doi: 10.1111/1753-6405.12956

Addressing female genital mutilation in the Asia Pacific: the neglected sustainable development target

Angela Dawson,[1] Abdul Rashid,[2] Rashidah Shuib,[3] Kolitha Wickramage,[4] Meiwita Budiharsana,[5] Irwan Martua Hidayana,[6] Gabriele Marranci[7]

1. The Australian Centre for Public and Population Health Research, Faculty of Health, University of Technology Sydney, New South Wales
2. Department of Public Health Medicine, Royal College of Surgeons in Ireland and University College Dublin Malaysia Campus, Malaysia
3. Universiti Sains Malaysia, Health Campus, Malaysia
4. International Organization for Migration, UN Migration Agency, Philippines
5. Department of Biostatistics and Population, Faculty of Public Health, University of Indonesia
6. Department of Anthropology, Center for Gender and Sexuality Studies, University of Indonesia
7. Department of Anthropology, Macquarie University, New South Wales

Sustainable Development Goal (SDG) target 5.3.2 focuses on the elimination of all harmful practices including female genital mutilation (FGM), a deeply entrenched cultural practice also referred to as female genital cutting or female circumcision. FGM is defined as the partial or total removal of the external female genitalia for non-therapeutic reasons. It is strongly associated with adverse obstetric outcomes and serious immediate and long-term physical, sexual and psychosocial complications resulting in excruciating injuries, disability and death.[1] The practice affects more than 200 million woman and girls globally and while the prevalence is decreasing in some countries it is increasing overall due to population growth.[2]

While much work has focused on advocacy and prevention efforts in countries of high prevalence in Africa and diaspora in Europe, there has been a paucity of discussion on FGM in the Asia-Pacific region. FGM is practised in India, Sri Lanka, Bangladesh, Thailand, Malaysia, Brunei, Singapore, Cambodia, Vietnam, Laos, the Philippines and Indonesia; however, none of these countries are supported by the UNFPA-UNICEF Joint Programme on the Abandonment of FGM.[3] Australia and New Zealand are also home to migrant women and girls with FGM. There are reports of the practice being undertaken in Australia and cases where parents have travelled to their countries of origin to have their daughters excised.[4] However, despite legislation, there have been very few prosecutions.

Different types of FGM are practised in the region, (largely type I and IV), which are associated with a range of motivations that are complex and disputed. FGM, for example, is considered by some to be a rite of passage in the Philippines,[5] while in Southern Thailand it is associated with 'softening' the female character.[6] Research from India, Indonesia and Malaysia has found the practice is associated with cleanliness,[7] reducing female sexual desire and maintaining purity,[8,9] and to purify the body.[10] FGM, also known as *Katna* or *Khafd,* is largely regarded as an important religious observance for Muslim girls in the Asia-Pacific and for non-Muslim women who marry into the faith.[6] However, there is no reference to FGM in the Holy Quran, but religious scholars sometimes refer to the *hadith* (words and practices of Prophet Muhammad) to explain this practice.

Data on the prevalence of FGM in the region are scarce and hence not included in global reporting.[2] National prevalence data are only available from Indonesia where, although the practice varies greatly across provinces, 49% of approximately 34 million girls under the age of 12 in 2013 were found to have undergone some form of FGM.[11] Modelling based on census data in Australia has estimated that there are 53,000 migrant girls and women with FGM in the country, the majority of whom have undergone the practice before migration.[12] Of the little research on FGM in the region, most studies are focused on specific populations and are not necessarily representative. Data collection efforts may be hampered in situations where authorities deny or ignore the existence of FGM. For example, in 2008, a Sri Lankan Ministry of Health and World Health Organization report on violence and health in the country clearly stated that FGM does "not exist in Sri Lanka".[13] A lack of data present challenges for planning a health system response to FGM, as well as reporting on behavioural change. Only Indonesia has made passing reference to FGM in the available Voluntary National Reviews that are a central feature of the monitoring and evaluation framework for the SDGs.[14]

There have been some efforts at national levels to prevent FGM and provide better care for affected women and girls. Despite previous denial of the existence of FGM, recent advocacy efforts have raised awareness that has led to the publication of a circular by the Sri Lankan Ministry of Health in 2018 cautioning medical practitioners and authorities in the health sector against conducting FGM.[15] While there have been no national approaches to addressing FGM in Australia and New Zealand, community education and health professional training has been undertaken to improve healthcare and prevent FGM by counselling affected pregnant women and advocating against the practice.[16-18] In contrast, the Ministry of Health in Malaysia[19] and Indonesia[20] have made moves to regulate the practice. In 2010, the Indonesian Ministry of Health issued a regulation (Article 1, paragraph 1 Permenkes 1636/2010), that permits the act of "scratching the skin" that covers the front of the clitoris without injuring the clitoris. The Malaysian Minister of Health recently referred to FGM as a "cultural responsibility" of Malaysians,[21] suggesting that this practice is associated with one's ethical duty to care about present and future generations and is bound to attitudes about human relationships and economic behaviour. These actions appear to contravene the 'zero tolerance approach' taken by the United Nations to achieve SDG 5.3.2.

The responses of the Indonesian and Malaysian Ministries of Health should be understood in the context of religious identity and political change. Islamic Southeast Asia

largely adheres to the Shafi'i school of law, and religious leaders in many countries have issued strong support for FGM. In 2008, the Indonesian *Ulema* Council released an edict (*Fatwa*) that FGM is part of religious practice and recommended it be undertaken on girls.[22] A year later, the National Council of Islamic Religious Affairs in Malaysia introduced a *Fatwa* declaring that FGM is part of Islamic teachings and it should be observed by Muslims.[19] Religious authorities in other countries in the region have made similar announcements. In 2011, Dr Iyaz Abdul Latheef, the Vice President of the Fiqh Academy, the primary religious academy in the Maldives, encouraged the practice during a broadcast on national radio.[23] The All Ceylon Jamiyyathul Ulama Council of Muslims in Sri Lanka declared in 2007 that FGM was obligatory.[24] The introduction of these *Fatwas* and proclamations from religious leaders appear to emphasise that FGM is not *sunnah* (recommended) but now *wajib* (obligatory).

There is also evidence of community support for FGM that in some countries has not changed a great deal over time. In Indonesia, a 2003 survey in eight provinces found that 92% of parents expressed support for the continuation of FGM for their future granddaughters.[25] Ten years later, in 2013, 80% of parents still expressed their continued support for this practice.[11] While most FGM appears to be type I or IV, symbolic acts such as wiping the clitoris with antiseptic or placing a knife on the abdomen have been described in some Indonesia provinces[8] and other countries in the region[26] that do not involve genital cutting.

Exponents of FGM have reacted to moves to prevent the practice. The recent Sri Lankan Ministry of Health circular emphasising the harmful nature of FGM has been met with resistance, with some Muslims stating this is an infringement on their religious rights and freedoms and an attempt to "discredit and marginalize the Muslim community".[27] Furthermore, the practice has been justified on the grounds that it is no different than male circumcision, not the same as the practice performed in some African nations – namely, type II and III – and can safely be provided by health professionals in hygienic conditions.[27,28] Supporters of FGM in Indonesia have stated that the Government's regulation of FGM could prevent adverse outcomes for girls.[29]

While traditional practitioners have been recorded performing FGM in some rural areas in Thailand[30] and Indonesia,[10] it has largely become medicalised in many countries including Malaysia,[31] Indonesia[20] and Singapore.[32] Clinics in Singapore, for example, advertise FGM for 30–35 Singapore dollars along with ear piercing.[33] Health professionals in Australia have also been approached to perform FGM.[34] Interestingly, much of the argument for the medicalisation of FGM centres around harm reduction and does not include a discussion of important moral and ethical issues around consent and the child's right to bodily autonomy and integrity.[35]

The medicalisation of FGM places health professionals in a difficult position. With no laws making the practice illegal in all countries but Australia and New Zealand,[36] and the lack of guidance or even tacit support of FGM from health authorities in some countries, it is easy to see why the elimination of FGM has been largely ignored in SDG discussions in the region. However, there is also confusion around FGM and female genital surgery for children for non-medical reasons. While the legal situation regarding FGM is clear in Australia and New Zealand and focused on migrant and refugee communities, female genital surgery for cosmetic purposes is permitted. Labiaplasty and other surgery to the vulva is provided in the private sector to children and increasing numbers of adolescents for cosmetic reasons that is often driven by maternal concerns.[37] This apparent double standard in the case of minors needs to be addressed.

Given the sensitive nature of the issue of FGM, the religious support for this practice and the present-day ethnic and religious tensions in the region, meeting SDG 5.3.2 with respect to FGM will require collaborative approaches tailored to each context. A recent systematic review of prevention in high-income countries suggests that a multifaceted, comprehensive health promotion approach is required to address FGM that involves multiple agencies working with communities and religious leaders across the health, education, legal and community sectors.[38] Other reviews that have focused on prevention efforts in African countries have reached similar conclusions[39,40] and a review of the role of men in the abandonment of FGM highlights the importance of dialogue between men and women.[41] However, overall there is a paucity of evidence to inform the effectiveness of interventions to reduce the prevalence of FGM, suggesting that investment is required to improve the rigour of evaluations.

While research is clearly needed, so are co-ordinated primary prevention efforts in the region, such as those led by the End FGM European Network, to link community organisations and NGOs and build their capacity. The approach of the End FGM European Network could serve as a model for intergovernmental agencies such as the Association of Southeast Asian Nations, or the Asia-Pacific Economic Cooperation, to advocate for improved, routinely collected data in line with that in the UK[42] and the prioritisation of multi-disciplinary, evidence-based, culturally appropriate prevention efforts, policy and investment to address SDG 5.3.2.

References

1. World Health Organization. *Guidelines on the Management of Health Complications from Female Genital Mutilation*. Geneva (CHE): WHO; 2016.
2. United Nations Childrens Fund. *Female Genital Mutilation/Cutting: A Global Concern*. New York (NY): UNICEF; 2016.
3. United Nations Population Fund-United Nations Childrens Fund. *2015 Annual Report UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting - Metrics of Progress Moment of Change*. New York (NY): UNFPA-UNICEF; 2015.
4. Zurynski Y, Phu A, Sureshkumar P, Cherian S, Deverell M, Elliott EJ. Female genital mutilation in children presenting to Australian paediatricians. *Arch Dis Child*. 2017;102(6):509-15.
5. Basher SL. The stages of female circumcision practice among Meranaos living in the rural and marginalized areas in Lanao. *Int J Humanit Soc Sci*. 2016;8(2):69-75.
6. Merli C. *Negotiating Female Genital Cutting (Sunat) in Southern Thailand. Self-determination and Women's Rights in Muslim Societies*. Waltham (MA): Brandeis University Press; 2012. p. 169-87.
7. Rashid A, Iguchi Y. Female genital cutting in Malaysia: A mixed-methods study. *BMJ Open*. 2019;9(4):e025078.
8. Hidayana IM, Djamilah JDI, Kartikawati R, Zahro FA. Female circumcision in Indonesia: Between policy and practice. In: Fusaschi M, Cavatorta G, editors. *FGM/C: From Medicine to Critical Anthropology*. Torino (ITL): Meti Edizioni; 2018.
9. Anantnarayan L, Diler S, Menon N, WeSpeakOut, Manch NS. *The Clitoral Hood A Contested Site: Khafd or Female Genital Mutilation/Cutting (FGM/C) in India*. New York (NY): Maharashtra Foundation; 2018.
10. Putranti B. To Islamize, becoming a real woman or commercialized practices? questioning female genital cutting in Indonesia. *Fin J Ethn Migr*. 2008;3(2):23-33.
11. United Nations Children's Fund. *Indonesia: Statistical Profile on Female Genital Mutilation/Cutting*. New York (NY): UNICEF; 2016.
12. Australian Institute of Health and Welfare. *Towards Estimating the Prevalence of Female Genital Mutilation/Cutting in Australia*. Canberra (AUST): AIHW; 2019.
13. Wickramage K, Senanayake L, Mapitigama N, Karunasinghe J, Teagal E. The need for an evidence-informed, multi-sectoral and community participatory action framework to address the practice of female genital mutilation in Sri Lanka. *Ceylon Med J*. 2018;63(2):53-7.
14. Government of Indonesia. *Republic of Indonesia Voluntary National Review Eradicating Poverty And Promoting Prosperity In A Changing World*. New York (NY): United Nations Department of Economic and SocialAffairs Division for Sustainable Development Goals; 2017.
15. MoH. General Circular letter no. 02/33/2018. Colombo: Ministry of Health Sri Lanka; 2018.

16. Dawson A, Varol N. Continuing professional education on Female Genital Mutilation for obstetricians, gynecologists, and midwives in Australia: Educational program development. *Reprod Health*. 2017;14 Suppl 2:115. doi:10.1186/s12978-017-0362-x
17. Denholm N. The New Zealand national FGM education program: Case study of a successful training and prevention model for NZ healthcare professionals. *Reprod Health*. 2017;14 Suppl 2:115. doi:10.1186/s12978-017-0362-x
18. Scott M, Jerse Sd. *Female Genital Mutilation Education Program Evaluation: Final Report*. Sydney (AUST): New South Wales Health; 2011.
19. Ainslie MJ. The 2009 Malaysian female circumcision fatwa: State ownership of Islam and the current impasse. *Womens Stud Int Forum*. 2015;52:1-9.
20. Budiharsana M. Female genital cutting common in Indonesia, offered as part of child delivery by birth clinics. *The Conversation* [Internet]. 2016 [cited 2019 Aug 2]; Feb 16. Available from: https://theconversation.com/female-genital-cutting-common-in-indonesia-offered-as-part-of-child-delivery-by-birth-clinics-54379
21. Bernama. *Khatan bayi perempuan di Malaysia berbeza - Dr Dzulkefly (The baby's circumcision in Malaysia is different - Dr Dzulkefly)*. Kuala Lumpur (MYS): Astro AWANI; 2018.
22. Lubis AM, Jong HN. FGM in Indonesia hits alarming level. *The Jakarta Post*. 2016;Feb 6.
23. Zaheena R. Figh Academy VP endorses female genital mutilation. *Minivan News*. 2014;Feb 6.
24. Save the Girl Child. *Submission on the Practice of Female Genital Cutting (FGC) in Sri Lanka*. Colombo (LKA): Save the Girld Child; 2018.
25. Budiharsana M, Amaliah L, Utomo B. *Female Circumcision in Indonesia: Extent Implications and Possible Interventions to Uphold Womens Health Rights. Research Report*. Jakarta (IDN): Population Council; 2003.
26. Daniel S. Butter knife or sharp blade? Either way, FGM survivors in Sri Lanka want it stop. *Reuters*. 2017;Nov 22.
27. Hussein A. *Let's Respect Muslim Rites & Rights – Why Moves to Ban Female Circumcision Infringe on our Religious Rights*. Colombo (LKA): Sailan Muslim Foundation; 2017.
28. Federal Territory Mufti Office. *AL-KAFI #419: Hukum Berkhatan Bagi Kaum Wanita (Women's Circumcision Law)*. Putrajaya (MYS): Malaysian Government's Prime Minister's Department; 2016.
29. Patel R, Roy K. *Female Genital Cutting In Indonesia A Field Study*. Ontario (CAN): Islamic Relief Worldwide; 2016.
30. Merli C. Sunat for girls in southern Thailand: Its relation to traditional midwifery, male circumcision and other obstetrical practices. *Fin J Ethn Migr*. 2008;3(2):32-41.
31. Dahlui M, Wong YL, Choo WY. Female circumcision (FC) in Malaysia: Medicalization of a religious practice. *Int J Behav Med*. 2012;19 (Suppl):1-341.
32. Marranci G. Female circumcision in multicultural Singapore: The hidden cut. *Aust J Anthropol*. 2015;26(2):276-92.
33. The Asian Parent Singapore. *Female Genital Mutilation in Singapore: What Do You Know About It?* Singapore (SGP): Tickled Media; 2018;April 2.
34. Moeed SM, Grover SR. Female genital mutilation/cutting (FGM/C): Survey of RANZCOG Fellows, Diplomates & Trainees and FGM/C prevention and education program workers in Australia and New Z ealand. *Aust N Z J Obstet Gynaecol*. 2012;52(6):523-7.
35. The Brussels Collaboration on Bodily Integrity. Medically unnecessary genital cutting and the rights of the child: Moving toward consensus. *Am J Bioeth*. 2019;19(10):17-28.
36. World Bank. *Compendium on International and National Legal Frameworks on Female Genital Mutilation*. Washington (DC): World Bank; 2018.
37. McQuillan SK, Jayasinghe Y, Grover SR. Audit of referrals for concern regarding labial appearance at the Royal Children's Hospital: 2000–2012. *J Paediatr Child Health*. 2018;54(4):439-42.
38. Njue C, Karumbi J, Esho T, Varol N, Dawson A. Preventing female genital mutilation in high income countries: A systematic review of the evidence. *Reprod Health*. 2019;16:113.
39. Johansen REB, Diop NJ, Laverack G, Leye E. What works and what does not: A discussion of popular approaches for the abandonment of female genital mutilation. *Obstet Gynecol Int*. 2013;2013:348248.
40. Waigwa S, Doos L, Bradbury-Jones C, Taylor J. Effectiveness of health education as an intervention designed to prevent female genital mutilation/cutting (FGM/C): A systematic review. *Reprod Health*. 2018;15(1):62.
41. Varol N, Turkmani S, Black K, Hall J, Dawson A. The role of men in abandonment of female genital mutilation: A systematic review. *BMC Public Health*. 2015;15:1034.
42. National Health Service. *Female Genital Mutilation (FGM) - September 2014, Experimental Statistics*. London (UK): NHS Audit Support Unit, Health and Social Care Information Centre; 2014.

Correspondence to: Professor Angela Dawson, Professor of Public Health, The Australian Centre for Public and Population Health Research, Faculty of Health, University of Technology Sydney, New South Wales; e-mail: angela.dawson@uts.edu.au_