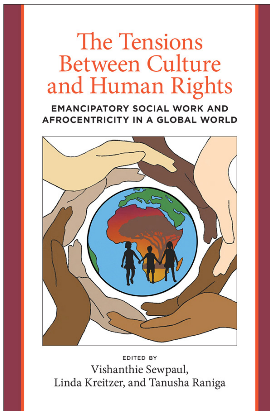

THE TENSIONS BETWEEN CULTURE AND HUMAN RIGHTS: Emancipatory Social Work and Afrocentricity in a Global World

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Human Rights and Medicalization of FGM/C in Sudan

Paul Bukuluki

Perpetuation of harmful practices such as female genital mutilation/cutting (FGM/C) is rooted in social motivations that do not have health benefits, and it constitutes a violation of human rights for girls and women. This chapter conceptualizes FGM/C in Africa and Sudan as a manifestation of social conventions or norms that have serious consequences for sexual and reproductive health rights (SRHR). It analyzes the drivers of FGM/C and its medicalization from a human rights perspective. It argues that FGM/C and its medicalization have socio-cultural, structural, and socio-economic drivers that need to be taken into account in SRHR policy and programming aimed at the demedicalization and abandonment of FGM/C. Social workers and health professionals in multidisciplinary teams should engage in social norm change and behavioural change interventions as well as systematic advocacy for policies and programs that address FGM/C and its medicalization in Sudan.

Background

The World Health Organization (WHO, 2018) classification describes four types of female genital mutilation/cutting (FGM/C): (1) clitoridectomy; (2) excision; (3) infibulations; and (4) other. The WHO (2019) offers the following characterization of types of FGM/C:

> Type 1 is characterized by: partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals), and in very rare cases, only the prepuce (the fold of skin surrounding the clitoris) while type 2 involves the partial or total removal of the clitoris and the labia minora (the inner folds of the vulva), with or without excision of the labia majora—the outer folds of skin of the vulva. (p. 1)

The WHO (2019) further notes that FGM/C types differ in terms of severity, and in particular the type 3 (re-infibulation) that is common in Sudan is documented to be the most severe:

> The most severe is type 3; often referred to as infibulation, this is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoris. (p. 1)

The WHO (2019) has described type 4 as encompassing "all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area" (p. 1).

Although there is considerable variation in form, content, motivations, extent of genital tissue removed, instruments used, age at which FGM/C is performed, and terminology used to describe the practice, it has been aptly noted that all forms of FGM/C are characterized by "the partial or total removal of the female external genitalia or other injury to the female genital organs for cultural or other non-therapeutic reasons" (WHO, 2019, p. 1).

According to the WHO (2010), the word "mutilation" emphasizes the gravity of the act while the term "female genital cutting" is used to reflect the importance of using non-judgmental terminology with practising communities. However, the main premise of this chapter is that irrespective of who, how, when, and where it is done, FGM/C represents a gross violation of human rights and dignity of children, girls, and women. The research adopts a human rights approach as its analytical framework.

Human Rights and FGM/C

Several scholars have emphasized the health–human rights nexus and have argued for the need for complementarity between public health and human rights. One of the key protagonists for this perspective, Jonathan Mann, noted that "people could not be healthy if governments did not respect their rights and dignity as well as engage in health policies guided by sound ethical values. Nor could people have their rights and dignity if they were not healthy" (Gostin, 2001, p. 121). From Mann's perspective, health is at variance with "dignity violations," and therefore, promoting and protecting health depends upon the promotion and protection of human rights and dignity (Mann et al., 1994). Gostin (2001) took this perspective further by arguing that a health and human rights analysis requires uncovering the rights violations, failures of rights realization, and burdens on dignity that constitute the societal roots of health problems. His perspective examines how a whole human being is made vulnerable to a wide variety of pathogens and unhealthy conditions as a result of how the person is treated by society—and how this affects human rights and dignity. This observation points to the notion of social determinants of health and how they are linked to human rights, freedoms, and dignity.

Social determinants of health (SDH) and their relation to human rights are clearly articulated by the WHO (2008) Commission on SDH. The commission aptly states that "inequalities in health arise because of circumstances in which people grow, live, work and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social and economic forces" (WHO, 2008, p. 3). There is probably no better document that heralds and advocates for human rights, especially the sexual and reproductive health rights (SRHR), than the Sustainable Development Goals (SDGs). One of the vision statements (number 8) of the SDGs aptly states:

> We envisage a world of universal respect for human rights and human dignity, the rule of law, justice, equality and non-discrimination; of respect for race, ethnicity and cultural diversity; and of equal opportunity permitting the full realization of human potential and contributing to shared

> prosperity. A world which invests in its children and in which every child grows up free from violence and exploitation. A world in which every woman and girl enjoys full gender equality and all legal, social and economic barriers to their empowerment have been removed. (UN, 2015a, Article 8)

Further still, the SDGs encompass health-related strategic targets that espouse promoting women's and children's health which augment the human rights–based approach to health (UN, 2015a). Three of these targets are particularly relevant for promoting SRHR, one each under the health, gender equality, and education goals. Specifically, SDG5, "Achieve Gender Equality and Empower All Women and Girls" (p. 14) provides a clear framework for the human rights–based approach to SRHR. This is further elaborated upon in the 2015 UN Secretary General's Global Strategy on Reproductive, Maternal, Newborn, Children's and Adolescents' Health (UN, 2015b), which provides a road map to advancing the health of women, children, and adolescents, including promoting abandonment of harmful social norms that affect SRHR for women and girls. This has further added impetus to the conceptualization of FGM/C as a harmful social norm and practice that constitutes a violation of the human rights of girls and women given its short-term and long-term health consequences (WHO, 2019).

The cultural diversity–human rights paradox

Whereas FGM/C has serious health consequences and is a violation of human rights, it is not immune to the cultural diversity, cultural rights, and human rights paradox. For those who argue for the negotiation between cultural relativism[1] and human rights that tend to claim universality, the debate still goes on about how to find middle ground with respect to universalism, cultural diversity, and cultural relativism (Donnelly, 1984) in the context of FGM/C. In this case, leaning toward cultural relativism and contextualization, without taking into account the global discourses and evidence that show that FGM/C is detrimental to the health of girls and women, raises moral questions as well as issues of political correctness rather than focusing on the health and well-being of women and girls

(Nyangweso, 2016). However, it is also important to appreciate that human rights need to be translated into action in culturally sensitive ways that acknowledge cultural diversity and emphasize using cultural resources but also send a clear message that castigates harmful cultural practices. This message requires nurturing spaces for constant negotiation between cultures, rather than suffocating it in favour of the local context or universals or political correctness. This process is closely associated with what has been described as cosmopolitan localism,[2] which means taking into account global discourses (or universals like human rights) (Sachs, 2006). However, it also maintains a strong focus on the context in which people experience challenges, suffering, or illness as perceived by them. As argued by Kleinman (1978), it is important to give adequate consideration to the social and historical context, as well as the experience of suffering, in the assessment of disease. For example, it is important to avoid generalizing FGM/C to be the same and to mean the same thing in every culture or society where it is practised, because doing this would mean designing one-size-fits-all interventions. Not paying adequate attention to contextualization would also lead to falling into the trap of blind universalism like one described by Sachs (2006):

> For centuries, universalism has been at war with diversity. Science, the state and the market have dominated this campaign. . . . Science, the state and the market are based on a system of knowledge about man, society and nature that claims validity everywhere and for everybody. (p. 219)

Therefore, from this perspective, interventions against FGM/C and its medicalization as a human rights violation need to be contextualized and viewed relative to the various settings.

Medicalization of FGM/C

Medicalization of FGM/C has been defined to refer to "situations in which FGM/C is practiced by any category of health-care provider, whether in a public or a private clinic, at home or elsewhere (WHO, 2010, p. 2). "It also includes the procedure of re-infibulation at any point in time in a woman's

life" (p. 2). Analysis of data from several countries shows that more than 18 percent of all girls and women who have been subjected to FGM/C in the countries from which data are available have had the procedure performed on them by a health-care provider (WHO, 2010). However, this report notes that there are large variations between countries, ranging from less than 1 percent in several countries to between 9 and 74 percent in six countries, including Sudan (WHO, 2010). Studies have shown that the categories of health-care providers that carry out FGM/C 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 (Berggren et al., 2004; WHO, 2010).

The World Health Assembly (2008) adopted the resolution WHA 61.16 on the elimination of FGM/C, in which all member states agreed to work toward the abandonment of FGM/C, including ensuring that the procedure is not performed by health professionals. This was a follow-up to earlier high-level statements by the WHO (1998) made as early as 1979 that condemned the medicalization of FGM/C at the first international conference on FGM/C, held in Khartoum, Sudan. Since then several other statements from international agencies have been issued, including a formal statement of the WHO's position to the United Nations Commission on Human Rights in 1982 (WHO, 1998). In addition, several United Nations Treaty Monitoring Bodies, including the Committee on Elimination of all forms of Discrimination Against Women (UN, 2014), have called on countries to eliminate the medicalization of FGM/C. As clearly stated in the WHO's Global Strategy to Stop Health-Care Providers from Performing FGM/C:

> 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. . . . 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. (WHO, 2010, p. 5)

Therefore, this chapter discusses the status and drivers of the medicalization of FGM/C in Sudan from a human rights perspective and includes research conducted between February and March 2016 concerning drivers of FGM/C medicalization among community midwives in Sudan.

Methods

The chapter is predominantly based on a document review supplemented by consultative meetings in the form of focus group discussions (FGDs) with health workers, particularly midwives, in Khartoum. The study design was phenomenological; it encouraged midwives to reflect on their own experiences in relation to FGM/C at facilities and communities where they work. The intention of the FGDs was to understand the experiences of health workers, particularly midwives, about their perceptions and experiences in relation to drivers of the medicalization of FGM/C. Two FGDs were conducted with each group consisting of 6–10 midwives. The FGDs also served as consultative meetings to generate information to facilitate development and pretest the protocol and tools for an implementation research protocol, intended to develop and test interventions to promote the demedicalization of FGM/C. The FGDs were conducted with the help of a translator fluent in Arabic and English.

FGDs were aimed at supplementing information collected through the document review process using the search engine Google Scholar, and published and unpublished reports from agencies working on FGM/C. One of the key sources of quantitative data was the secondary analysis of the 2014 multiple indicators cluster (MICS) survey report (UNICEF, 2016). The analysis of qualitative evidence from consultative meetings was thematic; it involved identification of prominent or recurring themes and sub-themes in the primary data (Dixon-Woods et al., 2005). Some verbatim extractions from key informant interview transcripts are inserted directly into the results of this chapter. The findings from secondary data were also organized into thematic categories, based on commonality of meaning. Approval to conduct interviews and FGDs was obtained from

Federal Ministry of Health given that these were part of the preliminary consultations that informed the design of a formative study.

Verbal informed consent was sought from participants using a consent form detailing the purpose of the consultations, with emphasis on voluntary participation, requesting permission to record interviews and assuring participants of confidentiality, and informing them of the risks and benefits of participation.

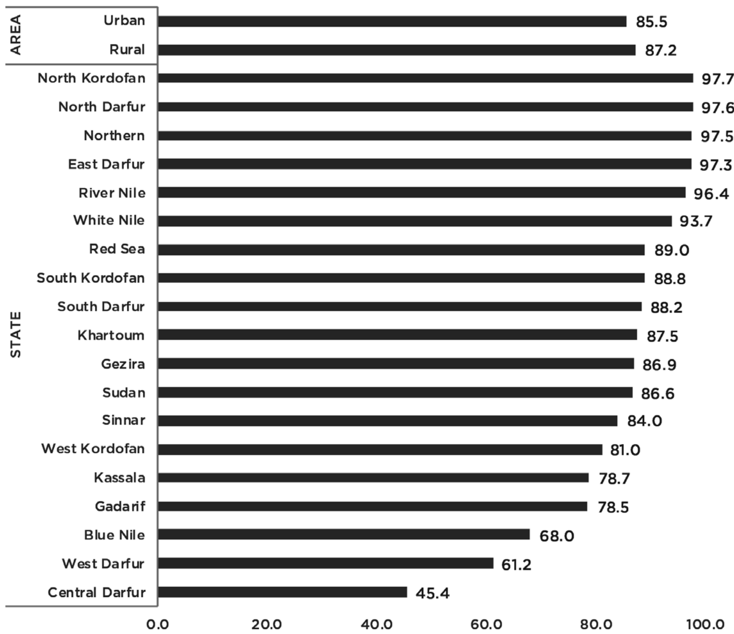
Results

The results of the research include the following themes: (1) magnitude of FGM/C in Sudan; (2) health consequences of FGM/C and violation of health rights; and (3) medicalization of FGM/C in Sudan, with sub-themes of the (a) perception of harm reduction, (b) power dynamics, (c) harm reduction "dilemma," (d) perception of FGM/C as a religious obligation, (e) understanding of re-infibulation to be different from FGM/C, and (f) negotiation between societal norms, values, and policies. This section presents results generated from primary sources and the review of secondary data from relevant documents.

Magnitude of FGM/C in Sudan

In Sudan, the prevalence of FGM/C among females aged 15–49 years is 86.6 percent (UNICEF, 2016 (about 8,369,890) with 77.0 percent (UNICEF, 2016) having type 3 (flesh sewn) (UNICEF, 2016) (See Fig. 10.1). The FGM/C prevalence is different within generations: 66.3 percent among those aged 0–14 years, 88.3 percent among those aged 30–34 years, and 91.8 percent among those aged 45–49 years (UNICEF 2016). The prevalence of FGM/C type 3 in 1966 was 81.9 percent compared with 2014 when it was 73.3 percent. Furthermore, secondary FGM/C (defined as recircumcision in the last 12 months) was highest among women 15–19 years (31.2 percent) compared to 20–39 years (23–24 percent). FGM/C overall prevalence in Sudan is high (86.6 percent), and the highest rates are in North Kordofan (97.7 percent), Northern State (97.5 percent), North Darfur (97.6 percent), East Darfur (97.3 percent), and River Nile (96.4 percent). There is a slight variation between rural areas (87.2 percent) and urban areas (85.5 percent) (UNICEF, 2016).

Figure 10.1: Prevalence of FGM/C in Sudan.



Health Consequences of FGM/C and Violation of Health Rights

The World Health Organization (2016) "Guidelines on the Management of Health Complications from Female Genital Mutilation" (pp. 6–8) provide a succinct description of the short-term and long-term consequences of FGM/C. See Table 10.1 below:

Given its harmful social and health consequences to women and girls (UNICEF, 2013), FGM/C is described as a reflection of the deep-rooted inequality between the sexes, and an extreme form of discrimination against women (WHO, 2016). FGM/C is therefore one of the cultural norms and practices that have been recognized as sitting at the intersection between violence against children (VAC) and violence against women (VAW). One of the major reasons why FGM/C is considered a human

Table 10.1: Health Consequences of FGM/C. Source: WHO (2016, pp. 6–7), Guidelines on the Management of Health Complications from Female Genital Mutilation/Cutting.

RISK	REMARKS
IMMEDIATE RISKS[1]	
Haemorrhage	
Shock	Haemorrhagic, neurogenic or septic
Genital tissue swelling	Due to inflammatory response or local infection
Infections	Acute local infections; abscess formation; septicaemia; genital and reproductive tract infections; urinary tract infections;
	The direct association between FGM and HIV remains unclear, although the disruption of genital tissues may increase the risk of HIV transmission.
Urination problems	Acute urine retention; pain passing urine; injury to the urethra
Wound healing problems	
Death	Due to severe bleeding or septicaemia
OBSTETRIC RISKS[2]	
Caesarean section	
Postpartum haemorrhage	Postpartum blood loss of 500 ml or more
Episiotomy	
Prolonged labour	
Obstetric tears/lacerations	
Instrumental delivery	
Difficult labour/dystocia	
Extended maternal hospital stay	
Stillbirth and early neonatal death	
Infant resuscitation at delivery	

[1] Also see Berg, Underland et al. (2014) and Iavazzo et al. (2013).
[2] Also see WHO (2006) and Berg, Odgaard-Jensen et al. (2014).

Table 10.1 (*continued*)

RISK	REMARKS
SEXUAL FUNCTIONING RISKS[3]	
Dyspareunia (pain during sexual intercourse)	There is a higher risk of dyspareunia with type III FGM relative to types I and II
Decreased sexual satisfaction	
Reduced sexual desire and arousal	
Decreased lubrication during sexual intercourse	
Reduced frequency of orgasm or anorgasmia	
PSYCHOLOGICAL RISKS	
Post-traumatic stress disorder (PTSD)	
Anxiety disorders	
Depression	
LONG-TERM-RISKS[4]	
Genital tissue damage	With consequent chronic vulvar and clitoral pain
Vaginal discharge and Vaginal itching	Due to chronic genital tract infections
Menstrual problems	Dysmenorrhea, irregular menses and difficulty in passing menstrual blood
Reproductive tract infections	Can cause chronic pelvic pain
Chronic genital infections	Including increased risk of bacterial vaginosis
Urinary tract infections	Often recurrent
Painful urination	Due to obstruction and recurrent urinary tract infections

[3] Also see Berg, Underland et al. (2014) and Berg, Denison et al. (2010).
[4] Also see Berg, Underland et al. (2014) and Iavazzo et al. (2013).

rights abuse is that it is nearly always carried out on minors, making it a violation of the rights of children. WHO (2016) conceives FGM/C as

> a practice that violates a person's rights to the highest attainable standard of health, right to health, security and physical integrity, the right to be free from torture and cruel, inhuman or degrading treatment, and the right to life when the procedure results in death. (p. 9)

FGM/C is a human rights violation also for the reason that it damages healthy genital tissue and can lead to severe consequences for girls' and women's physical and mental health (Vloeberghs et al., 2012). For example, several studies have shown prevalence of depression and anxiety disorders, including post-traumatic stress disorder (PTSD) among survivors of FGM/C (Applebaum et al., 2008; Kizilhan, 2011; Vloeberghs et al., 2012; Whitehorn et al., 2002).

By contributing to violation of these rights, FGM/C contravenes several international human rights instruments that promote the rights of women and girls. These include the International Covenant on Economic, Social and Cultural Rights (UN, 1966); the Universal Declaration of Human Rights (UN, 1948, Articles 1 and 3); the International Covenant on Civil and Political Rights (ICCPR) (UN 1976, Preamble and Articles 6 and 9); and the Convention on the Rights of the Child (UN, 1989, Article 19). These rights are also dealt with in the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Commission on Human and Peoples' Rights, 2003, Article 5); the Joint General Recommendation/General Comment No. 31 of the Committee on the Elimination of Discrimination against Women (UN, 2014); and the Joint General Recommendation/General Comment No. 18 of the Committee on the Rights of the Child on Harmful Practices (UN, 2014).

Studies in several African countries have also revealed that the health consequences of FGM/C increase the burden of care and the economic costs of treatment. For example, a study carried out in Gambia on health consequences of FGM/C established that the practice of FGM/C has significant health consequences and economic costs as one of three patients (299 cases of871) suffered medical consequences requiring treatment

(Kaplan et al., 2011, pp. 5–6) This finding is corroborated by other studies showing that the annual costs of FGM/C-related obstetric complications ranged from 0.1 to 1 percent of government spending on health for women aged 15–45 years (Adam et al., 2010).

Other scholars have argued that FGM/C justifies acts of sexual control by devaluing bodily pleasure, thus undermining individual sexuality and reproductive rights (Nyangweso, 2016). Anthropologist Ellen Gruenbaum (2001) described FGM/C as "an expression of sexism and patriarchy" (p. 133) and conceived of it as a cultural practice that is part of and reinforces social structures that promote similar practices like polygamy and child marriage that are all designed to limit women's self-realization and well-being (Gruenbaum, 2001; Nyangweso, 2016).

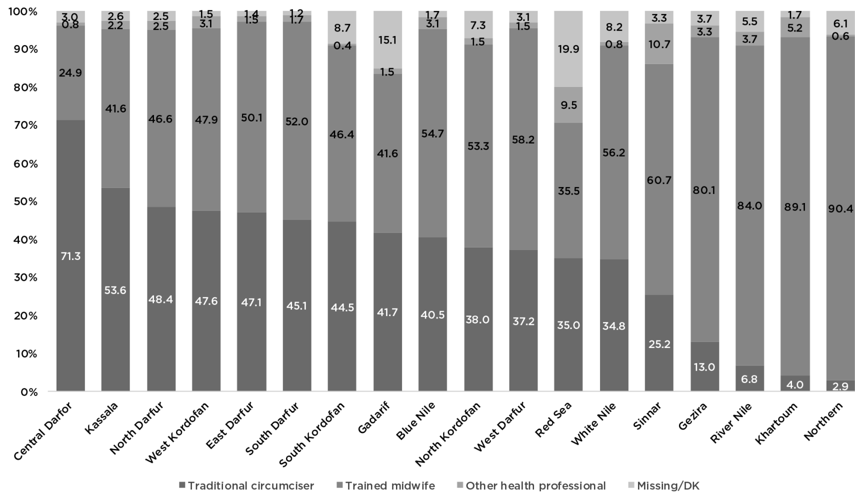
Medicalization of FGM/C in Sudan

FGM/C practice has become increasingly medicalized among women (15–49 years), from 55.4 percent during 1966 to 1979 to 76 percent in the years 2000 to 2014 (UNICEF, 2016). Trained midwives (76.0 percent) perform most of the cutting compared to traditional birth attendants (18.4 percent) (UNICEF, 2016). The trend analysis of cadres that carry out FGM/C in Fig.10.2 and 10.3 below also clearly demonstrates that FGM/C is primarily carried out by health-care workers, especially midwives.

Perception of harm reduction

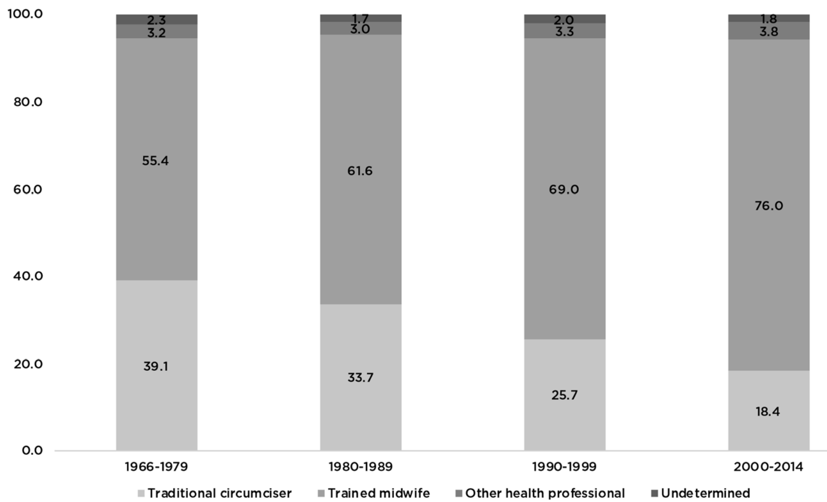
The major sources for data for this sub-theme were literature review and consultative meetings with midwives from two health facilities in Khartoum. From both primary and secondary sources, it was noted that the major driver of medicalization is the perception that health workers or health professionals, especially midwives, perform "milder" forms, for example, the *Sunna* type perceived as a religious rite. Health professionals are perceived to be more skilled in performing FGM/C and in reducing the health consequences arising from FGM/C. This perception thrives in the context of insufficient training of community midwives, especially in relation to ethical issues ("do no harm"), to counter existing social and religious norms and limited knowledge among health workers, particularly midwives, about the health consequences of FGM/C.

Figure 10.2: Medicalisation of FGM/C.



Source: Unicef—Secondary analysis of Sudan 2014 MICS Data, Feb. 2016.

Figure 10.3: Analysis of trends in medicalisation of FGM/C.



Source: Unicef—Secondary analysis of Sudan 2014 MICS Data, Feb. 2016.

Power Dynamics

Dahl (1968) has suggested that power refers to "subsets of relations among social units such that the behaviors of one or more units . . . depend in some circumstances on the behavior of other units" (p. 407). It has been described by Dahl (1968) in terms of A getting B to do something she or he would not otherwise have done. As argued by Elisheva (2004) in his commentary on Dahl's theory of community power:

> Power is exercised in a community by a particular concrete individual, while other individuals, also actual, are prevented from doing what they prefer to do. Power is exercised in order to cause those who are subject to it to follow the private preferences of those who possess the power. Power is the production of obedience to the preferences of others, including an expansion of the preferences of those subject to it so as to include those preferences. (p. 36)

This notion of power resonates with Finke's (2006) argument in the context of FGM/C, that

> from an intra-cultural perspective, the focus of FGM is not primarily on surgical intervention or the manipulation of a girl's or woman's sexual organs but rather on raising the status of the woman/(future) wife or even on initiating her into a "powerful" secret society. Even when the cutting is experienced as traumatic, the practice is not rejected. Instead, the excised body is viewed as having achieved the aesthetic norm: the genitals in their natural state are denigrated as being unaesthetic, unclean or even as harmful to health. (p. 13)

Therefore, FGM/C as a rite of passage becomes the determining factor for access to the various social institutions and resources required for normal social functioning in a society and becomes a source of inclusion or exclusion, leaving women and girls with limited options. For example,

eligibility to marriage or preparation for marriage hinges on undergoing FGM/C.

Given the significance of the FGM/C as a rite of passage or a determinant of access to societal resources, the actors involved in executing FGM/C, especially mothers, circumcisers, and others, mostly elder women, enjoy their power. As explicitly stated by Finke (2006):

> Their skills with the ritual are in demand, their knowledge of how to raise the young is respected. They know the significance of virginity and the power of sexuality, which needs to be checked. Or they are bowing to the necessity of excising from the bodies of their daughters the—from their point of view—dangerous "maleness" to be found there. . . . Thus the circumcisers are proud to do their (religious) duty and join in the process of increasing the girls' eligibility for marriage. (p. 13)

During the consultative meetings with midwives it was evident that they, at the community and societal level, wield power and control over issues of sexuality and reproduction, and that they are trusted and protected by the community. The midwives noted that if you asked women and men in their community to rank powerful people in the community, midwives would be among those at the top given their significant role in relation to sexuality, reproduction, family, marriage, childbirth, and safe motherhood. They are the experts and are consulted on all aspects involving sexuality, fertility, marriage, reproduction, and FGM/C. With the increase in awareness about the health consequences of FGM/C, midwives wield even more power because they are believed to perform milder FGM/C and to contribute to harm reduction. Several midwives explain:

> The only three people are allowed to see her forbidden body parts are: her mom, the midwife and her husband, no one else is allowed. A midwife since history is known to be a secret keeper, even when women are facing issues with their husbands, they run to the midwife to solve their problems, such as sexual issues, social issues. (FGD midwives).

Another midwife states,

> Well, the midwife is an influential person; she can communicate with the Emam, El Shaiekh, with the president and actually with everyone." Another midwife elaborated: "Because she is the one the people trust on the neighborhood, the one who knows the complications and how to manage it, the midwife job it's not exclusively about deliveries, she's the one who gives education, awareness and so on.

Therefore, medicalization of FGM/C adds to the power of midwives because they are now perceived as the only ones who can do it right. It was interesting to learn from midwives that those who do not perform FGM/C were generally perceived by community members who want FGM/C as incompetent, and young, with limited understanding of the cultural, religious, and family stability values associated with FGM/C. For example, during the FGD, one midwife said:

> Some of the community members think that we are new proud and young midwives, if we said we will not perform the circumcision, they will choose to go to the other midwives who will do the circumcision, although we have the knowledge and we have been trained, but this is not the knowledge the community wants, because they believe the community have the alternatives—the old midwives.

Another stated,

> Well, the communities will not force you to do something you don't want to do, but sometimes when the midwife refuses, they will seek for another midwife to perform it and so on.

The harm reduction "dilemma"

Harm reduction, which generally is about measures to improve its (FGM/C's) safety, raises a moral dilemma highlighted by Shell-Duncan (2001), who argues that

> the debate over medicalization of FGM has, up until now, been cast as a moral dilemma: to protect women's health at the expense of legitimating a destructive practice? Or to hasten the elimination of a dangerous practice while allowing women to die from preventable conditions? (p. 1013)

Harm reduction is a new paradigm in public health that aims to minimize the health hazards associated with risky behaviours, such as intravenous drug use and high-risk sexual behaviour, by encouraging safer alternatives, including but not limited to abstinence. Harm reduction considers a wide range of alternatives and promotes the alternative that is culturally acceptable and bears the least amount of harm. A systematic review on understanding why health-care providers perform FGM/C found that a proportion of health-care providers practise FGM/C or re-infibulation to prevent or reduce the risks for girls and women of undergoing the procedure with a traditional practitioner (Doucet et al., 2017). For example, some studies established that some health workers believe that performing FGM/C in hygienic conditions would reduce the harm for girls (Mostafa et al., 2006; Njue & Askew, 2004); and medicalized procedures, particularly administration of anesthetic medication, would reduce pain for girls. Some midwives in FGDs claimed that they choose to practice re-infibulation "because somebody else would and perform it worse than they would" (Berggren et al., 2004, p. 304); for financial gain; and in response to the requests of families and community members (Berggren et al., 2004; Doucet et al., 2017).

These arguments notwithstanding, human rights protagonists argue that promoting harm reduction, as a strategy in response to FGM/C, would entrench medicalization of the practice, which would further complicate efforts to eliminate it entirely. It would also derail advances in promoting abandonment of FGM/C because it violates women's rights,

advances illustrated by the adoption of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Commission on Human and Peoples' Rights, 2003), which explicitly recognizes women's right to be free from FGM/C. It would also derail the advances in legislation against FGM/C, given that the law is being used increasingly to combat the practice and legislation criminalizing FGM/C has been adopted in many countries (Center for Reproductive Rights, 2006, p. 1). Similar arguments have been made that health-care providers are generally respected members of the community, and when they practise FGM/C, this can give the impression that the procedure is acceptable and safe, which can further promote the practice (Doucet et al., 2017, p. 2). It is further argued that "since FGM/C is performed for sociocultural reasons rather than for medical reasons, the practice goes against the Hippocratic Oath of 'Do no harm,' and it violates girls' and women's right to physical integrity, health and life" (p. 3).

Perception of FGM/C as a religious obligation

Some midwives and other health professionals have the perception that FGM/C is a religious issue and that they have an obligation to respond positively to requests from families to cut their daughters. Those with this belief feel that they have a religious and cultural obligation to perform FGM/C: "they being midwives is the will of God and their reward for being midwives will come from God" (Participant FGD midwives). Another midwife elaborated further"

> A reward from God, that's the first thing. We don't pay attention to anything else, as long as we put in our mind to do our job perfectly with dedication, we ask God to reconcile us in what we do, in the sake of God, that's all what we want. . . . From this perspective, those who reject requests from families to cut girls would be acting against the will of God.

Human rights activists and the WHO (1996) have argued that this perception runs counter to what the Prophet Mohamed says: "God curses females who alter His creation." This is interpreted to mean that "God

created human beings in the best mold and wanted them to keep the nature in which they were created, forbidding them to make any changes in God's creation" (p. 5).

Despite attempts by Islamic scholars to explain the non-authenticity of the hadith related to female circumcision, there are still claims among sections of the Islamic community that FGM/C, particularly the *Sunna* type, is linked to religion (Shell-Duncan, 2001). Similarly, UNICEF (2005) argues that

> FGM/C is not prescribed by any religion. This is not, however, the general perception, especially regarding Islam. Although there is a theological branch of Islam that supports FGM/C of the *sunna* type, the Koran contains no text that requires the cutting of the female external genitalia. . . . Moreover, the majority of Muslims around the world do not practice FGM/C. Sudan is one of the countries that has a theological branch of Islam that supports the Sunna type of FGM/C. (p. 12)

This is therefore still an area of controversy, and it creates doubts among some families in relation to making decisions for their daughters to undergo FGM/C and puts them at risk of succumbing to pressure from the society and imams. This too creates a dilemma for some health workers, who believe the *Sunna* type of FGM/C is linked to the Islamic religion, about how to respond to the requests from families to have their daughters undergo FGM/C. This is happening in the context of limited awareness about the health consequences of FGM/C by some midwives, and belief that circumcised women are clean and do not attract infections. For example, one of the midwives in the FGD believed that "circumcised women are [as] clean as possible, and they don't get the infections like the uncircumcised women."

Understanding of re-infibulation to be different from FGM/C

There is a perception among midwives that when a woman gives birth, re-infibulation (a procedure to recreate an infibulation, for example after childbirth when de-infibulation is done) is necessary because it restores

the vagina to its original state and "avoids more complications and helps her to increase her value and maintain her marriage . . . striving for beautification and completion" (Berggren et al., 2004, pp. 299–300). Midwives in the FGDs had a perception that re-infibulation would only refer to "narrowing beyond the initial infibulation." To them, restoring the woman to the status of her original infibulation state was not perceived as re-infibulation. In other words, for the midwives in the FGDs re-infibulation is the norm as long as it does not go beyond the initial infibulation. "We restore as much as we cut for delivery, we stitch it back, nothing more, even if her original vagina was narrow; we get it back the same." Another midwife remarked that

> we only cut what is suitable for the baby's head to come out (de-infibulation), nothing more, and then we stitch this cut itself, only. And if there is a previous scar of episiotomy, I open at the same place with the same measures and then stitch it from inside to outside. . . . We measure it with our digits along with head of the baby avoiding cutting more than it is supposed to be . . . because the cut that is made by the scissors won't be self-returning, and if you don't do the stitches, it will get infected and she may bleed as well, so the stitches to stop bleeding and not to get the area infected.

Therefore, for these midwives, re-infibulation is the normal thing to do. This indicates a lack of training in clinical management of FGM/C complications aligned to the WHO guidelines.

Negotiation between societal norms, values, and policies

One of the issues emerging from interaction with midwives was that they belong to a culture and religion that treasures FGM/C and they had to constantly negotiate and balance between demands from families, their cultural/religious obligations, and professional ethics, especially to do no harm and not violate the rights of people. With respect to social norms, Doucet et al. (2017) in their systematic review found a number of studies in which health-care providers, including those from Sudan, cite cultural reasons to justify their practice of FGM/C (Berggren et al., 2004; Refaat,

2009). In the FGDs with midwives in Khartoum, one of the midwives described how she carefully negotiated between culture and medical ethics in relation to FGM/C:

> Two girls came from Gezira state, to study at university, they felt they are less than their colleagues because they were uncircumcised, and even their aunts gave them a hard time because of that. They actually developed a psychological complexity because they were uncircumcised, so one of them dropped the university for two weeks and she said won't get back till I'll be equal with my colleagues. They brought me to her, I tried to discuss with her the situation and she was insisting to do the Pharaonic circumcision, I said do you know what is it? She said yes and I want it, I actually did for her a very light cutting for her clitoris and stitched her and that was it, then she called her aunts to prove to them that now she became a circumcised girl, her aunts were finally pleased.

This is happening in a context where many midwives are administratively not hired by the Ministry of Health (MOH) and with limited livelihood options. A considerable number of community midwives (trained for nine months) are not employed and perform FGM/C as a financial survival strategy. For these midwives, previous studies have established that re-infibulation represents a considerable source of income, but motives of midwives are more complex than simply economic (Berggren et al., 2004). Therefore, the complexities of entrapment by social norms, religious beliefs, not being employed, and not accountable administratively to MOH to apply existing code of conduct policies make midwives susceptible to engaging in the medicalization of FGM/C.

Conclusions

FGM/C is one of the major forms of gross SRHR abuses in countries where it is still practised. Its medicalization under the guise of harm reduction has exacerbated the vice because it tends to project it as legitimate, although it

is a human rights violation for the girls and women. As clearly shown by the results of the MICS (UNICEF, 2016), trained midwives that are part of the health-care system represent the major health-care worker cadre who are carrying out FGM/C. FGM/C medicalization has socio-economic drivers, and it has a social norms dimension that needs to be considered in SRHR policy and programming in prevention and response to FGM/C. Strengthening knowledge on health consequences of FGM/C is very important, but this needs to be coupled with social norm interventions targeting midwives because they also share similar socio-cultural and religious norms and beliefs with the other community members.

These results point to the need for a health-system and multi-sectoral response to FGM/C and for strengthening accountability frameworks for health workers as deterrence to medicalization. They point to the need to develop training tools that, from the onset, conceptualize FGM/C and its medicalization as a violation of human rights. Given the complexity of FGM/C and its social norms, changing workload, and clinical management of complications, multi-sectoral and multi-disciplinary teams involving health workers and social workers need to work together, especially in the context of health and social policies, in the realization of the sustainable development goals that link gender equality and health as well as universal health coverage. The health professionals and social workers, who command respect in communities, can play a key role in providing a supportive social environment, where the consequences of FGM/C and the benefits of abandoning the practice are discussed (WHO, 2010).

Given the purported religious inclinations associated with FGM/C, community-driven approaches involving religious and cultural leaders, including Islamic scholars, as part of multi-disciplinary social norm change interventions are critical to the success of interventions. The literature on FGM/C shows that using an approach that reinforces the human rights values and social support has catalyzed communities to collectively dialogue and agree on better ways to fulfill these values, "and has led to sustainable large-scale abandonment of FGM as well as other harmful practices" (WHO, 2010, p. 3).

This chapter has made reference to evidence that demonstrates that FGM/C of any type, and irrespective of who carries it out, is a violation of the human rights of girls and women, including, as stated by the WHO

(2010, p. 6), “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.” The findings mainly suggest that health-care providers need more information and training in order to refrain from engaging in these harmful practices (Doucet et al., 2017). However, I argue that the training should be rooted within the human rights–based approach. It should also go beyond providing technical tools and knowledge about health consequences of FGM/C to include social norm change, address structural issues like high unemployment, particularly of community midwives, and deal with the power dynamic that motivates midwives and other health professionals to carry out FGM/C. Interventions, though rooted in the human rights approach, should elicit and address specific drivers of medicalization in each of the diverse contexts.

NOTES

1. Jack Donnelly (1984) in his article “Cultural Relativism and Universal Human Rights,” noted that cultural relativism is a doctrine that holds that such variations are exempt from legitimate criticism by outsiders, which is mostly supported by the notions of communal autonomy and self-determination. He adds that radical cultural relativism would hold that culture is a sole source of the validity of moral right or rule.
2. “Cosmopolitan localism seeks to amplify the richness of a place while keeping in mind the rights of a multi-faceted world. It cherishes a particular place, yet at the same time knows about the relativity of all places” (Sachs, 2006, p. 224).

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