Social, cultural and clinical aspects of female genital cutting

Thursday 16 May 2024

The content in this session is valid at date of presentation

Acknowledgement of Country

GenWest, Women's Health In the North and the NWMPHN recognise that the land on which we work and provide our services always was and always will be Aboriginal land. We pay our respects to Elders past and present.

We proudly acknowledge the Aboriginal and Torres Strait Islander communities across Melbourne's northwest, their rich cultures, diversity, histories and knowledges, and the deep contribution they make to the life of this region.

We acknowledge the ongoing impacts of colonisation, as well as the strength and resilience of Aboriginal and Torres Strait Islander communities, and express solidarity with the ongoing struggle for land rights, self-determination, sovereignty, and recognition of past injustices.

Who we are

GenWest and Women's Health In the North are both organisations working towards gender equity. A key aspect of this work is sexual and reproductive health.

Our work includes providing health education to communities in the north-west region and advocating for sexual and reproductive health and rights.

We work in partnership with women's health services across the state and partners from community health, local Government and health services.

GenWest Gender Justice and Change.

Women's Health in the North
voice • choice • power

Housekeeping

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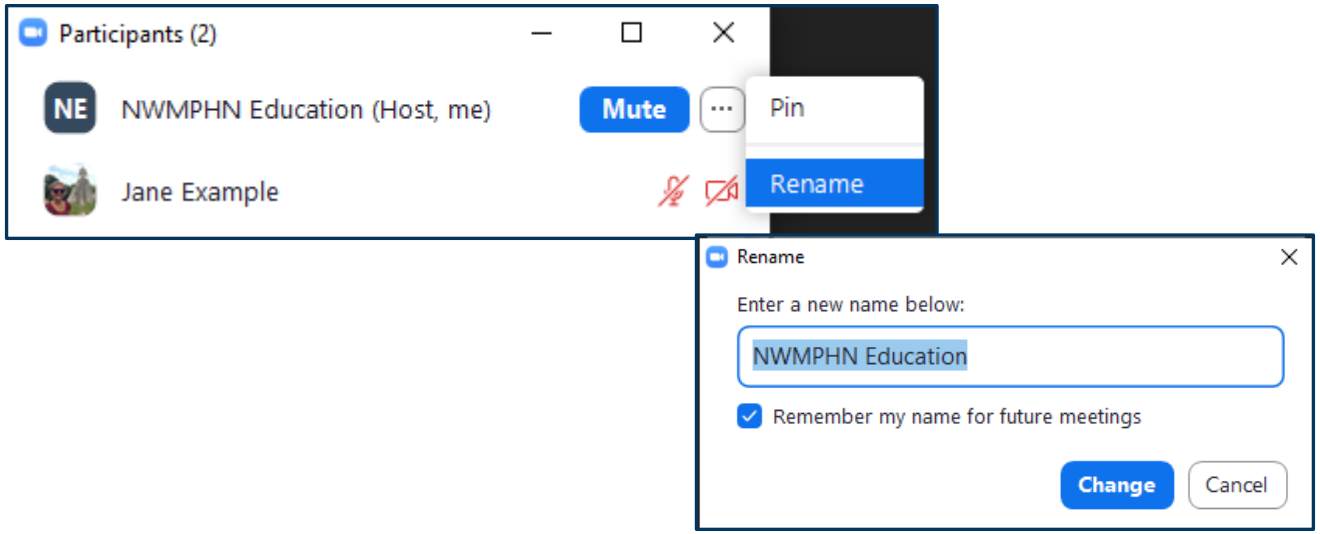
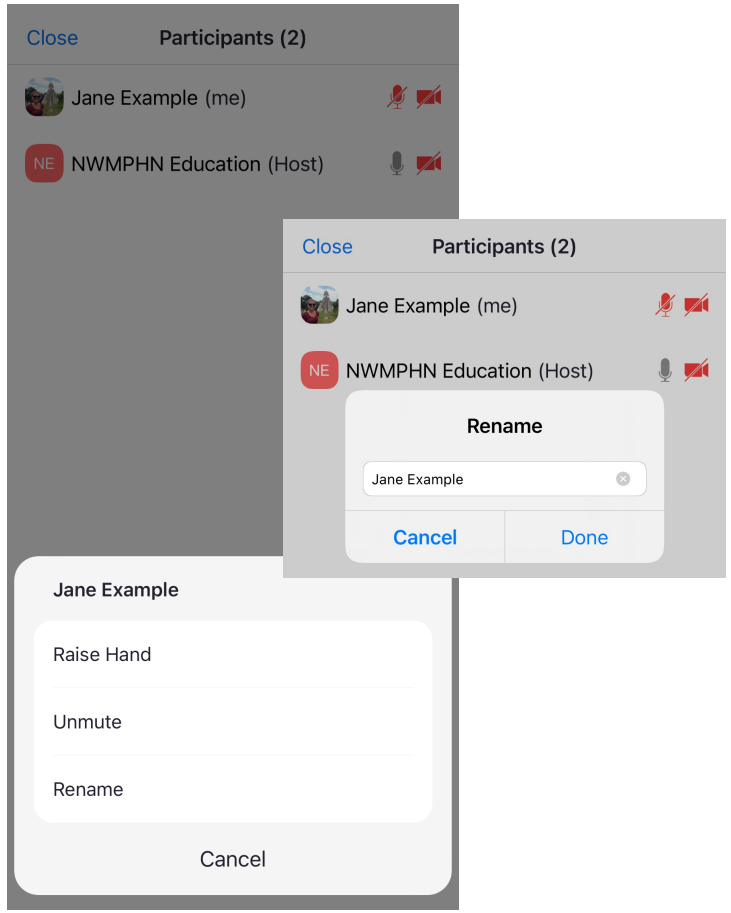
   Done / Change / Rename





Agenda

Session Outline

- Introduction to female genital cutting
- Family and Reproductive Rights Education Program (FARREP) and providing culturally sensitive support
- Clinical services at The Women’s
- Discussion and Q&A

Speakers

- Intesar Homed, Women’s Health In the North
- Shukria Alewi, GenWest
- Marie Jones, The Royal Women’s
- Rosie Downing, The Royal Women’s
- Joanne Gardiner, cohealth

Introduction to FGC, Family and Reproductive Rights Education Program (FARREP) and providing culturally sensitive support

Intesar Homed, Women's Health in the North
Shukria Alewi, GenWest

Overview

Part 1: Introduction to female genital cutting

- Definitions and terminology
- Prevalence rates
- History of FGC
- Cited reasons for practice
- Human rights frameworks

Overview

Part 2: Family and Reproductive Rights Education Program (FARREP) and Providing Culturally Sensitive Support

- Overview of FARREP
- FARREP at GenWest and Women's Health In the North
- Working with communities who have migrated from countries with prevalence of FGC
- Barriers to sexual and reproductive health services for women who have migrated from countries with prevalence of FGC
- Referral pathways
- Existing resources and clinical guidelines.

230 million

women and girls worldwide undergone some form of FGC

144 million

women and girls in Africa alone undergone FGC

30 countries

Practiced in parts of Africa, Asia and the Middle East

53,000

estimated people living in Australia from countries known to practice FGC in 2019

Definition

Female genital cutting can be defined as:

"All procedures that include partial or total removal of female genital organs or other injury to female genital organs for non-medical reasons."

For discussion

- **What do you know about FGC?**
- **What have you heard about the history of the practice?**

History of the practice

- Mummies of Egypt back to the 16th century
- In Roman times, forms of infibulation were used on female slaves as a form of contraception (French, 1992).
- United States (1890s), FGC was practiced by doctors to cure female weakness.
- Western countries including England have used FGC to “cure” women for psychological ailments and so called “female deviances” (Tubia 1995, p.21).

For discussion

- **Do you know at what age the procedure is carried out?**

When is the procedure carried out?

- The procedure may be carried out when the girls are:
    - newborn
    - during childhood
    - adolescence
    - just before marriage
    - during first pregnancy

- Most FGC cases are thought to take place between the ages of 5 and 8.

For discussion

From terminology listed below, which terms will you use when discussing FGC with community?

1. Female circumcision
2. Female genital mutilation
3. Traditional cutting

Terminology

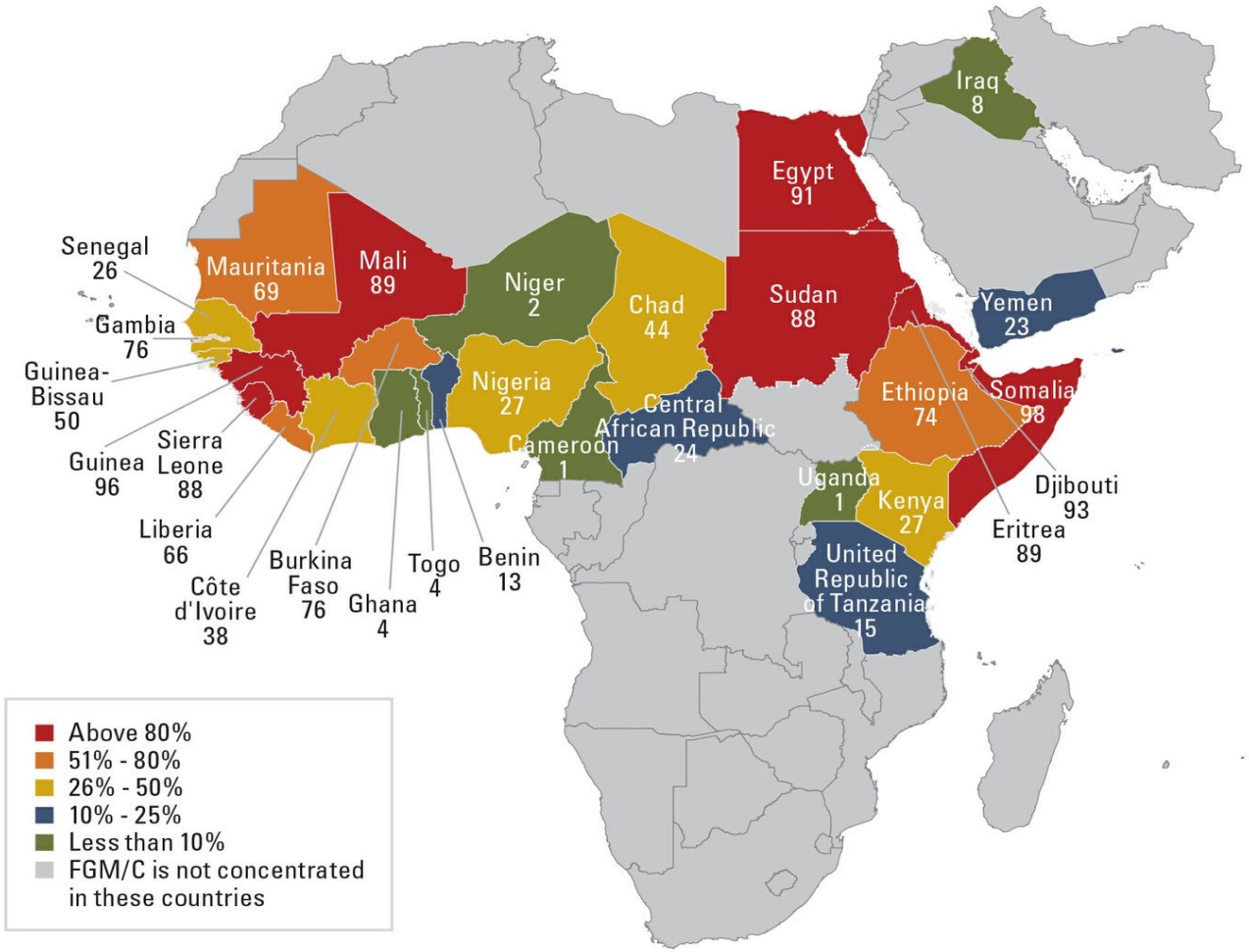
- Use of the word ‘mutilation’ reinforces the harm caused by the practice and reiterates that it is a gender-based, human rights violation.

- Terms such as ***‘Female circumcision’*** or ***‘Traditional cutting’*** are more effective in engaging families and communities.

- Terminology is very important as the term ‘mutilation’ can polarise communities where the practice is a cultural custom.

Map 4.1 FGM/C is concentrated in a swath of countries from the Atlantic Coast to the Horn of Africa

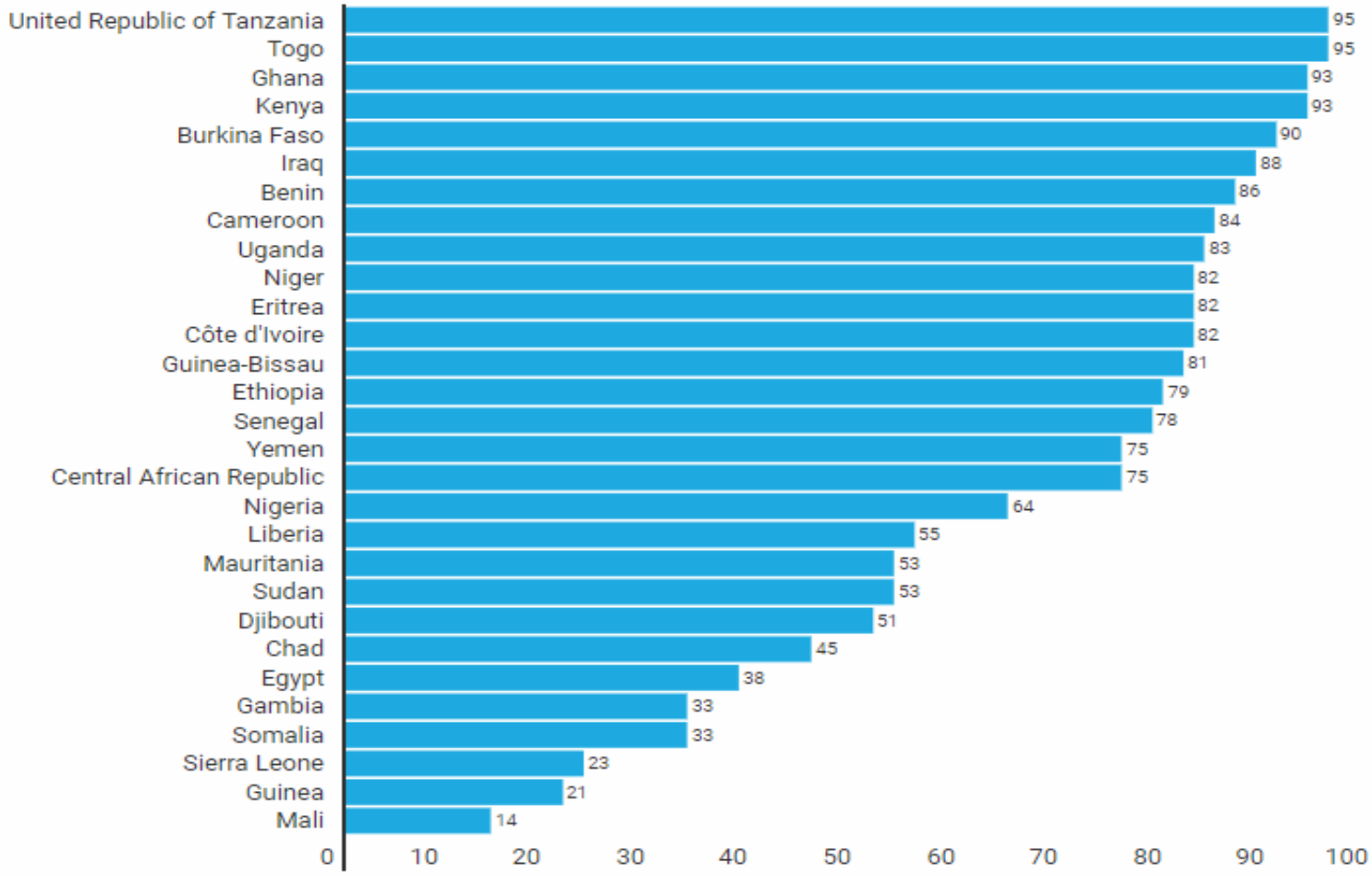
Percentage of girls and women aged 15 to 49 years who have undergone FGM/C, by country



Notes: This map is stylized and not to scale. It does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers. In Liberia, girls and women who have heard of the Sande society were asked whether they were members; this provides indirect information on FGM/C since it is performed during initiation into the society, as explained in Box 4.2. Data for Yemen refer to ever-married girls and women. The final boundary between the Republic of the Sudan and the Republic of South Sudan has not yet been determined.

Sources: DHS, MICS and SHHS, 1997-2012.

Percentage of girls and women aged 15 to 49 who have heard about FGC and think the practice should end



UNICEF global databases, 2017

For discussion

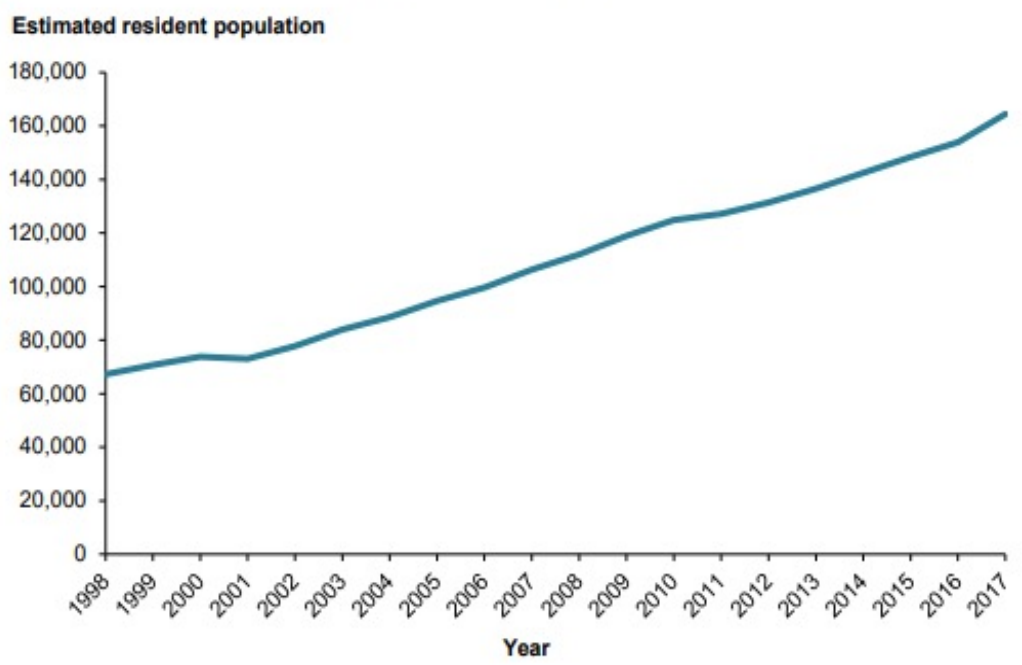
Do you know what the prevalence rate of FGC is in Victoria?

Prevalence of FGC in Victoria

- Difficult to estimate because we have no data
- However, there is high settlement of women and girls from countries where FGC is prevalent

Estimated number of females living in Australia who were born in one of 30 countries known to practice FGC, 1998–2017

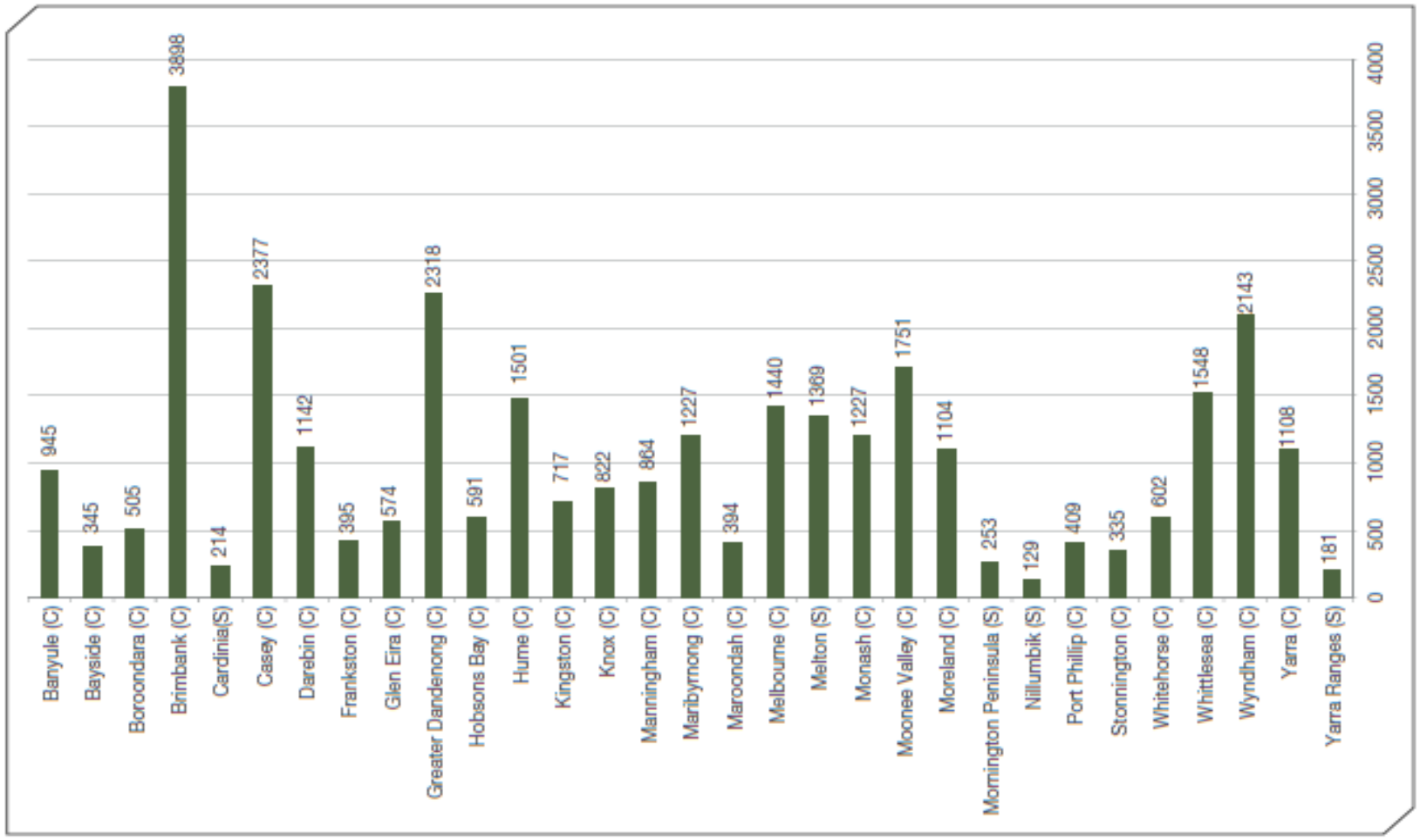
Figure 1.1: Estimated number of females living in Australia who were born in one of 30 countries known to practise FGM/C, 1998–2017



Note: Data included for the following countries of birth: Benin, Burkino Faso, Cameroon, Central African Republic, Chad, Côte d'Ivoire, Djibouti, Egypt, Eritrea, Ethiopia, (The) Gambia, Ghana, Guinea, Guinea Bissau, Indonesia, Iraq, Kenya Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Somalia, Sudan (north), Tanzania, Togo, Uganda, Yemen.

Source: AIHW analysis of data from ABS 2018.

Settlement status of women from countries with high FGM/C prevalence rate in Victoria



Family Planning Victoria, 2013 - Female Genital Cutting LGA Profiles – women from communities affected by FGC residing in LGAs

For discussion

Do you know what people's reasons are to get FGC done?

Main reasons cited for practice

- Preservation of traditional practice and cultural identity
- Hygiene and cleanliness
- Protection of virginity
- To ensure fidelity
- To promote marriageability and social and economic status
- To enhance the husband’s sexual pleasure
- Religious observance
- Social pressure from peers
- It is a rite of passage
- It upholds the family honour

Royal Women’s Hospital 2018

For discussion

Do you think religious scriptures advocate or justify the practice of FGC?

FGC and Religion

- FGC is practised by communities and often claimed to be carried out in accordance to religious beliefs
- However, FGC predates Christianity, Islam and Judaism
- The Bible, Quran, Torah and other religious text do not advocate or justify FGC

For discussion

- **Where do you think the procedure of FGC carried out ?**
- **Who do you think carries out FGC?**

Who carries out FGC?

- Usually carried out by an older women for whom it’s a way of gaining prestige and can be a source of income
- It is also carried out in hospitals (in some practising countries)
- The procedure includes the girl being held on the floor usually by a lot of women, and the procedure carried out without medical expertise, attention to hygiene or anaesthesia

Human Rights Framework

- FGC constitutes a violation of the rights of women and girls.
- FGC violates a number of treaties
  - 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; Rahman & Toubia 2000)

Efforts to Eradicate FGM/C

- International response
- Australian response

International status of FGC

- Illegal in Europe, North America, New Zealand and Australia.
- Illegal in parts of Africa

  Issues with enforcement of legislation
- Medicalised in some countries as part of a ‘harm reduction strategy’

International response

- UN General Assembly accepted in December 2012 resolution to eliminate FGC.
- WHO published global strategies to stop health care providers from performing FGC in 2010.
- Research shows decrease in prevalence of FGC as increased number of women and men support ending of the practice.
- Post-COVID has seen an increase in the practice, in part due to disruptions in schooling, and impacts on NGO advocacy work.

For discussion

- **Do you know what the legal status of FGC is in Victoria?**

Legal status of FGC in Victoria

Relevant Victorian legislation:

- Crimes (Female Genital Mutilation) Act 1996
  - Legal status of FGM/C
- Children, Youth and Families, Act 2005
  - Mandatory reporting

Part II

What is FARREP?

- Established in 1995
- A state-wide program funded by Department of Health (DoH)
- Aims to prevent FGC and redress the sexual and reproductive health issues in communities affected by FGC
- Based on UN initiatives to eradicate FGC

FARREP at GenWest

- Sits within Action for Equity which is a sexual and reproductive health strategy for Melbourne's west

- Work with a range of health professionals to their build capacity to ensure the provision of culturally appropriate services in Melbourne’s west

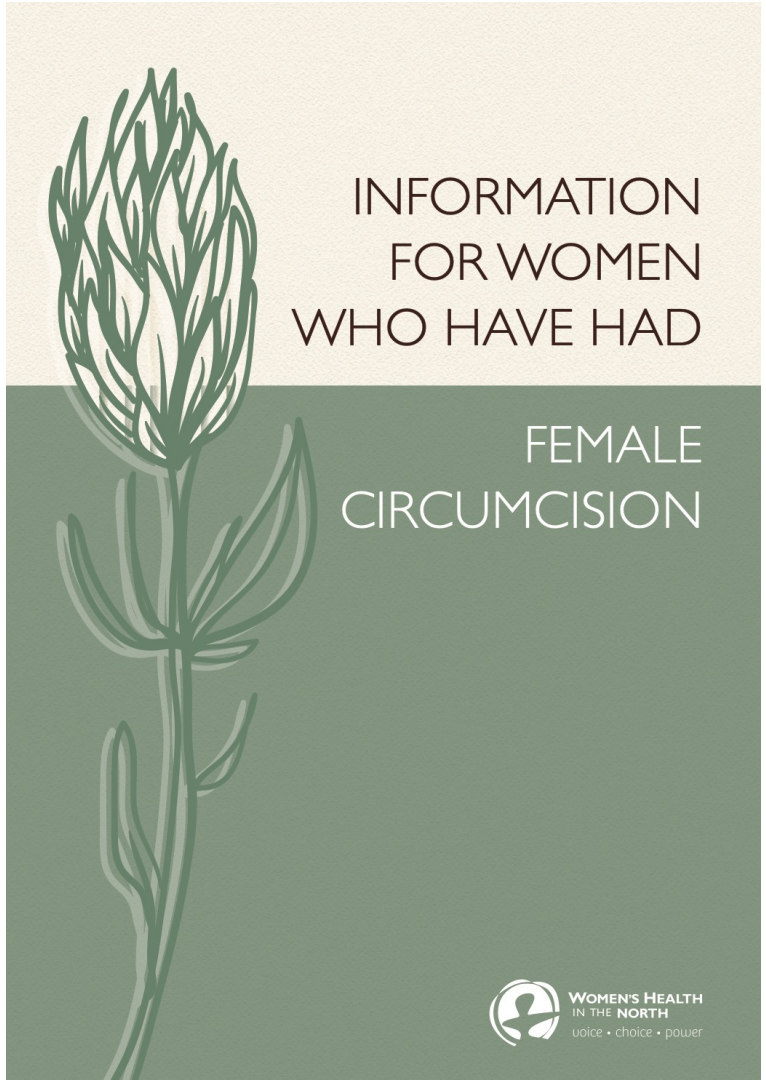
- Improving the sexual and reproductive health and wellbeing of women from communities who have migrated from countries with FGC prevalence and work to prevent the practice

FARREP at WHIN

- Sits within Freedom, Respect and Equity in Sexual Health which is a sexual and reproductive health strategy for Melbourne's north.

- Delivers FGC professional education sessions to clinicians and allied health staff focusing on culturally sensitive service provision.

- Works with women from communities that traditionally practise FGC, to support their sexual and reproductive health and to work to prevent the practice



Working with communities who have migrated from countries with prevalence of FGC

For discussion

Do you know the implications of settlement on communities?

Impact of migration and settlement for communities who have come from countries with high FGC prevalence rate

- Grief
- Settlement issues and language barriers
- Isolation and mental health issues
- Culture shock
- The legal status of FGC
- Intergenerational conflict
- Different gender roles/ expectations
- Health illiteracy
- Difficulty navigating bureaucratic systems
- Experience of racism

For discussion

What do you think are the health needs of women and girls from FGC prevalence communities ?

Health needs of the women and girls are:

- Education
- Counselling
- Regular gynaecological check ups
- Intensive ante-natal and post-natal care
- Restorative surgery (De-infibulations)
- Menopausal care

Why is it important to work with women and girls?

- Assist in meeting the sexual and reproductive health needs of women and girls who have migrated and settled from countries with prevalence of FGC and prevent its occurrence.
- Improve health outcomes.
- Improve access to services.

Traditional African communities

- Women's traditional role is to be good mother and carer
- Pregnancy and birth is mostly 'women's business
- Women rely on female relatives and friends for support during this time
- Traditional practices (e.g. 40 days rest) are common in some communities
- Many African cultures are oral, so information is passed on verbally

Traditional African communities

- Health systems in many African countries are inadequate
- There is no context for preventative health (e.g. having cervical screening)
- Health education is limited
- Women experience barriers when accessing the health system
- Different gender roles and expectations
- Poor health literacy
- Experiences of racism and discrimination

Things to consider when working with women

- 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
- Do not assume anything
- FGC comes in many forms

Things to consider when working with women

- Use skilled female interpreters where possible
- Consult with FARREP workers and the target community
- Use welcoming manner and friendly body language
- Maintain a non-judgemental and respectful approach

Have in the back of your mind

- Countries where FGC is more prevalent but don’t generalise
  - Somalia, Eritrea, Djibouti, North Sudan: Type III
  - Egypt, Ethiopia, Mali, Sierra Leone, Middle East , India etc: Type I & II
  - Indonesia: Type I
- There will always be women from areas of these countries who will not practice FGC… therefore you need to ask the question?

Starting the conversation

1. “Many women from XXXX practice traditional cutting, is this something you have experienced?” (some may not know)

2. Explain that when examining her it may be that if it is difficult to perform the test and she will need referral to another specialist clinic

Cohealth video: https://www.cohealth.org.au/health-promotion/fgc/

How to support the woman

1. Always use female interpreters – onsite is preferable but not always possible
2. Reassure the woman that the consultation is confidential and private. It might take more than one appointment
3. Let the woman know that she can bring a friend or relative to the appointment for support
4. Use simple English to explain the test – use diagrams/ flip charts/ appropriate websites

Referral/Support Services

- The Royal Women's Hospital
- FARREP workers in Victoria:
  - GenWest
  - Women's Health In the North
  - Cohealth
  - Monash Health
  - Darebin Council Youth Services
  - Multicultural Centre for Women's Health
  - Banyule Community Health
  - Mercy Hospital for Women

Clinical Services

Marie Jones and Rosie Downing
The Royal Women's Hospital

The African Women's Clinic

The Royal Women's Hospital Parkville

Marie Jones and Rosie Downing

May 16th 2024

the women's
the royal women's hospital

Responding to Women's Needs in Victoria

- **1997** – FARREP established
- **2010** – *Deinfibulation Clinic* established Nurse Midwife led response in collaboration with FARREP
- **2015** – Renamed *African Women's Clinic*

FARREP and AWC Team

- FARREP are the link between the woman and the AWC and enable women to achieve timely and accessible services at The Women's Hospital
- To support, advocate on behalf of, and address health needs of women affected by FGM
- To strengthen knowledge and build the capacity / expertise of health professionals in relation to cultural issues of affected women in educational presentations with AWC clinicians
- Support women in clinic appointments and when an inpatient
- Located in the Social Work Department
- Currently recruiting

Legal responsibilities - mandatory notification

- The performance of FGM and/or the removal of a child from Victoria to have such procedures performed are specifically prohibited in Victoria under the *Crimes (Female Genital Mutilation) Act 1996*
- Health practitioners are required to report possible FGM if they believe:
  - A child is in danger of having their genitals cut, including plans for this to occur overseas, or
  - A child has had their genitals cut since living in Australia
- It is mandatory to report suspected cases (under the *Children, Youth and Families Act 2005*)

What are the types of FGM?

The World Health Organisation describes FGM into four Types:

Type 1 (sometimes called “Sunna”)

Type 2

Type 3 (infibulation)

Type 4

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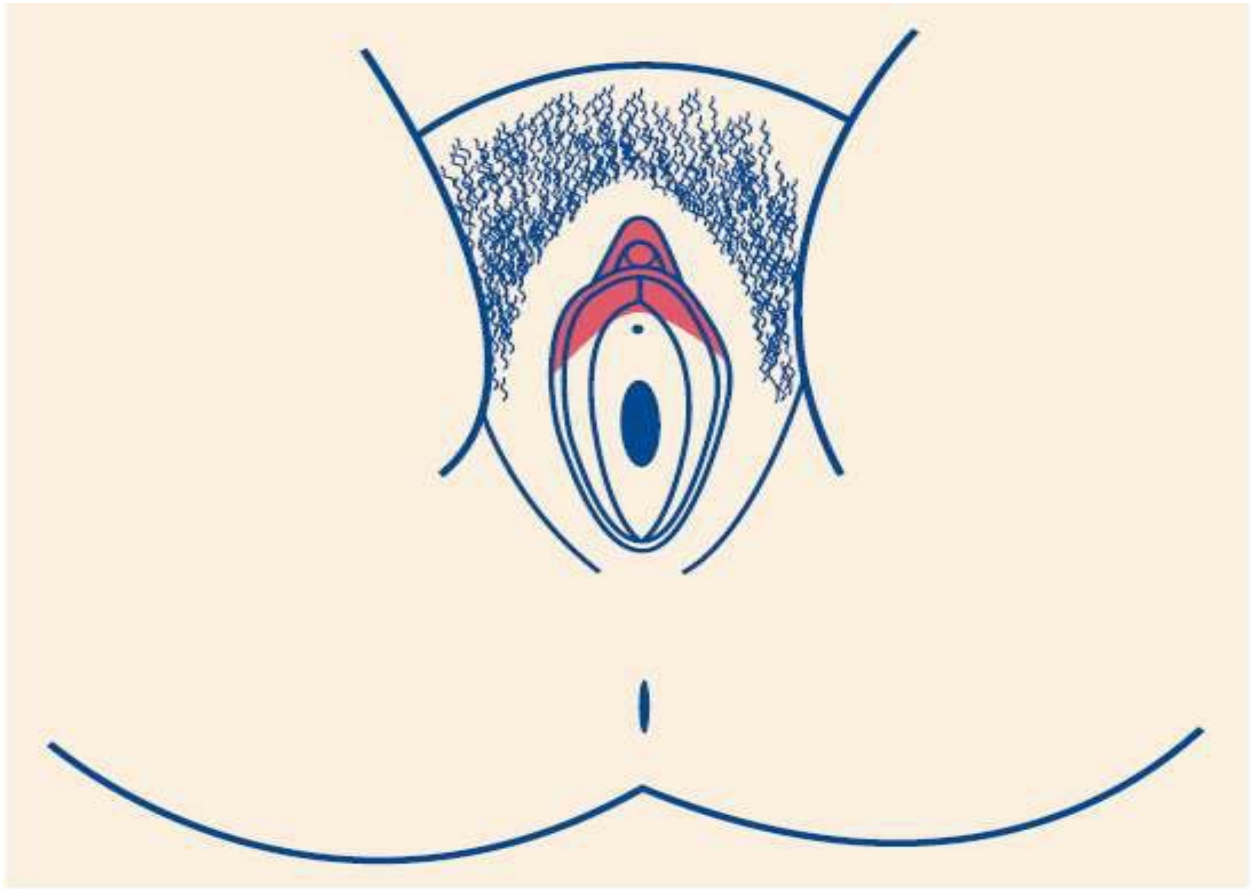
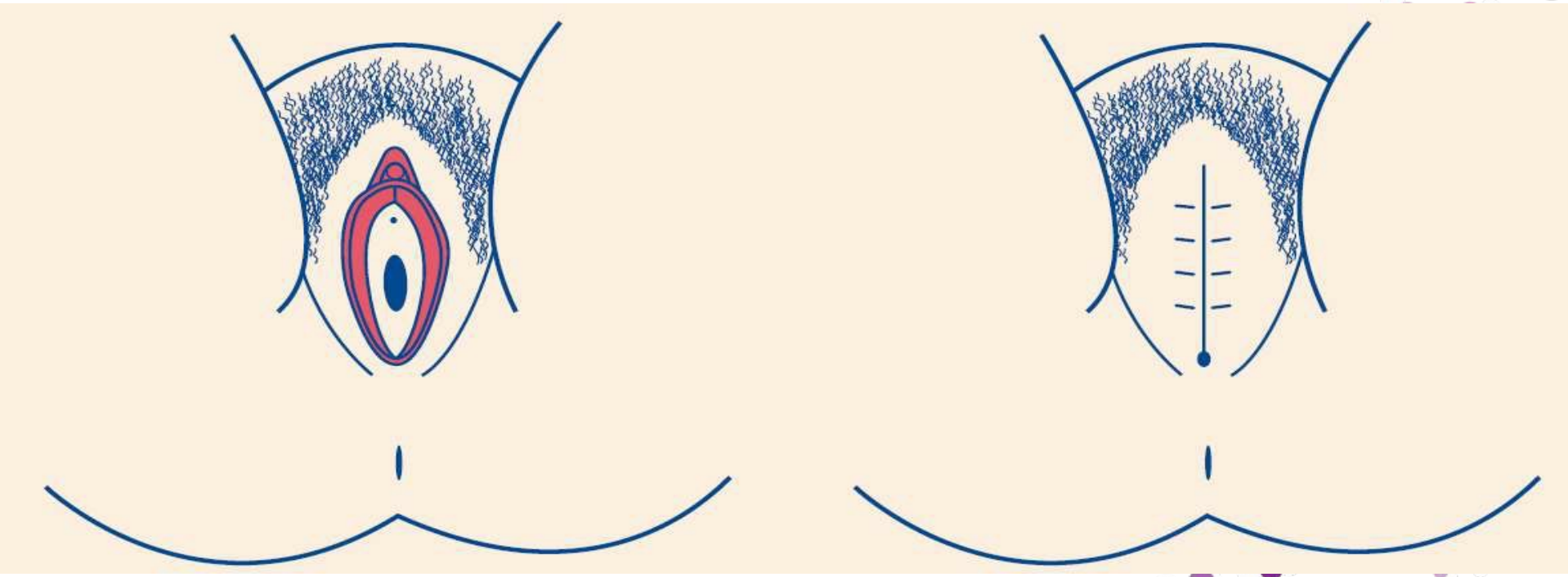
FGM Type 1

Clitoris has been cut which is often called ‘Sunna’



FGM Type 2, 3 and 4

Type 2: Clitoris cut/removed and labia minora cut/removed.
Type 3: Clitoris cut/removed, labia minora cut/removed and vagina sutured to close with a small hole left for urine and menstruation.
Type 4: piercing/ other cutting/ cauterisation of the vagina.



Consequences of FGM

Short Term

- Pain and distress, haemorrhage, infection or sepsis, urinary retention, death

Long Term

- Extensive scarring, cysts, abscesses
- Urological – dysuria, recurrent urinary tract infections
- Gynaecological and sexual function – dyspareunia, dysmenorrhea, inability to perform cervical screening
- Reproductive Issues – infertility, pain, difficulty with digital and speculum vaginal examinations
- Childbirth complications – Caesarean Section, perineal trauma

Consequences of FGM

Psychological Impacts:

- Often for the first time learning they are ‘different’ which is a huge shock and cause of distress
- Shame and stigma of the practice and that they have experienced it
- Traumatic memories / flashbacks/ triggers of flashbacks that affect their sexuality and health assessments
- Conflict – dealing with realisation harm initiated by family/ but done with love and for the “ right” reason
- Marriage and sexuality – pleasure vs trauma, consent vs duty

Referring into the African Women's Clinic

- **We see and assess women who have experienced FGM with referrals received from:**
- Self-referral (Online research, word of mouth through family, friends, community)
- General Practitioners or other community HCPs
- RWH clinicians: Antenatal Clinics, childbirth education classes, Emergency Department, Gynaecology clinics

Our patients

- Women of all ages
- Pregnant and non-pregnant women
- Women planning to marry
- Women experiencing sexual difficulty
- Women wanting to know “ have they been cut?”

Interdisciplinary Care

AWC refer to :

- Pelvic Floor Unit Consultants
- Psychosexual Counselling Service
- Physiotherapy
- Social Work
- Plastic Surgeon Mr. Mansoor Mirkazemi
- Any other clinic that is appropriate for the woman’s health

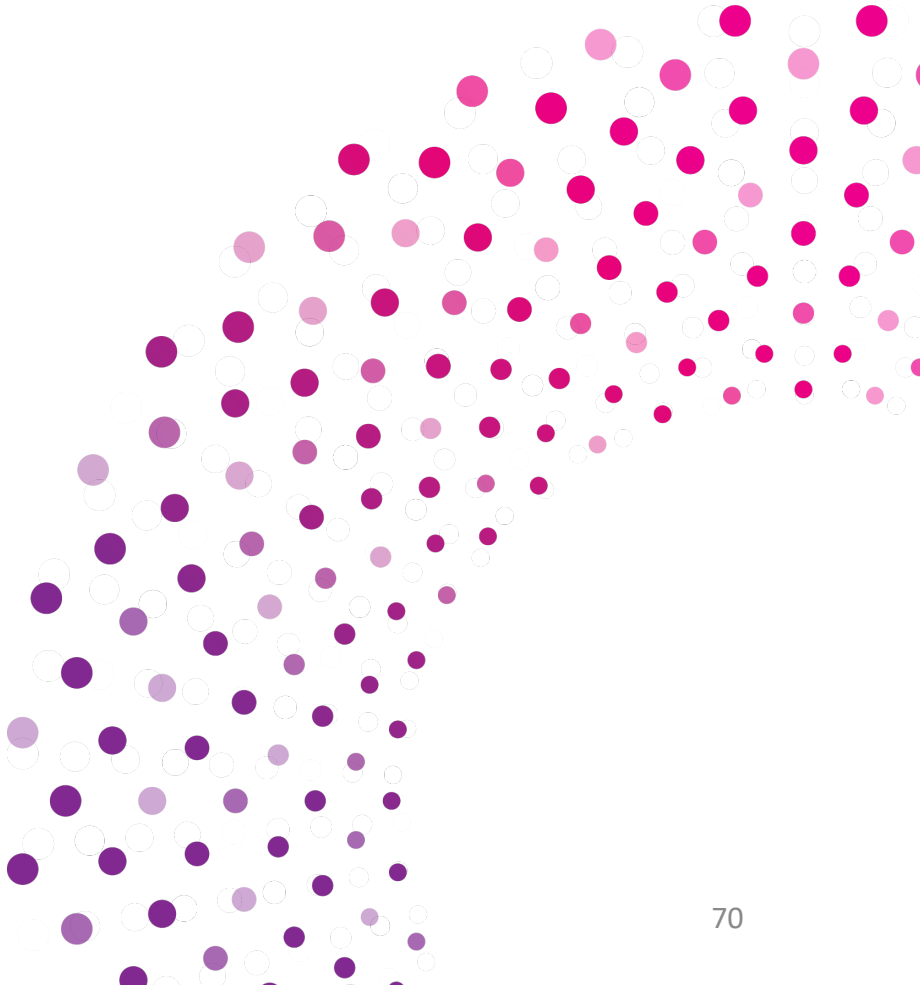
Impacts on Maternity Care

- Caesarean Section due to FGM especially if not identified antenatally
- Perineal trauma again especially if not identified antenatally
- Women's comprehension of difference between necessary suturing following episiotomy versus anterior de-infibulation
- Lack of knowledge by health care providers
- Stigma
- Difficulties with communication and culturally sensitive care
- Lack of exposure to and experience with assessing FGM and
- De-infibulation
- Suboptimal access to and utilisation of trusted interpreters for education, support and informed consent

African Women's Clinic

Assessment

- FARREP support
  - Other support persons, interpreter as needed
- Age, Country of birth, Migration status
- Source of referral
- General health status
- Reproductive health and Pregnancy health
  - Cervical screening, immunisation status
- Type of FGM
  - Age performed, Where performed, Recollection of events
  - Is deinfibulation indicated and requested?
  - Is procedure appropriate for local anaesthesia?
  - Comorbidities requiring further investigation?



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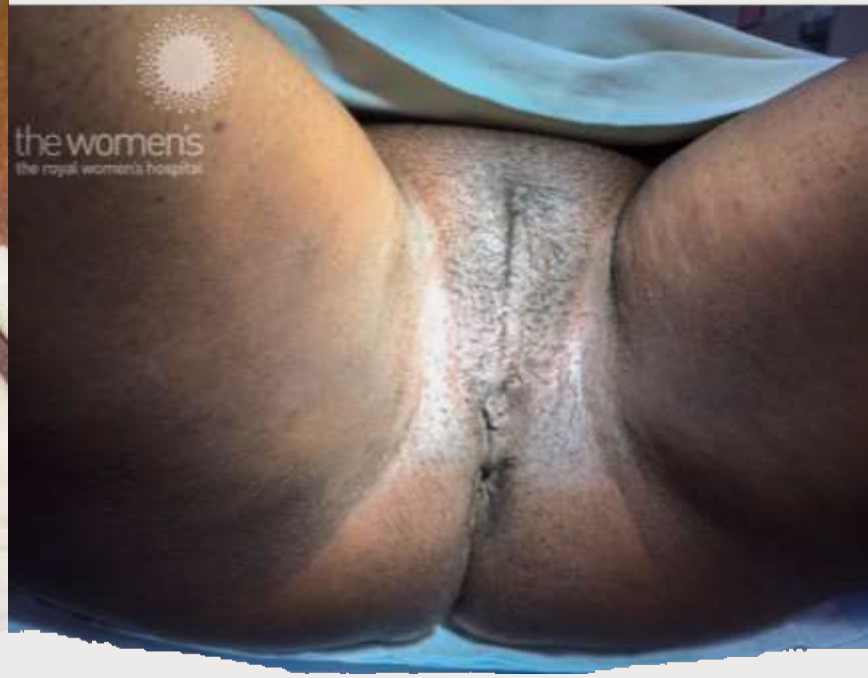


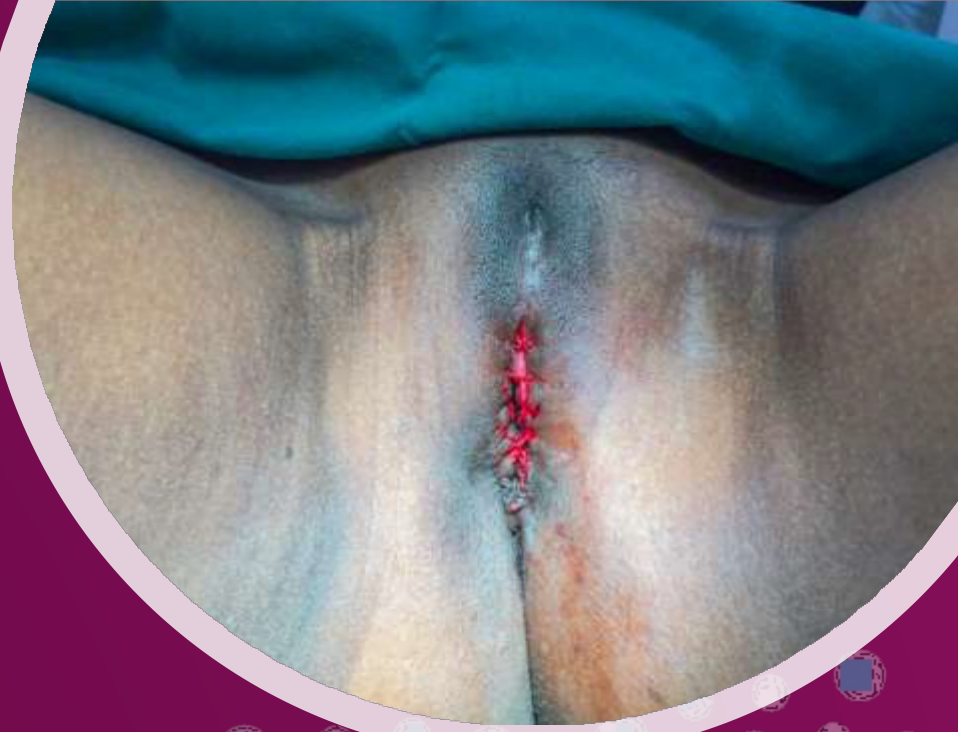
FGM Type Three

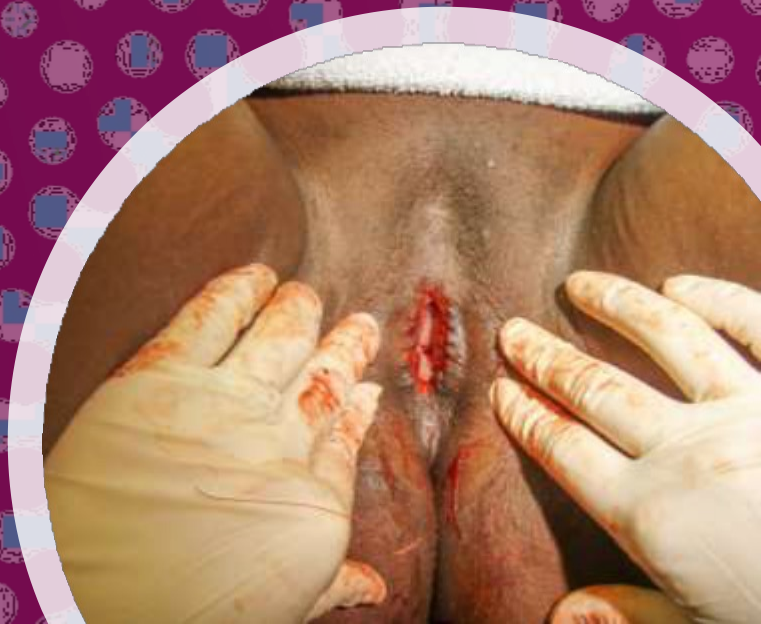
These pictures are of African Women's Clinic attenders, reproduced with permission for educational purposes, but not for general display

The Royal Women's Hospital

Deinfibulation Procedure

- Topical anaesthetic cream applied prior to procedure
- Admission and informed consent
- Baseline observations
- Infiltration of local anaesthetic
- Deinfibulation procedure
  - Sterile field for sterile procedure
  - Straight Mayo scissors
  - Open infibulated tissue to level of urethra
  - Dissolvable interrupted sutures (Vicryl 3.0)
- After Care
  - Debrief, emotional support and education regarding recovery
  - Urinary alkaliser and Paracetamol
- Written information
- Review phone call same day
- Review appointment 4 weeks post procedure





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Conclusion

AWC Achievements and Goals

- Responsive healthcare to complex and diverse needs of women in Victoria affected by FGM
- Innovative response established through Nurse Midwife led clinic in collaboration with FARREP
- Planned deinfibulation allows restoration of normal anatomy and function to the extent possible
- Deinfibulation undertaken prior to the commencement of a sexual relationship to improve sexual function and experience
- Deinfibulation undertaken during pregnancy to facilitate birth, minimise perineal trauma, hemorrhage, allay maternal anxiety regarding birth, reduce rate of Cesarean due to FGM
- Provide accurate, reliable, and evidence based health information
- Improve and extend reach of targeted clinical education and training

Outcomes

- Improved access to culturally appropriate care
- Improved access to evidence based health information
- Improvement in capacity of MORE clinicians to provide culturally competent care for women affected by FGM
- Improvement in capacity of MORE clinicians to educate and disseminate accurate information to break stigma, prevent recurrence
- Expect these endeavours to contribute to elimination of FGM

Thankyou!

For more information, contact:

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the women's
the royal women's hospital

Case studies

Case Study

- K is 35 years old. She just had her first baby in Australia.
- Records show that she had a vaginal birth and de-fibulation before labour.
- K is upset because her body feels ‘different’ and ‘abnormal’. She wants to be refibulated and wants to find someone who can perform the procedure.
- K is worried about how her menstrual and urinary pattern has changed.
- She is also worried about how her husband might feel if she did not have a refibulation. She is worried that this might affect their relationship and that he might leave her and look for another wife.
- **How might you support K in this situation?**

For discussion

- Inform her about the reason the procedure was performed to deliver her baby.
- Invite her partner for consultation together
- Inform both of them about the health implication of FGC
- Inform them both about the why she can not have re-infibulation
- Inform them about the law of FGC in Victoria
- Refer them to FARREP services for further support

Case Study 2

- S is 29 years old. She just had her first baby girl in Australia 6 months ago.
- S wants to know where she could take her daughter to circumcise her.
- **How might you support S in this situation?**

For discussion

- Ask her the reasons of why she wants to circumcise her daughter as this will help you inform your response.
- Inform her about the FGC and the health implications
- Inform her about the law in Victoria
- Share your concern with parent/guardian
- Document in your notes her intentions and monitor the child
- Consult with management if you have assessed that a report needs to be made to DHHS
- Inform family about the report made to DHHS

Health Pathways

HealthPathways – Female Genital Cutting

melbourne.healthpathways.org.au

Disclaimer: For presentation purposes only

Pathways are written by GP clinical editors with support from local GPs, hospital-based specialists and other subject matter experts

- clear and concise, evidence-based medical advice
- Reduce variation in care
- how to refer to the most appropriate hospital, community health service or allied health provider.
- what services are available

Female Genital Cutting Relevant and Related Pathways

Relevant Pathways

Female Genital Cutting/Mutilation (FGC/M)
Interpreter and Translation Services
Reporting to Child Protection

Referral Pathway

Adult Psychological Therapy and Counselling Referral

Adult Mental Health Service Referrals

Child and Youth Mental Health Referrals

Non-acute Obstetric Referral (> 24 hours)

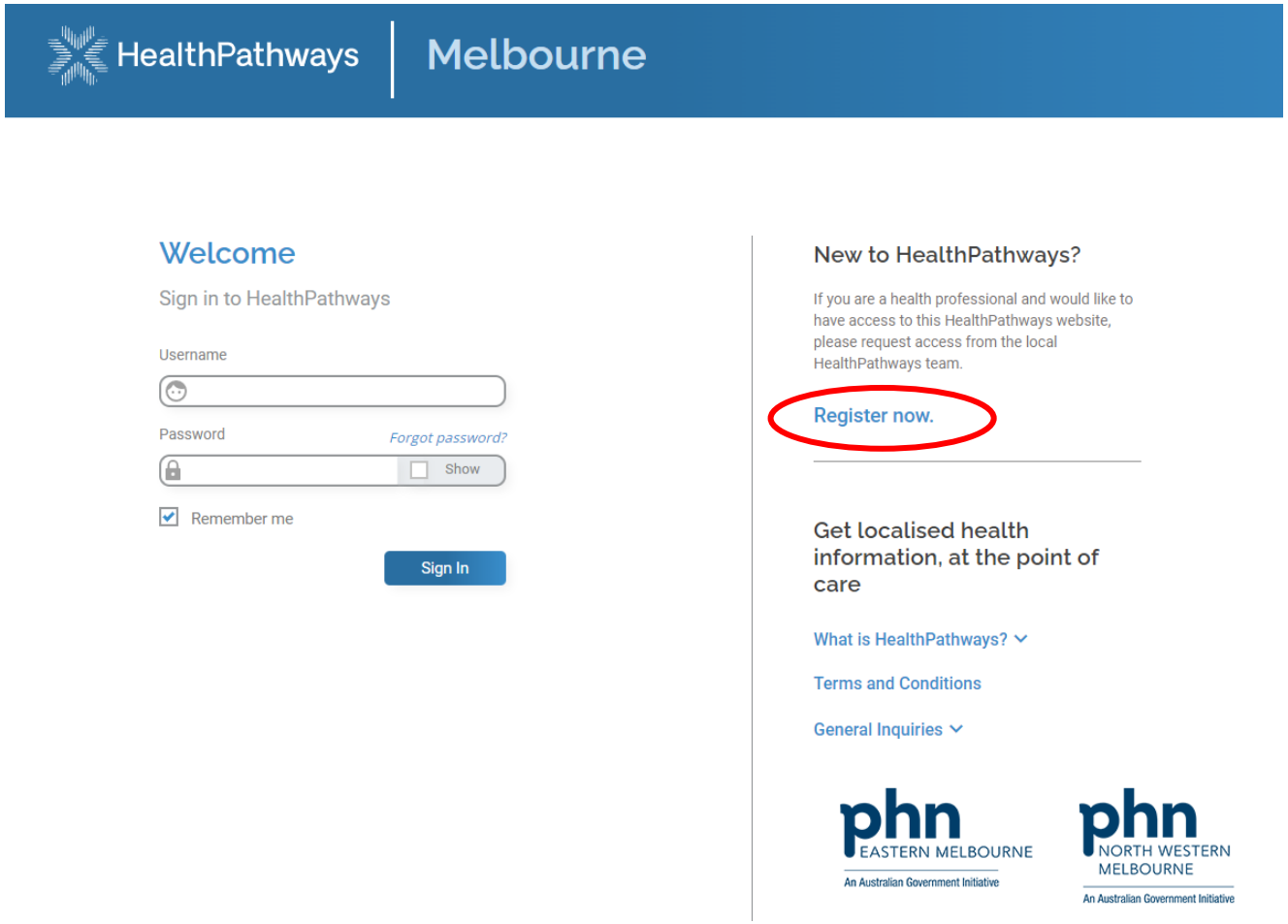
Refugee Health Referrals

Related Pathways

Refugee Health
Vulval and Vaginal Pain (Vulvodynia)
Cervical Screening
Preconception Assessment
Women's Health
Gynaecology
Obstetrics

HealthPathways Melbourne

Go to melbourne.healthpathways.org.au



Register via QR code

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Question time

Session Conclusion

Scan this QR code

You will receive a post session email within a week which will include slides and resources discussed during this session.

Attendance certificate will be received within 4-6 weeks.
RACGP CPD hours will be uploaded within 30 days.

This session was recorded, and you will be able to view the recording at this link within the next week.
https://nwmphn.org.au/resources-events/resources/

Thank you

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