

Female genital mutilation: Australian law, policy and practical challenges for doctors

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In May 2010, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) was reported to be considering the sanctioning of medically performed “ritual nicks” to satisfy the desire of some cultures for genital mutilation of young girls, while protecting them from more severe forms of the practice.¹ Although the RANZCOG immediately issued a press release stating it did not support this approach,² these events, which were similar to a recent debate in the United States,^{3,4} provide a timely opportunity to explore issues concerning female genital mutilation (FGM) in Australia.

Exploring the medicolegal context of this practice is topical because of the increasing numbers of people arriving and settling in Australia from African nations in which FGM is customary.^{5,6} As long ago as 1994, the Family Law Council accepted it was likely that FGM was being conducted in Australia.⁷ In 2010, doctors and hospitals reported that it is being conducted and that they are seeing female patients who have experienced FGM; the Melbourne Royal Women’s Hospital alone has reported seeing between 600 and 700 affected women annually.⁸ As FGM is illegal and conducted in private in Australia, it is impossible to obtain precise data about the extent to which it is performed.^{7,8} However, the data cited here indicate that FGM is a relevant issue for Australian medical practitioners. The medical profession has an interest in this topic because its members may be asked to conduct FGM, advise those considering it, or treat female patients with effects from the practice.

Here, I give some background on the practice of FGM, explain the relevant Australian law, consider whether the current legal prohibition on FGM is justified, and discuss the practical challenges facing individual practitioners and the profession. To inform further discussions about methods of responding to demand for FGM, reference is made to strategies being promoted in African nations to abolish this cultural practice.

The practice of female genital mutilation

FGM involves the intentional, non-therapeutic physical modification of female genitalia. It is a cultural practice that has been experienced by 100–140 million girls and women currently living, and, although concentrated in Africa and some Asian nations,⁹ has been reported worldwide.¹⁰ About three million girls in Africa are at risk every year of suffering FGM.⁹ Eleven African nations have rates of FGM in girls and women aged 15–49 years of 70%–98%: in descending order, these are Somalia, Egypt, Guinea, Sierra Leone, Djibouti, Sudan, Eritrea, Gambia, Ethiopia, Burkina Faso and Mauritania.⁹

There are considered to be four different forms of FGM, which may be administered separately or in combination: clitoridectomy (partial or total removal of the clitoris); excision (partial or total removal of the clitoris and the labia minora, and sometimes also the labia majora); infibulation (narrowing or closing of the vaginal opening); and all other harmful non-therapeutic procedures (including pricking, and nicking or incising).^{9,10} Infibulation is estimated to affect 10% of those who have experienced FGM and is especially likely to occur in Djibouti, Eritrea, Ethiopia, Somalia

ABSTRACT

- The issue of whether medical practitioners should perform “ritual nicks” as a method of meeting demand for female genital mutilation (FGM) has recently been debated in the United States and Australia.
- Due to increasing numbers of people arriving and settling in Australia from African nations in which FGM is customary, demand for FGM in Australia is present and may be increasing.
- Australian law clearly prohibits performance of any type of FGM.
- FGM is also prohibited by the most recent policy of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG).
- For legal, medical and social reasons, the RANZCOG policy is sound, and medical practitioners should not administer FGM in any form.
- Development of an evidence base regarding incidence of and attitudes towards FGM, and the need for post-FGM treatment, would help inform sound policy and practical responses.
- Strategies adopted in African nations to abolish FGM may assist in refining educational and supportive efforts.

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and Sudan, with clitoridectomy and excision more typical in the other African nations.¹¹

Analysis of immigration data shows that in the decade from 1999–2000 to 2008–09, Australia received 38 299 people as settlers from four of these 11 African nations, with 24 082 being from Sudan, and the remainder from Egypt (6258), Ethiopia (5223) and Somalia (2736).⁶ There has been a particularly high rate of increase in settlement of people from Sudan; over this decade, this group experienced the second highest rate of proportionate increase in Australia’s population.⁵ Accordingly, it is plausible that demand for FGM in Australia may be increasing.

Australian law about female genital mutilation

The RANZCOG prohibition on FGM is demonstrably justifiable from a legal perspective. Reversing the prohibition would contravene existing law and would either require legal reform or would expose medical practitioners to legal liability. Several well settled legal principles govern the medicolegal context.

First, it is generally not lawful to administer medical treatment to a child without the child’s consent, or the consent of a person or court empowered to consent on the child’s behalf. Such treatment would constitute criminal assault and civil trespass.¹² This principle promotes the general legal right to bodily inviolability, long recognised by superior courts.¹²

Second, for infants and young children, parents generally have the power to give consent on the child's behalf. Parents have a duty to maintain and protect the child, and from this is derived a right to consent to the child's medical treatment.¹² This power can only be exercised in the child's best interests,¹² and the Supreme Court may overturn a parental decision to consent to treatment if it deems the decision is not in the child's best interests.^{12,13}

Third, unless legislation provides an age at which the child is empowered to provide her or his own consent (as is the case in South Australia, where the age is 16 years),¹³ the parent's right to consent to the child's treatment exists only until the child possesses "sufficient understanding and intelligence to enable him or her to understand fully what is proposed" regarding the specific treatment.¹²

These principles are settled common law (that is, law emanating from court decisions) and will determine the legal position in the absence of legislation. However, what is notable in the context of FGM is that parliaments in every Australian jurisdiction have perceived it as warranting legislative regulation.¹⁴⁻²¹ This legislation takes precedence over common law. The legislation prohibits a person from performing any type of FGM, defined as including clitoridectomy, excision of any other part of the genitalia, infibulation, and any other mutilation of the genitalia, on a child or an adult.¹⁴⁻²¹ Consequently, even though those aged over 18 years (or 16 years in South Australia¹³) may consent to medical treatment, any medical practitioner administering FGM would commit an offence even if the child or adult consents.

Is the legal prohibition on female genital mutilation justified?

FGM is not a recent practice, appearing in historical texts dating to 450 BC.¹⁰ It predates the Koran and the Bible, has no basis in any religious text and is therefore not based in religious observance. Rather, FGM is focused on social control of girls' and women's bodies and capacity for sexual enjoyment and fulfilment.^{9,10} Justifications offered for FGM include that: it is a rite of passage into womanhood; it ensures virginity (promoting family honour); it helps attract a husband because uncircumcised women are seen as immoral; and it prevents infidelity by controlling sexual desire and capacity.^{9,10}

There are multiple adverse physical and psychological consequences of FGM.^{10,22} The process is often conducted in unsterile environments without anaesthetic, antiseptic or antibiotics, by persons with no surgical training, using crude implements such as stones, razors and glass.¹⁰ The risk of infection is high, and death from haemorrhaging is not infrequent.¹⁰ The more invasive the FGM, the greater the complications for intercourse, childbirth, menstruation, recurrent infections, chronic pain, and perinatal death.^{10,22} Those who are infibulated suffer re-incision to facilitate intercourse and childbirth, with a higher risk of fatalities in childbirth.⁹ Psychological consequences of all types of FGM commonly include post-traumatic stress disorder, depression, anxiety and fear of sexual relations.^{10,22} Significant effects on longevity have also been found.²²

The Australian legal and policy prohibition on FGM (including "medicalised" FGM by nicking) appears to be warranted based on the health effects, breaches to autonomy and liberty, and lack of compelling justification. To sanction medically performed FGM would leave undisturbed the damaging assumptions motivating it, and would endorse the unjust attitudes to girls' and women's rights

embodied in the practice. The lack of justification for FGM, including medicalised FGM,²³ is reflected in recent developments in Africa, where growing acceptance of girls' and women's rights and scientific discrediting of the practice have influenced at least 16 nations, including some where the practice has been particularly common, to ban FGM in legislation.²⁴ All forms of FGM (including medicalised FGM) are also prohibited by the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2003) (the Maputo Protocol). Other international instruments also contain articles apposite to the eradication of FGM, most notably the Convention on the Elimination of All Forms of Discrimination against Women (1979) (articles 1, 2, 5 and 12), and the United Nations Convention on the Rights of the Child (1989) (articles 19, 24 and 34).

How might medical practitioners and the profession respond to any demand for female genital mutilation?

Australian law and professional policy relating to FGM are sound and settled. However, individual medical practitioners and the profession may face practical challenges in response to demand for FGM, including any increased demand due to recent population changes. Practitioners should not accede to any request to perform FGM, but will need to sensitively provide advice and support to members of families involved in this context. In performing this role, practitioners may benefit from consulting with health agencies currently dealing with FGM, such as relevant divisions of hospitals and health departments, and family planning agencies. In addition, the Family and Reproductive Rights Education Program, based in Victoria, has a nationwide remit to educate key communities about FGM, and to support both specialist health providers and the general profession in responding to girls and women desiring FGM or needing treatment related to it.²⁵

Individual practitioners and dedicated health agencies entrusted with educational and supportive roles are key agents of social change in this context. In this regard, and because of the lack of good evidence about key factors concerning FGM in Australia, practitioners, the profession and the community would benefit from research involving the relevant communities into attitudes towards FGM, the need for treatment and support of those who have already experienced FGM, and the incidence of FGM conducted in Australia. Development of an evidence base concerning these phenomena can inform refined and renewed efforts to respond to FGM and its consequences in this country. Research evaluating the efficacy of strategies that have already been implemented in Australia to respond to FGM would help to inform future efforts. This is all the more necessary if the demand for FGM and associated treatment is indeed increasing, or if such demand is spreading beyond the confined geographical locales in which it has historically been present in Australia, such as parts of Victoria.⁸

Finally, if refined efforts are deemed appropriate to supplement existing educational and supportive efforts to communities, relevant agencies may be able to draw on strategies adopted in African nations to change attitudes towards FGM and eradicate its performance. Such strategies may need to be adapted to suit local contexts, and there is no proof to suggest they are bound to produce comprehensive and instant results in changing entrenched cultural attitudes.²³ Nevertheless, there is some evidence of success: over 1800 communities in Senegal are reported to have abandoned FGM in the decade to 2007; Muslim scholars in Egypt and Kenya banned FGM in 2006; and Tanzania experi-

enced a 3% decrease in FGM from 1996 to 2005.²⁴ The strategies that helped to make these advances include:²⁵

- public discussion of issues around FGM;
- cooperation between government and non-government agencies, religious leaders, societal opinion leaders and health experts in educating the public about FGM;
- using culturally and linguistically appropriate methods of communication with the community, including theatre and role-play, to heighten awareness of the issues and catalyse self-starting cultural change;
- involving men and community leaders in these educational and awareness-raising efforts (including facilitating conversations between men and women who have suffered FGM);
- education of young girls (since mothers play a major role in FGM of their daughters); and
- promoting awareness of key human rights instruments.

The legal, medical and social context in Australia may even provide a rare opportunity to test the efficacy of responses to FGM. Australia has strong and clear prohibitions of FGM in both law and medical policy, and possesses a generally enviable record of gender equality and health provision. With a small population and a small but growing number of residents born in nations where FGM is customary, the current context may offer a chance to contribute to new ways of investigating FGM, reducing its incidence and altering its motivating attitudes.

Competing interests

None identified.

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