

Female Genital Mutilation 2017

Introduction

Female Genital Mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other deliberate injury to the female genital organs for non-medical reasons, most commonly carried out between infancy and age 15¹.

The AMA uses the term “female genital mutilation” or “FGM” to reflect the severity of the practice. Women who have undergone FGM may not identify with the term “mutilation”. Medical practitioners who provide care to these patients are encouraged to adopt language that the individual patient is comfortable with. Terms such as “cutting” or “khatna”, when used in a one-on-one setting, can assist physicians to engage in meaningful and sensitive discussions with their patients.

The AMA Position:

1. The AMA condemns the practice of any form of female genital mutilation.
2. Female genital mutilation is a direct violation of the human rights of any person who is subjected to it, including; the Right to Equality, Freedom from Discrimination, Right to Life and Personal Security, and, Freedom from Torture and Degrading Treatment.²
3. FGM legislation exists in every Australian jurisdiction. These laws should be continuously monitored to assess effectiveness in preventing FGM.
4. Any medical practitioner who engages in the practice of any form of female genital mutilation is guilty of professional and criminal misconduct.
5. The AMA recognises the need for increased training and education for doctors in identifying and treating women and girls who have undergone FGM, and recommends the inclusion of FGM training in tertiary medical curricula.
6. Programs intended to eliminate the practice of female genital mutilation should be based on engagement with those cultural or ethnic groups who practise it, as well as the education of health professionals and the general community.
7. It is a criminal offence to remove a child from Australia, or to assist, whether overtly or tacitly, in such a removal for the purpose of submitting her to any form of female genital mutilation overseas. It is important that the process through which these laws are enforced must be sensitive to the needs of the child affected.
8. All possible medical care and support should be offered to victims of female genital mutilation and their families, whilst respecting the privacy and autonomy of individual patients.
9. International medical bodies, legislators, judiciary and police should co-operate in eradicating the practice of female genital mutilation world-wide.
10. Legislators should work together with medical practitioners to clarify the legal status of female genital cosmetic procedures within the context of the Australian FGM legislative framework.

Background

FGM is a harmful, internationally condemned practice that violates human rights and numerous international laws and resolutions^{3 4}, including the UN resolution *Intensifying global efforts for the elimination of female genital mutilations*, which was co-sponsored by Australia. Achieving total abandonment of the practice by 2030 is a priority within the Sustainable Development Goals⁵, which Australia is committed to achieving.

FGM is practised to varying extents in approximately 30 countries throughout Africa, Asia and the Middle East. However, changing migration patterns have seen FGM emerge in diaspora communities in countries with no previous history of the practice. Although precise methods vary across different communities, FGM most commonly occurs in unsterile environments and in the absence of registered medical practitioners.

FGM is classified into four types: clitoridectomy, excision, infibulation, and all other harmful procedures to the female genitalia for non-medical purposes, such as pricking, piercing, incising, scraping, and cauterization.⁶

There is no medical justification for FGM. The practice can have devastating and, in extreme cases, fatal consequences. Survivors of the procedure are often left with lifelong medical complications, in addition to lasting psychological trauma⁷.

Many proponents of FGM cite religious custom as justification for its continuation. However, there is no mention of the practice in any major religious doctrine¹. The primary purpose of FGM is to control female sexuality, specifically, ensuring premarital virginity and sexual fidelity.

Prevention

Prevention must be the primary goal for addressing FGM, as the potential for repairing the physical and psychological damage done once the procedure has occurred is limited.

In recognition of the limited evidence base for FGM prevention efforts in diaspora communities, the *National Education Toolkit for FGM/C Awareness (NETFA) Best Practice Guide* was developed in 2014 to provide a nationally accepted benchmark for culturally appropriate FGM prevention programs⁸. The key to effective prevention is community-based education, centred on an understanding of the values and beliefs that underpin the practice. Models that have proven to be effective are generally facilitated by peer educators, and focus on educating the whole community, including men, about the dangers of FGM⁶.

Dedicated FGM education programs exist in all Australian states and the ACT, to provide culturally sensitive, targeted education, and prevention programs for communities affected by FGM⁹.

Medical practitioners have a valuable role to play in the prevention of FGM. Physicians who identify an at-risk child have a responsibility to initiate a non-judgmental, culturally sensitive discussion with the parents to ensure that they are adequately informed about the devastating consequences of the practice. Where possible, this discussion can be followed up with a referral to a specialist FGM education program. If a medical practitioner feels that a child remains at risk, he or she is bound by mandatory reporting requirements to inform the appropriate child protection authorities.

Identifiable risk factors for FGM include: girls or children born to a mother who has undergone the procedure, children whose familial country of origin is an FGM practicing country, and children being taken out of the country, or returning to their country of origin¹⁰. Whilst the identification of at-risk children presents a valuable opportunity to engage in targeted prevention efforts, it is important that these discussions are based on observed individual circumstances and not generalised cultural assumptions.

Whilst legislative prohibition is essential, this alone is not enough to effectively prevent the practice from occurring.

Health Implications

Women who have undergone FGM are likely to need significant specialised medical care in the immediate aftermath of the procedure, and in the long-term, particularly throughout the antenatal period, and during labour, birth and the immediate postnatal period.

Immediate risks of FGM include: infection, severe pain, haemorrhage, shock, urinary complications, and death¹¹. For many women who have undergone FGM, the consequences of the procedure may have lifelong implications. Long-term complications of FGM that are likely to require ongoing medical care include: formation of scar tissue, sexual dysfunction, and chronic genital, reproductive and

urinary difficulties¹². As women who have been subjected to FGM may also be left with lasting psychological trauma, it is important that their psychological needs are addressed alongside their physical needs.

With permission of the patient, it may be beneficial for the partner or family of a woman who has undergone FGM to be counselled about any ongoing physical and psychological health complications she may be experiencing. Without undermining the autonomy of the woman or violating her privacy, informing the family may equip them to offer a greater level of support and understanding.

There are significant cultural and practical barriers that may limit an FGM survivor's propensity to seek medical help for FGM complications¹³. Where possible, measures such as adopting culturally appropriate terminology, and the provision of qualified language services may be necessary to improve access. Some survivors of FGM may have a preference for a female physician. While it may not always be possible for these requests to be accommodated, patients should be confident that they will receive appropriate care and due sensitivity from any Australian medical practitioner.

It is important for medical practitioners to be aware of the clinical indications that FGM may have occurred, in order to correctly identify women who may require specialist care throughout gynaecological procedures. Clinical indications that a woman may have undergone FGM can include frequent urinary infections, chronic genital pain and anxiety during or reluctance to undergo routine examinations. Medical practitioners should be particularly mindful of these indications when caring for patients from countries where FGM is commonly practiced. Women who have undergone FGM may need to undergo reconstructive surgery in order to regain urinary, menstrual, sexual, or birthing functionality, although complete restoration of function is not guaranteed. Pregnancy can present unique challenges for FGM survivors, and it is vital that they are identified early in the pregnancy to allow for appropriate planning and consultative decision-making to occur with the patient and treating practitioners.

FGM in Australia

FGM is prohibited in all Australian jurisdictions, as is transferring a person overseas to undergo the procedure or performing FGM on an Australian citizen overseas. FGM legislation has existed in Australia since the 1990s, though it remains relatively underutilised.

Collecting comprehensive data on the prevalence of FGM in Australia is particularly problematic as it is a practice that is shrouded in secrecy. However, there is evidence that FGM is occurring. Surveys conducted by the Australian Paediatric Surveillance Unit (APSU) have revealed that up to 10 percent of Australian paediatricians have treated patients who have undergone FGM^{14 15}. In 2010, the Royal Women's Hospital in Melbourne reported that it was treating between 600 and 700 women for FGM - associated complications each year¹⁶. These indicators are likely to be an under-representation of the true prevalence of FGM in Australia, as they only account for women and girls who have sought medical care for their ongoing difficulties.

Implications for Doctors and Health Practitioners

For migrants and refugees who live outside of major cities, where referral may not be possible, it is important that all Australian medical practitioners receive training in the identification and appropriate management of FGM complications as part of the tertiary medical curriculum and ongoing professional development.

There has been an emerging global trend towards medical practitioners carrying out the procedure, under the erroneous belief that this constitutes a form of harm minimisation¹⁷, which is not the case. The harm caused by FGM does not arise out of unforeseen complications. On the contrary, it is in essence the purpose of the procedure. It is both illegal and unethical for medical practitioners to perform the procedure, and any medical practitioner who is found to have participated in an FGM procedure should be reported to the police and the Medical Board of Australia to face criminal and professional disciplinary action.

The current Australian FGM legislation does not delineate between FGM and certain forms of female genital cosmetic surgery or female genital piercing, which may undermine the utility of the legislation. In 2013, the Attorney General's Department recommended that the Commonwealth and State Governments work together with relevant community stakeholders to better clarify and define the

legal position of female genital cosmetic procedures¹⁸. Demand for female genital cosmetic procedures has increased significantly since the implementation of the FGM legislation¹⁹. In the event that this trend continues, the need to distinguish between the two types of procedures is likely to become increasingly urgent.

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