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# Medicalisation of female genital mutilation is a dangerous development

**Medicalisation of female genital mutilation is a troubling development that hinders efforts to abandon the practice, jeopardising the wellbeing of girls and women, write Samuel Kimani and colleagues**

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The world is still grappling with the challenge of ending female genital mutilation (FGM). It is unlikely that the United Nations' sustainable development goal target of stopping FGM by 2030 will be achieved. One reason for this is the increasing medicalisation of FGM—that is, FGM performed by healthcare professionals.

As medicalisation gains momentum, it normalises and perpetuates FGM.[1] The emergence of this trend means that everyone, especially healthcare professionals, must make tackling FGM a priority.

FGM is known to be practiced in 31 countries that have representative data, including 28 African nations.[2,3] It has also been reported in Australia, Europe, North America, and New Zealand in diaspora communities migrating from FGM practicing countries.[4]

FGM practices comprise all procedures involving partial or total removal of female external genitalia or injury for non-therapeutic reasons.[5] An estimated 200 million girls and women globally live with FGM while 4.2 million girls are at risk of being cut each year.[2] It is important to highlight that the practice of FGM has changed considerably with medicalisation and traditional practitioners using less severe forms of cutting and cutting girls younger

Medicalised FGM is performed by healthcare providers including doctors, nurses, midwives, and health allied professionals or trainees. It is conducted in a public or private clinics, chemists, homes, or elsewhere, at any age, often using surgical tools, anaesthetic, analgesics, and antiseptics.[2,8] It includes reinfibulation, which involves reclosing of the external genitalia of a woman who has been deinfibulated to allow for childbirth, sexual intercourse, or other therapeutic gynaecologic procedures.[6,8]

Evidence shows that families are increasingly opting for medicalised FGM for their daughters.[2,7] Despite being illegal in most countries it is estimated that over 16 million women and girls globally have had medicalised FGM.[7,9] This shift is geographically concentrated, with the highest proportion of women aged 15-49 years who have undergone medicalised FGM living in Sudan (67%), Egypt (38%), Kenya (15%), and Nigeria (13%).[6] Analyses show the risk of medicalised FGM is higher in daughters compared with their mothers in Egypt, Sudan, Kenya, and Nigeria,[6,9] clearly indicating that medicalised practice is gaining traction. The growing popularity of medicalisation is associated with its alleged potential to minimise health risks; anti-FGM campaigning primarily uses a narrative of harm to health.[9]

Some health professionals are willing to conduct the procedure for financial benefit[10] and to elevate their social status within the community for offering "special services."[6,9] Recently, medicalisation has been veiled in secrecy and has circumvented the law by cutting girls younger, individually in a clinic or at home, impeding evidence gathering and prosecution.[6,7]

Medicalisation does not have any medical benefit, nor does it prevent long term medical, psychological, or sexual complications that may be associated with FGM, or curb the human rights violations linked to FGM.[6,7]

Whereas previous studies depicted medicalisation as a less severe type of FGM, evidence shows that health professionals could be cutting more severely. In Indonesia, where over 60 million women have FGM mainly performed through medicalisation,[2,6] studies showed that 46% of health professionals cut more tissue by removing the clitoral hood compared with 23% of traditional cutters. Since no health professional is trained in performing FGM the likelihood of extensive tissue damage is high. With girls being cut younger, including in infancy, there is more likelihood of removing more tissue when cutting than if operating on an adult. Furthermore, the effect of anaesthesia on damping pain during FGM procedures may allow for more tissue to be cut. The evidence refutes harm reduction as a justification for medicalisation and indicates that healthcare professionals may be performing equally or more severe forms of FGM.

Action to end the medicalisation of FGM must include open dialogue with doctors, nurses, midwives, and other health professionals who treat girls and women with or at risk of FGM. The human rights violations associated with FGM, the principle of "first, do no harm," and the role of healthcare professionals in preventing and responding to FGM must be central to the dialogue. Action to end FGM should be enshrined in laws and regulatory policies that impose sanctions and disciplinary actions against perpetrators of medicalisation. Health professionals and trainees must be taught using health and human rights approaches. Anti-FGM efforts should partner with communities in trust boosting initiatives to aid data collection, community awareness, and work towards ending the practice, including clarifying that medicalised FGM is equally severe as other forms. Further research into the damages, severity, and prevalence of FGM and those involved is required. Healthcare professionals must have greater awareness of and involvement in interventions,

including training to end FGM with a renewed focus on ending medicalisation.

Efforts to tackle medicalisation of FGM are in place but there is a lack of rigor and data, while many stakeholders are not yet fully prepared to deal with FGM. This calls for the inclusion and leadership of health professionals in tackling FGM. Interventions to end medicalisation of FGM must be prioritised and funded to the same extent as wider anti-FGM campaigns. Ending FGM in all forms should be on everyone's agenda, including healthcare professionals and their governing bodies.


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