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The medicalization of female “circumcision”: harm reduction or promotion of a dangerous practice?

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Abstract

In recent decades the practice of female “circumcision” has come under intense international scrutiny, often conceptualized as a violation of women’s basic right to health. Although the adverse health consequences of female “circumcision” form the basis of opposition to the practice, anti-circumcision activists, as well as many international medical associations, largely oppose measures to improve its safety. The debate over medicalization of female “circumcision” 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? This paper seeks to re-examine this debate by conceptualizing medicalization of female “circumcision” as a harm-reduction strategy. Harm reduction is a new paradigm in the field of public health that aims to minimize the health hazards associated with risky behaviors, such as intravenous drug use and high-risk sexual behavior, 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. This paper evaluates the applicability of harm reduction principles to medical interventions for female “circumcision,” and draws parallels to other harm reduction programs. In this light, arguments for opposing medicalization of female “circumcision”, including the assertion that it counteracts efforts to eliminate the practice, are critically evaluated, revealing that there is not sufficient evidence to support staunch opposition to medicalization. Rather, it appears that medicalization, if implemented as a harm-reduction strategy, may be a sound and compassionate approach to improving women’s health in settings where abandonment of the practice of “circumcision” is not immediately attainable. Published by Elsevier Science Ltd.

Keywords: Female circumcision; Female genital mutilation; Harm-reduction strategies; Medicalization

The argument that female genital mutilation performed under hygienic and medically controlled conditions is a lesser evil compared to the greater risk of severe complications is also not acceptable, since the cause of the risk is human behaviour, which can be changed, and not an uncontrollable pathology such as malignancy. Since all medical research and clinical efforts aim at making uncontrollable causes of damage to the human body more controllable, it would be unethical for a health professional to damage a healthy body in order to prevent a more destructive human behaviour.

Toubia and Izette (1998, p. 33)

In recent decades, heated debates surrounding the practice of female “circumcision” have often centered on the health risks associated with genital cutting procedures. The adverse health consequences of female genital cutting are central in two prominent — yet contradictory — arguments. On the one hand, by emphasizing that female genital cutting exposes women to unnecessary, and often severe, medical risks, a right-to-health argument forms the foundation of most anti-circumcision campaigns. On the other hand, any efforts to minimize the health risks by providing or improving medical support are strongly opposed by anti-circumcision advocates, based on the

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belief that medicalization counteracts efforts to eliminate the practice.

Medical interventions have been attempted in various forms, ranging from promoting precautionary steps, such as the use of clean sterile razors on each woman and dispensing prophylactic antibiotics, to obtaining genital operations in clinics or hospitals by trained nurses and physicians. The impact of these interventions on the health of women has received surprisingly little attention. Without consideration of health improvements resulting from various forms of medicalization, these approaches have been strongly criticized.

Opposition to all forms of medicalization is central in international efforts to eliminate female “circumcision”. In 1982 the World Health Organization issued a statement declaring it unethical for female genital cutting to be performed by “any health officials in any setting — including hospitals or other health establishments” (WHO, 1982). In 1994, the International Federation of Gynecology and Obstetrics passed a resolution that calls on all doctors to refuse to perform “female genital mutilation”, and was joined by many other major organizations such as the American College of Obstetricians and Gynecologists, the United Nations International Children’s Emergency Fund, and the American Medical Association (ACOG committee opinion, 1995). Additionally, in response to pressures from local and international anti-circumcision activists, ministries of health in many African countries have issued similar statements.

This staunch opposition to medical intervention rests on one central assumption: that medicalization will counteract efforts to eliminate female “circumcision”. This assumption is, however, not based on empirical evidence, and deserves critical examination. This need is underscored by the fact that, regardless of legislation or international opinion, female genital cutting is, and will likely continue to become increasingly medicalized throughout sub-Saharan Africa. It is therefore necessary to determine whether medicalization is best viewed as one in a series of steps in improving women’s health, or an impediment to efforts to eliminate the practice.

The merits and drawbacks of medicalization of female genital cutting may be clarified if it is compared and contrasted to other programs that seek to improve human health by adopting interim solutions that fall short of total abolition. “Harm reduction” is a new paradigm that emerged over the past two decades in the field of public health. It is an approach that seeks to minimize the health hazards arising from a variety of behaviors by encouraging safer alternatives, including, but not limited to, abstinence. According to the Director of the Addictive Behaviors Research Center at the University of Washington, Dr. Alan Marlatt (1996), harm reduction is a revolutionary approach to the way we respond to a wide variety of human problems,

ranging from drug abuse to AIDS. Perhaps the most publicized examples involve efforts to minimize the risk of AIDS for intravenous drug users by providing needle exchange programs, education on safer drug use, and “shooting-gallery” motel rooms to provide safer places to inject drugs and exchange needles (Marlatt, 1996). This approach is also used with licit drugs. For example, to reduce the individual and social costs of accidents by drunk drivers, public health campaigns have promoted “responsible drinking” (e.g., designated drivers and free taxi service), and to reduce the cancer risks from smoking, alternative sources of nicotine have been made available (e.g. the “patch” and chewing-gum) (Duncan, Nicholson, Clifford, Hawkins & Petosa, 1994). Harm-reduction efforts are, however, not confined to drug abuse. Other examples include school-based condom distribution and educational programs to prevent adolescent pregnancy and the spread of sexually transmitted disease. Overall, the goal of harm reduction is to reduce the health consequences of various behaviors for both the individual and the community in which they live by offering a pragmatic and culturally acceptable set of alternatives (Marlatt, 1996). In this paper it is suggested that the medicalization of female “circumcision” may be appropriately viewed as a harm reduction approach.¹

As a harm-reduction strategy, medicalization has the potential to improve the health of women undergoing “circumcision” via two avenues: (1) reducing risk of attendant medical complications by improving hygienic conditions, preventive medical measures, and/or skill level of the cutter², and (2) reducing the amount of cutting, and presumably risk of complications. To assess the potential impact of each avenue, it is necessary to first clarify range of practices classified as female “circumcision”, and then determine the range and frequency of associated health complications as a baseline against which to evaluate impact of any intervention, including various forms of medicalization. Finally, while outlining principles of harm reduction as a public health alternative, the strengths and limitations of the application of this measure for reducing the adverse health consequences of female genital cutting are evaluated.

¹ I would like to credit my colleague, Ylva Hernlund for first drawing the connection between medicalization of female “circumcision” and harm reduction, and for encouraging me to explore the literature on harm reduction.

² As outlined below, improving the skill-level of the cutter does not necessarily imply the substitution of trained medical personnel for traditional cutters. The skill level of traditional circumcisors and the impact of training programs has yet to be evaluated.

Definition of the practice

The term “female circumcision” is a euphemistic description for what is really a variety of procedures for altering the female genitalia. While numerous terms have been used to describe the wide range of procedures, there are generally four commonly recognized forms of genital cutting. The least extensive type, and the only one that can be construed as analogous to male circumcision, is commonly referred to as *sunna* (Arabic for “tradition” or “duty”), and involves removal of the prepuce or hood of the clitoris. Toubia (1994) claims that in actuality, no medical reports document the existence of this procedure. Rather, in the majority of cases categorized as *sunna*, the clitoral prepuce is removed with all or part of the clitoris as well. Therefore, in the medical literature it is sometimes referred to as *clitoridectomy* (Toubia, 1994), or Type I circumcision by the World Health Organization (WHO). The second type, often referred to as *excision*, or Type II by the WHO, entails the partial or complete removal of the clitoris, along with part or all of the labia minora. A sharp distinction between clitoridectomy and excision is difficult to draw since one grades into the other. Consequently, attempts to differentiate the two in survey research has proven to be difficult, and commonly the two become collapsed into a single category (e.g., Myers, Omorodion, Isenalumhe & Akenzua, 1985; Singateh, 1985).

The most radical form of female circumcision is known as infibulation or Pharaonic circumcision (being attributed in ancient folk legend to the time of the ancient Pharaohs). This procedure involves the complete removal of the clitoris, labia minora, as well as most of the labia majora. The cut edges are stitched together so as to cover the urethra and vaginal opening, leaving only a minimal opening for the passage of urine and menstrual blood. A small stick is commonly inserted to maintain the opening, and the legs of the girl are often bound together to promote healing. The minimal opening that remains following this procedure must be opened for intercourse and childbirth, and for some women, opening is followed by reinfibulation after each birth.

In the Sudan there is a fourth form of circumcision known as *matwasat*, or “intermediate circumcision”, which is a modified form of infibulation that usually involves a similar amount of cutting, but stitching together only the anterior two-thirds of the outer labia, leaving a larger posterior opening (Toubia, 1993). This practice is believed to have evolved as a compromise by circumcisors to the 1946 ban which outlawed infibulation in the Sudan, although in a recent survey less than 2% of Sudanese women reported having had an intermediate circumcision (Balk, 1996). The WHO classifies both *matwasat* and infibulation as type III.

Another form of infibulation known as “sealing” is occasionally practiced in West Africa. This procedure involves excision and subsequent sealing of the vagina not by stitching, but by allowing blood to coagulate and to form into what amounts to an artificial hymen (see Singateh, 1985; Hernlund, 2000; Mackie, 2000).

Apart from these four main types of genital cutting, Hosken (1993) reports a variation called “symbolic circumcision”, which is said to occur in Indonesia and Malaysia, and involves nicking the clitoris with a sharp instrument to cause bleeding but no permanent alteration of the external genitalia. In recent years, symbolic cutting has been proposed elsewhere as part of an effort to eliminate more extensive cutting. This procedure was proposed to be performed on African immigrants in the US before being blocked by new legislation (Kelly, 1996), and a few isolated cases have been reported in indigenous African populations (Dorkenoo, 1994; Caldwell, Orubuloye & Caldwell, 1997).

The general term “female circumcision” has often been used to refer collectively to these procedures. With the spread of feminist consciousness and the development of international women’s health movements, objection to this term has been voiced, and the term “female genital mutilation” (FGM) has been promoted by activists as a more accurate term. The use of the word “mutilation” has been criticized by some African women’s groups because it is “thought to imply excessive judgment by outsiders and insensitivity toward individuals who have undergone the procedure” (Eliah, 1996, p. 13). Members of the Uganda-based initiative REACH (Reproductive, Educative, And Community Health programme) have proposed the term “female genital cutting” (FGC), as a more precise, but less value laden term (Eliah, 1996). I will use this term, the euphemism, female “circumcision” (with quotes to acknowledge the imprecision of this term), or the more precise descriptive terms for each procedure: clitoridectomy, excision and infibulation.

Establishing the medical “facts”?

If less radical forms of cutting were to be promoted as a harm-reduction strategy, it would be necessary to document that the risk of adverse health outcomes declines as the extent of cutting is reduced. In the anti-circumcision literature, fragments of information from different types of genital cutting, performed under widely varying conditions, are melded and repeated as the “medical sequelae” (Shell-Duncan, Muruli & Obiero, 2000; Obermeyer, 1999). As variations in the practice (degree of cutting, training of the circumcisor, sanitary conditions, degree of medical support) are obliterated, presented is a seemingly objective, scientific discussion of the medical “facts” of a single practice —

“genital mutilation”. This discussion is often divided into three categories: short-term, long-term, and obstetrical consequences. Short-term complications include hemorrhage, severe pain, local and systemic infection, shock from blood loss and potentially death. Infection is associated with delayed healing and the formation of keloid scars. In addition, pain and fear following the procedure can lead to acute urinary retention. Long-term complications are said to be associated more often with infibulation than with excision or sunna (Toubia, 1993), although this has been poorly researched. Possible long-term complications include genito-urinary problems, such as difficulties with menstruation and urination that result from a near-complete sealing off of the vagina and urethra. Untreated lower urinary tract infections can ascend to the bladder and kidneys, potentially resulting in renal failure, septicemia, and death. Chronic pelvic infections can cause back pain, dysmenorrhea, and infertility. Another frequently mentioned complication is the formation of dermoid cysts, resulting from embedding epithelial cells and sebaceous glands in the stitched area. All forms of female genital cutting are reportedly associated with the potential for diminished sexual pleasure and, in certain cases, inability to experience a clitoral orgasm. “Circumcised” women may experience painful intercourse, and infibulated women often have to be cut open for penetration to occur at all. Infibulation is also associated with obstetrical complications, including obstructed labor, excessive bleeding from tearing and de-infibulation during childbirth. Obstructed labor may lead to the formation of vesico-vaginal and recto-vaginal fistulas. Some researchers have suggested that increased obstetrical risk exists for excised women as well (e.g. Epelboin & Epelboin, 1981), although supporting evidence is difficult to find (Shell-Duncan et al., 2000). Scar tissue may contribute to obstructed labor since fibrous vulvar tissue fails to dilate during contractions. Furthermore, hemorrhage may result from tearing through scar tissue.

This laundry list of adverse health outcomes is repeated in the introduction of nearly all papers in the voluminous literature on female “circumcision”. Yet, one serious problem with these accounts of the medical “facts” is that they largely fail to distinguish differences in the types and frequency of complications associated with different types of genital cutting (Shell-Duncan et al., 2000; see also Obermeyer, 1999). Nonetheless, noteworthy case studies on infibulation are generalized to describe the health risks of *all* forms of genital cutting.

An understanding of the range and frequency of adverse health outcomes is required to support the representation of all forms of female genital cutting as “harmful traditional practices” (Obermeyer, 1999), and to justify condemnation of its continuation. Whether conceptualized as a public health problem or a violation

of basic human rights, opposition is justified by the intolerable physical and emotional harm “circumcision” inflicts upon women. And while graphic sensationalized accounts of select cases of infibulation with severe complications are intended to ignite public outrage and fuel anti-circumcision campaigns, several scholars, myself included, have begun to question the generalizability and accuracy of information presented.

An excellent recent literature review by Carla Obermeyer represents the first systematic attempt to synthesize data on the nature and frequency of various types of health complications. She found that despite the “vast literature on the harmful effects of genital surgeries...evidence on complications is very scarce” (1999, p. 92). Only eight studies met the criteria for inclusion in her summary of major findings³, and led her to the conclusion that medical complications “are the exception rather than the rule” (1999, p. 92). While Obermeyer stresses that “it is rarely pointed out that the frequency and severity of complications is a function of the extent and circumstances of the operation” (1999, p. 91), this summary did not differentiate risk based on the type of genital cutting. Obiora — who completed a limited review of the biomedical literature — did differentiate risk by the type of genital cutting, concluding that “the available data does not implicate mild forms of the practice as dangerous” (1997, pp. 86–87). Here, based on a comprehensive review of the literature, the available information on the frequency of medical complications associated with each of the four major types of “circumcision” is summarized⁴.

Information is available from several sources, each of which has serious limitations for inference of population-wide frequencies of adverse health outcomes. Attempts have been made to quantify the range and frequency of circumcision-related medical complications from clinic and hospital records, and hospital-based case control comparisons (e.g. Aziz, 1980; Rushwan, 1980; DeSilva, 1989). However, because these data suffer from selection bias, they need to be interpreted with caution. Women are often reluctant to seek medical attention because of modesty and, in rural settings, inaccessibility

³These studies included hospital studies, as well as epidemiological studies and population surveys that met Obermeyer’s selection criteria, including adequate description of sampling and methods, large sample size, clear description of genital cutting and complications, and clearly presented results.

⁴As outlined below, the selection criteria for studies involves the selection of population-based surveys that differentiate the frequency of complications by type of genital cutting. This criterion is different than those of Obermeyer, whose selection criteria precluded her review from summarizing complications by form of “circumcision”. This does not imply that there is any fallacy in either set of selection criteria. Rather, as Obermeyer (1999) emphasizes, all currently available studies have serious limitations, and overviews must clarify these limitations.

of health services. Consequently, complications tend to be reported only if they are severe and prolonged (El Dareer, 1982). Furthermore, in some regions, such as the Sudan, certain types of genital cutting are illegal, and women hide medical complications for fear of legal repercussions (El Dareer, 1982; Toubia, 1993). Therefore, these data can only be used to generalize about the population of hospital users.

The best information available on the frequency of various complications attributable to genital cutting comes from several large-scale population-based surveys, the first of which was conducted by El Dareer (1982) in Northern Sudan between 1977 and 1981. However, self-reported retrospective survey data also suffer from a number of limitations. Recall error on details surrounding events that occurred many years ago is inevitable. Moreover, since many women may have been cut as infants or very young children, it may be impossible to remember immediate adverse health outcomes. Questionnaire design must take into account that women may not attribute health problems to their genital cutting, and informants' concept of illness or abnormality may be different from that of medical researchers. For example, in an account by Lightfoot-Klein (1989, p. 59), an infibulated woman claiming to not have difficulty with urination also indicated that it took up to 15 min to empty her bladder. This condition was considered normal in a community where all adult women were infibulated. Self-reported retrospective survey data also suffer from selection bias in that they

are limited to women who survived genital cutting. Finally, due to the cross-sectional nature of survey data, it is often impossible to determine whether genital cutting was itself causal of subsequent conditions, such as urinary tract infections, which may arise from other causes (Obermeyer, 1999).

Despite these limitations, survey data currently provide the best information on population-wide health risks associated with different forms of genital cutting. Until the 1990s, large-scale population-based survey data on the prevalence and consequences of female genital cutting were available only for the Sudan (El Dareer, 1982). More recently, findings on health complications have been reported from large-scale surveys from south and central Kenya (MYWO, 1991), northern Kenya (Shell-Duncan et al., 2000), the Central African Republic (Carr, 1997), and Egypt (Carr, 1997), as well as from four small, focused studies (Koso-Thomas, 1987 on Sierra Leone; Calder, Brown & Rae, 1993 on students in Somalia; Leonard, 1996 on the Sara of Chad; Dirie & Lindmark, 1992 on Somalia). Few studies, however, allow for detailed comparison of certain short- and long-term health consequences, broken down by type of genital cutting (Table 1). The available information on long-term and obstetrical complications is quite sparse. While many of the complications, such as recurrent urinary tract infection, do not occur in high frequency, there is not a clear pattern of lower frequency among less severe forms of circumcision. Many reported conditions, such as chronic

Table 1
Reported frequency of short-term, long-term and obstetrical complications

Short-term or Immediate complications	Type of genital cutting			
	Clitoridectomy (%)	Excision (%)	Intermediate (%)	Infibulation (%)
Pain	92 ^a	9.1 ^b –99 ^a	—	84 ^c
Hemorrhage	6 ^d –55 ^a	8.1 ^b –49 ^a	9.3 ^d	4.8 ^c –66 ^c
Urinary retention	9 ^a –30.5 ^e	9.1 ^e –16 ^a	4.4 ^d	2.8 ^d –87 ^c
Infection	0 ^d –27.6 ^e	14.1 ^b –24.2 ^e	3.5 ^d	5.2 ^d –35 ^c
Shock	0 ^d	—	0 ^d	1.2 ^d
Fever	0 ^d	—	4.2 ^d	4.4 ^d –81 ^c
<i>Long-term and obstetrical complications</i>				
Difficult childbirth	1.9 ^e	8.7 ^c –39.9 ^b	—	42.9 ^c
Keloid scar	0 ^d –78 ^e	62.8 ^c –65 ^a	0.5 ^d	0.3 ^d –48.1 ^c
Dermoid cysts	0 ^{a,d}	5 ^a	0.8 ^d	0.6 ^d
Abscess	0 ^{d,d}	2.5 ^a	3.9 ^d	4.9 ^d
Recurrent urinary tract infection	8.8 ^d	—	13.2 ^d	8.5 ^d
Chronic pelvic infection	6.3 ^d	—	7.3 ^d	7.9 ^d
Painful intercourse (problems with sex)	0 ^a –20.3 ^e	12.6 ^c	1.3 ^d	1.9 ^d –32.1 ^c

^aKoso Thomas (1987).

^bShell-Duncan et al. (2000).

^cCalder et al. (1993).

^dEl Dareer (1982).

^eMYWO (1991).

pelvic and urinary tract infections, may arise from factors other than genital cutting, and without further information, it is impossible to determine whether reported conditions are circumcision-related.

Clearer inferences can be drawn about short-term complications. These data demonstrate that women with all forms of genital cutting report serious immediate complications, such as hemorrhage and infection. Noteworthy as well is the wide range in reported incidence of complications associated with any one form of genital cutting. For example, the percentage of women reporting hemorrhage following clitoridectomy ranges from 6 to 55%, and 5 to 66% following infibulation. These broad ranges of estimated incidence suggest that when evaluating genital cutting as a risk factor, it is important to control for factors that may contribute to this range in variation, such as training of the circumcisor, location of the operation and medical support. Additionally, it highlights the need to cautiously interpret self-reported retrospective data.

Together, these studies provide only limited insight as to the range of potential adverse health outcomes that may arise from various types of genital cutting, and demonstrate that clearly, better information is needed in order to evaluate the potential impact of medicalization of FGC as a harm-reduction strategy. Prominent scholars and activists have made strong, yet contradictory, statements about the health consequences of milder forms of genital cutting. Obiora, a Nigerian legal scholar, claims that “sunna (has) . . . minimal health risks if scientifically performed and monitored”, (1997, p. 88) while Sudanese physician and activist Toubia writes in bold: “Because extreme complications are not as common with clitoridectomy as they are with infibulation, they are usually ignored, and clitoridectomy is falsely perceived to be safe” (1993, p. 14). This review of the literature, however, underscores the fact that generalizations about the safety or harmfulness of less severe forms of genital cutting cannot be supported by the available data. Information on the health risks of symbolic “circumcision” is not available, perhaps because of the relative rarity of this form of genital cutting, or the presumed (or observed and unreported) safety of this procedure. And while it is likely that the risk of attendant complications varies according to the degree of cutting, as well as the skill of the circumcisor, hygienic condition, and prophylactic measures, this must be verified by epidemiological studies.

The medicalization of female circumcision

The medicalization of female genital cutting is becoming increasingly common across Africa (see, for example, the contributions in Shell-Duncan & Hernlund, 2000). While medicalization is most commonly

conceptualized as what Obiora (1997) calls “clinicalization”, a broad spectrum of medical interventions has emerged. One of the most minimal forms involves nurses dispensing prophylactic antibiotics, anti-tetanus injections and sterile razors to girls who are later cut by traditional circumcisors (Shell-Duncan et al., 2000). A more controversial approach was implemented in the 1970s and 1980s in the Sudan and Somalia, involving the incorporation of training on aseptic procedures for genital cutting as part of training programs for traditional birth attendants (Gruenbaum, 1982; van der Kwaak, 1992). Midwives were given training on anatomy, and instructed to take precautionary steps such as using a local anesthetic and new sterile razors on each woman, and when available, dispensed prophylactic antibiotics (Gruenbaum, 1982; van der Kwaak, 1992). At the same time, efforts were made to encourage milder “sunna” circumcision. In Somalia, “sunna”, which is reported to consist of symbolic pricking of the clitoris (Obiora, 1997, p. 370), is now offered in clinics run by trained midwives, and is replacing the more radical practice of infibulation (see also Badri, 1999). In the Sudan, however, the use of the term “sunna” drew ideological linkages with Islam, and wishing to be faithful to religious codes, many people professed to practice “sunna circumcision” even though infibulation had been conducted (Gruenbaum, 1982). Consequently, reform efforts resulted in a change in nomenclature rather than change in the amount of cutting performed (Gruenbaum, 1982). A 1991 UN report has described a clinic in Djibouti, run by L’Union Nationale des Femmes de Djibouti, where a “mild” form of circumcision (something less than infibulation) is performed under anesthetic by a traditional circumcisor. At the same time as offering this service, the clinic also disseminates information “related to female circumcision and other traditional practices” (UN, 1991, p. 17). In some instances, Western-trained medical personnel is replacing traditional circumcisors. In urban regions of Nigeria and Mali, for example, it is becoming increasingly common for nurses to perform genital cutting (Orubuloye, Caldwell & Caldwell, 2000; Gosselin, 2000). In Western Kenya, where a ban from the Ministry of Health prevents medical professionals from performing FGC in government-run hospitals and clinics, nurses commonly perform the procedure at the initiate’s home while on leave for Christmas holiday (Njeru & PATH, 1996). Their services are reportedly in demand since they use sterile instruments, and administer a local anesthetic that reduces pain and swells the clitoris, allowing for more controlled cutting.⁵

⁵ Andrea Hamelrath, former Anthropology student at the University of Washington (Seattle, USA), personal communication.

In Egypt, official policy regarding medicalization has come under intense scrutiny and spurred public debate. In an effort to improve the safety of what was viewed as an “inevitable practice”, Egypt’s Ministry of Health issued in 1994 a decree permitting only doctors in government hospitals to perform female genital cutting (Anonymous, 1996). However, this policy was reversed in October 1995 after women’s rights and health advocates criticized it as government endorsement of “female genital mutilation” (Anonymous, 1996), and instead state hospitals were banned from performing the procedure. Following the widely publicized death of an 11-year-old girl in a clinic, further restrictions were implemented, barring all state-licensed health workers in either government or private clinics from performing female “circumcision”. As a result, the practice has been forced underground as the only available operators are unlicensed midwives and barbers. Additional circumcision-related deaths have been widely publicized, and a group of advocates supporting the practice of female circumcision attempted to sue the Minister of Health for withdrawing medical support (Awaken, vol. 1, 1997). They claimed that the prohibition of qualified medical personnel from practicing female circumcision has forced them to turn to traditional practitioners, and expose girls to an undue risk of injury and death (Awaken, 1997). Although this motion was struck down in Egyptian court (Awaken, vol. 2, 1998), the public debate surrounding this motion has drawn widespread attention.

In an effort to reduce more extensive forms of FGC and minimize health risks, several controversial proposals for medicalization have been developed in the West as well. Perhaps the most noteworthy are two proposals in which medically performed symbolic circumcision was evaluated as a safer alternative to infibulation for Somali immigrants. In the Netherlands, a Welfare, Health and Culture Ministry report recommended drawing a distinction between tissue-impairing circumcision and non-mutilating ritual incision, and proposed that doctors be allowed to perform an anaesthetized incision or pricking of the clitoral covering (Obiora, 1997, p. 285). This proposal drew a storm of protest, and was subsequently rejected by the Dutch government. Similarly, in 1996, a US hospital considered performing symbolic circumcision for members of the Somali immigrant community who were willing to let such a transitional measure replace infibulation for their daughters (Ostrom, 1996; Coleman, 1998). Although the so-called “Seattle compromise” would have involved only nicking the clitoral prepuce to draw a single drop of blood, and would have been performed under anesthesia on girls having given consent, the plan was blocked by intense lobbying from anti-circumcision activists, as well as an outpouring of negative public opinion (e.g. Ostrom, 1996; Paulson, 1996).

The opposition by anti-circumcision activists of all forms of medicalization, even as interim strategies is clearly articulated by Dorkenoo (1992, p. 14), who states, “The temptation to reduce pain and death by offering the operation in hospitals ‘in the mean time’ must be refused.” This firm stance against medicalization is taken without consideration of the degree to which medical support actually improves safety, or hampers efforts to eliminate various forms of the practice. Surprisingly little attention has been devoted to evaluating the health-related benefits of various types of medical intervention. The only study that has reported an evaluation of the impact of medicalization is that of Shell-Duncan et al. (2000), conducted among the Rendille of northern Kenya. Our data show that excisions performed by traditional circumcisors using sterile razors, anti-tetanus injections, and prophylactic antibiotics are associated with a nearly 70% lower risk of immediate complications, demonstrating that even minimal medical interventions markedly reduce health risks. However, whether medicalization counteracts efforts to eliminate FGC is an empirical question that remains to be carefully considered.

Toubia and Izette maintain that on ethical grounds “all forms of genital mutilation must be condemned by the health community”, (1998, p. 33) arguing that trained medical personnel who perform “FGM” violate two of the most important principles of professional health ethics: “do no harm and preserve healthy functioning body organs at all cost unless they carry life-threatening disease”. Yet the hypocrisy of a medical establishment that condemns even the mildest forms of FGC while condoning male circumcision and non-medically necessary cosmetic surgery has been pointed out by numerous commentators. Moreover, given that the Seattle proposal for symbolic circumcision was to involve no removal of tissue, and result in no long-term damage or scarring (Coleman, 1998), arguments on the basis of medical ethics are difficult to uphold. Implicit in such arguments, as well, is that medically assisted FGC is performed by licensed health professionals, overlooking the fact that in several instances attempts to provide “safer” procedures have involved training or providing medical supplies to traditional birth attendants or circumcisors. There is a tendency in the anti-circumcision literature to portray traditional cutters as aged, near-sighted women with no knowledge of anatomy, whose trembling hands wield rusty knives and razors. Little attention is devoted to describing the training and skill of traditional cutters, or the impact of training programs and medical support. Ogbu (1997), who opposes “clinicalization” of excision and clitoridectomy on the basis that they are already safe, argues that traditional circumcisors are fully qualified to perform the procedure: “These specialists not only know how to perform the operation on the penis or

clitoris, but they also have the medical knowledge necessary to treat their clients and usually continue to attend to them until the wounds are healed” (Ogbu, 1997, p. 416). While I argue that this statement cannot be supported without evaluation of the skill-level of traditional cutters, it is important to emphasize that not all forms of medicalization involve licensed medical personnel.

Toubia and Izette (1998, p. 33) further argue against medicalization since the cause of harm is “human behavior, which can be changed”. What is not emphasized in this statement is the inherent difficulty in changing this human behavior. FGC is often connected with complex and dynamic meanings that might include reproduction, sexuality, personhood, power, religious identity and marriageability, and it is well recognized that efforts toward change must take into account the broader social meanings, and may take decades to take hold (see, for example, Gruenbaum, 1982; Boddy, 1982).

Mackie (1996,2000) has argued that marriageability is the key factor promoting the practice of FGC in intramarrying groups, and that the abandonment of the practice rests upon altering this mutually supported convention. He suggests that if a critical mass of people publicly pledge to abandon FGC, the convention shifts and uncircumcised girls are not excluded from future marriageability and group support. Consequently, Mackie argues that when FGC ends, it will do so quickly. Recent events in Senegal support this theory. Through a non-directive education program designed and implemented by the non-governmental organization Tostan, Senegalese women identified FGC as an area of improvement, and resulted in 1998 in 31 villages publicly pledging to end the practice of female “circumcision” (Mackie, 2000). While this event is arguably the most promising initiative for eliminating FGC, it does not indicate that rapid abandonment of FGC is imminent across Africa. The amount of time required to “set the stage” for conventions shifts will likely vary considerably in different settings. While Mackie (2000) argues that the development of a consensus opposing FGC rests husbands and other community members of the need for change, Sargent argues such a perspective overlooks the difficulties often faced by African women in trying to persuade such people. “This is reminiscent,” Sargent writes, “of AIDS education in Africa that urged women to make their husbands wear condoms, with no success because they were powerless to do so.”⁶ Consequently, we must consider a crucial question: What is the fate of women in societies not yet willing to abandon the practice of FGC?

The fact remains that many women face a dilemma, weighing on one hand their physical welfare, and on the other the avenue to status, respect and support within their group. Advocating medicalization as a “temporary transitional compromise”, Obiora argues that “the dilemma of such a woman can be deflated by minimizing the relatively avoidable health risks of adhering to the tradition” (1997, p. 371). Consequently, the notion of harm reduction is not new in the medicalization debate, although explicit links to harm reduction as a public health policy have not been previously explored. It is argued here that insights about the costs and benefits of medicalization of female genital cutting can be gained by drawing comparisons to other harm-reduction efforts.

Harm reduction and the medicalization of female genital cutting

Harm reduction is an international public health policy movement that arose in response to the growing AIDS crisis in the 1980’s (Marlatt, 1998). It is an approach that embraces all measures that reduce the individual and social costs of risky behaviors, including, but not limited to, abandonment of such practices. Marlatt (1996) has outlined a set of central principles of the harm reduction approach to drug abuse. These principles may apply with equal appropriateness to the practice of FGC. The four main principles are as follows:

1. Harm reduction is a public health alternative to the moral/criminal and disease models of drug use and addiction.
2. Harm reduction recognizes abstinence as an ideal outcome but accepts alternatives that reduce harm.
3. Harm reduction has emerged primarily as a ‘bottom-up’ approach based on addict advocacy, rather than a ‘top-down’ policy.
4. Harm reduction promotes low-threshold access to services as an alternative to traditional high-threshold approaches (Marlatt, 1996, pp. 785–787).

Harm reduction is a public health alternative to the moral/criminal and disease models of drug use and addiction

According to Marlatt (1996), the two most established models for combating drug abuse are the moral model and the disease model of addiction. In the moral model, drug control policy has condemned and criminalized illicit drug use and distribution of drugs. In the 1980’s, American society declared a “War on Drugs” with the aspiration of developing a drug-free society. Similarly, a series of conferences honoring the United Nations Decade for Women (1975–85) became platforms for condemning “female genital mutilation”, and launching

⁶Carolyn Sargent, Anthropology Department, Southern Methodist University (Dallas, USA), personal communication.

current international campaigns to abolish all forms of the practice. A decade later, at the United Nations World Conference in Beijing, “FGM” was classified as a form of violence against women, along with battering, rape, sexual abuse and prostitution. As a violation of basic human rights, activists argued that “FGM” should be subject to condemnation, and in certain instances, punishment through legislative force. Legal scholar Bashir, for example, argues that criminalization will deter the practice by “fostering an environment . . . that is clearly intolerant to FGM” (1997, p. 13).

The second model, the disease model, defines drug addiction as a biological disease, and focuses on drug prevention and treatment programs that aim to reduce an individual’s desire or demand for drugs. A disease model has also been applied to female “circumcision” in the voluminous anti-circumcision literature which repeatedly recounts the “medical sequelae”, as alleged health hazards form the cornerstone of opposition to the practice, and support the view that “genital mutilation should be treated as a public health problem and recognized as an impediment to development that can be prevented and eradicated much like any disease” (Hosken, 1978, p. 155).

By contrast, the harm reduction approach offers a practical alternative that supports any policy that improves public health. Rather than taking a moral stand on the practice (female “circumcision” is immoral and illegal and therefore punishable), the focus is on the degree to which any form of behavior is harmful to the individual or the community. Additionally, unlike the disease model that views abstinence or eradication as the only acceptable outcome of prevention efforts, harm reduction considers a wide range of alternatives, and promotes the alternative that is culturally acceptable and bears the least harm. By focusing on culturally appropriate responses, it is clear that one solution, such as abstinence, may not be feasible in all settings. Anti-circumcision campaigns have only in a few instances persuaded people to completely abandon female genital cutting. Alternatively, even the most ardent supporters of female “circumcision” are often willing to offer suggestions for altering the practice in an effort to improve safety. For example, many Rendille men and women in northern Kenya regard abandoning the practice of excision or reducing the amount of cutting as entirely unacceptable, but express strong interest in receiving additional medical support (Shell-Duncan et al., 2000). Consequently, in any one setting, a culturally acceptable alternative must be identified.

Critics of medicalization in Somalia argue that “clinicalization” of female “circumcision” undermines the cultural meaning, and “reduces the practice to an empty ceremony devoid of transitional role and ritual connotation” (Obiora, 1997, p. 371). Indeed, as Hernlund (2000) describes, in many African societies where

FGC was “historically” carried out as part of girls’ coming-of-age ritual, it is becoming increasingly common for the practice to be performed at younger and younger ages, and become a purely physical procedure with little or no accompanying celebration or transmission of cultural knowledge — a trend she describes as “cutting without ritual”. The separation of ritual and cutting, however, does not necessarily occur in response to or in the presence of medicalization; in the Gambia, for example, the lack of ceremony surrounding FGC has occurred entirely in the absence of medicalization (Hernlund, 2000, personal communication). By contrast, medical support has, in some instances, become incorporated into ceremonial aspects of “circumcision”. An interesting example has occurred in male circumcision among the Rendille of northern Kenya. The male circumcision ritual is performed at a temporary encampment, comprised of huts built for the initiates by their mothers. Historically, a traditional circumcisor moves from boy to boy waiting outside of their hut, first blessing them with a sprinkling of milk and water, and then performing the circumcision procedure. During the last age-set initiation, however, the warriors, after receiving a blessing, stopped at a station set up by a nurse, where each one was administered anesthesia and treated with topical antibiotics after being cut with a sterile razor. One elder remarked, “If warriors can stop by the nurse (for circumcision), why can’t the young brides?”

Harm reduction recognizes abstinence as an ideal outcome but accepts alternatives that reduce harm

Currently, the World Health Organization and many industrialized nations promote a zero-tolerance policy on female “circumcision”, a policy that states that all forms of female “circumcision” must be eliminated without intermediate steps. A harm reduction approach shares the goal of eventually eliminating female genital cutting, but is willing to promote intermediate steps that offer safer solutions in the process of change. Just as the nicotine patch is an acceptable transitional alternative to cigarette smoking because it confers fewer health risks, less severe genital cutting and medical support would be encouraged as steps in the right direction in societies where abandonment of the practice is not a viable alternative. For example, medical anthropologist Ellen Gruenbaum (1988) notes that for many women in the Sudan, the concept of femininity is closely tied to virginity and marriageability, and can only be guaranteed through female “circumcision” (in most cases, infibulation). In the absence of alternative means of defining gender and ensuring marriageability the practice of female “circumcision” is not easily challenged, even when the adverse health consequences are known, since it results in social ostracism and economic ruin for

women who abandon the practice (Ellen Gruenbaum, 1988). In communities such as these, socially acceptable forms of medicalization (e.g., anesthesia, cutting by trained medical professionals) have provided a means of reducing the human health costs while culturally sensitive strategies for elimination are gradually developed and implemented. The harm-reducing potential of such measures is supported by Obiora, who argues that “sanitation may not be the ultimate solution, but neither is abolition. The former remains the lesser of two evils, an interim measure targeted at attenuating potentially dire consequences until such a time that adequate groundwork can be laid for eradication” (1997, p. 367).

This approach directly parallels harm-reduction efforts for drug addiction. As Marlatt (1996, p. 786) describes, harm reduction attempts to “take it ‘one step at a time’ to reduce the harmful consequences of their (drug addicts) behavior. Abstinence is included as an ideal endpoint along a continuum ranging from excessively harmful to less harmful consequences.”

For intravenous drug users addicted to heroin, for instance, abstinence is often an outcome that is not immediately attainable. Harm reduction efforts in these cases include substance substitution, most commonly methadone, a synthetic opiate that prevents withdrawal symptoms and decreases the craving for opiates. Since methadone is administered orally in controlled amounts, it reduces the risk of HIV and hepatitis transmission from needle sharing and reduces the risk from unknown composition of street drugs (Tapert, Kilmer, Quigley, Larimer, Roberts & Miller, 1998). Methadone maintenance allows participants to function normally, and is associated with reduced criminality and improved health status (Tapert, Kilmer, Quigley, Larimer, Roberts & Miller, 1998). Moreover, it has been successfully used as a transition strategy between heroin use and abstinence. While abstinence is included as an ideal endpoint, intermediate steps that reduce harm are encouraged as steps in the right direction.

Anti-circumcision activists argue that medicalization is not, in all instances, a ‘step in the right direction’ since it does not necessarily imply a progression toward less severe forms of cutting. Dorkenoo (1994, p. 9) points out that “there is currently no evidence to show that a policy promoting less drastic forms of FGM in hygienic surrounding has led to its eradication”. Moreover, she speculates that when “milder” circumcisions are performed, disgruntled patrons may go elsewhere to be “re-circumcised”, thereby compounding the physical and emotional trauma. While most commentators argue that the lack of anesthesia increases the risk of accidentally cutting excess tissue on a struggling girl (e.g. Dorkenoo, 1994), it has been argued that medicalized genital cutting may actually result in more, rather than less, drastic cutting. Abdullah (1982, p. 21) reports that in Somalia, “the danger that arises from the use of the anaesthetics is

that the patient cannot struggle or protest; surgeons may, therefore, remove too much tissue”. These concerns are well founded, and highlight the fact that medicalization of FGC, as it is currently unfolding across Africa, is not necessarily guided or informed by harm-reduction principles.

Even when harm-reduction principles are clearly articulated, interim solutions are still often viewed as problematic. For example, a common criticism of methadone maintenance as a harm-reduction strategy is that it is merely “replacing one addiction with another, “and is unappealing because participants are not truly ‘drug free’ (Tapert et al., 1998, p. 155). Similarly, opponents of medicalization of FGC charge that “the practice is unacceptable even under sterile conditions (since it) does not prevent many of the serious health consequences” (Huby, 1999, p. 3). Even symbolic “circumcision” fell under attack in 1996 after an Egyptian girl died from the administration of anesthesia (Obiora, 1997). Although intermediate steps do not preclude all health risks, harm reduction as a public health policy supports interim solutions when abstinence is not attainable. Abstinence is the ideal outcome since it is the most harm-reductive solution. Yet any interim solution that reduces the risk of adverse health outcomes would be encouraged as a strategy for minimizing harm. Consequently, harm-reduction strategies may offer pragmatic and compassionate approaches to improving women’s health and welfare.

Dissenting views, however, do exist. Opponents of medicalization of FGC argue that such measures send a message “giving the green light” to legitimizing and perhaps even encouraging a practice that has been deemed intolerable and reprehensible. Sierra Leonan-American anthropologist Fuambai Ahmadu forcefully rejects this claim: “The position that this (medicalization) only legitimizes the practice is dangerously arrogant: the practice is already seen as legitimate by proponents who have themselves undergone excision, and denying them the benefits of medicalization only continues to endanger the health and lives of innocent young girls” (Ahmadu, 2000, p. 309). Moral arguments against other types of harm reduction programs are also based on the belief that they “condone or promote immoral behavior that contributes to societal deterioration” (Peterson, Dimeff, Tapert, Stern & Gorman, 1998, p. 257). Such a criticism as been leveled against needle exchange programs that, in an effort to prevent the spread of HIV, supply intravenous drug users with new, sterile syringes in exchange for their used syringes. Most programs also offer educational materials and other strategies to reduce the risk of HIV infection, and the combined efforts have been estimated to reduce the risk of new HIV infections by 50% (Des Jarlais, Paone, Marmor, Titus, Sotheran & Friedman, 1994, cited in Peterson et al., 1998). Despite their success in HIV

prevention, critics argue that needle exchange programs encourage or increase illicit drug use. Existing evidence, however, does not support this argument. A review of evaluations of needle exchange programs throughout Europe, Australia and the US revealed that these programs do not increase the frequency of drug injection among users, nor do they recruit non-users into intravenous drug injection (Peterson et al., 1998). It has also been suggested that these programs bear other positive outcomes, such as promoting safer sex behaviors, recruitment to drug treatment programs, and enhanced concern about general health (ibid.).

Harm reduction strategies to prevent HIV infection among adolescents have also been opposed on the basis that they may “lure” youths to initiate sexual activity, and have featured prominently in “abstinence versus harm reduction” debates (Peterson et al., 1998). Harm reduction efforts include information or skills training about how to use condoms, education on sexual behaviors that pose HIV or STD risks, and condom distribution (Peterson et al., 1998). Fearing that such programs would promote sexual promiscuity, opponents argue that the only appropriate approaches are abstinence-only sex education programs. The available evidence, however, does not support the contention that school-based programs on risk reduction or condom distribution programs increase the rate of sexual initiation or the frequency of sexual behavior among adolescents (Sellers, McGraw & McKinley, 1994). While empirical evidence for the case of FGC does not exist, this example, as well as others, suggests that harm-reduction strategies do not encourage people to engage in risky behavior.

A related concern is whether medicalization hinders efforts to eliminate the practice of FGC. Opponents of medicalization argue that the incorporation of female genital cutting procedures in the biomedical healthcare system institutionalizes the custom, and counteracts efforts to eliminate the practice of female “circumcision” (Gordon, 1991; Toubia, 1993; Dorkenoo, 1994). Does medicalization, in fact, counteract efforts to eliminate the practice of female circumcision? At present, evidence from two regions provides insight to answer this question. In Nyamira District in western Kenya, the Seventh Day Adventist Church has been leading a campaign to eliminate clitoridectomy, arguing that Christianity refutes this practice (Njeru & PATH, 1996). In the past clitoridectomy was universal in this community, while today 14% of women aged 15 – 30 are not circumcised (Njeru & PATH, 1996; Hamelrath, unpublished data). This decline in the demand for clitoridectomy has occurred simultaneously with an increase in the medicalization of clitoridectomy. While 20 years ago all circumcisions were performed by traditional specialists (*omosari*), the procedure is currently mainly performed by health-

care workers at the “initiate’s” home (Njeru & PATH, 1996).

Similarly, a series of large-scale survey in southwest Nigeria in 1994–1995 found that 6% of girls in urban areas and 2% of girls in rural areas were uncircumcised (Caldwell et al., 1997). A 1997–1998 follow-up survey in one city showed that the incidence of female “circumcision” has continued to decline, with 13% of girls uncircumcised (Oruboloye et al., 2000). This trend was fueled by a campaign of the Ministry of Health instructing government health facilities to provide a case against female “circumcision” to all women receiving prenatal or postpartum care (Oruboloye et al., 2000). At the same time, the level of medicalization has remained extremely high in southwest Nigeria, with over 50% of recent circumcisions performed by a medical professional. Additionally, a major shift from clitoridectomy to symbolic nicking is attributed to the employment of nurses, who seek to minimize the attendant health risks (Oruboloye et al., 2000).

These examples suggest that the incorporation of female “circumcision” in biomedical healthcare services do not necessarily completely counteract efforts to eliminate the practice. But does it slow the rate of change? The answer to this question is unclear. The Nigerian case, however, demonstrates that medical professionals can be important engines of change, reducing the severity of female genital cutting, and minimizing, although not eliminating, the health risks. Both cases also demonstrates that this “interim” solution can be sought at the same time as delivering a message in support of eliminating the practice. Consequently, medicalization may in some cases promote, rather than counteract, efforts to eliminate female genital cutting.

Harm reduction has emerged primarily as a ‘bottom-up’ approach based on addict advocacy, rather than a ‘top-down’ policy

Many harm-reduction projects for drug abuse have originated at the local level, and have often been promoted by the grass-roots advocacy of those receiving and providing services. It has been suggested that the success of harm-reduction programs depends on the involvement of the target community in the development and provision of culturally appropriate services (Cheadle et al., 1997). A noteworthy example is that needle exchange programs for intravenous (IV) drug users were first conceived and implemented in the Netherlands in the 1980’s in response to input from “Junkiebond”, a trade union for concerned hard-drug users (Marlatt, 1996). Since that time, locally developed needle exchange programs have emerged throughout the US, Europe and Australia, spurred by the plight of the HIV epidemic among drug users (Des Jarlais, 1995).

Similarly, the importance of involvement of “insiders” in designing programs to confront female genital cutting has been widely recognized. For example, Ginsburg (1991, p. 18) writes, “Clearly, imposing rules from the top (even when generated by well-intentioned Sudanese and Egyptian feminists) has not been effective.” Obiora (1997, p. 329), as well, notes that “throughout the years in Africa, outside interventions, whether colonial or missionary (and now feminist), tend to pre-judge and alienate the only forces — women, the ‘victims’ and perpetrators — capable of facilitating or subverting meaningful change”. Attempts to eliminate FGC through legislative force have repeatedly been met with opposition, as have attempts to promote “safer” forms of FGC by criminalizing more severe forms. Examples include the 1946 Sudanese law banning all forms of female genital cutting, which was met with resistance at the community level. In 1974 this law was relaxed to allow excision but forbid infibulation. Nonetheless, the practice of infibulation has continued unabated (Gruenbaum, 1988). Similarly, in 1931 in Kenya, the Local Native Councils in Meru and Embu Districts passed a resolution to restrict the severity of excision, and to provide instructions for circumcisors in the newly authorized procedure (Thomas, 1996). Nonetheless, a missionary reported witnessing the illegal and more severe form of excision in 1939 (Thomas, 1996). Anticircumcision advocates use the reactance and opposition to mandated “safer” forms of genital cutting to bolster the case against medicalization. However, as Ginsberg suggests, a pragmatic solution may be to “establish collaborative policies with men and women at the local level, which account for them as whole beings whose health *and* cultural status are deeply intertwined” (1991, p. 18). As noted by Obiora (1997, p. 362), “Dr. H. Najakima, the Director of the World Health Organization, articulated a similar conviction when he remarked that people will change their behavior only when they themselves perceive the availability of meaningful, functional alternatives that are not a threat to essential aspects of their culture.” Consequently, a critical factor in the success of harm-reduction programs is that they are designed, implemented, and often run at least partially by insiders.

An enormous challenge of the harm-reduction approach, however, lies in obtaining support from the general public in promoting improved safety for behaviors that are often widely viewed as reprehensible. As Marlatt (1996, p. 787) points out, “addiction and AIDS are problems that are so plagued with stigma and tainted with moral condemnation that individuals who suffer from these problems are often marginalized from society.” While practitioners of FGC are not typically marginalized in their own society, the tone in international debates, exemplified by rhetoric such as Mary Daly’s essay, “African Genital Mutilation: The Un-

speakable Atrocities” (Daly, 1978), clearly conveys condemnation and intolerance of a behavior deemed reprehensible. Such moral outrage often couches the negative and emotional public reaction to harm reduction proposals. Pragmatic remarks by the former US Surgeon General Joycelyn Elders on the importance of sex education in HIV prevention among adolescents sparked an uproar of public opposition, and ultimately led to her dismissal from office (Peterson et al., 1998). Parallels to the public outcry to a proposal to perform symbolic circumcision in a Seattle hospital are easily drawn. As such, a major hurdle in the implementation of harm reduction as a public health policy lies in generating public support. A challenge that remains is not only in facilitating grass-roots initiatives in outlining and implementing harm-reduction strategies, but in educating the general public on the merits of supporting these initiatives.

Harm reduction promotes low-threshold access to services as an alternative to traditional high-threshold approaches

Rather than setting abstinence as the single high-threshold alternative to high-risk behavior, advocates of harm reduction are willing to consider lower-threshold intermediate solutions, thereby making it easier to “get on board” (Marlatt, 1996, p. 787). Low-threshold programs do this by several means, including developing partnerships and cooperation with the population developing new programs and services, reducing the stigma associated with the behaviors, and incorporating programs into integrative healthcare services (Marlatt, 1996).

Critics have argued that medicalization would overburden a healthcare system that is already struggling to combat more pressing problems such as maternal mortality, diarrheal disease, and malnutrition (Mandara, 2000). It is not, however, clear that nurses and physicians would be the only experts qualified to perform “safer” genital cutting (Obiora, 1997). As discussed above, whether other specialists, in fact, possess necessary skills for performing various types of genital cutting is an empirical question that remains currently unexplored. Concerns about medicalization as “clinicalization” and the replacement of traditional circumcisors by modern health care workers also focuses on the “transfer of the provision of health care for women from a female-dominated and traditional model to a more male-dominated and Western model” (Gunning, 1997, p. 457). Gunning convincingly argues that the “domination of health care by men has, in some instances, had a detrimental effect on the health care needs of women” (Gunning, 1997, p. 457). Clearly, there is ample evidence to document discrimination against women in Western medical care and research. This fact, however, does not so much dissuade arguments for the

medicalization of FGC as it underscores the need to carefully consider how and by whom medical assistance is provided.

A related argument suggests that medicalization of FGC will divert funding from a healthcare system that already suffers from limited resources (e.g. Hosken, 1982, pp. 210–211). This argument assumes that state or public financial support is required to fund medicalized procedures. Yet some African medical professionals are unopposed to medicalization if it does not draw on state funds (Mandara, 2000). Moreover, economic arguments against harm reduction are difficult to support when compared to the cost of treating unaverted harm: the cost of operating a needle exchange program for each HIV conversion averted is approximately US\$9000 — much less than the estimated US\$119,000 average lifetime cost of treating an HIV-infected individual (Peterson et al., 1998). While the disparity between prevention and treatment is unlikely to be equally large for FGC, it seems probable that medicalization may avert unnecessary cost, as well as suffering. Obiora further argues that when compared to legislative actions to criminalize FGC, “it is not obvious that clinicalization entails more expense than prosecution or monitoring” (1997, p. 376). Moreover, with unprecedented amounts of money earmarked for programs to eliminate FGC,⁷ the possibility of obtaining external funding for medicalization as a harm reduction approach certainly exists.

An important aspect of low-threshold approaches for the treatment of high-risk behaviors such as IV drug use is that they are most often integrated with the treatment of commonly associated problems such as unsafe sexual practices, aggression and violence, and psychological problems (Marlatt, 1996; Tapert et al., 1998). The possibility of including medicalized “circumcision” as part of a broader health service delivery program would be consistent with the principles of harm reduction. Concern has been expressed about the consequences of transferring the income derived from FGC from traditional circumcisors to medical professionals. Obiora (1997, p. 373) notes that such a change would deprive traditional circumcisors of an important source of income and suggests “exploring the possibility of training them as extension workers equipped to deal with the delicacies of the procedure”, or exploring new training opportunities. Gunning, by contrast, objects to transferring income to health care workers who “could become professionally invested in the perpetuation of the surgeries” (1997, p. 457). The logical fallacy of this argument has been addressed by Mackie who points out that the availability of services does not drive the

demand: “Functionalism would claim that people have babies because obstetricians are paid to deliver them. . . . People have babies for many obvious reasons, but to keep doctors in business is plainly not one of them” (2000, p. 273). Nonetheless, a valid concern is expressed over the message delivered by health workers, and the possibility that they become “powerful opposition voices to the long-term abolition of the surgeries.” (Mackie, 2000). Dr. Kamil, leader of the Cairo Family Planning association project on FGM, argues that in the process of medicalization, “all the respect and authority given to doctors will be transferred to the practice, and we (activists) lose our credibility” (quoted by Toubia, 1993, p. 16–17). It is possible that the inclusion of medicalized “circumcision” as part of integrative healthcare services could counterbalance the self-interest of specialists in encouraging the practice, and could link a high-demand service to underutilized health services. Clearly, any harm reduction policy, regardless of the title of the cutter, would need to have clearly articulated goal of minimizing harm, with abstinence emphasized as an important option. In this way, those seeking FGC could become empowered to make decisions about safeguarding women’s health based on complete information.

Conclusion

Despite being opposed by international, and often local, policy and condemned by numerous medical associations, the fact remains that female genital cutting is becoming increasingly medicalized across Africa. Rather than staunchly opposing this trend, it is necessary to carefully consider the consequences of various forms of medicalization, and evaluate whether medicalization has the potential to reduce harm and serve as an engine of change. Mackie (1996, 2000) has argued that when societies decide to abandon FGC, they will do so quickly. However, the time required to change beliefs and establish a consensus may take years in some societies. Parallel to the case of drug use, delivering the message of “just say no” — in this case to female “circumcision” — is much more simplistic in principle than application. What must be carefully considered is whether, in the name of a right to health, women are entitled to interim solutions that reduce the harm of genital cutting. When conceptualized as a form of harm reduction, aimed at the eventual elimination of all health risks, medicalization of FGC emerges as a humane, compassionate and practical strategy that is worthy of careful consideration.

Logic would suggest that decreased amounts of cutting and increased medical support reduce the risk of adverse health outcomes. Epidemiological data are, however, required to substantiate this as fact.

⁷ See *Awaken* Volume 2, Issue 1, March 1998 for an overview of organizations that fund projects aimed at reducing or eradicating the practice of female circumcision.

Harm-reduction strategies ought to be based on epidemiological data about the incidence of negative consequences, allowing the evaluation of the effectiveness of interim strategies (Duncan, Nicholson, Clifford, Hawkins & Petosa, 1994). Unfortunately, for many behaviors amenable to harm-reduction principles, inadequate epidemiological data is available. FGC is, in this respect, no different. Yet the medicalization of FGC differs from other harm-reduction efforts in several important ways. Unlike IV drug use and high-risk sexual behavior, FGC is not, in most instances a repeat behavior, subject to modification (the notable exception being reinfibulation). In most cases, once it is done, it is done. There are not, consequently, repeat opportunities to improve the safety of the procedure. It is also not an addictive behavior conducted by individuals marginalized from mainstream society. Moreover, the decision to be cut or not most often is not solely in the hands of the individual. Instead, it is often a collective decision of numerous members of the family or society. Therefore, harm-reduction efforts need to solicit community support, not simply that of the individual. Successful implementation of harm-reduction policies requires the support of outsiders as well, since international opposition has the potential to block well-intended proposals to minimize the health risks of FGC.

The application of harm-reduction principles to the medicalization of FGC appears to be a promising avenue for improving women's health. There is, however, much left to learn before this approach can be embraced as a public health policy that is in the best interest of women's health. Efforts to eliminate FGC have so far shown modest but nevertheless limited successes. A harm-reduction approach offers creative and practical strategies when one considers that, despite strong condemnation by outsiders, the practice persists, and, for better or worse, continues to become increasingly medicalized. However, given the limitations in current knowledge, several important questions about harm reduction and the medicalization of FGC remain unanswered. First, are communities in which FGC is practiced less likely to abandon the practice if harm reduction policies are implemented? The elimination of any form of cutting is clearly the most harm-reductive outcome of all. Would the existence and support of medicalization slow the process of changing attitudes of supporters of FGC, or might it act as an engine of change? Secondly, would implementing medicalization as harm reduction encourage others to adopt the practice? And finally, would pursuing a policy of harm reduction overburden healthcare systems and spread resources for research, education and intervention too thinly? While insights can be gained by drawing comparisons to other harm-reduction strategies, definitive answers cannot be claimed. These questions are, however, empirical, and answerable through carefully

planned social scientific and public health research. Moreover, with such questions remaining, we do not, at this juncture, have the grounds to advocate staunch opposition to medicalization of FGC. Indeed harm reduction through medicalization may represent an important avenue for reducing risk and promoting health among those who currently view abandonment as an unacceptable option. If improvement in women's health is truly targeted as a priority, the harm reducing potential of medicalization of FGC warrants careful investigation.

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