Section 1: Female Genital Mutilation

This section provides a comprehensive overview of FGM

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Female Genital Mutilation

Chapter 1: FGM

This chapter provides an overview of FGM and a summary of the human rights and legal context of FGM in Australia and internationally.

Definition

The World Health Organisation (WHO) defines Female Genital Mutilation (FGM) as a practice that encompasses 'all procedures that involve partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons'.

Terminology

FGM is also known as 'female circumcision' or 'female genital cutting'. However, it is thought that the term 'female circumcision' can falsely imply that the practice is comparable to male circumcision. The term 'female genital mutilation' was formally adopted by the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children in 1990 and its use was recommended by the WHO in 1991. The term FGM is used to emphasise that the practice is both harmful and a violation of the rights of women and girls (WHO 2008).

The term 'Female Genital Mutilation' can be potentially offensive for target communities who may not necessarily see the practice as a form of 'mutilation'. Health professionals may use other terms such as 'cutting' or 'circumcision' when working with affected communities. Although WHW use the WHO endorsed term in our publications, we encourage the use of other terms as a culturally sensitive approach when working directly with affected communities.

The term FGM will be used throughout this manual.

Prevalence and incidence

FGM is practiced worldwide, but it is most prevalent in Africa. It is estimated that three million girls in Africa are at risk of FGM every year. FGM is prevalent in western, eastern and north-eastern regions of Africa as well as in some countries in Asia and the Middle East. FGM is also practiced among some migrant communities in Europe and North America.

Background and history

FGM predates Islam and Christianity and is practiced by Muslims and Christians. FGM is not practiced exclusively by any group. Therefore, factors such as country of birth, religion and dress style are not reliable indicators of FGM.

Missionaries and administrations in Burkina Faso, Kenya and Sudan first documented FGM in the 1900s. Laws and church rules were introduced to stop the practice. However, native communities resisted the laws because they regarded them as 'foreign interventions' (Rahman & Toubia 2000).

In the 1940s and 50s, the Sudanese and Egyptian governments introduced laws to ban FGM. However, these laws may have been more effective had they been preceded by education campaigns against FGM.

HUMAN RIGHTS AND LEGAL STATUS OF FGM

Human rights framework

The WHO recognises FGM as a violation of the rights of women and girls (WHO 2008). It violates international treaties that protect the rights of women and girls, including:

- Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
- Covenant on Civil and Political Rights
- Covenant on Economic, Social and Cultural Rights
- Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW)
- Convention on the Rights of the Child
- Convention Relating to the Status of Refugees and its Protocol Relating to the Status of Refugees

(WHO 2008, p.8)

Human rights status of FGM in Australia

Australia is committed to working towards the elimination of FGM in accordance with its role as party to the United Nations Convention on the Rights of the Child and the Universal Declaration of Human Rights (1948). Australia is also party to the following international treaties:

- Women's Convention (ratified in 1983)
- Children's Rights Convention (ratified in 1990)
- Civil and Political Rights Covenant (ratified in 1980)
- Economic, Social and Cultural Rights Covenant (ratified in 1975)
- Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW)

In addition, the *Victorian Charter of Human Rights and Responsibilities Act 2006 (s.17)* states that 'Every child has the right, without discrimination, to such protection as is in his or her best interests and is needed by him or her by reason of being a child.'

Legal status of FGM in Victoria

FGM is illegal in Australia and every state and territory has its own legislation. Below is a summary of the Victorian legislation regarding FGM.

Table 1 Victorian Legislation – FGM

Act	Summary of Act
Crimes (Female Genital Mutilation) Act 1996	• 'It is illegal to perform FGM procedures on a child or adult'
	• 'It is illegal to take a person (child) from Victoria to have FGM procedures performed'
Children, Youth and Families Act 2005	• 's162 (c) The child has suffered, or is likely to suffer, significant harm as a result of physical injury and the child's parents have not protected, or are unlikely to protect, the child from harm of that type'
	• 's162 (e) The child has suffered, or is likely to suffer emotional or psychological harm of such a kind that the child's emotional or intellectual development is, or is likely to be, significantly damaged and the child's parents have not protected, or are unlikely to protect, the child from harm of that type'
	• s184 Professionals such as education staff, police, medical and nursing staff are mandated to report FGM to the Secretary (Department of Human Services) if they form a 'belief on reasonable grounds that a child is in need of protection'

(Adapted from RWH 2008)

FGM in Australia

Australia is home to diverse communities from regions where FGM is practiced. Although there is little evidence to determine whether FGM is being practiced in Australia, it is documented that a number of medical officers received requests to perform FGM (Ryan 1994; cited in Ogunsiji et al. 2007).

While it is important to be aware that FGM can occur in Australia despite the current legislation, it is equally important not to assume that individuals or groups are likely to practice FGM.

Community attitudes towards FGM vary considerably, even within a given community. Such beliefs and attitudes can also change with time. Therefore service providers need to facilitate change by adopting a culturally appropriate and inclusive educational approach when working with target communities.

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Female Genital Mutilation

Chapter 2: Understanding FGM

This chapter provides and overview of the different types of FGM, their implications for women's health and wellbeing and a summary of cited reasons for FGM.

Types of FGM

The World Health Organisation (WHO) first introduced a classification system for FGM in 1995 to aid gynaecological examinations and ensure the comparability of data collected around the prevalence, trends and types of FGM. However, this classification did not reflect the variations that occurred in practice.

In 2008, following consultations with technical experts, the WHO introduced a modified classification system. This modification comprised a change in the typology of each type of FGM with the introduction of new subcategories. Table 1 depicts a comparison between the 1995 system and the modified classification system.

Table 1:
Comparison between the WHO 1995 typology and the 2007 modified typology of FGM (adapted from WHO 2008 p. 24; Braddy and Files 2007, p. 159).

FGM Type	WHO typology 1995	WHO modified typology 2007	Diagram of affected areas
TYPE I	Excision of the prepuce, with or without excision of part or the entire clitoris.	Partial or total removal of the clitoris and/or prepuce only (clitoridectomy). **Type Ia:** removal of the clitoral hood or the prepuce only. **Type Ib:** removal of the clitoris with the prepuce.	 Type I
TYPE II	Excision of the clitoris with partial or total excision of the labia minora.	Partial or total removal of the clitoris and labia minora, with or without excision of the labia majora (excision). **Type IIa:** removal of the labia minora only. **Type IIb:** partial or total removal of the clitoris and the labia minora. **Type IIc:** partial or total removal of the clitoris, the labia minora and the labia majora.	 Type II
TYPE III	Excision of part or all of the external genitalia and stitching/ narrowing of the vaginal opening (infibulation).	Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation). **Type IIIa:** removal and apposition of the labia minora. **Type IIIb:** removal and apposition of the labia majora.	 Type III
TYPE IV	**Unclassified. Includes:** • Pricking, piercing or incising the clitoris and/or labia. • Stretching of the clitoris and/ or labia. • Cauterization by burning of the clitoris and surrounding tissue. • Scraping of tissue surrounding the vaginal orifice (angurya cuts). • Cutting of the vagina (gishiri cuts). • Introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purpose of tightening or narrowing it. • Any other procedure that falls under the broad definition of female genital mutilation.	Unclassified. Includes all other harmful procedures to the female genitalia for non-medical purposes, for example, pricking, piercing, incising, scraping and cauterization.	

Infibulation, defibulation and refibulation

In communities where type III FGM is practised, girls undergo infibulation, where the vaginal orifice is narrowed by cutting and appositioning (or stitching) of the labia minoras or majoras with or without excision of the clitoris.

Years later, when the woman becomes pregnant and approaches labour, the circumcision is undone by the traditional birth attendant (defibulation). Once the woman gives birth and recovers from labour, the circumcision is then restored (refibulation). This process is repeated with each pregnancy and has long lasting effects on the woman's health.

Refibulation is recognised as a form of FGM, therefore it unlikely that requests for refibulation will be granted

Rationale for FGM

A number of reasons are cited for the practice of FGM including religious observance, increasing fertility and preventing promiscuity.

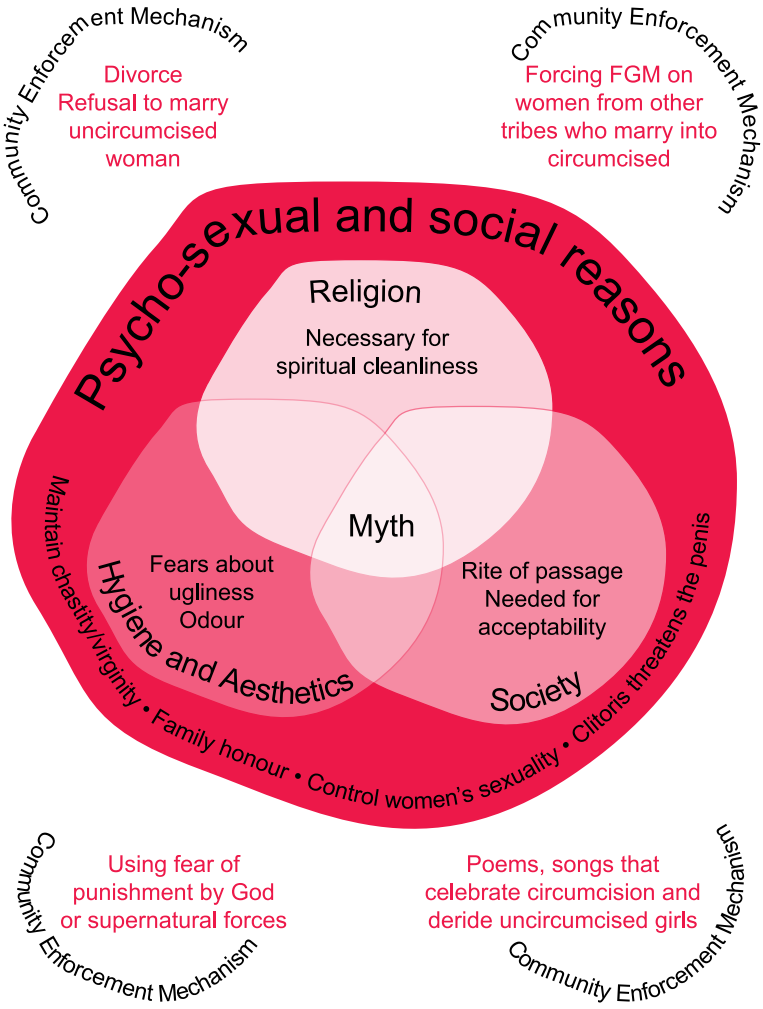

Figure 1: Factors contributing to the continuity of FGM (WHO 1999, p. 7).

FGM is deeply embedded in the culture of many FGM practicing communities. It is often considered part of a woman's identity and a symbol of her membership within the community. In some cultures, FGM is performed as part of a girl's 'coming of age' celebration and to indicate her readiness for adulthood and marriage.

Parents (especially mothers) may believe that it is their duty to ensure that FGM has been performed on their daughters. Girls who undergo FGM are believed to be more accepted in their community and are deemed suitable for marriage. This is particularly important in societies where women are highly dependent on men for income and support as men may refuse to marry a woman who has not undergone FGM.

Women are often compelled to uphold the practice of FGM because of pressure from extended family, peers and community members. Families that discontinue the practice may be excluded from their community and social networks.

Some migrant communities in Australia might want to continue to practice FGM as a way of preserving their own culture, especially if they fear losing their cultural identity. However, the rationale for continuing the practice of FGM can be challenged upon migration and settlement in Australia. Examples of this include the legal status of FGM in Australia, the diminished influence of practicing communities following migration and increased opportunities for education and employment.

FGM and women's health

Implications for women's health

There are no known health benefits associated with FGM according to the World Health Organisation. The practice can have lasting short and long-term complications. Health complications can vary between women and can occur at any time in life. Depending on the type of FGM, some women may not suffer from, or be aware of, any complications.

FGM has a range of implications for women's health and wellbeing. These will vary according to the type of FGM performed, the conditions under which it was performed and the skill of the person performing FGM. Table 2 depicts a number of implications for women's health and wellbeing associated with each type of FGM.

Table 2: Implications of the different types of FGM (adapted from WHO 2008; RHW 2008)

	Type I	Type II	Type III	Type IV
Menstruation	✕	✕	Slow menstrual flow and accumulation of menstrual blood	✕
Hygiene	✕	✕	Reduced menstrual and urinary flow leading to increased risk of infections	✕
Physical examinations	✕	✕	Difficulty with physical examinations	✕
Pap tests	✕	✕	Pain and discomfort during pap tests	✕
During sex	Reduced sexual response	Reduced sexual response	• Difficulty with sex (forced penetration/ defibulation) • Reduced sexual response	✕
Pregnancy	✕	✕	• Difficulty with regular examinations • Accumulation of mucosal secretions that normally increase during pregnancy	✕
Birth: woman	✕	✕	• Prolonged labour • Defibulation may be needed to allow childbirth • Increased risk of obstetric fistula	✕
Birth: newborn	✕	✕	Risk of foetal distress	✕
Psychological	Psychological trauma due to pain, shock and use of physical force. Potential for psychological distress due to health professionals' refusal to refibulate women with type III FGM following childbirth.			
Social/cultural	Women may be excluded from their community if they do not have FGM, which can have negative implications for their social and economic status			

✕ = *no documented implications*

FGM is known to cause long-term complications for women. Women can suffer from chronic pain (including back and pelvic pain) and excessive scarring at the site of the cutting. Women and girls can also experience severe pain, psychological trauma, shock and/or excessive bleeding. They can be at risk of acquiring infections and/or HIV/AIDS because of the use of non-sterile/contaminated instruments. Infections, shock and excessive bleeding can cause death.

FGM can also affect the psychological wellbeing of women. Examples include anxiety, depression, fear of sexual intercourse and reduced sexual enjoyment.

Women with type III FGM can suffer from reduced flow of urine and menstrual blood. Women might have difficulty in urinating and might experience painful periods. As a result, they might be at risk of recurrent urinary and reproductive tract infections.

Women with type III FGM also risk complications during childbirth in Africa. The narrowing of the vaginal opening that is caused by type III FGM can obstruct and prolong labour, thereby increasing the risk of infant death. Labour obstruction can also increase the woman's risk of haemorrhage, tearing and obstetric fistula. Obstetric fistula is an opening that occurs between the vagina and the bladder and/or rectum and causes continual and uncontrollable leakage of urine and/or faeces. Women with obstetric fistula are often excluded from the community because of the stigma attached to their condition.

In Australia, women with type III FGM may choose to undergo defibulation during pregnancy or birth. Defibulation is a procedure whereby 'the scar associated with FGM' type III is opened (Jenkins & Nanayakkara 2008). Women may choose to undergo either a complete or partial defibulation. However, women who opt for partial defibulation may need an anterior episiotomy upon delivery.

Women who have undergone defibulation for childbirth might wish to be refibulated. Refibulation is a procedure where type III FGM is restored by narrowing the vaginal orifice. Refibulation is common in communities where type III FGM is practiced; however it is generally considered illegal in Australia.

Defibulated women might be concerned that they cannot be refibulated in Australia. They might be anxious about how this will affect their physical health and may need counselling by health professionals.

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Female Genital Mutilation

Chapter 3: FGM in Africa

This chapter focuses on FGM in Africa and provides an overview of the status of health care and women's health across Africa.

Prevalence of FGM in Africa

FGM is practiced worldwide, but it is most prevalent in Africa. Figure 1 illustrates the prevalence of the practice across Africa. The estimated prevalence of FGM in Somalia and Djibouti is 97.9% and 93.1% respectively neither of which are shown in figure 2 (WHO 2008). In Sudan, FGM is more prevalent in the northern region of the country.

As seen on the map, FGM is most prevalent in the Horn of Africa region (Djibouti, Eritrea, Ethiopia and Somalia) and some parts in West Africa (including Mali and Guinea).

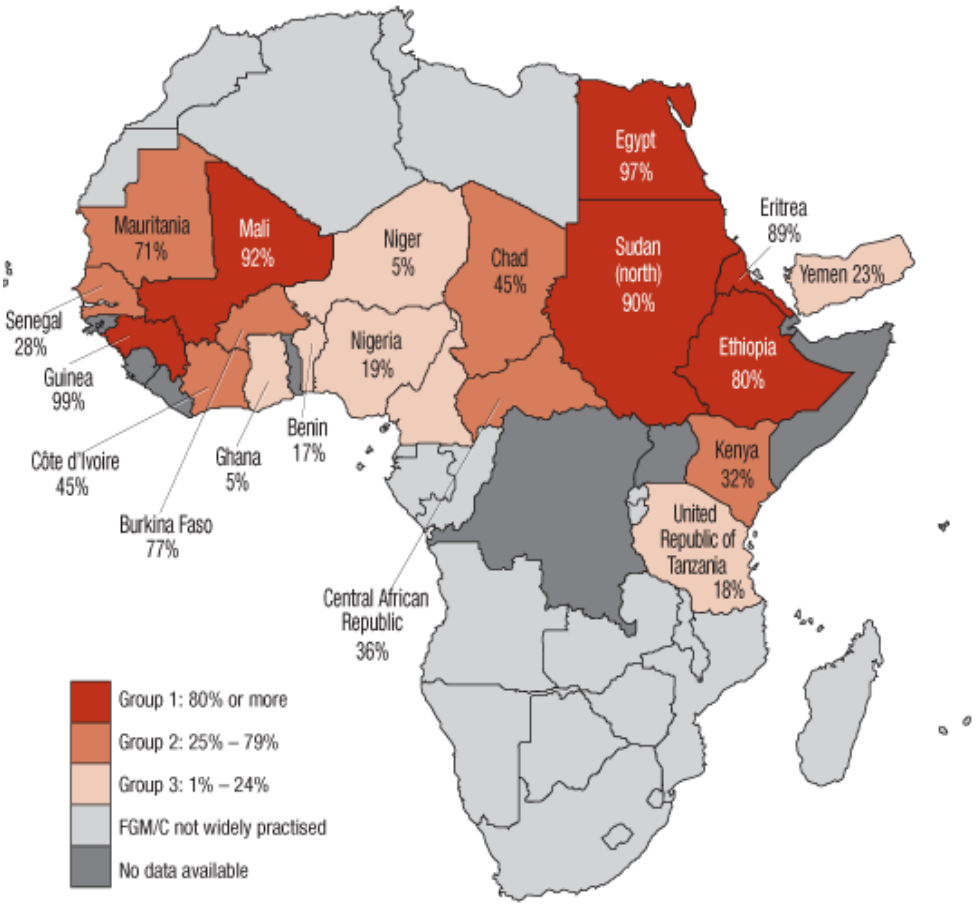

Figure 2: FGM prevalence in Africa (UNICEF 2005)

Overview of FGM

FGM is mostly performed by a traditional midwife or circumciser, often using non-sterile instruments (such as razors) without anaesthesia. FGM is performed on girls who are a few days old or between 4-14 years of age. It is also performed on women prior to marriage, during pregnancy or after giving birth.

In some countries, FGM is performed by health professionals (doctors or nurses) at hospitals and clinics.

Legal status of FGM in Africa

FGM is illegal in a small number of African countries, including Burkina Faso, Djibouti, Cote d'Ivoire, Ghana, Senegal and Togo. However, wars, political unrest and poverty have impacted on the effectiveness of the legislation in some countries.

Other approaches to addressing FGM in Africa

The medicalisation of FGM was adopted by some governments, non government organisations (NGOs) and health professionals as a 'harm-reduction' strategy to reduce immediate health risks associated with FGM (WHO 2008). However, the WHO considers this strategy to be a violation of women's and girls' right to life, physical integrity and health. The WHO also state that health professionals who perform FGM are violating the medical ethic of 'Do no harm'.

HEALTH AND HEALTH CARE SYSTEMS IN AFRICA

Africa

War, political unrest, droughts and poverty continue to affect various regions in Africa. The Horn of Africa region (Djibouti, Eritrea, Ethiopia and Somalia), in particular, is currently facing a crisis caused by droughts and armed conflicts.

Health status of Africa

Africa is home to 14 percent of the world population, 25 percent of global disease but only around 1 percent of global health workers. Africa also has the highest maternal mortality ratio in the world, at 1000 deaths per 100,000 live births. Causes of maternal death are attributed to severe bleeding, sepsis, pregnancy-induced hypertension, unsafe abortion, obstructed labour and ectopic pregnancy. Indirect causes include malaria, anaemia and HIV/AIDS.

Worldwide, women account for 50 percent of HIV infections, which has severe implications for pregnant and breastfeeding women who are at risk of transmitting the infection to their children.

Health care systems

Health care systems in many African regions are highly under-resourced and under-funded. Governments often fail to prioritise health care and the health system is weakened by shortages in the number of health professionals and inadequate planning and funding.

Access to health care

People mostly rely on traditional medicine in areas where health care is expensive or not available. It is reported that about 80 percent of Africans use traditional medicine in their lifetime (Samba 2003). Traditional medicine is cheaper and more readily available than western medicine. It also constitutes part of the local culture in many African communities.

Practitioners of traditional medicine have a large client base and are well respected in the community for their important services. This includes traditional birth attendants, who are heavily relied upon for their skill in areas where health services are almost non-existent. They also provide cultural and holistic support for women in labour.

'Village birth attendants are experienced and know what to do even if they are untrained. They help with the birth and can come to check on your baby and its navel.'

(Sudanese focus group)

Women's health

Preventative health is largely unfamiliar in Africa. As a result, procedures such as pap tests and breast screening are not be available in many countries. The concept of health is often only understood as physical health and health services are not accessed unless a physical illness is experienced.

'We don't have this in Africa. If you have symptoms like headache you go to the doctor to find out the cause. You only find out you are sick by accident. Sometimes the doctor won't find out what you had until you are dead. Then he'd say "Ah. He had cancer." We don't have those modern checking techniques.'
(Sudanese focus group)

Sexual and reproductive health is rarely conceptualised as a health issue and women might not regard it as part of their general health. In addition, sexual health is often regarded as a private matter that is not discussed with others.

Within Australia, African women can find it difficult to prioritise their own health and wellbeing because of settlement issues and competing priorities related to their role as carers. As a result, women do not always access health services in a timely manner.

Pregnancy and birth

Many African cultures are communal and women often form strong networks with female friends, relatives and community members. These social networks provide an important form of support for women, particularly during pregnancy and childbirth, where the role of men is often limited.

A range of factors including education, ethnicity, religion and cultural beliefs influence African women's understanding and beliefs around pregnancy and birth. Pregnancy and birth tend to be viewed by African women as a natural and integral part of life. This is apparent in the traditional practices associated with pregnancy and childbirth. Female friends and relatives look after a pregnant woman by providing her with herbal remedies, nutritious food and traditional self-pampering practices. Childbirth is also considered a natural process and pain is often handled without medical intervention or anaesthetic.

'In the villages there is no care, maybe care is provided a month away from delivery. A midwife is not contacted until near delivery time to help with the birth. Other ladies also help with the birth. Sometimes you give birth alone; you receive your baby while waiting for the birth attendant to come. A man can help with the birth but only if you are alone and need help and he was available. Just by coincidence.'

(Sudanese focus group)

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