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To Medicalise or Not to Medicalise: Is That the Question?
Exploring Medicalisation of Female Genital Cutting in Egypt and Kenya

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Abstract
Today, female genital cutting (FGC) is more often performed by health professionals. In this dissertation we aim to answer the question of why mothers opt to medicalise their daughters’ cut, and how this decision relates to her social position within her community. We focus on Egypt and Kenya.

The first important conclusion of our research is that increasing medicalisation and decreasing FGC prevalence can coexist. Moreover, we identify three major drivers behind mothers’ choice to medicalise their daughters’ cut. Firstly, mothers argue that they opt for a medicalised cut to reduce the health risks related to the cut. They seek a less harmful but still culturally acceptable alternative. Secondly, the medicalisation of FGC is socially stratified. Thirdly, medicalisation may act as a social norm in itself.

In conclusion, we state that the debate about medicalisation should be more nuanced and that the general discourse on medicalisation should be challenged and empirically grounded.

Keywords: female genital cutting, medicalisation, women’s social position, social norms, harm reduction

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Background

Female genital cutting (FGC) comprises all procedures that involve the partial or total removal of the external female genitalia, or other injuries to the female genital organs for non-medical reasons (WHO, 1997). The practice is highly concentrated in a range of countries on the African continent from the Atlantic coast to the Horn of Africa, in areas of the Middle East and in some countries in Asia, with wide variance in prevalence (UNICEF, 2020). It is estimated that at least 200 million girls and women alive today have undergone FGC, and every year 3.6 million girls are at risk of undergoing the procedure (UNICEF, 2020). FGC has no known health benefits. On the contrary, it is known to be harmful to girls and women in many ways (Andro et al, 2016; Kimani, Muteshi and Njue, 2016). It interferes with the natural functions of girls’ and women’s bodies, as it removes and/or damages healthy genital tissue. Moreover, it is internationally recognised as a form of gender-based violence, and the “elimination of all harmful practices, including FGC, by 2030” is part of the Sustainable Development Goals (SDG 5.3). For these reasons, international and national initiatives have attempted to convince people to abandon female genital cutting by focusing on the practice’s health consequences (Shell-Duncan, Njue and Moore, 2017). As a result of these initiatives, the prevalence of female genital cutting has, to varying degrees, decreased in recent years in almost all countries where the procedure is practised. At the same time, FGC has become increasingly medicalised in several countries; this includes FGC being practised by any category of healthcare provider, whether in a public or private clinic, at home, or elsewhere” (WHO, 2010).

The current state-of-the-art research on the medicalisation of FGC, including academic and policy articles, most often questions whether medicalisation is to be discouraged or encouraged, and whether it is a positive or negative development. To medicalise or not to medicalise – that is the question. Underlying the discussion of this question are various ethical debates: whether FGC could, under certain circumstances, be carried out safely, or whether all forms of the practice should be prohibited, no matter how minimal (Toubia and Izett, 1998); whether it is more important to protect the health of women at the expense of legitimating a destructive practice, or to hasten the elimination of a dangerous practice altogether, while allowing women to die from preventable conditions (Shell-Duncan, 2001). Anti-medicalisation policies implemented at the regional (e.g. activist organisations), the national (e.g. national legislation) and the international (e.g. by the WHO) levels are based mainly on the ethical argument that preventing the medicalisation of FGC is an essential component of a holistic, human-rights-based approach to the elimination of the practice, and that no forms of FGC should be tolerated (Serour, 2013). Moreover, they strongly oppose medicalisation based on the argument that the involvement of health professionals in the performance of FGC will counteract efforts to eliminate it and impede progress towards its abandonment (Shell-Duncan, 2001; WHO, 2010). Nevertheless, despite policies at the national and international levels clearly condemning medicalised FGC, the empirical basis for the debate, which could prove or disprove the moral argument in this discussion, has remained under-researched.

Research Objectives and Discussion

The aim of this dissertation was to add empirically grounded knowledge to the debate surrounding the medicalisation of FGC. We aimed to contribute to the understanding of the shift towards the medicalisation of FGC from the perspective of practising communities. The overarching research question within this PhD
dissertation was “Why do mothers opt to medicalise their daughters’ cut and how does this decision relate to her social position within mothers’ community?” We aimed to identify the social correlates of the shift towards medicalisation, and the meaning and motivation behind them. We focus on two countries: Egypt and Kenya (Kisii county). A comparison of Egypt and Kenya is interesting due to their divergent FGC trends. While half of medicalised cuts worldwide are performed in Egypt, the general FGC prevalence percentages also remain high. Kenya, in contrast, is the only country where increases in medicalisation percentages have occurred alongside a general decrease in FGC prevalence percentages (Shell-Duncan, Njue and Moore, 2017).

We developed four research objectives. Firstly, we sought to explore the association between FGC medicalisation trends and a girl’s risk of being cut. International, national and local institutions strongly oppose the medicalisation of FGC, arguing that the involvement of health professionals in the performance of FGC will counteract efforts to eliminate the practice. However, no empirical research to date has confirmed or refuted this claim. It remains unclear how the medicalisation of FGC relates to changes in the prevalence of the practice. We examined the association between the medicalisation trend and girls’ risk of being cut in Egypt by conducting a discrete-time event history regression analysis combined with governorate fixed effects, using the Egyptian Demographic Health Surveys (EDHS) from 2005, 2008 and 2014 (N = 49,273 daughters clustered across 29,810 mothers) (Van Eekert, 2020; Van Eekert et al, 2020a).

Secondly, we aimed to explore the association between the mother’s social position and her decision to medicalise her daughter’s cut. Mothers are the primary decision-makers on (their daughters’) FGC (Yount, 2002). Where FGC is practised, it is nearly always seen as part of a woman’s preparation for marriage (Finke, 2006). In a context where women have few opportunities to participate in economic and social activities outside the family, FGC is therefore perceived as a means to acquire both economic security and social identity (Grose et al., 2019). By safeguarding the social position and marriageability of daughters through FGC, mothers also secure their own social position (Gruenbaum, 2001). In comparison with research on the prevalence of and attitudes towards FGC, the literature on the association between women’s social position and the medicalisation of the practice is less extensive. We could, however, expect that women’s social position is positively associated with the medicalisation of FGC. Access to medical institutions and resources may be greater among women with a higher social position, and medicalised cuts might be more expensive (Johansen et al, 2013; Njue and Askew, 2004). Additionally, women who have more socio-economic resources available to them may also have stronger trust on and better experiences of dealing with medical professionals (Ensor and Cooper, 2004). Socially advantaged women are also more likely than other women to live in urban areas, where medical facilities tend to be concentrated (Yount, 2005). Moreover, compared with less educated women, those with higher levels of education are more likely to have incorporated Western ideas about health and individual rights (through their schooling and exposure to the media) (Johansen et al, 2013). Data from the EDHS 2005, 2008 and 2014 were used to conduct logistic regression models identifying the associations between measures of social position and the decision to have genital cutting done by a health professional (Van Eekert, 2020; Van Eekert, Leye and Van de Velde, 2018).

Thirdly, we looked at the normative context within practising communities, aiming to examine how social norms concerning FGC and its medicalisation influence the association between a mother’s social position and her decision on her daughter’s FGC. Focusing merely on the social position of the mother tends to downplay the fact
that FGC is not solely determined by an individual decision of the mother. The commonly used arguments for performing FGC – social pressure, culture, tradition and religion – are substantially social in nature. A woman may feel that she has to conform to social norms regarding FGC to ensure her daughter’s social position, unless she knows that others have also refused to cut their own daughters (Mackie, 2000). Here, medicalisation can be understood as a compromise between complete abandonment of the practice and a cut by a traditional circumciser, which is associated with more health hazards than the medicalised cut. Women may opt for a medicalised version of FGC to retain the social benefits related to the practice while simultaneously reducing some of its health hazards (Shell-Duncan, 2001). Finally, we may expect that medicalisation of FGC may act as a social norm itself. When the medicalisation of FGC is normalised, many may deem its medicalisation a hegemonic practice (Clarke et al, 2003; Conrad, 2005). We examined the normative context by applying multi-level multinomial regressions using the EDHS 2005, 2008 and 2014 waves (Van Eekert, 2020; Van Eekert et al, 2020b).

While the first three research objectives are aimed at quantitatively examining associations between trends within the practice of FGC, mothers’ social position and social norms within the Egyptian context, the fourth and last research objective is to explore mothers’ motives for medicalising their daughters’ cut in the Kenyan context. A qualitative research in Kisii county, Kenya, was conducted in order to collect and analyse mothers’ narratives on the decision they made regarding their daughters’ FGC (Van Eekert, 2020; Van Eekert et al, 2020c).

Discussion and Conclusion

The general aim of this PhD dissertation was to explore why mothers opt to medicalise their daughters’ cut and how this decision relates to mothers social position within her community. The research project aimed to identify the drivers behind the medicalisation of FGC, focusing on mothers within practising communities, and its association with girls’ risk of being cut. Based on our research, we arrived at three major conclusions.

Firstly, many mothers who opt for medicalised FGC do so because they believe that it will reduce the possible health risks related to the practice. Both our quantitative research in the Egyptian context and our qualitative research in Kenya showed that the major driver behind the choice to opt for a medicalised cut for a daughter was to reduce possible harm to the health of the girl. Within practising communities, medicalisation is seen as a safer way to conform to a social norm and maintain a cultural and traditional practice. Women who want their daughters to be cut look for less harmful, but still culturally acceptable, alternatives (Shell-Duncan, 2001) rather than considering medicalisation as a compromise between abandonment and traditional methods.

Secondly, the medicalisation of FGC is socially stratified. Women who are more highly educated and who live in more wealthy households are more likely to medicalise their daughters’ cut. Educated women are often among the first to become aware of the potential risks of FGC and/or to be in a position to decide not to cut their daughters (El-Gibaly et al, 2002; Yount, 2002). Mothers with both knowledge about and the financial capacity to access healthcare, as well as knowledge about the potential risks of FGC, may have better access to medicalised procedures (Clarke et al, 2003; Shell-Duncan, 2001). Moreover, it appears that women with a certain social position have the power to be involved in making these decisions and have the final say on how the practice should be performed, while possibly remaining dependent on the practice of FGC in order to preserve the family system and their family’s social position. While they want to avoid health risks for their daughter, they still appear to lack
sufficient extrafamilial opportunities that might provide alternative ways to ensure social inclusion while taking a stance against the practice (Van Rossem, Meekers and Gage, 2015; Yount et al, 2020).

Thirdly, the medicalisation of FGC seems to act as a new social norm in itself. In addition to the advocacy of medicalisation as a rational response to a need for the reduction of harm, it can also be copying behaviour; for example, it may be based on the observation that most other people in the community have gone to health professionals to have FGC performed. FGC is a strongly socially embedded practice (Bicchieri, 2017; Mackie, 2000; Yount et al, 2019), such that continuation or abandonment implies an interaction between personal beliefs and community characteristics (Yount et al, 2019). It seems that the tipping point, where personal beliefs become the main drivers because social pressure has decreased, has not yet been reached; however, increased medicalisation seems to indicate a shift in the practice that is supported by the community, reducing health risks while still complying with social norms. FGC remains a practice that is based on beliefs concerning what it is to be a “good woman” and a “desirable partner”. The practice still involves gender expectations and notions of appropriateness, and it is still considered to be a way for women to express gender in the light of normative expectations concerning femininity and female sexuality (Collins et al, 1993; Jagger, 2008; Yount, 2002; Zimmerman and West, 1987). Nevertheless, this social norm might come to encompass new norms concerning the way the practice should be performed – including in a medicalised way. In other words, community effects are applicable not only to FGC abandonment but also to its medicalisation (Grose et al, 2019; Hayford, 2005).

While medicalisation might act as a social norm, our qualitative research in Kisii county showed that the medicalisation of FGC increasingly individualises the practice and sometimes even functions as a tool to increase its secrecy. The medicalisation of FGC has, in this context, changed the event from a social ritual to an individualised practice. Moreover, in line with Halfmann (2011), we acknowledge that the processes of medicalisation and demedicalisation might occur simultaneously at different levels. The shift from a health framework to a human, women’s and children’s rights discourse at national and international levels might be seen as a form of demedicalisation – as it can suggest a deliberate intention to cease framing FGC as a medical and health issue. Notwithstanding this possibility, the health approach still has its effects on practising communities, within which people turn to health professionals to perform the practice – and thus medicalisation is still ongoing, while demedicalisation is not occurring. These counter-movements reveal an area of tension between national and international policies and their detachment from practising communities.

Finally, our research challenges several assumptions that are found within the contemporary discourse surrounding the medicalisation of FGC. Our research contradicts the assumption that medicalisation counteracts the abandonment of FGC as such. In both of the contexts examined (Egypt and Kisii county), the increasing medicalisation of FGC coexists with decreasing FGC prevalence. Moreover, this association suggests that increasing medicalisation trends decrease the likelihood of girls being cut. These findings challenge the idea that the practice of FGC is maintained within practising communities by the shift towards medicalisation. Having the practice performed by trained health professionals does not seem to legitimise it, despite the existing perception that harm is reduced when FGC is performed by a health professional. Moreover, FGC is possibly already seen as legitimate by its proponents, independently of who the practitioner is (Ahmadu, 2000). Going even further, we can possibly infer that medicalisation itself could be an indicator of increasing risk awareness that might, in turn,
function as a driver of FGC abandonment. Moreover, our findings suggest that medicalisation might transform FGC from a community issue into a less visible and more individual practice, which leads to reduced social pressure to perform it, as the importance of FGC to a woman’s social position declines when conformity to social norms is no longer as visible (Kimani and Shell-Duncan, 2018; Shell-Duncan, 2001).

To conclude, writing this PhD dissertation started with a focus on the medicalisation of FGC, assuming that the question was: “To medicalise or not to medicalise?” Now, having written and successfully defended this dissertation, I realise that there is no clear answer to this question, as various new and interrelated questions have arisen along the way. I believe that the assumptions made in the general discourse on FGC should be challenged and empirically researched. Moreover, I think it is important to clarify what is at the core of the discussion. If the question, “To medicalise or not to medicalise?” is raised, the aim of raising it should be clarified. Is the aim to fully abandon the practice, or is it to decrease the health risks related to the practice? In addition, there is a need to identify whose aim it is: that of a practising community itself or of national or international policymakers? As my PhD research has shown, the medicalisation of FGC is a complex multi-layered issue that cannot simply be reduced to the decision made by the mother but is instead driven by multiple factors. This research contributes to the scarce evidence on the question of whether medicalisation should be encouraged or discouraged. When I started this PhD, I simply asked myself whether the medicalisation of FGC was a “good” or “bad” practice; now, at the end of the trajectory, I ask myself: “To medicalise or not to medicalise: is that the question?”
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