, for example: 'nicking' or piercing. WHO (2008) Eliminating Female genital mutilation: An interagency statement. http://www.un.org/womenwatch/daw/csw/csw52/statements_missions/Interagency_Statement_on_Eliminating_FGM.pdf.

FGM is widely recognized by the international community to pose serious risks to the health and wellbeing of girls and women, and numerous governments and global and national agencies have deemed it a human rights violation. Nevertheless, it is estimated that at least 200 million girls and women alive today have undergone some form of FGM and a further 68 million are at risk of being cut by 2030.² Although rates of FGM are declining in many of the 31 countries where it is practiced, population growth rates in various settings mean that the absolute numbers of girls who will be cut will continue to grow if the practice continues at current levels.³ The procedure is mostly carried out on girls from infancy to age 15,⁴ although some women undergo the procedure after this time.⁵

Recently, scholars and practitioners have noted a growing trend towards the medicalization of FGM in many African settings.⁶ The term 'medicalization' is used to refer to the involvement of any kind of medical or health professional in the practice of FGM, whether at home, in a public or private clinic, or elsewhere. It also includes the procedure of re-infibulation (Type III), which can take place at any point in a woman's life.⁷ In some contexts, such as Somalia and Sudan, the medical establishment has long been known to provide surgical supplies such as sterile gauze and disposable razors for cutting.⁸ There is evidence, however, from across the continent, that physicians, nurses, midwives, trained traditional birth attendants, and other health care workers are increasingly involved in the cutting itself.⁹ Some of these practitioners may be in the midst of medical training, working in the private or public health care sector, or retired.¹⁰ UNFPA and UNICEF, among other agencies, have characterized medicalization as one of the greatest threats to the elimination of FGM.¹¹

Medicalization rates are highest in five countries: Egypt (38%), Sudan (67%), Guinea (15%), Kenya (15%), and Nigeria (13%) and continue to rise in all but Nigeria.¹² Data from other settings are unevenly available, as they depend on responses to a question that is not always administered in the FGM module of the national Demographic and Health Surveys that asks who specifically performed the procedure. One of the aims of the UNFPA-UNICEF Joint Programme on the Elimination of FGM is to better understand whether and how FGM is being medicalized in its focus countries in order to further develop targeted policies and interventions to stop it.

The purpose of this short brief is to explore these questions as they pertain to Kenya, Somalia, Ethiopia, and Eritrea. The paper begins with an examination of broad trends in relation to medicalization across the region, why it is happening, and dominant views in favour and against it. It then provides short snapshots of how the issue is currently manifested in each of the four countries. Finally, it summarizes the information needs and research gaps that must be filled in order to better understand the growing phenomena of medicalization in these contexts.



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Why does medicalized FGM happen?

Scholars and those working directly with women and girls in multiple settings have provided a series of explanations for the growing involvement of medical professionals in FGM. Many have suggested that increasing rates of medicalization can be explained, at least in part, by the emphasis placed by anti-FGM campaigns over the last thirty years on the short term health and mortality risks of the practice.¹³ It is generally agreed that this approach has led parents and relatives to seek safer, medicalized procedures for their daughters rather than to abandon the practice altogether.¹⁴ These campaigns may have motivated the supply of the procedure as well.¹⁵

Indeed, across the region, medicalization is perceived by parents and relatives to be a less risky way for a girl to be cut. Health care providers are seen to be more cautious, more focused on hygiene and more knowledgeable about how to address any complications should they arise.¹⁶ Medicalized cuts are understood to heal more quickly than those performed by traditional cutters.¹⁷ Furthermore, when performed by a health worker, FGM can be done in secret, under the auspices of treating another health issue, a necessary tactic in those settings where the procedure is illegal.¹⁸

Girls' views on medicalization are largely missing from the published literature on the topic, which, like studies of FGM more generally, tends to privilege the views of adults, especially parents, and statistical analyses over more qualitative explanations. Women's perspectives are reflected to some extent in reports of qualitative studies on cutting and trends over time.

Health professionals who perform genital cutting appear to be motivated in three main ways. The first is to continue a valued tradition or custom. Because health workers are often members of the community they serve, they frequently share the same social, cultural and/or religious norms that shape families' decisions to cut their girls.¹⁹ This motivation has been revealed in Kenya and Somaliland,^b where qualitative studies have shown that health workers cannot be viewed in isolation from their membership in the community: the vast majority of nurses, midwives, and other medical professionals whose daughters have been cut have undergone a medicalized procedure.²⁰ The second motivation to perform medicalized FGM is financial gain. Where health systems are weak and salaries are low, some health workers may choose to augment their income with money earned by cutting. In countries where the practice is criminalized, such as Kenya, medicalization may offer a substantial source of income.²¹ The third, and perhaps most common, motivation for medical professionals to perform the practice is to reduce its negative health impacts – a desire shared with the families and communities with whom they live and work.²² Even those who do not support the practice may feel compelled to perform it in order to protect a girl from the risks she would encounter at the hands of a traditional cutter.²³ From this perspective, medicalized FGM is a pragmatic response to an intractable problem, a means of reducing harm.

[b] This paper follows the UNICEF protocol of referring to Somalia as a federated state with several regions, including Somaliland and Puntland.

Medicalization: harm reduction or human rights?

On the global stage, the medicalization of FGM has long been a highly contested issue, characterized by complex ethical debates. To a large extent, these disputes have now receded into the background at international conferences and fora. Condemnation of medicalization by the WHO in 1979²⁴ was followed by more than three decades of discussion and disagreement between those who advocate for harm reduction versus those motivated by a human rights approach that calls for total abandonment. For a time, associations of medical professionals and other health workers argued that in some settings, FGM is so embedded in culture and tradition that people will practice it, regardless of educational campaigns and legal bans to convince them otherwise.²⁵ From this perspective, it is the ethical imperative of the medical community to ensure that cutting is done as safely and humanely as possible.²⁶ Moreover, by choosing to engage with families on these issues, it has been argued that health professionals can use their positions of respect and social standing to encourage families to avoid invasive procedures by choosing to perform a symbolic 'nick' or a less severe form of cutting.²⁷

These viewpoints have been vociferously challenged and eventually quietened by those who contend that medicalized FGM, like FGM performed by traditional practitioners, is a violation of human rights. As an irreversible violation of the body, with lifelong consequences, the procedure brings no short or long-term benefits to an individual girl or woman (and may indeed bring sexual and reproductive health problems throughout the life course). Seen in this way, medicalization is a violation of professional ethics and the commitment to do no harm.²⁸ Those who argue this position assert that making the practice safer does not mean making it safe. Moreover, efforts to medicalize FGM may do more to perpetuate the practice than to eliminate it.²⁹ From this perspective, and according to the WHO (2016), medicalization is incompatible with 'a holistic, human rights-based approach towards the elimination of the practice',³⁰ a type of violence against girls and women that should be prohibited in all forms. This is the argument underlying the UN General Assembly's adoption of the first ever resolution to ban FGM in 2012, and the articulation of Global Goal 5 of the SDGs, to eliminate all harmful practices, including FGM, by 2030.

To a large extent, arguments against medicalization have informed the legislative and policy frameworks in most African countries where FGM is practiced. The governments of Ethiopia, Kenya, and Eritrea have anti-medicalization laws in place. There is no current legislation at the national level in Somalia that criminalizes medicalization or punishes its perpetrators, however Somaliland and the federal state of Puntland have introduced interministerial decrees that prohibit FGM and the participation of health professionals in the practice.³¹ The effectiveness of these regulations is variable because their implementation relies on community-level surveillance and reporting. The embeddedness of FGM in culture and tradition means that in some contexts national laws that prohibit the practice are overridden. Moreover, the secrecy surrounding an 'underground' practice makes it difficult to establish levels of support for medicalized FGM – and FGM more generally – and the extent to which it is happening.

In the Horn of Africa, as elsewhere, it is impossible to separate discussions of medicalization from those about FGM more generally. Decision-making about whether a girl should be cut or not appears to be informed not by erroneous knowledge of the practice, but instead by an effort to balance conformity to social expectations with the minimizing of adverse health risks and impacts.³² This important issue is discussed in greater detail in the following sections, which explore the medicalization of FGM and the specific circumstances in which it happens in each of Kenya, Somalia, Ethiopia, and Eritrea.



Medicalization of FGM in Kenya

The 2014 Kenya Demographic and Health Survey estimates that 21 percent of girls and women aged 15-49 years have undergone FGM. 89 percent report having had 'flesh removed' (Types I and II), while 9 percent report having been 'sewn closed' (Type III).^c Prevalence data for Type IV are not available. Although there has been a steady decline in the prevalence of the practice over the past 20 years, national statistics mask significant variances within the country. Although some communities, such as the Kalenjin and the Kikuyu, have seen substantial reductions in the numbers of girls and women 15-49 years old who are cut to 28 and 15 percent respectively, rates remain especially high in this age cohort among Somali (94%), Samburu (86%), Abagusii (84%), and Maasai (78%) populations.³³

[c] Importantly, Shell-Duncan, Gathara and Moore (February 2017:18) point out that it is not always possible to establish a clear correspondence between survey questions and local vernacular descriptions and that some women may not be aware of the specifics of their own genital modification.

Making sense of data on medicalization is tricky in this context. Nationally, it was reported in 2014 that 15 percent, or nearly 36,000, girls and women between the ages of 15-49 years had been cut by a doctor, nurse or midwife.³⁴ This rate represents a decline in the proportion of women in this age group who reported to have been cut by a medical professional, from 19.7 percent in 2008-9. It has been suggested that this reduction may be a consequence of increased awareness raising campaigns on the legal implications for health care workers who perform FGM.³⁵ However, alongside this decline are more nuanced data that reveal that among populations that continue the practice, medicalized cutting is increasingly common: girls in Kenya who experienced FGM under the age of 15 years are more likely than their mothers to have been cut by a medical professional.³⁶ Medicalization in Kenya is also linked to an earlier age at cutting and to less severe forms of FGM,³⁷ as it is in other countries.³⁸

Medicalization is especially common among the Abagusii, Somali and Maasai.³⁹ Legal bans and concerns about FGM-related complications compel families to seek the procedure from medical professionals whose assistance reduces both the health risks of the procedure and the chances of being caught.⁴⁰ Medicalization appears to happen exclusively in Nyanza and Rift Valley Provinces and is more common in urban than rural settings.⁴¹ Studies in other countries have found that urban families practice less severe forms of cutting and some have argued that this change in social norms is the result of increased access to higher levels of formal education and the inter-cultural fusion that accompanies the experience of migration and urbanization.⁴² Little research has explored the reasons for this difference in the Kenyan context.

Medicalized cutting tends to take place primarily in girls' homes, and occasionally in private medical clinics.⁴³ These locations provide a necessary level of secrecy for both the girl and the medical professional. In their study among the Abagusii and Somali, Kimani et al (2020:16) found that some clinicians performed FGM under the pretext of 'genital modification', and in so doing were able to obscure their actions by using the label of 'plastic surgery'. The authors argue that these efforts to conceal FGM are increasingly emerging, especially in urban settings, and in so doing are promoting the continuation of the practice and making its abandonment increasingly difficult to achieve.⁴⁴ Another study conducted among the Abagusii in the early 2000s (Christoffersen-Deb, 2005) suggested that adolescent girls may choose medicalized cutting as a means of not just negotiating the tensions between tradition and modernity, but also as a way of demonstrating that they are taking individual responsibility for themselves as a woman, a mother, a sexual being, and a wife.⁴⁵

Medicalization of FGM in Somalia (including Somaliland and Puntland)

FGM is a nearly universal practice in Somalia. The recent Somali Health and Demographic Survey (2020) showed a prevalence rate of 99%, including Types I, II, III and IV.⁴⁶ There are no available disaggregated data according to ethnicity, but rates appear to be largely the same across communities in the regions of Somalia, Puntland and Somaliland,⁴⁷ with the notable exception of those living in part of lower Shabelle, the coast and some districts in Banadir region. FGM is prohibited in Somalia's Provisional Constitution (2012: Article 15.4), which declares female circumcision to be 'a cruel and degrading customary practice...tantamount to torture'. This position is further reinforced under the currently contested 2019 Somali Child Rights Bill, which specifically outlaws FGM.

Medicalization data are not available for all regions of the country. Nevertheless, indications are that rates are increasing, particularly in urban centres in Somaliland and Puntland.⁴⁸ For example, in the urban sites of a broader study conducted in Somaliland in 2016, the percentage of daughters cut by health professionals was found to be 33 percent, compared to 5 percent of their mothers.⁴⁹ Likewise, in Puntland, the head of the Midwives Association has reported growing numbers of requests to cut baby girls when they are born.⁵⁰ More recently, project-based research in some districts of Puntland and Jubbaland found that between 2016-2019, 63 percent of new FGM cases were medicalized.⁵¹ A programme evaluation conducted in 2019 in a number of regions in all states of Somalia also reported the growing engagement of health professionals in cutting.⁵² These reports reinforce assertions from government officials, UN agencies, health workers and community members that medicalized FGM is increasing in parts of the country. However, to date there are no published regional or national-level data.



Despite this dearth of data, it is generally argued that the increasing medicalization of FGM is inextricably linked to a broader movement away from Type III (infibulation) to Type I (also known as the 'Sunna cut').⁵³ This shift towards less severe forms of cutting appears to be a result of long-term sensitization campaigns on the physical, sexual and reproductive health risks associated with infibulation.⁵⁴ In order to avoid these threats, families seek trained health care providers to cut their daughters in safer and less harmful ways. They also tend to choose to cut girls at younger ages than was previously common (currently 5-8 years),⁵⁵ in part to do so as discretely as possible.⁵⁶ These changes in the type of FGM performed and the manner in which it is practised are thought to be most common among wealthier families and those with higher levels of formal education.⁵⁷ As among some populations in Kenya, it has been argued that these transformations are increasingly associated with notions of modern womanhood that are seen as socially acceptable and thus have the potential to derail efforts to abandon FGM altogether.⁵⁸

There are conflicting schools of thought in Somalia in relation to the medicalization of FGM. On the one hand, those working towards the abandonment of the practice have assumed a zero tolerance approach. Over the last four years, the Ministry of Health in Somaliland has developed anti-medicalization policies and legislation, trained health care workers on their legal responsibilities,⁵⁹ and established Professional Health Networks against FGM.⁶⁰ They have also trained more than fifty 'Health Champions' to actively engage with communities and to advocate against medicalization.⁶¹ Some teaching hospitals have integrated training materials on the topic into the curricula for midwifery and nursing students,⁶² and communication materials about the problems associated with medicalization have been developed and disseminated.⁶³ Community-based organizations working to combat FGM have also openly opposed the involvement of health professionals because doing so would legitimize a practice they seek to eliminate.

Likewise, in Puntland, under the leadership of the Ministry of Health, an inter-ministerial decree against FGM was developed and signed in 2014. The law prohibits medicalization and grants the authority to arrest perpetrators, cancel the licenses of health professionals who practice FGM, and shut down clinics and hospitals where FGM is performed.⁶⁴



On the other hand, there is strong opposition to these measures among those who support medicalization. Adult community members across the regions, some health workers, and a number of senior clerics actively argue in favour of the involvement of medical professionals in cutting.⁶⁵ These groups assert that health workers should be trained to cut girls safely and hygienically, using the Sunna cut, without stitches, in order to reduce immediate complications and long-term harm and hasten the abandonment of Type III FGM.⁶⁶ This is a view that has been expressed in both rural and urban settings.⁶⁷ Newell-Jones (2016:25) points out in her research across twenty-five communities in Somaliland that although the number of girls who have been cut by health specialists is low, the overwhelming majority of community leaders would like more girls to have access to medicalized cutting. In these contexts, half of all health workers interviewed who said that they intend to cut their daughters reported an intention to have a medical professional perform the cut.⁶⁸ These stakeholders argue that rather than banning medicalized FGM, it is more appropriate and more humane to place the focus of current efforts on reducing the severity of the practice (from Type III to Type I). Abandonment, they argue, will come later.

These tensions between a zero tolerance versus a step-wise approach to eliminating FGM are a long way from being resolved in Somalia, and other places characterized by extremely high rates of FGM prevalence. Importantly, these debates bring a critical question to the fore: when abandonment is not attainable in the immediate term, what can and should be done to ensure girls' and women's safety and wellbeing? Shell-Duncan (2001) has suggested that in these contexts, medicalization, if applied as a harm-reduction strategy, may be a reasonable and compassionate approach.⁶⁹ The challenge for those who advocate this position is that the international community is in complete opposition to it: the argument among the vast majority of global health and human rights advocates is that not only can FGM never be 'safe', there is no medical justification for the practice. Governments that seek to resolve these tensions are in a difficult and complicated position as funding from global agencies is often tied to the implementation of legislative frameworks that require a ban on medicalized FGM. Yet the reality is that unless an approach resonates with local populations, in the absence of strict enforcement, it is unlikely to be effective in the long term.

Medicalization of FGM in Ethiopia

In 2016 in Ethiopia, 65 percent of girls and women aged 15 to 49 years were reported to have undergone FGM.⁷⁰ Although other countries have reported higher prevalence rates, Ethiopia has the largest absolute number of females who have undergone the practice in the region: 25 million.⁷¹ As is the case in Kenya, there are considerable sub-national differences in prevalence. Among the Somali population the rate is 98.5 percent; Afar, 98.4 percent; Hadiya and Welaïta, 98.4 percent. These rates are more than four times those reported among the Tigray.⁷² These variances are mirrored by differences in the age of an individual girl or woman when she is cut, and the type of cutting that is done.⁷³ For example, Afar girls tend to undergo FGM in infancy, whereas among the Somali and Hadiya, cutting can take place up to late adolescence.⁷⁴ Likewise, infibulation, or Type III, is the most common form of FGM in Somali region, but is rarely practiced in Benishangul-Gumuz, where Types I and II are prevalent.⁷⁵

The vast majority of FGM in Ethiopia is carried out by traditional cutting practitioners and traditional birth attendants.⁷⁶ Across the country, the practice is said to involve medical professionals only 2 percent of the time,⁷⁷ except for the Southern Nations, Nationalities, and Peoples' Region, where in 2016 it was reported that 10 percent of girls and women between the ages of 15-49 who have undergone FGM had been cut by a doctor, nurse, midwife or other health professional.⁷⁸ This region lies to the south of the country, and is host to more than forty-five ethnic groups. Disaggregated data on the prevalence of medicalized FGM within these different populations are not available and it has not been possible to locate any

published studies on the topic to inform this brief. Moreover, the relationship between higher rates of medicalization in this region and its proximity to neighbouring Kenya and Sudan, where medicalized FGM is far more common, is an important area for further research.

In 2017, Ethiopia banned all medicalized FGM. Although prohibition is addressed in general terms in the Criminal Code, and applies in theory to medical practitioners who perform FGM, there is no national legislation that explicitly criminalizes health professionals who condone, perform, attempt to perform, or assist in the practice. The strengthening of the legal framework is a priority for those working to combat FGM,⁷⁹ as is the provision of training and professional guidelines for health professionals. UNICEF has been supporting this work in Afar and Somali regions since 2015.



Medicalization of FGM in Eritrea

In Eritrea, the national prevalence of FGM among 15-49 year old girls and women is 83 percent, according to the 2010 Eritrea Population and Health Survey (the most recent data set available). 'Nicked, no flesh removed' and 'sewn closed' are the most common types of FGM practised.^d The rate of FGM prevalence in this age group has been in consistent decline for the last twenty-five years, from 95 percent in 1995,⁸⁰ to 89 percent in 2002,⁸¹ to 83 percent in 2010.⁸² Typically, girls are cut between infancy and 5 years of age. The sharpest rates of decline, according to the Ministry of Health's community mapping studies,⁸³ relate to girls under the age of 15 and girls under the age of 5.

Generally, the decline in the prevalence of FGM in Eritrea is attributed to two main factors. First, the large number of anti-FGM campaigns are said to have improved communities' level of awareness of the practice, and particularly its health, physical and psychological effects. Second, decline is understood to also have occurred because of a general awareness of the 2007 legal ban on the practice and the sanctioning of those who perform it. Evidence of this association is grounded in the mapping exercises undertaken in 2016 and 2018 in which up to 94.8 percent of respondents stated that they knew about the proclamation, and in the EPHS 2010 survey, in which two-thirds of mothers reported that they did not cut their youngest daughter because it was against the law.⁸⁴

[d] The precise prevalence of Types I, II, III and IV is not known because the EPHS (2010:346) did not ask respondents for this information. Typologies of FGM were argued to be inexact because of variations in the procedure and as a result, the survey asked respondents about the severity of the operation.

Other than in Asmara where official rates of FGM are lower, there is little variance in prevalence rates between towns and rural areas. Prevalence rates between regions, however, do differ substantially: Debub has the lowest levels (71%) and Anseba, the highest (96%).⁸⁵ There is also a direct correlation between poverty levels and prevalence rates, with sharper declines and lower prevalence among more affluent women (75%) than among those less affluent (89%).⁸⁶ This is a common pattern across the country.



FGM is performed overwhelmingly by traditional cutting practitioners. According to EPHS 2010, 0.6 percent of cutting is carried out by medical practitioners. The criminal code specifies an elevated penalty of imprisonment and/or a fine specifically for health care personnel who perform FGM, and allows for the option of suspending their licenses.⁸⁷ Those working to combat the practice in Eritrea say that medicalization has never been an issue in the country, and that medical professionals are effectively deterred from performing the procedure because the consequences of being caught doing so are so great. These statements concur with those made by scholars and others working in this area.⁸⁸

Recommendations and research gaps

Literature on the medicalization of FGM in Kenya, Somalia, Ethiopia and Eritrea reveals a number of pertinent approaches and promising directions for work in this area. It also suggests a series of research gaps that should be addressed.

Pertinent approaches and promising directions

Share learning across settings where medicalization is happening to understand what works to stop it.

Provide health professionals with information on FGM and its negative sexual, reproductive and psychological health consequences. Establish a systematic means of training all health professionals, including on the important preventive role that they can play.

Support health care workers to share experiences with peers in their country and in the region, including on ways to resist pressures to perform medicalized FGM, as well as ways of communicating information in a way that communities can understand and relate to.

Capitalize on the respected social roles of health workers by supporting them to act as agents of change when it comes to FGM. Rely on deep contextual knowledge in specific settings in order to ensure that this role is undertaken in a relevant and appropriate way.

Support health care workers to engage and discuss with communities the health implications of all types of FGM (not only the Pharaonic type, also known as infibulation, or Type III).

Strengthen curricular amendments and reform/inclusion of anti-FGM content in medical schools and other settings for health worker training.

Support the capacity development of health institutions, associations and professional bodies to provide technical support to their members on FGM-related issues and FGM elimination (doctors, clinicians, nurses and others)

Work with communities to develop alternative rites of passage (ARPs) as a way to support the cultural value of the practice while simultaneously eliminating its harmful aspects.

Research gaps

It is commonly believed that promoting the medicalization of cutting suggests to practising communities that FGM is acceptable when health professionals do it and therefore legitimizes its practice more generally. However, it is not known whether or how the promotion of medicalized cutting hinders efforts to eliminate FGM. This important question needs to be explored in detail in specific contexts where FGM prevalence is high and/or is medicalized.⁸⁹

More research is needed to understand the complexities that are facilitating the medicalization of FGM, including how to work for change in the context of powerful traditional and social norms. Greater insights are also needed into the strategies that can be strengthened and built to support policy to accelerate this achievement of SDG 5.3.

Beyond personal financial gain, the supply-side drivers of medicalized FGM are not well understood. Some already identified by the evaluation of the Joint Programme include lack of awareness of the impact of FGM on sexual and reproductive health; social, personal and professional incentives for medical and the who may feel that s/he can build trust within a community by providing desired services; financial incentives; cultural attitudes on the part of the medical professional that FGM is acceptable; and a view that if the medical professional does not provide the service someone else will and likely under less hygienic conditions. Understanding which of these factors are most important in different settings and the proportional weight of each is essential to understanding more specifically why medical professionals continue to practice FGM and therefore to develop more appropriate and targeted advocacy messages.

Sources

- [1] <https://data.unicef.org/topic/child-protection/female-genital-mutilation/>. Published Feb 2020.
- [2] Ibid (Feb 2020).
- [3] Ibid.
- [4] WHO (Feb 2020) Female Genital Mutilation Fact Sheet. <https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation>
- [5] Shell-Duncan, B., Gathara, D. and Moore, Z. (February 2017) Female Genital Mutilation/Cutting in Kenya: Is change taking place? Descriptive statistics from four waves of Demographic and Health Surveys. Evidence to End FGM/C: Research to Help Women Thrive. New York: Population Council.
- [6] For a comprehensive review of studies, see Doucet, M-H., Palitto, C. and Groleau, D. (2017) 'Understanding the motivations of health care providers in performing female genital mutilation: an integrative review of the literature.' Reproductive Health. 14:46.
- [7] WHO (2010:2). Global strategy to stop healthcare providers from performing female genital mutilation. Geneva: World Health Organization.
- [8] Shell-Duncan (2001:1018); Newell-Jones (2016).
- [9] Shell-Duncan, B., Njue, C. and Moore, Z. (February 2017: 2) 'The Medicalisation of Female Genital Mutilation/Cutting: What do the data reveal?' Evidence to End FGM/C: Research to Help Women Thrive. New York: Population Council.
- [10] Leye et al (2019:158) 'Debating Medicalization of Female Genital Mutilation/Cutting: Learning from (policy) experiences across countries'. Reproductive Health. 16:158. <https://doi.org/10.1186/s12978-019-0817-3>.
- [11] UNFPA & UNICEF (Nov 2019) Beyond the Crossing: Female genital mutilation across borders: Ethiopia, Kenya, Somalia, Tanzania, and Uganda. New York: UNFPA.
- [12] Shell-Duncan, Njue & Moore (2017: iv). These data are derived from a question in the DHS module on FGM/C that asks specifically who performed the procedure.
- [13] See, for example: Shell-Duncan (2008) 'From Health to Human Rights: Female Genital Cutting and the Politics of Intervention' American Anthropologist 110(2): 225-236; Shell-Duncan, Njue & Moore (2017); Leye et al (2019); 28 Too Many (2016).
- [14] Shell-Duncan, 2001; Njue and Askew, 2004; Christoffersen-Deb, 2005; Shell-Duncan and Njue, 2017; Leye et al (2019); 28toomany (2016).
- [15] Johansen E, Nafissatou J, Laverack G, Leye E. (2013) 'What Works and What Does Not: A Discussion of Popular Approaches for the Abandonment of Female Genital Mutilation.' Obstetrics and Gynecology International; <https://doi.org/10.1155/2013/348248>.
- [16] Shell-Duncan, B., Njue, C. and Moore, Z. (February 2017) 'The Medicalisation of Female Genital Mutilation/Cutting: What do the data reveal?' Evidence to End FGM/C: Research to Help Women Thrive. New York: Population Council.
- [17] Christoffersen-Deb, A. (2005) 'Taming tradition: Medicalized Female Genital Practices in Western Kenya'. Medical Anthropology Quarterly. 19(4): 402-418.
- [18] Leye et al (2019: 164).
- [19] Doucet, M-H., Palitto, C. and Groleau, D. (2017) 'Understanding the motivations of health care providers in performing female genital mutilation: an integrative review of the literature.' Reproductive Health. 14:46.
- [20] Christoffersen-Deb (2005:414); Newell-Jones (2016: 57).
- [21] Serour (2013).
- [22] Leye et al (2019).
- [23] Knipscheer J, Vloeberghs E, Kwaak AVD, Muissenbergh MVD (2015) 'Mental health problems associated with FGM/C'. Br J Psychol Bull. 39:273-7.
- [24] Shell-Duncan (2001)
- [25] For example, the American Association of Pediatrics (AAP), issued a policy statement in 2010 that proposed allowing pediatricians to perform the 'nicking' form of FGM/C. Cited in Shell-Duncan (2017:4)
- [26] Shell-Duncan (2001: 1013)
- [27] Mwanri, L. and Gatwiri, G.J. (2017) 'Injured bodies, damaged lives: experiences and narratives of Kenyan women with obstetric fistula and Female Genital Mutilation/Cutting' Reproductive Health 14:38. doi 10.1186/s12978-017-0300-y; Arora and Jacobs (2016); Leye et al (2019: 159)
- [28] Leye et al (2019: 163).
- [29] Powell RA, Yussuf M. (2018) Changes in FGM/C in Somaliland: medical narrative driving shift in types of cutting. New York: Population Council.
- [30] WHO (2016) WHO guidelines on the management of health complications of female genital mutilation. Geneva: WHO.
- [31] [https://www.28toomany.org/static/media/uploads/Law%20Reports/somalia_law_report_\(july_2018\).pdf](https://www.28toomany.org/static/media/uploads/Law%20Reports/somalia_law_report_(july_2018).pdf) (page 4).
- [32] Christoffersen-Deb (2005); Newell-Jones (2017); Powell and Yussuf (2018).

- [33] Matanda et al (2018: 1); Shell-Duncan, B., Gathara, D. and Moore, Z. (February 2017:4) Female Genital Mutilation/Cutting in Kenya: Is change taking place? Descriptive statistics from four waves of Demographic and Health Surveys. Evidence to End FGM/C: Research to Help Women Thrive. New York: Population Council.
- [34] Shell-Duncan and Njue (2017)
- [35] Shell-Duncan et al (2017:4).
- [36] Shell-Duncan et al (2017:43).
- [37] Kimani et al (2020:8); Shell-Duncan, Gathara and Moore (February 2017).
- [38] Shell-Duncan et al (2017:43).
- [39] Kimani et al (2020:3); Kimani and Kabiru (2018)
- [40] Kimani et al (2020:11).
- [41] Shell-Duncan et al (Feb 2017).
- [42] Kimani et al (2020:11).
- [43] Kimani et al (2020:12); Christoffersen-Deb (2005).
- [44] Kimani et al (2020:13).
- [45] Christoffersen-Deb (2005).
- [46] Directorate of National Statistics, Federal Government of Somalia (2020) The Somali Health and Demographic Survey 2020. Mogadishu: Federal Government of Somalia.
- [47] UNFPA & UNICEF (Nov 2019) Beyond the Crossing: Female genital mutilation across borders: Ethiopia, Kenya, Somalia, Tanzania, and Uganda. New York: UNFPA.
- [48] Yussuf, M., Matanda, D. & Powell, R. (2020) 'Exploring the capacity of the Somaliland healthcare system to manage female genital mutilation/cutting-related complications and prevent the medicalization of the practice: a cross-sectional study'. BMC Health Services Research; Newell-Jones (2016); <https://reliefweb.int/report/somalia/midwives-fight-medicalization-fgm-they-lead-campaign-end-practice>
- [49] Newell-Jones (2016: 25).
- [50] <https://reliefweb.int/report/somalia/midwives-fight-medicalization-fgm-they-lead-campaign-end-practice>
- [51] Kipchumba, E., Korir, J., Abdirahman, N., and Mwai, C. (2019) Accelerating Change towards Zero Tolerance to Female Genital Mutilation/Cutting: Effects of Community Dialogues on FGM/C and Child Marriage: Mid-Term Review of the NCA/SCI Joint Programme 2016-2018 Save the Children International and Norwegian Church Aid.
- [52] Aungo, J. (October/November 2019). Mid-Term Evaluation of Challenging Harmful Attitudes and Norms for Gender Equality in Somalia CHANGES PROJECT. International Rescue Committee, Care International and Save the Children.
- [53] Yussuf, Matanda and Powell (2020), Newell-Jones (2016).
- [54] Powell, R.A. and Yussuf, M. (January 2018:vi) 'Changes in FGM/C in Somaliland: Medical narrative driving shift in types of cutting'. Evidence to End FGM/C: Research to Help Women Thrive. New York: Population Council.
- [55] Powell and Yussuf (January 2018:22).
- [56] Shell-Duncan et al (2010).
- [57] Crawford, S and Sagal, A. (2015) Situational Analysis of FGM/C Stakeholders and Interventions in Somalia. Available: <http://www.heart-resources.org/wp-content/uploads/2015/11/Situational-analysis-if-FGM-stakeholders-and-interventions-somalia-UN.pdf>.
- [58] Powell and Yussuf (January 2018:22). See also Shell-Duncan (2001).
- [59] Newell-Jones (2016: 75).
- [60] UNFPA (no date) Accelerating the abandonment of FGM in Somalia. <https://somalia.unfpa.org/sites/default/files/pub-pdf/GoodPracticeonFGMinSomalia.pdf>
- [61] UNFPA (no date).
- [62] Newell-Jones (2016: 74).
- [63] UNFPA (no date).
- [64] UNFPA-UNICEF Joint Programme to Eliminate Female Genital Mutilation (2017:62) 2016 Annual Report of the UNFPA-UNICEF Joint Programme on FGM/C: Accelerating Change.
- [65] Newell-Jones (2016).
- [66] Newell-Jones (2016:75).
- [67] Newell-Jones (2016:48).
- [68] Newell-Jones (2016:57).
- [69] Shell-Duncan B (2001) 'The Medicalization of female 'circumcision': harm reduction or promotion of a dangerous practice?' Social Science & Medicine p1013-1028.
- [70] Central Statistical Agency/CSA/Ethiopia and ICF (2016) Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: CSA and ICF.
- [71] UNICEF (2020) A Profile of Female Genital Mutilation in Ethiopia. New York: UNICEF.
- [72] Central Statistical Agency/CSA/Ethiopia and ICF (2016)
- [73] UNFPA & UNICEF (Nov 2019) Beyond the Crossing: Female genital mutilation across borders: Ethiopia, Kenya, Somalia, Tanzania, and Uganda. New York: UNFPA.
- [74] Ibid (2019).
- [75] Child Frontiers (2020) Assessment of barriers to accessing violence against women and children response services in refugee and host communities of Ethiopia. Addis Ababa: UNICEF.

[76] UNICEF (2020) A Profile of Female Genital Mutilation in Ethiopia. New York: UNICEF.

[77] UNICEF (2020);

[https://www.28toomany.org/static/media/uploads/Law%20Reports/ethiopia_law_report_\(july_2018\).pdf](https://www.28toomany.org/static/media/uploads/Law%20Reports/ethiopia_law_report_(july_2018).pdf)

[78] Central Statistical Agency (CSA) [Ethiopia] and ICF (2016) Ethiopia Demographic and Health Survey 2016, p.325. Addis Ababa, Ethiopia, and Rockville, Maryland: CSA and ICF.

[79] [https://www.28toomany.org/static/media/uploads/Law%20Reports/ethiopia_law_report_\(july_2018\).pdf](https://www.28toomany.org/static/media/uploads/Law%20Reports/ethiopia_law_report_(july_2018).pdf)

[80] National Statistics Office (NSO) [Eritrea] (1995) Eritrea Demographic and Health Survey 1995. Asmara: National Statistics Office.

[81] National Statistics Office (NSO) [Eritrea] and Fafo AIS (2013) Eritrea Population and Health Survey 2010. Asmara, Eritrea: National Statistics Office and Fafo Institute for Applied International Studies.

[82] Data from DHS 2002 and EPHS 2010 as reported in the National Handbook on women and children rights and elimination of harmful traditional practices, 2020; Ministry of Health, Ministry of Labor and Social Welfare and National Union of Eritrean Women (2018) Eritrea's Community Mapping on Female Genital Mutilation/Cutting (FGM/C) (2016 and 2018. Asmara: Government of Eritrea.

[83] The Government of the State of Eritrea, in collaboration with UNICEF/UNFPA, decided to implement FGM mapping studies to generate data related to the knowledge, attitudes, and practice of FGM in selected villages and identify the level of communities' readiness to declare themselves FGM-free. The first FGM mapping study was conducted in 2014 in 110 villages. The second was carried out in 2016 and the third in 2018. The 2016 study covered all zobas except Southern Red Sea and the 2018 study covered villages from Anseba and Maekel zobas only. Findings from the 2016 and 2018 studies were combined into one report (cited above).

[84] National Statistics Office (NSO) [Eritrea] and Fafo AIS

(2013) Eritrea Population and Health Survey 2010. Asmara, Eritrea: National Statistics Office and Fafo Institute for Applied International Studies.

[85] National Statistics Office (NSO) [Eritrea] and Fafo AIS (2013).

[86] National Statistics Office (NSO) [Eritrea] and Fafo AIS (2013).

[87] Shell-Duncan et al (2013).

[88] Shell-Duncan et al (2013); Doucet, Palitto and Groleau (2017); Shell-Duncan, B., Njue, C. and Moore, Z. (February 2017) 'The Medicalisation of Female Genital Mutilation/Cutting: What do the data reveal?' Evidence to End FGM/C: Research to Help Women Thrive. New York: Population Council.

[89] See page 71: <https://www.unfpa.org/admin-resource/unfpa-unicef-joint-evaluation-unfpa-unicef-joint-programme-female-genital>

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