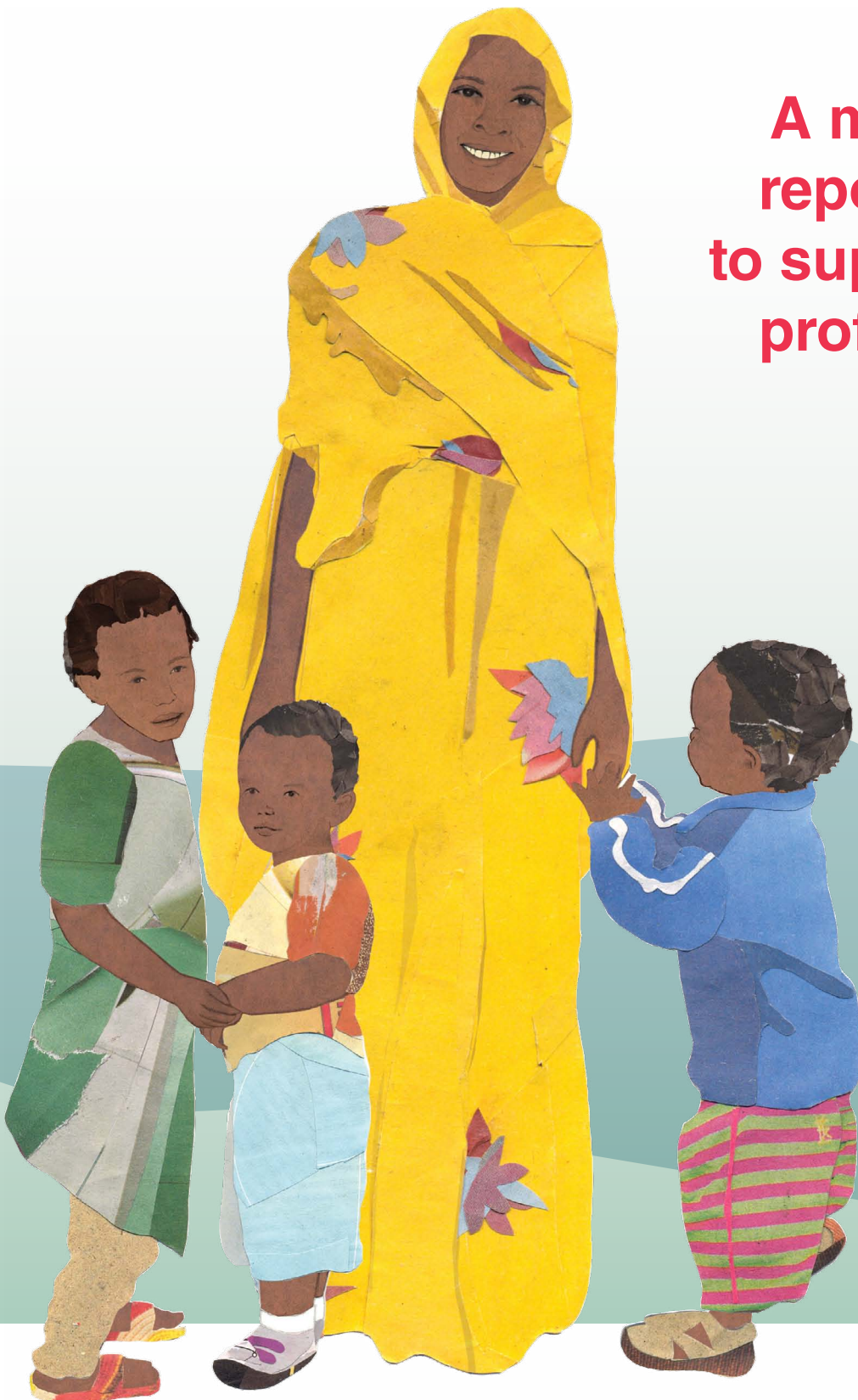


FEMALE GENITAL MUTILATION/CUTTING

**A mandatory
reporting tool
to support health
professionals**





AUTHOR

Intesar Homed

CONTRIBUTORS

Elly Taylor, Helen Makregiorgos

DESIGN

Veronica Garcia

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FEMALE GENITAL MUTILATION OR TRADITIONAL CUTTING (FGM/C)

Female genital mutilation or traditional cutting (FGM/C) affects an estimated 100 to 140 million women and girls worldwide.¹ Every year approximately two million girls undergo the procedure, which is internationally recognised as a gender-based health and human rights violation.² FGM/C is predominantly practiced in Sub-Saharan Africa, Middle Eastern countries and in some parts of Malaysia, Indonesia, India and Pakistan.³ Women and girls are increasingly migrating to Australia from countries where FGM/C is widely practiced, so we need to develop timely and culturally appropriate healthcare, support and community education. Specific communities affected by FGM/C are increasing in Melbourne's western region.






This tool has been designed for practitioners, midwives and other health professionals that work with women and families from communities who practice FGM/C.⁴ Early intervention during prenatal care, birth and the early years of childhood development can prevent FGM/C. Health practitioners can support parents to abandon the practice by working with families from affected communities to provide education, information and referral.

TERMINOLOGY

'Female genital mutilation' is the term preferred by the World Health Organisation (WHO), the United Nations and is used throughout Australian and Victorian legislation that prohibits the practice. Use of the word 'mutilation' aims to reinforce the gravity and harm caused by the practice and reiterate that it is a gender-based, human rights violation. WHO, in line with best practice community development approaches, maintains that women, their families and communities will more effectively engage with health practitioners who use terms such as 'female circumcision' or 'traditional cutting'. This is important as the term 'mutilation' can polarise affected communities where the practice is a cultural custom. Using culturally appropriate language is essential to build trust and respect with your client and ensures that people from minority communities don't feel stereotyped, stigmatised and marginalised.

DEFINITION AND TYPES

The practice involves 'all procedures that include partial or total removal of female genital organs or other injury to female genital organs for non-medical reasons.'⁵ FGM/C is mostly carried out on young girls some time between infancy and age 15 years and includes four types:

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: <ul style="list-style-type: none"> 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.	

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

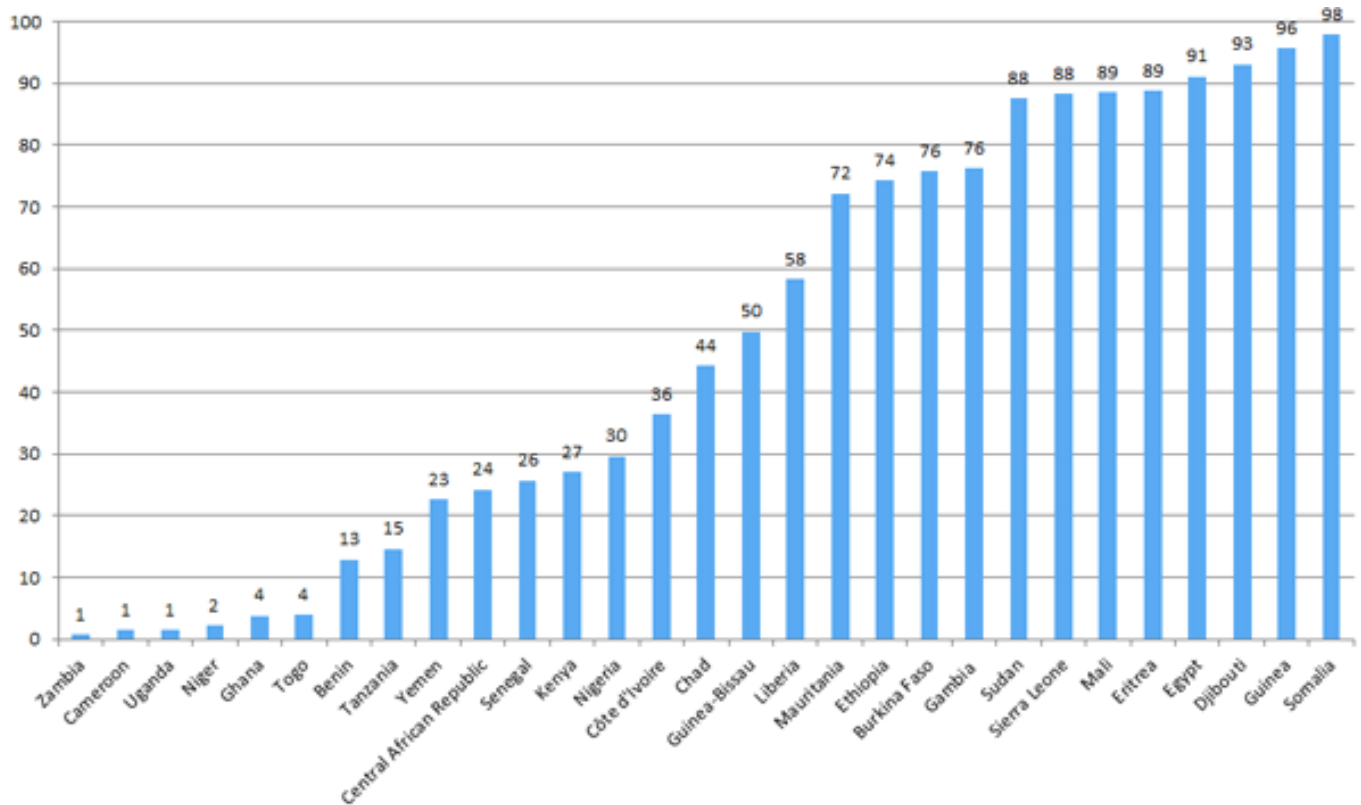
Source: Women's Health West (2008) *What is female genital mutilation?*
Available at <http://whwest.org.au/resource/female-genital-mutilation-2/>

COUNTRIES WHERE FGM/C IS PRACTICED

Understanding the communities that practice traditional cutting will support you to assess and support migrant and refugee families. Prevalence rates in Africa vary between countries. Countries with high prevalence rates (greater than 85 per cent) include Somalia, Egypt, Eritrea, Ethiopia and Mali. Countries with prevalence rates of less than 30 per cent include Senegal, Central African Republic and Nigeria. If you are supporting women or families from these and other communities that practice FGM/C, it is important that you begin a conversation about the practice and their possible intentions regarding their daughters.

For example: *I understand that many Eritrean women have had traditional cutting. Is this something you are considering for your daughter?*

Percentage of women 15–49 years old who have been cut



Source: UNICEF global databases (2012) Based on DHS, MICS and other national surveys, 1997-2011.

HEALTH IMPACTS OF FGM/C

There are an array of short and long term health implications associated with FGM/C. Short term health impacts include: excessive bleeding, infection, shock, urinary retention, damage to the urethra and even death. Long term effects include painful menstruation, chronic pelvic infection, reproductive tract infection, complications during pregnancy and childbirth and infertility.⁶

It is important to communicate the severity of the short and long term health and wellbeing impacts of the practice on their daughters once you begin a conversation with a woman or family about female circumcision.

For example: *I have a professional responsibility to talk with you and your family about the health impacts that traditional cutting can have on your daughter.*

The mother is also likely to have been circumcised. One way to convey and reiterate the negative implications of the practice is to explore whether she has experienced any pain, trauma and ill health.

LEGISLATION PERTAINING TO FGM/C

Many communities are now aware that FGM/C is illegal in Victoria and laws are enforced, not ignored.

Intergenerational conflict is common as younger generations have a different value system when compared to their parents or grandparents. Certain traditional practices are often no longer practiced or adhered to by the younger generation.

Each Australian state and territory has legislation relating to FGM/C. In Victoria, FGM/C falls under the *Crimes (Female Genital Mutilation) Act 1996* and the *Children, Youth and Families Act 2005*. Below is a summary of each act.

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 (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.
	The Children, Youth and Families Act section 182. Professionals such as education staff, police, medical and nursing staff are mandated to report FGM to Child Protection, if they form a 'belief on reasonable grounds that a child is in need of protection'. These professionals are required to make a report to Child Protection if they have formed a belief on reasonable grounds that a child has suffered or is likely to experience FGM/C however you do not need to be mandated to make a report to DHS.
Source: Women's Health West (2008) <i>What is female genital mutilation?</i> Available at: http://whwest.org.au/resource/female-genital-mutilation-2	

ASSISTING WOMEN WITH ACCESS TO HEALTH SERVICES

When working with African women and their families:

- It is important to maintain a respectful and non-judgmental attitude without making assumptions based on their appearance, cultural or religious background
- It is important to maintain a friendly and professional approach and to be clear about your role and responsibilities
- Record demographic information for women as accurately as possible. This includes country of birth, cultural background and preferred language, which is important for interpreter purposes
- Use simple language when asking questions and where possible avoid medical terminology or jargon. Women might not be familiar with basic health topics and concepts
- Establish what they are familiar with and build your discussion around their knowledge base
- It is important to remember that women's English proficiency will vary considerably
- Avoid using judgmental words or terms. For example, always use terminology such as 'female circumcision or traditional cutting' rather than 'female genital mutilation' for the reasons described above
- Discuss with the woman what the practice means to her and what it means in Australia and how she feels about it. This should be a two-way discussion

USING INTERPRETERS

Women are likely to be more comfortable with a female interpreter when discussing traditional cutting. Ensure that the interpreter is fluent in English, the woman's language and proficient in the required health or medical terminology. It is also important to ensure that the interpreter maintains a professional attitude, complies with confidentiality regulations and is not known to the woman.

When using interpreters ensure that you explain to all women that confidentiality will be maintained, and that interpreters are required to interpret accurately without editing, adding or omitting any information. Explain clearly that a failure to do so will result in a breach of confidentiality and outline the subsequent consequences for interpreters. Providing this information to the woman can help her understand her right to confidentiality when accessing your service.

It is good practice to provide the interpreter with a similar brief before you invite them to attend a session.

REASONS WHY COMMUNITIES PRACTICE FGM/C

FGM/C is a culturally complex practice with many families and communities considering it an essential tradition and cultural necessity.⁷ While the reasons for the practice vary between communities, FGM/C is sustained by the belief that it is in the best interest of the child, as it provides her with a future as an honourable wife and mother. This is why a cultural sensitivity non-judgemental approach is so necessary.

Some of the reasons why FGM/C is practiced include:

TRADITION

The practice marks the important passage of the young girl to womanhood and is often associated with cultural celebrations. This tradition is upheld by social pressure to the extent that girls and their families can be stigmatised and ostracised for non-compliance.⁸

RELIGION

FGM/C pre-dates most modern religions, including Christianity and Islam. For some women the procedure is understood to be 'sunna', a religious requirement prescribed within teachings of the Prophet Mohammed. Although commonly perceived to be part of the Islamic religion, many Islamic people do not practise FGM/C.⁹

HYGIENE AND CLEANLINESS

FGM/C is associated with cleansing in some communities where the clitoris is thought to produce an offensive discharge.¹⁰ This is illustrated by the Arabic word for FGM/C 'tahur', which literally means purity and cleanliness. Some also believe that if a woman has not undergone infibulation, air will enter through her vagina and cause infection.

Sheikh Isse Musse is the Imam at the Werribee Islamic Centre. He believes that Islamic religion prohibits traditional cutting on girls and women.

Islamically people feel that it's a religious duty to circumcise children, male and female, and they use, people use quotation from prophet Mohamed, peace be upon him, when he was instructing the woman in charge of circumcision. But if you carefully look at the saying of his, you do not find that it amounts to mutilation or genital mutilation.

Because he said to her: Do not go deep, don't cut deep so that the husband and the wife later on can have gratification. What he's saying is if the whole external is removed, then there would be no gratification and it will be a terrible thing.

The Sharia view is we have to weigh up everything that we do. How much disadvantage is there, how much advantage is there, it's the concept of utility. Whenever the disadvantage is quite outweighed, then it becomes prohibited.

Well given the stories that the victims have told and how traumatic it is and the pain involved and all those issues, well, it is disadvantaged more than any assumed advantaged. So on that face it becomes prohibited islamically.

Transcript from the Insight program, SBS, 18 February 2013

GENDER ROLES, MARRIAGEABILITY AND SEXUALITY

FGM/C is predominantly practised in communities where women's access to education, economic and social resources is limited and marriage is a means to secure a future.¹¹ FGM/C is thought to increase marriageability by ensuring girls' and young women's virginity and their fidelity during marriage.

FGM/C is also believed to enhance fertility and increase men's sexual pleasure, both of which enhance a woman's attractiveness as a wife.¹²

A CULTURALLY SENSITIVE APPROACH TO WORKING WITH WOMEN AND FAMILIES FROM COMMUNITIES AFFECTED BY FGM/C

- Be clear about your role, scope, authority and responsibility
- Make appropriate referrals by knowing what services are available in your area and what they can do
- Be clear with women about what is happening and ensure that they are informed at every stage
- Use skilled female interpreters where possible
- Consult with FARREP workers and the target community
- Use a welcoming manner and friendly body language
- Maintain a non-judgemental and respectful approach

IMPACT OF MIGRATION AND SETTLEMENT FOR FGM/C AFFECTED COMMUNITIES

African communities (where FGM/C is commonly practised) are not only affected by the ramifications of FGM/C, they are also affected by a range of concerns that add layers of complexities to African women's lives and can affect their health in many ways. Grief is most common among refugees where they have experienced separation or loss of loved ones, settlement difficulties, language barriers, isolation and racism. Migrants and refugees are also confronted with difficulties in accessing housing, employment and difficulty navigating bureaucratic systems such as the banking system. Some have low level of English proficiency, isolation and mental concerns.¹³ Many believe that if they seek mental health services they will be considered by their communities as 'crazy'. Intergenerational conflict about different gender roles and expectations is also common.

MAINTAINING AND ENSURING CONFIDENTIALITY

It is always important to consider the confidentiality of women and their family, particularly when using interpreters. It is likely that interpreters from minority communities and language groups will be familiar with the woman and her family. In this instance, it might be more appropriate to use a telephone interpreter and change the woman's name, even if only her first name is used. Women might be concerned that using an interpreter could compromise their privacy and confidentiality. Women might also request that family or friends act as interpreters. However, in the interest of maintaining confidentiality and for professional purposes, it is good to avoid using family and friends as interpreters. Instead, encourage women to use family and friends for other forms of support such as attending appointments. It is also important to inform women about whether or not your services are confidential and explain the circumstances under which confidentiality or privacy could be breached, as both of these concepts might be unfamiliar to many women.

MAKING APPROPRIATE REFERRALS

Be aware of health services in your catchment area and the services they provide to ensure you can make appropriate referrals. Be aware of any specific requirements such as language, location, cost and childcare provisions that can facilitate access. In addition, consult with other service providers, community workers, bicultural workers and Family and Reproductive Rights Education Program (FARREP) workers, where necessary.

RESPONDING TO FAMILIES WHERE THERE IS A RISK OF FGM/C BEING PRACTICED ON CHILDREN

Consult with a Women's Health West FARREP worker. FARREP is led by women from FGM/C affected communities and delivers community education, professional development training and other culturally appropriate health promotion interventions aimed at eliminating the practice. This program also works to increase access to timely and appropriate specialist and mainstream sexual and reproductive health services for women and girls affected by, or at risk of, FGM/C.

Arrange a secondary consultation with a FARREP worker who can work with you to support women and their families to understand the health and social impacts, and the legality of FGM/C in order to support the prevention of the practice. This might include linking women with the FARREP community education program, a health promotion strategy that works to meet the health and wellbeing needs of women who have migrated from countries where FGM/C is practiced.

For more information about FARREP at Women's Health West contact (03) 9689 9588 or visit www.whwest.org.au/health-promotion/sexual-health/farrep/

You could also refer women and their families to Child FIRST. Child FIRST links vulnerable children, young people and their families with relevant services and supports. Child FIRST services in Melbourne's West include:

CHILD FIRST SERVICE	PHONE NUMBER
Brimbank, Melton	1300 138 180
Hobsons Bay, Maribyrnong, Melbourne, Moonee Valley and Wyndham	1300 786 433
Department of Human Services Child Protection North and West Region	1300 664 977
After hours Child Protection Emergency Services	131 278

FEMALE GENITAL MUTILATION/CUTTING: PRACTICE PRINCIPLES FOR HEALTH PROFESSIONALS CONSIDERING A REPORT TO THE DEPARTMENT OF HUMAN SERVICES

These guidelines have been developed to assist health professionals who are considering making a report to the Department of Human Services (DHS) because they believe a child is at risk of having FGM/C performed on them or has had FGM/C performed on them.

Health professionals responding to families where the risk of FGM/C being performed on a child is identified will need to refer to their organisational policies, procedures and guidelines. Risk assessment is often a complex activity that certain professionals within your organisation are responsible for leading, such as social workers.

Where you have identified a risk that FGM/C may be performed on a child or has been performed, conduct a risk assessment with the family and professionals involved with the child. A risk assessment involves identifying risk and protective factors and making a decision about the likelihood that child abuse or neglect will happen in the future. Work with the family to formulate a plan for mitigating the risks identified. For example the family can meet with a FARREP worker to discuss the legal, health and cultural context of FGM/C.

It is important to document the assessment and actions, inform the family you are doing this and what – if any – rights they have to read the documentation.

Share your concerns with the parent or guardian and engage in an open discussion about FGM/C legislation and health implications wherever possible. This enables the client/s to increase their awareness of the health implications and legal status of FGM/C in Australia, as well as discuss any cultural and/or religious reasons given for the practice.

Consult with your manager if you have assessed that a report needs to be made to the DHS before discussing a report with the family or making the report.

If your assessment indicates that the child is at risk of FGM/C consult with a FARREP worker in your region, if possible. Where FARREP workers can provide direct services consider – with the family's consent – a referral to them for additional support.

If a decision is made to make a report to DHS you need to share this decision with the parent or guardian. If you are concerned there is a risk to the child or another person by informing the family, consult with your manager.

The client does not need to consent to a report. It is important to inform the department about the client's response to the report and any risks associated with this, potential reactions to DHS workers contacting them.

When making the report, it is important to note the date, time and the name of DHS worker you spoke to and request information regarding how DHS will now proceed with the report.

For further information please refer to Department of Human Service website
<http://www.dhs.vic.gov.au/for-individuals/children,-families-and-young-people/child-protection>

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