

Joint Evaluation of the UNFPA-UNICEF Joint Programme on the Elimination of Female Genital Mutilation: Accelerating Change Phase III (2018-2021)

Female genital mutilation and complex situations

Medicalization

Cross-border

Social norms



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The purpose of the joint evaluation is to assess the programme contributions to outputs and outcomes during Phase III of the Joint Programme on the Abandonment of Female Genital Mutilation (2018-2021). The evaluation aims to inform the design of the Joint Programme post-Phase III in the framework of the 2030 Agenda for Sustainable Development.



Challenges

The practice of FGM persists in diverse and often covert ways, despite achievements in anti-FGM legislation and progress in social norms change



Observation

Such modifications of the practice lead to complex situations to address within policy and programming



Action

Build on momentum to address cross-border FGM and address attitudes and behaviours of health service providers

While global efforts have been made to curb FGM, evidence shows that some families, excisors and practitioners find alternative ways to uphold the practice.

The Joint Programme has contributed to efforts to introduce legislation for eliminating FGM in the countries in which it operates. Currently, 14 of the 17 Joint Programme countries have a legislative framework in place, with efforts still underway in the remaining three countries. In addition, there has been significant support to community engagement initiatives and communications to bring about social norm change. Whilst progress has been made to change legislative and social norms, it has also become evident that some individuals and groups respond by modifying their behaviour rather than abandoning FGM. This represents complex situations to address with policy and programming.

There is growing concern that FGM is persisting in new or different ways to circumvent legal prosecution. For instance, FGM is being practised in secret and without public ceremony, or is being conducted pre-school age to avoid taking the girl out of school for an extended period of time (making detection harder). In addition families may travel across a border into another country, where FGM is legal or less policed, known as 'cross-border FGM'. There are also changes in how FGM is being performed, including a trend towards FGM being conducted by health professionals, known as 'medicalization'. Medicalization can be seen to confer a legitimacy to the practice, although it remains a violation of girls and women's human rights and bodily autonomy.

This thematic note pulls together findings on FGM and complex situations, particularly on cross-border issues and medicalization, from an evaluation of the third phase of the UNFPA/UNICEF Joint Programme on the Abandonment of Female Genital Mutilation: Accelerating Change. It focuses on the evaluation question, 'to what extent has the JP contributed to strengthening national policies and legislative frameworks on the elimination of FGM through integration of evidence-based analysis on FGM emerging issues, including medicalization and cross-border issues?' (EQ 5 in the main evaluation report).

There are three headline findings which this note is structured around:

1. The extent to which the Joint Programme has strengthened its work on cross-border FGM
2. Trends that are emerging around migratory FGM
3. The extent to which the Joint Programme has been effective in responding to the medicalization of FGM.

About the UNFPA/UNICEF Joint Programme on FGM

The Joint Programme on the Abandonment of Female Genital Mutilation: Accelerating Change (referred to here as 'the Joint Programme') is currently being implemented in 17 countries, and links community-level transformation of social norms that often drive FGM with laws banning the practice and access to quality sexual and reproductive health and child protection services for girls and women at risk of and affected by FGM. It is global in nature and began in 2008.

This thematic note is an output of an evaluation of the third phase (2018-2021) of the Joint Programme.

The problem

Experience in the Joint Programme indicates that as legislation is established and/or social norms shift towards FGM becoming unacceptable, some individuals or groups modify their practices and behaviours rather than abandon FGM.

The practices that have been observed by the Joint Programme and others include:

- **Cross-border FGM:** Travelling across a border into a neighbouring jurisdiction where laws are not in place or are not as enforced
- **Medicalization of FGM:** A growing trend of FGM being conducted by health professionals, continuing the practice with the semblance of being cleaner, safer and medically acceptable.

Furthermore, there is growing concern that FGM is being carried out in other ways in secret. This includes FGM being performed without public celebration. In this way, community members who disapprove are less likely to find out about cases. This is particularly apparent in communities where there has been a substantial shift in the social norms, with the shame and disrepute that once was associated with those who were uncut now being focused on those who continue to practice, or support or enable FGM.

Girls in some communities or groups are being cut at a younger age. Not only is the girl unaware of what is happening to her and unable to resist or report it, if she is pre-school age then parents do not need to withdraw her from school for the procedure and risk detection by authorities.

The evaluation found an emerging theme of families travelling to other villages for FGM to be performed, referred to as 'internal cross-border FGM'. This may occur when a Public Declaration of Abandonment has been made in a village, leading a parent to take a daughter to be cut to another village where FGM is still publicly acceptable.

There are also changes in the type of FGM being practiced. Evidence from Somalia, for example, indicates an increasing change from Type III, the most severe form of FGM, to a less physically damaging procedure, illustrating a resistance to complete abandonment.¹ This alternative practice remains a human rights violation.

Raising the alarm

The Joint Programme has been instrumental in raising the issue of 'alarming trends' of cross-border FGM and medicalization globally, within the 44th Human Right Council resolution which expressed the concern that 'despite increased national, regional and international efforts, the practice of female genital mutilation persists in all parts of the world and that new forms, such as medicalization and cross-border practice, are emerging'.

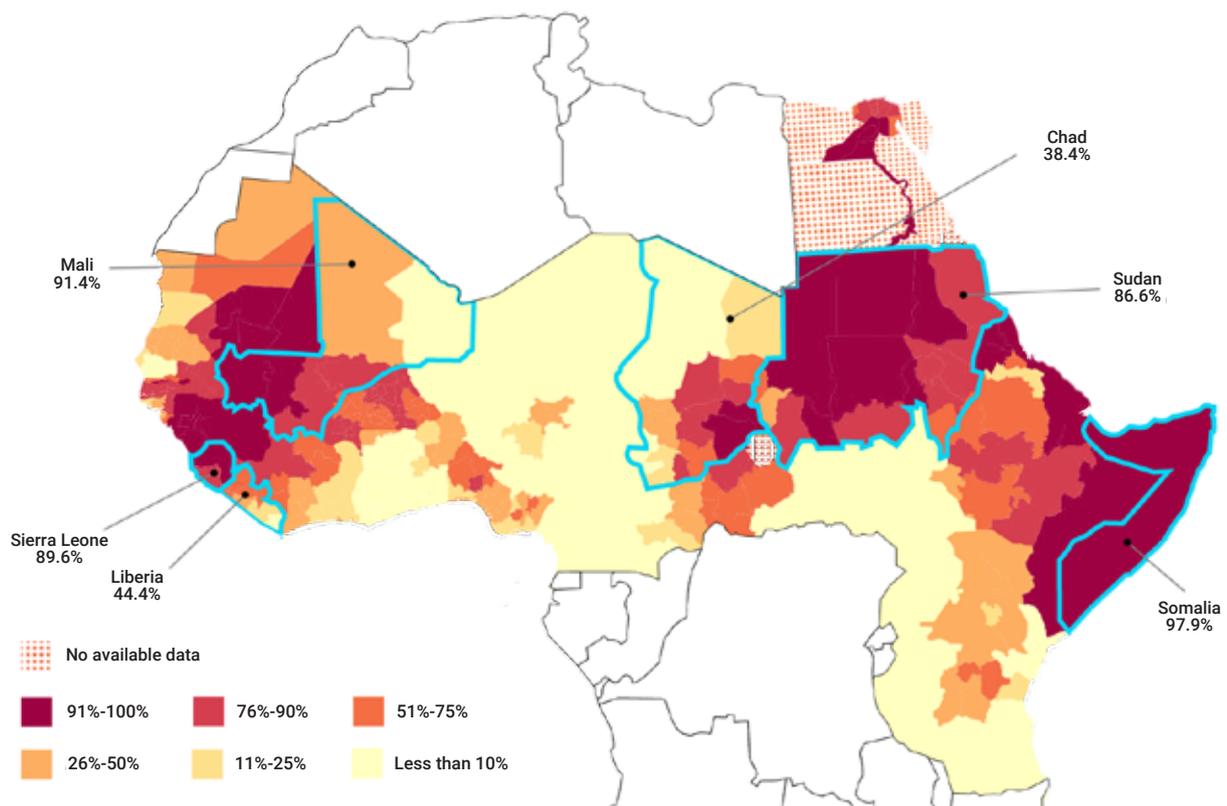
1 UNFPA, UNICEF. 2019. Joint Evaluation of UNFPA/UNICEF Joint Programme on the Abandonment of FGM: Accelerating Change Phases I and II.

BACKGROUND TO CROSS-BORDER FGM

Cross-border FGM has three main scenarios: 1) Excisors move across borders towards the families, 2) Families move across borders to the excisors, 3) Concurrent moving of excisors and families across borders.

In 2019, a community of practice supported by the Joint Programme held a discussion on cross-border FGM, which highlighted that “the main factors that drive cross-border FGM seem to be: seeking to avoid prosecution; family, ethnic and cultural connections; and, avoiding family disputes over cutting or not.”² The movement of families and traditional practitioners across national borders for the purpose of FGM is a complex challenge for the campaign to end the practice, and women and girls living in border communities can be particularly vulnerable.³

FIGURE 1: Cross-border risk: FGM prevalence rates in countries without anti-FGM legislation



Source: 28 Too Many, 2018, *The Law and FGM*.

Map disclaimer: The designations employed and the presentation of material on the map do not imply the expression of any opinion whatsoever on the part of UNFPA concerning the legal status of any country, territory, city or area or its authorities, or concerning the delimitation of its frontiers or boundaries.

Figure 1 shows the countries in Africa that do not have legislation in place (whose borders are highlighted in light blue), mapped against the bordering countries' prevalence levels.⁴ Since the map was produced, Sudan has developed a legislative framework. In addition, Somalia, including Somaliland and Puntland have developed anti-FGM laws, however they are not applicable to the whole national territory. Cross-border FGM occurs across many other borders aside from those illustrated in Figure 1, although data is poorly documented (partly because of its clandestine nature).

2 Building Bridges to End FGM. 2019. The Debates of the Community of Practice on FGM Cross Border Female Genital Mutilation.

3 28 Too Many. FGM and social norms. A guide to designing culturally sensitive community programming. 2019.

4 28 Too Many. 2018. *The Law and FGM*. An Overview of 28 African Countries. September 2018.

BACKGROUND TO MEDICALIZATION

Medicalization is defined by the World Health Organization as a “situation in which FGM is practiced by any category of health-care provider, whether in a public or private clinic, at home, or elsewhere.” It also includes the procedure of reinfibulation at any point in time in a woman’s life.⁵

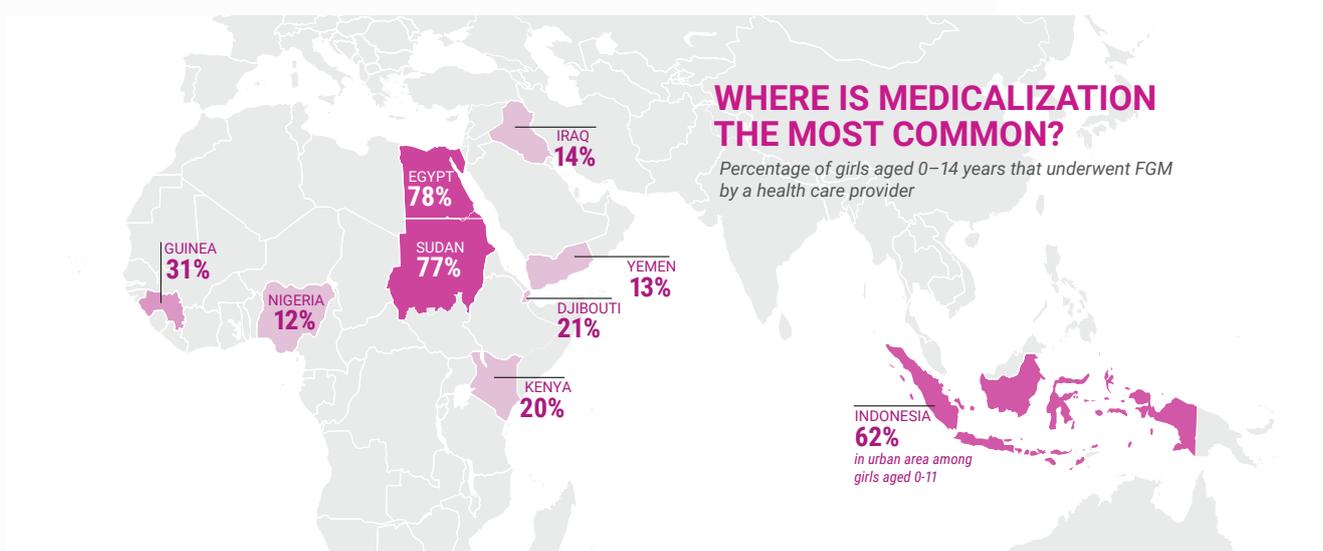
Medicalization is often justified as a ‘harm reduction strategy’ to prevent or reduce the negative effects of FGM on women and girls’ health. For the same reason, medicalization is also associated with the trend of performing less invasive forms of FGM (e.g. from more severe forms of cutting such as infibulation, toward nicking or “cutting, no flesh removed”), although the data is limited and need to be treated carefully given potential biases.

It is now widely held that the original health-first approach taken by initial anti-FGM campaigns (that focused on adverse health consequences of the practice, assuming that this would help to raise awareness of the health risks and in turn motivate people to abandon the practice) unintentionally drove the medicalization of FGM, on both demand and supply sides.

FGM can never be “safe” and there is no medical justification for the practice. Even when the procedure is performed in a sterile environment by a health care provider, there is risk of health consequences both immediately and later in life. Under all circumstances, FGM violates the right to health, the right to be free from violence, the right to life and physical integrity, the right to non-discrimination, and the right to be free from cruel, inhuman or degrading treatment.

As illustrated in Figure 2, the countries where the percentage of girls aged 0-14 years who underwent FGM performed by health professionals is highest are Egypt (78 per cent) and Sudan (77 per cent). These are followed by Indonesia (62 per cent), Guinea (31 per cent), Djibouti (21 per cent), Kenya (20 per cent), Iraq (14 per cent), Yemen (13 per cent) and Nigeria (12 per cent).⁶

FIGURE 2: Countries with the highest rate of medicalization of FGM



Source: UNFPA-UNICEF-WHO (2018), Factsheet on FGM Medicalization.

Map disclaimer: The designations employed and the presentation of material on the map do not imply the expression of any opinion whatsoever on the part of UNFPA concerning the legal status of any country, territory, city or area or its authorities, or concerning the delimitation of its frontiers or boundaries.

The medicalization of FGM is reported to be growing in certain programme countries like Guinea and Kenya, as well as Egypt and Sudan where the phenomenon has been present for longer.

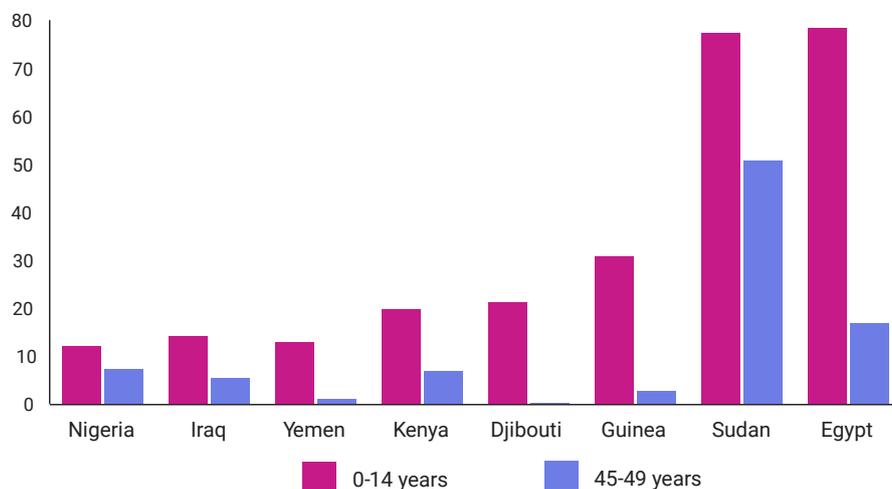
In the past 20 years, the data available on medicalized FGM has been generated through major household surveys, such as the Demographic and Health Surveys (DHS) and the Multiple Indicator Cluster Surveys (MICS). In these surveys, women

⁵ WHO, Care of Girls and Women Living with Female Genital Mutilation: a Clinical Handbook. Geneva, 2018. p. 392, and WHO and others, “Global strategy to stop health-care providers from performing female genital mutilation”. 2010. p. 1.

⁶ Percentages drawn on the UNFPA-UNICEF-WHO Factsheet on FGM Medicalization of June 2018.

of reproductive age (15-49 years) are asked about their own FGM status, as well as the type of cutting performed and by whom. However, it is difficult to find sufficient recent evidence to fully measure the extent of the phenomenon and its patterns, especially given the underground practice of FGM.

FIGURE 3: Percentage of girls aged 0-14 years and women aged 45-49 years who underwent FGM by health care providers



Secondary source: UNFPA-UNICEF-WHO (2018), *Policy Brief on FGM Medicalization Brochure*.

Findings

1. The extent to which the Joint Programme has strengthened its work on cross-border FGM during Phase III

Finding: The Joint Programme has strengthened its focus on understanding cross-border issues during its third phase of implementation (2018-2021), and has made a significant contribution in East Africa to the development of a regional agreement and plan.

The Joint Programme has made a significant contribution to the progress made in East Africa in tackling cross-border FGM across Kenya's borders with Ethiopia, Somalia, Uganda and the Republic of Tanzania. The generation of data has been an important foundation for the work. A Kenyan baseline study commissioned by the Anti-FGM Board and UNICEF in 2017 showed the influence of border communities on the prevalence of FGM. "Before that, the information was anecdotal, so it was important to have credible and sound data."⁷ A further report in 2019 by UNFPA highlighted the differences in the practice across and within countries in East Africa, particularly with regard to age of cutting. At the same time, the report shows that ethnic groups across the borders can share similarities in the practice. For example, Somali girls in Ethiopia, Kenya and Somalia are at risk of undergoing FGM at the same period in their lives.⁸

Recognising that tackling cross-border FGM required a regional approach and the engagement of inter-governmental organisations, the Joint Programme contributed to the successful convening of an inter-ministerial meeting across all countries in Mombasa in 2019. This was considered a "landmark meeting to declare an end to FGM, particularly cross-border dimensions of FGM."⁹ During the meeting, government ministers from Ethiopia, Kenya, Somalia, Uganda and the

⁷ Interview with Joint Programme staff in Kenya.

⁸ UNFPA 2019 Annual report.

⁹ UNFPA/UNICEF. 2019. Joint Programme on FGM Annual Report.

United Republic of Tanzania adopted the Eastern African Declaration and Action Plan calling for improved regional coordination involving collaboration on policies and legislation as well as the development of joint communication strategies that discourage individuals and families from crossing borders for FGM.¹⁰

The Plan of Action has four priority areas:

1. Improvement of the legislative and policy frameworks as well as the environment to end cross border FGM
2. Effective and efficient coordination and collaboration amongst the five national governments to end FGM within their borders
3. Communication and advocacy on cross border FGM prevention and response
4. National governments, academia and statistical offices have a better capacity to generate and use evidence and data for addressing cross border FGM.¹¹

Coverage of laws¹²

At the time of a review of laws in Africa in 2018, only 3 of the 22 countries in Africa that have an anti-FGM law in place, extend the applicability of the law to people who have performed or undergone FGM outside the country.

The Joint Programme has worked to support the enabling environment for the initiative by providing support to the sensitisation of the police force and other duty bearers, strengthening referral mechanisms, promoting cross-border commitments (especially where there is clan leadership across both sides), and linking surveillance systems to more formal referral systems.

Some of the innovative approaches include:

- 'Passports' providing information about girls' rights
- Open source mapping (used in Tanzania and applied within cross-border work) to locate and protect girls at risk of FGM, as well as providing local officials data needed to plan for the development of services¹³
- A mobile phone app to support ending FGM, which aims at providing timely reporting of FGM cases within Kenya and along the border communities (Uganda, Tanzania, Somalia and Ethiopia) for both prevention and response services.

Communication activities have documented and created videos around what work has been done, including making sure that the voices of survivors are heard. Survivors are involved in subsequent surveillance (report and rescue).

Despite these efforts, there have not been prosecutions of cross-border cases to date. However, there is positive anecdotal data, including 12 Ugandan girls who had crossed over the border with Kenya to be cut and were rescued; they were offered psychosocial support, temporary shelter and were handed over to the Ugandan authorities for further action and support.¹⁴ Interviewees noted the need to strengthen monitoring to ensure that there is appropriate data on the scale of the issue and how it is changing.¹⁵ Particular challenges exist around the limited resources available to monitor and police the borders.

Intensified efforts are required in other regions to generate data (where still needed), utilise data to raise awareness of the issue, convene and support appropriate inter-national dialogue and agreements.

Within other regions of the programme, data gathering has taken place or is planned. The UNFPA Arab States Regional Office (ASRO) and the UNICEF Middle East and North Africa Regional Office (MENARO) have undertaken comprehensive research into migration more generally and its effect on FGM in the Arab League Region. The region has a high level of mobility and characterised by having a few countries with high level of FGM, and many others where it is not traditionally practised (see Box below). The research has been disseminated but has not yet informed planning: this will be an important

10 UNFPA/UNICEF. 2018. Joint Programme on FGM Annual Report.

11 UNFPA/UNICEF. 2019. Joint Programme on FGM Annual Report.

12 28 Too Many. 2018. The Law and FGM: An Overview of 28 African Countries.

13 <https://www.hotosm.org/projects/crowd2map-tanzania>.

14 Kenya Joint Programme Annual Report 2020.

15 Interviews with UNFPA/UNICEF regional staff.

next step and is a priority towards facilitating a regional process and commitment on harmful practices. Enhanced co-operation with the League of Arab States and African Union is important to achieve the process.

Migration trends within the Arab States region

Migration of non-FGM practicing groups to regions/countries with high FGM prevalence. The trend appears to be that FGM non-practicing migrants moving to high prevalence regions have taken up FGM in order to integrate into their new social environment. For instance in Sudan, was traditionally practiced in the northern parts of the country but has spread to other non-FGM practicing ethnic groups, in other parts of the country, as displaced people from the west and south of the country moved to safety in the northern regions (before the separation of South Sudan from Sudan in 2010) (IOM, 2009).

Migration of FGM practicing groups to regions/countries with low FGM prevalence. Some researchers claim that after migration (most from European countries), migrants abandon the practice of FGM. However, the evidence is not conclusive and other researchers suggest that many migrants do stop performing FGM Type III but continue to perform FGM Types I, II and IV. It would appear that there is an increasing trend for migrants living in the West to perform Type IV on babies or young girls in the belief that this will be undetectable by medical and legal authorities in countries where FGM is illegal.

Migration of FGM practicing groups to regions/countries with high FGM prevalence. The few studies of FGM in refugee camps indicate that FGM Type III is less favoured, being replaced with Types I, II and IV. FGM in refugee camps is also associated with parents trying to prevent their daughters from being the victims of sexual violence, including rape.

Source: Hazel R. Barrett, Nafisa Bedri & Nishan Krishnapalan (2020): The Female Genital Mutilation (FGM) – migration matrix: The case of the Arab League Region, Health Care for Women International.

Turning to the West and Central African region (WCARO), there is awareness of the existence of cross-border FGM from Burkina Faso, Cote d'Ivoire, Mauritania and Senegal to Mali,¹⁶ and between Gambia and Guinea-Conakry.¹⁷ There is a lack of quantitative data about the scale of these migrations.¹⁸ WCARO has conducted a study of six countries which should be an important foundation for work in the area. A priority going forward will be learning from the data generated, and convening regional dialogue to progress and facilitate regional agreement.

A key lesson has been the importance of engaging communities on both sides of the borders at the same time so that all have access to information and are appropriately informed. At the heart of the cross-border issue is the shared kinship ties/ethnic group across borders. A study by UNFPA Kenya shared that in five different countries (Kenya, Somalia, Ethiopia, Tanzania and Uganda) five different ethnic groups reside in more than one country (the Kikuyu, Kuria, Maasai, Pokot and Somalis). They share traditions and cultures, including the practice of FGM, and found some similarities (around age of cutting) but also some differences (e.g. the type of practice).¹⁹

Activists from Kenya testify of cross-border FGM in regions close to the Tanzanian border. "Maasai communities that live in both countries share cultural practices, including FGM, and have land and family members on both sides of the national borders. They can easily move girls to one side or the other to have them undergo FGM".²⁰ A Population Council Burkina Faso and Mali cross-border study also confirmed that kinship relations outweigh the border division, noting that people move easily along the border, with members of the same ethnic groups living on either side, and they have relatives on each part of the border, share the same customs and culture. The practice of FGM is therefore embedded in this cultural cross-border exchange.²¹

16 UNFPA/UNICEF Joint programme. 2018. How to Transform A Social Norm: Reflections on Phase II of the UNFPA-UNICEF Joint Programme on Female Genital Mutilation.

17 Interviews with UNFPA/UNICEF staff.

18 Ibid.

19 UNFPA. 2019. Beyond the Crossing: Female genital mutilation across border.

20 <https://copfgm.org/2020/07/lessons-learnt-from-the-discussion>.

21 Wouango, J., Ostermann, S., Mwanga, D. 2020. When and how the law is effective in reducing the practice of FGM/C: A cross-border study in Burkina Faso and Mali.

The box below shares lessons that emerged within the Joint Programme supported community of practice on FGM, including the need to consider communities that span across borders.

Lessons shared at the Joint Programme supported community of practice: Discussion on cross-border FGM

- Begin thinking in terms of communities who live and share cultures and traditions which go beyond borders. People crossing borders do not perceive themselves as “foreigners” in the country they visit. Thus, increased cooperation and collaboration is needed between countries who house the same communities
- A regional law to harmonize sanctions acts as a common tool so that the fight is unanimous and consistent
- The introduction of border controls is not seen as an efficient or ethical solution to fight cross-border FGM
- Consider law enforcement and the efficiency of controls rather than the existence or not of legislation
- Reinforce awareness actions at community level so that people understand WHY they must stop the practice, using respected local leaders who have enormous power in the community and who are above all convinced of the merits of the abandonment of the practice, and in particular work with the youth who are the decision-makers of the future.

Source: <https://copfgm.org/2020/07/lessons-learnt-from-the-discussion>.

2. Trends that are emerging around migratory FGM

Finding: Other forms of ‘migratory FGM’ are emerging and the complex interplay of migratory patterns and FGM needs to be further understood, and integrated within programming.

The evaluation heard anecdotal evidence about ‘internal cross-border’ FGM within countries, notably raised within five of the six deep dive countries (Ethiopia, Guinea, Kenya, Mali, Nigeria). In one example in Nigeria, it was reported ‘the big challenge that we have is [movement] from one local government area to another... where one community has declared abandonment, parents take their girls to the other community to be cut.’²² In Ethiopia, which has observed a similar pattern, the programme is responding by starting to work in geographical areas in a more concentrated way, covering ‘*whole woredas*’ (local districts) rather than individual communities scattered across a *woreda*.

Another area in which the notion of borders becomes less relevant is diasporas and migration flows. Some diaspora communities practice FGM in their host country, where it is illegal. The Joint Programme has continued to support the Building Bridges programme in Phase III.²³ Organisations working on this issue recognise that the diaspora can be supportive in influencing change, and can also be instrumental in breaking the FGM cycle. However, it can be challenging to bring together diaspora.

More data is needed to fully understand the interplay of migratory patterns and FGM in different contexts. In addition, some country-level and inter-country work needs more global ‘upstream’ and regional support. Real world borders, such as Sudan and Ethiopia, involve multiple United Nations regional offices (ASRO and ESARO in this example), and the institutional structure needs to accommodate such configurations.

22 Wouango, J., Ostermann, S., Mwanga, D. 2020. When and how the law is effective in reducing the practice of FGM/C: A cross-border study in Burkina Faso and Mali.

23 <https://www.endfgm.eu/what-we-do/building-bridges/>.

3. The extent to which the Joint Programme has strengthened its response to the medicalization of FGM

Finding: The Joint Programme has strengthened its response to prevent the medicalization of FGM by working on both supply side (of health-care providers) and demand side (of communities). However, given the rising trends, sustaining the current engagement is required to effectively address not only capacity but also attitude and behaviour of health professionals to act as agents of change in the prevention of FGM.

During Phase III, the Joint Programme has continued working through a two-pronged approach by addressing both the supply side (of medical practitioners) and the demand side (within communities) of FGM medicalization. Although a defined programme strategy to prevent the medicalization of FGM has not been developed yet, the Joint Programme has strengthened its response by implementing different activities included in the Global Strategy to Stop Health Care Providers from Performing FGM, developed jointly with WHO.²⁴

The Joint Programme has also continued collaborating both with WHO and the Ministries of Health in programme countries to advocate for the elimination of FGM, including the medicalization of FGM. WHO has been working with programme countries to strengthen their health strategies to work on this issue, developing training packages for midwives and nurses, and conducting research on the cost of FGM to the medical sector. In the context of the Joint Programme, a training package originally developed in Ethiopia by WHO for midwives and nurses was also used to train extension workers. This aimed at strengthening their skills towards a more person-centred approach when communicating about FGM.

In line with programme output 'increased national capacity for the development, enactment and implementation of FGM laws and policies' in Phase III, Egypt has delivered important achievements. Four out of five girls in Egypt report that FGM was performed on them by a health care provider, of which 67 per cent were doctors. In January 2021, the Cabinet adopted tougher penalties for FGM, imposing jail terms up to 20 years and banning health care providers from practicing for up to 5 years. Burkina Faso offers evidence that a strong legal framework with heavy penalties for medical practitioners seems to have been effective in reducing medicalization, as fear of incurring a prison term or losing the licence to practice acted as a deterrent.²⁵

Despite some good instances of the collaboration with WHO and the Ministries of Health at the country level, key stakeholders both at the global and at the country levels report the need for greater partnership between WHO and the Joint Programme (for instance to avoid duplications and ensure communication). They also call for enhanced involvement of the ministries of health at the national and sub-national levels in the programme countries in addressing the issue of FGM-medicalization.

On the supply side of medicalized FGM, the Joint Programme has adopted different strategies mainly to increase the awareness of health workers, including medical doctors, midwives, nurses, and community health workers, so that they decide not to perform FGM. Given the various reasons behind the medicalization of the practice, the Joint Programme has continued investing in the capacity building of health staff through training not only on the health consequences of FGM but also on the legal and ethical implications of practicing it.

The Joint Programme has collaborated with universities and medical schools for the development of university curricula for students of medicine and nursing - a positive initiative that potentially has a significant reach. For instance, FGM material was integrated into the training programme of eight health schools in Guinea, where conferences and debates on FGM have also been organised with students from health schools from five regions. Similarly, in Kenya the Joint Programme has worked with the Ministry of Health, ACCAF and the University of Nairobi to develop training materials to be included in the curricula for those studying medicine and nursing.

In Guinea, Kenya and Mali, the Joint Programme has facilitated the dissemination of the law and a circular that prohibits FGM-medicalization amongst health centres and professional associations to increase medical and health staff awareness on the existence of such laws or circulars. In Nigeria, health workers were trained to identify in their facilities cases of women who had undergone FGM in the past, whether they suffered or were suffering complications, and refer them to

24 UNFPA-UNICEF-WHO. 2018. Calling for the End of the Medicalization of Female Genital Mutilation, Policy Brief.

25 Human Rights Council. 2020. Expert group meeting on the elimination of female genital mutilation: report of the United Nations High Commissioner for Human Rights.

relevant services. This approach is in line with the idea that documenting the long-term complications resulting from medicalized female genital mutilation, including sexual, psychological and obstetric complications, is expected to help prevent medicalization.

Investments in increasing health care providers' knowledge and competencies on FGM are a fundamental step towards changing their attitude towards FGM, and can make them agents of change in the prevention of FGM. However, rising trends of FGM medicalization suggest that this type of initiative may not be enough. An important aspect seems to be to also build their capacities on how to resist pressures from the community. This is part of effectively communicating and promoting social norm change. A study from Nigeria showed that health workers should be educated and empowered to advocate for the abandonment among patients and also among fellow health workers.²⁶

Reasons reported to be driving health-care professionals in practicing FGM^{27,28,29}

- **FGM medicalization as a “harm reduction strategy”.** This was one of the key reasons reported to be driving health care professionals in practicing FGM. They argue that when FGM is performed by skilled professionals, medicalized FGM reduces the immediate health risks and pain, especially when antiseptic techniques, anaesthetic and analgesic medication are used. However, whilst medicalized FGM might reduce – but not avoid - some of the physical consequences of FGM, there are no perceived health benefits of the practice itself. Moreover, it risks contributing to the normalization or institutionalization of the practice, rendering it a routine procedure and potentially encouraging it. To the contrary, there is actually evidence of the long-term complications associated with FGM, particularly regarding sexual and reproductive rights, and psychological and obstetric complications. The ‘harm reduction strategy’ is therefore considered to be against good medical practice and a violation of the medical code of ethics, as it contradicts the Hippocratic Oath’s primary principle of ‘do no harm’
- **Health professionals limited knowledge of long-term health consequences of the procedure, in particular the mental health implications.** Even if women do not report physical after-effects of FGM, research suggests that the majority of women subjected to FGM have reported mental health problems and emotional disorders with living with the effects of FGM
- **Health professionals limited awareness that even medicalized FGM is a violation of human rights, a breach of medical ethics, and often a violation of the law.** The legal implication of what constitutes a crime with regard to medicalization of FGM is not always clear amongst health professionals
- **Sharing the same social norm as the community they serve.** This is often a key aspect in preventing health care professionals from resisting the pressure or the demand to perform FGM. A study from Nigeria for example, demonstrated that most health workers that engage in FGM do so because they share the same FGM beliefs as the community they serve, and this was evidenced by the fact that four out of five health workers with daughters had also cut their own daughters. Another study, from Sudan, concluded that medicalization is primarily driven by the demand motivated by social norms
- **Economic incentives.** Financial gains to perform FGM for both health professionals and parents should not be underestimated, as FGM can bring in additional income to health professionals and for parents (as a higher bride price/dowry can be expected when their daughter is married). Health professionals’ motivation to perform FGM is reinforced by the fact that many health systems in countries where FGM is prevalent are weak, and so extra financial income is attractive, especially in countries where FGM is illegal.

26 Obianwu, Otibho, Adetayo Adetunji, and Osasuyi Dirisu. 2018. “Understanding medicalisation of female genital mutilation/cutting (FGM/C): A qualitative study of parents and health workers in Nigeria,” Evidence to End FGM/C: Research to Help Girls and Women Thrive. New York: Population Council.

27 Experts group meeting.

28 Obianwu, Otibho, Adetayo Adetunji, and Osasuyi Dirisu. 2018. “Understanding medicalisation of female genital mutilation/cutting (FGM/C): A qualitative study of parents and health workers in Nigeria,” Evidence to End FGM/C: Research to Help Girls and Women Thrive. New York: Population Council.

29 Leye, E., Van Eekert, N., Shamu, S., Esho, T., & Barrett, H. 2019. Debating medicalization of Female Genital Mutilation/cutting (FGM): learning from (policy) experiences across countries. *Reproductive health*, 16(1), 1-10.

In line with Phase II plans, Phase III placed greater emphasis on establishing partnership with medical syndicates, and professional associations and bodies. These are considered to be key agents to sensitise their members on the issue of FGM medicalization, and to advocate for policies and legislations to be enforced, for example by sanctioning health professionals who engage in FGM. Since health professionals are at the core of the issue, working with medical syndicates and professional associations and bodies is a strategy to both target and involve health practitioners as part of the solution to counter the medicalization of FGM.

The Kenya Medical Association, a membership for registered medical or dental practitioners, and the National Nurses Association of Kenya have 100 per cent declared that FGM is an unethical practice. Any member found to have practiced it is removed from their registrar and prevented to continue working in the health sector. Overall, at the global level, the number of doctors and midwives who support the cause of the 'Doctors and Midwives against FGM' initiative has increased from 956 in 2018 to 3,166 in 2020.

On the demand side for families seeking FGM practised by health care professionals, the Joint Programme has placed greater emphasis in Phase III on social norm change by bringing attention to women and girls' rights during community dialogues and sensitizations. This promotes FGM abandonment overall, not specifically abandonment of using health care providers. However, even amongst programme implementers, the harmful consequences of FGM on women and girls' health has continued to emerge as the main argument for abandoning the practice.

The health risks and potential consequences linked with FGM were often mentioned during key informant interviews as the main reason why FGM should be abandoned, aware that that when performed by medical staff FGM is not necessarily safer. They rarely cited the human rights argument that girls and women have a right not only to health, but also to be free from violence, to life and physical integrity, to non-discrimination, and to be free from cruel, inhuman, and degrading treatment.

Amongst the identified challenges to social norm change there is difficulty in translating the human rights messaging around FGM in communities often deprived of their basic rights, and the need to build better responses to arguments supporting the practice as a means to gain access to social capital. Beyond raising awareness and increasing knowledge on FGM, there is need for a more holistic approach that places emphasis on attitudes and behaviours of both health-care providers and community members, including women and girls' themselves.

Finding: The Joint Programme has contributed to generate new knowledge on FGM medicalization. However, further research would help shed more light on sub-trends, context specific drivers, and the issue of women's choice and consent.

During Phase III, the Joint Programme continued to increase knowledge around the medicalization of FGM through research studies commissioned by regional and country offices. These include a brief to explore the issue in Kenya, Somalia, Ethiopia and Eritrea commissioned by UNICEF ESARO. In Guinea, UNFPA is planning a research study on the determinants of medicalization of FGM to inform the planning of next the phase of the programme. The Joint Programme has also promoted knowledge sharing on this topic through a cross-regional webinar on medicalization in West Africa organised by WCARO. However, stakeholders especially at the regional level, have highlighted the need for further research to better understand this context-specific phenomenon. Different areas that remain unclear would benefit from further research. For instance, the weight/importance of the different incentives for medical staff to continue practice FGM procedures are still not clear.

Other emerging areas that require further research include a new sub-trend emerging in countries like Guinea and Mali referred to as '*fair semblant*', whereby the girl is taken to a health centre to have FGM performed by a health worker but, in fact, FGM is not practiced. Although data are limited and need to be treated carefully given potential biases of self-reporting, medicalization is often associated with a trend toward less severe forms of cutting (toward nicking or "cutting, no flesh removed"). Performing less invasive forms of FGM is has in some cases been promoted as 'a harm reduction strategy', in line with the idea that medicalization allegedly reduces negative health effects. The application of less intense FGM procedures (e.g. from Type III to lesser types), was previously reported in the evaluation of Phase I and II. Further research on the magnitude of these sub-trends, as well as their drivers, would help better understand what measures to take to address them.

Another area for further research, indicated by the Expert group meeting on the elimination of female genital mutilation held in Addis Ababa in July 2019, is the meaning of consent, bodily autonomy, choice and harm in the context of patriarchy

and its implications on adult women. This is needed to better inform policy and legal approaches in relation to the medicalization of FGM. Experts have been discussing whether adult women could consent to female genital mutilation in medical settings and, if so, how to support medical practitioners in assessing their full, free and informed consent. Some experts felt that the practice should never be allowed, even when requested by adult women, given the social pressure to which they might have been exposed that could void consent. Other experts, however, warned about double standards when other medically unnecessary, potentially harmful surgical interventions on female genitalia, such as female medical cosmetic surgery, were allowed and reasons to perform them might also be attributed to social pressure.

One of the pillars of the 'Global Strategy to Stop Health Care Providers from Performing FGM' developed by UNFPA, UNICEF and WHO is to strengthen monitoring, evaluation and accountability. It comprises activities to routinely collect data on FGM prevalence (e.g. through antenatal records).³⁰ Although this appears to be a fundamental step towards having a better picture of the size of the phenomenon and its trends, it also raises the issue of mandatory reporting of FGM by health-care professionals. It entails ethical dilemmas in terms of confidentiality, potential harm to the patient-doctor relationship, and public trust. In the aforementioned Addis Ababa expert group meeting in July 2019, mandatory reporting of the practice was indicated as an intervention that might potentially result in adverse consequences.³¹ For this reason, targeted research would help provide more light in this aspect and help identify adequate measures to address it.

Conclusions and future considerations

Conclusion: The Joint Programme has utilised its global position to raise the issues of alarming trends in the practice of FGM within global advocacy work and enshrined them within Human Rights Council agreements.

The Joint Programme has continued to recognise that as the legal and/or social environment changes, and FGM becomes unacceptable (through legislative change and social norm change), individuals or groups may modify their practice rather than abandon FGM. The design of the programme recognises the importance of working on complex issues, which reflect modification of FGM practice. In particular, these include medicalization and cross-border FGM.

Conclusion: The Joint Programme has made some important progress in addressing cross-border FGM, in particular with the development of the Eastern African Declaration and Action Plan, as well as the development of joint communication strategies that discourage individuals and families from crossing borders for FGM.

This is an important example and learning-opportunity for the Programme, which could be advocated for amongst other cross-border 'hot spots' (with relevant adaptation to specific contexts). Regional offices will have an important role in supporting cross-border policy dialogue in the Arab States Region and the West and Central African Region.

Considerations for the future:

- Build on the momentum created by the development of a regional agreement and plan in East Africa to address cross-border FGM, advocating for the allocation of resources to implement the plan in post-Phase III
- Prioritise support to cross-border dialogue and policy within Western Africa and the Arab States drawing upon the data generated (or being generated in the case of West Africa). Regional offices should convene relevant regional and national actors to facilitate cross-country dialogue and agreements where needed. These need to be also cross-regional where necessary and appropriate
- Both at national and regional levels, the Joint Programme should work with governments and regional entities to identify strategies to enhance monitoring in order to ensure that there is appropriate data of the scale of the issue and how it is changing
- Increase emphasis on addressing 'internal cross-border' FGM (i.e. within countries), by overseeing the collection of data to facilitate an understanding also of this phenomenon.

30 UNFPA-UNICEF-WHO. 2018. Calling for the End of the Medicalization of Female Genital Mutilation, Policy Brief.

31 Human Rights Council. 2020. Expert group meeting on the elimination of female genital mutilation: report of the United Nations High Commissioner for Human Rights, p. 10.

Conclusion: During Phase III, the Joint Programme has strengthened its response to prevent the medicalization of FGM by implementing different activities comprised in the Global Strategy to Stop Health Care Providers from Performing FGM.

This addresses both the supply side of health care practitioners, and the demand side within communities. In Phase III, the Joint Programme also contributed to increase knowledge around the medicalization of FGM through research studies at the regional and country levels. However, rising trends of FGM performed by health care providers, especially in some countries, requires an intensification of efforts in the post-Phase III.

Considerations for the future:

- At the institutional level, stronger partnerships should be established with both WHO and the ministries of health at the country and sub-country levels, to coordinate efforts in supporting national and local governments creating a supportive legislative and regulatory framework, and implement it
- In targeting health care providers, initiative should aim to address not only their knowledge, but also their attitude and behaviour considering the different incentives behind health care staff practicing FGM, including the fact that they often share the same social norms as their communities they serve
- At the community level, it is important to reinforce the human right argument in favour of the elimination of FGM, within which the right to health lays
- Further research on emerging sub-trends of medicalization, context specific drivers for both health care providers and communities, the issue of women's choice and consent, and the ethical concern around the mandatory reporting of the practice are recommended.

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