The Women’s Health Strategy Unit compiled this manual by adapting the resource developed by the Royal Women’s Hospital, Melbourne.

This manual is intended as a working tool and will require additions and updates as resources and service delivery options at our hospital change. As such we propose to review the contents of this manual annually to ensure the on-going relevance of the manual to your work and will adapt this resource accordingly. Equally we welcome your feedback and direction regarding content as you utilise this resource.

If you would like additional information or if you have any comments or questions about this resource, please contact the Women’s Health Strategy Unit on 89858018.
## FGM Liaison Officers

### Medical Staff

<table>
<thead>
<tr>
<th>Department</th>
<th>Name</th>
<th>Position</th>
<th>Phone/Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstetric and Gynaecology</td>
<td>Nader Gad</td>
<td>Consultant Obstetrician and Gynaecologist</td>
<td>8922 8888</td>
</tr>
<tr>
<td></td>
<td>Sujatha Thomas</td>
<td>Consultant Obstetrician and Gynaecologist</td>
<td>8922 8888</td>
</tr>
<tr>
<td></td>
<td>Gina Wulf</td>
<td>Consultant Obstetrician and Gynaecologist</td>
<td>8922 8888</td>
</tr>
<tr>
<td>Accident and Emergency</td>
<td>Miriam Harris</td>
<td>Consultant</td>
<td>8922 8888</td>
</tr>
<tr>
<td>Paediatrics SARC</td>
<td>Annie Whybourne</td>
<td>Consultant Paediatrics &amp; Sexual Assault Referral Service</td>
<td>8922 8888</td>
</tr>
</tbody>
</table>

### Nursing, Midwifery and Allied Health Staff

<table>
<thead>
<tr>
<th>Department</th>
<th>Name</th>
<th>Position</th>
<th>Phone/Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity Unit</td>
<td>Cindy Sluggett</td>
<td>Midwife</td>
<td>8922 8688</td>
</tr>
<tr>
<td>Accident and Emergency</td>
<td>Precious Tshubangu</td>
<td>Registered Nurse</td>
<td>8922 8998</td>
</tr>
<tr>
<td>Patient Care and Nursing services</td>
<td>Frances Abbott</td>
<td>Clinical Nurse Consultant</td>
<td>8922 8152</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>Mary Noah</td>
<td>Registered Nurse</td>
<td>8922 8759</td>
</tr>
<tr>
<td>Women’s Health</td>
<td>Sharon Haste</td>
<td>Manager/ Midwife</td>
<td>8985 8018</td>
</tr>
</tbody>
</table>
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Introduction

This Resource Manual contains a range of information and resources on the subject of Female Genital Mutilation (FGM). The manual has been developed for use by all health-related professionals at the Royal Darwin Hospital and has been compiled to fulfil the following objectives:

- to increase understanding of the historical and cultural significance of fgm and its prevalence worldwide
- to resource and support staff at the Royal Darwin Hospital in developing the skills necessary for delivery of appropriate care to women affected by FGM
- to optimise service delivery within the Royal Darwin Hospital by defining and clarifying the roles and responsibilities of key workers including the fgm liaison officers
- to prevent the occurrence of FGM in Australia and its States/Territories through an emphasis on community information and support
- to promote streamlined service pathways for the pre and post-natal care of women affected by FGM.

The manual contains the following resources:

- key referral points for advocacy and support for women affected by FGM within the hospital
- a summary of and website reference to the FGM handbook Information for Australian Health Professionals, which provides comprehensive information for health professionals about FGM, the issues that surround it and information to assist an informed response
- service pathways at the Royal Darwin Hospital for women affected by FGM including antenatal care, Birthing Suite, postnatal care and community pathways
- references to an annotated bibliography of recommended reading for health professionals caring for childbearing women from affected communities.
Understanding FGM

FGM Booklet – Royal Australian College of Obstetrics and Gynaecologists (RACOG)

This booklet provides an excellent guide to:
- understanding the issue of FGM from a culturally sensitive perspective
- assist health professionals in their responses to women who have been affected by FGM.

The booklet covers the following areas:
- ethical and legal aspects of FGM
- health consequences of FGM
- psychological issues around FGM
- practice Guidelines
- deinfibulation
- pregnancy and childbirth.

Summarised Key Points
A summary of key points is provided for quick reference, including:
- definition
- prevalence
- reason for Practice
- types
- health consequences of FGM.

World Health Organisation Definition Of FGM

All procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs whether for cultural or other non-therapeutic reasons.

Prevalence of the Practice
- estimated 130 million women and girls affected worldwide
- reported in many countries including 29 African countries, Malaysia, Yemen and Indonesia.

While there is no direct evidence that FGM is practised in Australia, there are increasing numbers of immigrants who come from countries where FGM is practised. Increasing numbers of women affected by FGM are being seen in the Australian health care system.

Approximately 200 known refugees (men, women and children) enter Darwin each year from other countries, including those affected by FGM. Further numbers of immigrants (not refugees) are also arriving.

Each woman should be approached individually and non-judgementally. It should not be assumed that because she is from an affected country that she has FGM. For appropriate language to use see page 23 ‘Using Culturally Sensitive Language’.
Reasons for the Practice

- tradition, cultural identity, hygiene, protection of virginity, marriageability, husband’s sexual pleasure, aesthetics/purity, sense of belonging to a group and community economics
- not required by any religion although some people believe it to be of religious importance.

FGM may occur at any age, usually as part of a traditional ceremony. The surgical techniques used vary and the operation may occur with unhygienic, non-surgical equipment, ie. razor blade, that is shared between girls, without cleaning. This places the girls at greater risk of contracting communicable diseases as a result of this procedure.

Types of Female Genital Mutilation

Type I
Excision of the prepuce (the fold of skin above the clitoris) with or without excision of part or all of the clitoris.

Type II
Excision of the clitoris with partial or total excision of the labia minora.

Type III
Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation).

Type IV
Unclassified includes:
- pricking, piercing or incising of the clitoris and/or labia
- stretching of the clitoris and/or labia
- cauterisation by burning of the clitoris and surrounding tissue
- scraping of tissue surrounding the vaginal orifice or cutting of the vagina
- introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purposes of tightening or narrowing
- any other procedure which falls under the definition of female genital mutilation given above.

The RACOG booklet may be accessed at:
Health consequences of FGM

Short-Term
The immediate complications of FGM are not likely to be commonly seen in Australia. They are included here for reference but may not be relevant to the assessment and treatment of women who have undergone FGM many years ago. They may be useful in the education of parents with newborn female children.

- pain that can be severe
- shock that may lead to death
- haemorrhage (primary or secondary and may lead to death)
- injury to the urethra
- acute urinary retention
- infection due to unsterile conditions during the procedure (wound, septicemia or tetanus, pelvic inflammatory disease, urinary tract, blood borne diseases - hepatitis B, HIV - due to sharing implements)
- fractures, dislocations or other injuries due to restraining a struggling child.

Long-Term
The long-term consequences may be encountered by women in our community, although may not be the reason for presenting. Obstructive problems are more likely to be seen after infibulation (Type III FGM) although scarring may also be severe in women who have undergone some Type II procedures.

Vulval complications:
- scarring with or without keloid formation
- retention cysts that may become infected with abscess formation
- neuromas
- bleeding due to recurrent trauma, possibly resulting in anaemia
- aggravated atrophic symptoms after menopause.

Urinary tract problems:
- voiding difficulties due to urethral damage, scarring or obstruction (bladder emptying may take as long as 15 minutes in infibulated women, which may seem normal if this has happened throughout life)
- painful micturition
- chronic urinary retention due to urethral obstruction
- recurrent UTI due to stasis or obstruction
- renal damage
- urinary incontinence due to urethral damage or fistula formation.

Other Gynaecological problems:
- dysmenorrhoea, especially with genital tract obstruction
- pain due to chronic pelvic inflammatory disease
- infertility due to tubal damage and pelvic inflammatory disease
- difficult pelvic examination or taking cervical smear for screening for cervical cancer
• contraceptive difficulty, eg. with use of intra-uterine contraceptive device (IUCD)
• haematocolpos
• urethra-vaginal or rectovaginal fistula resulting from FGM, deinfibulation, reinfibulation or obstructed labour.

Complications during pregnancy or childbirth:
• obstructed miscarriage
• excessive pain associated with scar tissue
• restricted examinations resulting in inaccurate assessment and difficult bladder management
• prolonged and obstructed labour
• difficult induction of labour if required
• excessive perineal laceration and bleeding at delivery
• need for deinfibulation and episiotomy in labour (if type III FGM).

Sexual problems
• non-consumation due to obstruction, vaginismus or painful scar tissue
• trauma on deinfibulation by partner or traditional birth attendant.
• dyspareunia
• vaginismus with or without introital scarring
• impaired sexual response and enjoyment including lack of orgasm
• if vaginal intercourse is precluded, sexual expression may be problematic and/or a source of relationship conflict.

Psychosocial issues
There is limited research on the psychosocial consequences of FGM. Psychological stress may be experienced as a direct consequence of FGM or may be related to other experiences including those around immigration and settlement. Causes of psychosocial stress may be experienced as a direct consequence of FGM or may be related to other experiences including those around immigration and settlement.

• reactions to the trauma of FGM itself
• anxiety and depressive symptoms
• effects on sexuality
• war, famine, immigration issues
• conflict within family and community
• responses of host communities, including health professionals
• inter-generational issues regarding continuity of the practice
• post-immigration anxiety and regret regarding FGM.

Refer chapter 4 of the Royal Australian College of Obstetricians and Gynaecologists booklet for Australian Health Professionals for further information on psychosocial issues.

Services at Royal Darwin Hospital

The Royal Darwin Hospital (RDH) is the tertiary referral hospital for the Top End of Australia and the largest maternity provider in the Northern Territory. Darwin has a multicultural population and RDH is committed to working with women from a range of cultural backgrounds. In this context, women from countries where FGM has been practised have attended the hospital in the recent past and more women will be attend in the future.

The RDH has worked with representatives within Government and Non-Government Organisations to develop this manual and the following resources:

- establishment of self-nominated FGM liaison staff for each area (listed in the front of this resource)
- streamlined clinical care pathways
- information to form the basis of education and cultural awareness sessions.

This section contains the following information to work toward ensuring positive birthing and health care experiences for women affected by genital mutilation.

- role of FGM liaison officer
- streamlined care: clinical care pathways in the RDH and community for women affected by FGM.
Role of FGM Liaison Officers

Background
The RDH is committed to meeting the needs of women affected by FGM though the development and implementation of strategies. One such strategy is to establish a group of health professionals to act as liaison officers for women affected by genital mutilation.

The FGM working group thought the optimal model of care for women affected by genital mutilation would be mainstream service delivery through regular clinics with designated staff to support them. This was seen to be preferred against separate clinics due to the small numbers of women in Darwin and the stigma attached to a separate clinic, which may further isolate and segregate women.

The Working Group identified designated FGM liaison officers. The Maternity Unit, Emergency Department and Patient and Nursing Support Unit have nominated staff to act as liaison officer’s in their area. The primary role and responsibility of these people includes the following:

Role
- ensure the provision of support and continuity of care to women affected by FGM
- be available to other staff to provide support and advice in managing care of women
- support and encourage increased awareness and knowledge of FGM among service providers in the hospital
- facilitate improved service pathways for women affected by FGM.

Responsibility
Throughout the pathway of care through various clinics and units women should have access to an FGM Liaison Officer. This does not necessarily mean the liaison officer will be the staff member who provides the care but rather a nominated person who will oversee and resource the care provided to women.

The names of the FGM liaison officers in each area are located at the front of this manual.
Streamlined Care: Clinical Care Pathways for Women Affected by FGM

To provide effective care for women affected by FGM, it is essential service pathways ensure a smooth passage for women through their maternity care. Throughout their care, key issues include accurate, appropriate and timely assessment, referral and planning and thorough documentation.

The following flowcharts provide a graphic depiction of the pathways of care for women affected by FGM. In particular, the following points:

- a Social Assessment should be made at the first antenatal visit and referral made to the FGM Liaison Officer for support, advocacy and referral to other appropriate services with all actions clearly documented. Please note it is the women’s choice to take up the referral options

- at initial clinical assessment (first antenatal visit), a woman’s FGM status should be physically assessed, diagnosed, and documented clearly and accurately in the antenatal notes, with the aid of diagrams

- women should be supplied with appropriate information about the reasons for deinfibulation and counselled about the health consequences of infibulation, to enable them to give informed consent not to be reinfibulated. This may be done with the FGM medical officer for the Unit or clinical area

- a referral should be made to the FGM liaison officer for future antenatal follow up

- women affected by FGM will require a detailed birth plan, which should be developed in partnership with the woman and her family (bearing in mind that the women’s wishes are central and may change over the course of the pregnancy)

- the birth plan will include details of the timing of deinfibulation (antenatal or intrapartum). This should be clearly recorded in the notes. Women should be offered a hand-held copy, using dot points, which they can take with them to the Birthing Suite

- women attending for planned Caesarean birth will require counselling regarding deinfibulation and appropriate planning for elective deinfibulation. (See Practice Guidelines)

- if women present late in pregnancy, they still require full clinical and social assessment, and appropriate management

- before postnatal discharge, planning should include referral to appropriate community supports. A list of names is provided with this resource

- it is against the law in Australia to reinfibulate a woman after deinfibulation or to perform infibulation or any form of genital mutilation.
Pathways for Care
Deinfibulation for non-pregnant woman

Internal or External Consultation

Referral to RDH Gynaecology Clinic with Medical O+G FGMLO

Discussion and medical examination with Medical FGMLO (interpreter present)

Pre-marital deinfibulation

Urgent Day Surgery Procedure

Non-urgent deinfibulation

Semi-urgent Day Surgery Procedure

www.nt.gov.au/health
Antenatal Clinic

First Antenatal Visit
- identification of FGM at history taking
- referral to FGM Liaison Officer (FGMLO) for examination
- offer counselling at Melaleuca counselling Service or SARC
- arrange interpreter for next visit.

FGMLO Visit (with interpreter)
- grade FGM (Type I, II or III) and document
- discuss and document management plan with interpreter assistance
- initiate discussion regarding deinfibulation and not reinfibulating.

Type III
28-32 Week Visit
- Check healing if woman had antenatal deinfibulation.
- Review birth plan
- Review plan for deinfibulation and not reinfibulating.

36 week Visit
- Details of intrapartum care discussed and updated in Pregnancy record.
- Hand held birth plan given to woman, to include details of deinfibulation and not reinfibulating, including detailed plan for emergency caesarean birth if required before intrapartum deinfibulation performed.

Options for care discussed

ANC  Med/Obs  GMP  CMP  MWC  GP shared

Visit with FGMLO at 28-32 weeks and 36 weeks (Type III)

Birth
Birthing Suite

Woman admitted in labour

Management Plan?  No  Degree of FGM assessed by Registrar

Yes

FGM Type I or II with no physical affect on birth.

Planned Vaginal Birth?

Yes

Type I or II

Normal labour and birth care.

Type III

Antenatal deinfibulation?

Normal Vaginal Birth.

Planned intrapartum deinfibulation?

Normal Vaginal Birth with deinfibulation as per guidelines.

Repair trauma as required and as per management plan. No reinfibulation.

Caesarean Birth

Post Natal Ward

Contact Interpreter when woman comes into birthing suite if required.
Deinfibulation in Labour

Timing
Usually done in the second stage of labour as the head is descending. Suturing is performed after the birth of the baby and placenta are complete.

Sometimes early recourse to mediolateral episiotomy follows deinfibulation due to the presence of scar tissue around the introitus.

Occasionally deinfibulation may be needed early in labour or to allow for induction of labour. In this case it can be performed under epidural anaesthesia. Unless bleeding, suturing can be performed after the birth is complete.

Anaesthesia
Local infiltration is suitable to perform the procedure on a woman in labour. For elective deinfibulation during the antenatal period, spinal, epidural or general anaesthesia may be more appropriate. General anaesthesia is usually administered in non-pregnant women.

Technique
Place the woman in the lithotomy position. Wash the vulva with antiseptic solution. If the vagina is difficult to clean due to its narrowing then fill a 10-20 ml syringe with antiseptic solution and introduce the nozzle of the syringe inside the vagina and gently irrigate the vagina.

Introduce your left index finger behind the free flap of skin to assess for any dense adhesions and to stretch the free skin flap (see figure 1 below).

If the opening is too narrow to allow for a finger to be introduced then introduce a closed straight small artery forceps, then slightly open its blades for stretching the skin flap.

Scissors are used to perform a straight incision starting from the free edge and directed upwards. A scalpel is used in the presence of dense scarring or a very narrow opening. The underlying tissue can be protected by insertion of a straight artery forceps with its blades slightly opened behind the free skin flap during cutting.

Care should be taken as occasionally the upper limit of the scar tissue extends to the external urethral meatus.

Figure 1 - Deinfibulation (division of the midline skin fold)
Suturing

When birth of the baby and placenta is complete the cut ends of the incised skin on each side can be sutured together using interrupted sutures of 3/0 or 2/0 absorbable material. See figure 2 below.

No dressing is required, but if extensive raw areas remain after suturing, vaseline gauze can be applied over those areas.

Figure 2 - After division of the skin fold and suturing of side separately.
Postnatal Pathway

Woman received in postnatal unit

Is the baby a girl?

Yes

Family counselling and education regarding FGM

Degree of FGM?

No

Type I or II

Deinfibulation not performed, eg. Caesarean Birth

Discuss deinfibulation with medical FGMLO and book if woman chooses to have procedure. (occasionally may be done before)

Normal Postnatal Care

• referral to Maternal Child Health Nurse at appropriate Community Care Centre with woman’s consent
• referral to GP or arrange for RDH 6 week postnatal check
• FGM recorded on discharge summary for MCH Nurse and GP
• referral to Melaleuca for psychological counselling if required.

Woman discharged home

Type III

Deinfibulated

• provide support and advice on care of vulval, perineal, or vaginal wounds
• in the first few days ensure suture lines do not adhere together across the midline by passing a finger or soft cloth upwards across the vulva
• if extensive raw areas, apply vaseline gauze, if required.

Exam by FGMLO (midwife or Dr) prior to discharge
Practice Guidelines

- positioning yourself to provide best care in a culturally sensitive way.
- steps in providing clinical care
- guide to asking women whether they have had genital surgery
- terms used for circumcision
- counselling concerning deinfibulation and not reinfibulating
- caesarean birth
- informed consent and privacy
- a Teaching Case Study
- *My Birth Plan at RDH* - One woman’s story
- working with Interpreters
- languages of countries that practice FGM.

For a more detailed description refer to the RACOG booklet on FGM. The booklet may be accessed at:
Positioning Yourself To Provide Best Care

A Checklist:

✓ recognise FGM and its ramifications for the midwife, obstetrician and gynaecologist
✓ recognise the various types of FGM and their respective management protocols
✓ be informed of care pathways and management plans for women affected by FGM
✓ learn methods of approaching the patient with cultural sensitivity
✓ understand the legal and ethical issues pertaining to FGM
✓ be aware of appropriate resources, and how to find and use them.
Steps In Providing Clinical Care

In their approach to clinical care, health professionals should:

- aim to provide holistic care with attention to psychosocial factors in a culturally sensitive, non-judgmental manner
- be aware of communities who may practise FGM in order to be alert to the possibility, while making no assumptions on the basis of country of origin, race or religion
- be aware of the practices, which constitute FGM, their background and their consequences including medical, social and psychological aspects
- be aware of the influence of the Australian context including experiences relevant to immigration
- be aware of likely divergence between expectations and functioning of the health care system. Explanation of the system is likely to be necessary
- be aware of and deal with your own feelings and responses
- involve interpreters if possible/appropriate
- understand that husbands/partners may play an important role in decision making and explore and respect the woman’s wishes
- use terminology which is acceptable to the woman and which avoids endorsing the practices
- respect that some women may have difficulty discussing intimate matters and take time to develop a trusting professional relationship
- explain and illustrate normal anatomy and the woman’s own situation according to her needs and wishes
- explain reasons for examinations and procedures
- document findings in detail to minimise need for repeat examinations so that future difficulties such as catheterisation problems may be anticipated and planned for
- be aware that pelvic examination may be difficult, painful or impossible and do not persevere if unduly uncomfortable/painful: careful angulation of instruments and one finger examination may be necessary
- If infibulation has been performed, consider place and timing of deinfibulation.

Reference
Guide to Asking Women Whether They Have Had Genital Surgery

As with all maternity and gynaecology patients, women affected by FGM need to be accurately assessed with regard to their physical and social needs to ensure effective care. All women presenting in the Antenatal Clinic can be asked whether they have had genital surgery as part of their medical assessment. This provides:

- accurate assessment of clinical needs
- needs to be asked as a part of an overall medical and obstetric history to:
  - avoid stereotyping
  - entrench the question as part of routine assessment
  - avoid embarrassment on the part of both women and health professionals
- enables health professionals to develop critical pathways for care.
- enables women to develop birth plans
- opens up avenues for discussing deinfibulation and no reinfibulation
- enhances opportunities for health promotion and information exchange
- alerts health workers to women’s needs for health education and counselling
- raises opportunities for health professionals to reflect on practice and professional learning needs
- alerts health professionals to women’s special needs over and above mainstream care.

Assessment

It is appropriate for the woman to be asked the question by a midwife or doctor in the assessment clinic. Should the woman require a physical assessment to confirm the nature and extent of ritual surgery, it would be appropriate for the examination to be carried out by the FGM liaison officer for that ward or clinic area, or by a Senior Medical Officer or midwife experienced in the care of women affected by FGM. The type of FGM should be documented clearly in the antenatal notes, using diagrams as necessary. Although many women and their partners prefer a female doctor to examine them, it is usually possible for consent to be gained for a male practitioner to attend them, so long as this is negotiated, using an interpreter as necessary. If this is not possible at the assessment, a further appointment will be necessary.

Using Culturally Sensitive Language

In our Western context, the language used to describe FGM or circumcision is complex. In line with WHO guidelines, practitioners in Australia, particularly in the policy and public health arenas, use the term Female Genital Mutilation. It is a term used to emphasise the mutilating nature of the practice, as part of a worldwide campaign to eliminate the procedure. However, most women from affected communities would understand that the intent of their mothers and female relatives would have not been to mutilate, but to enhance their daughters’ opportunities for marriage and economic security, and success in the world. Different communities may use different descriptors, therefore it is essential that health practitioners explore sensitively with clients the terminology that they understand and are comfortable with. Terms that women may use include circumcision, cutting, traditional female cutting or surgery, or sunna. An interpreter may be able to assist in finding a mutually meaningful term.
There may be some anxiety among workers about who should be asked about genital surgery, who should ask the question and how it should be asked without causing offence. The available literature suggests that women affected by FGM prefer their status to be known to clinicians, to enable them to plan for antenatal care and delivery in conjunction with health care workers. They also feel more confident in the ability of the team to understand and recognise the needs of women affected by FGM if the health workers raise the issue as part of routine care.

If the question of genital surgery status is embedded in the framework of a routine medical and surgical history, it removes the onus from the workers of having to make a judgement about a woman’s cultural or ethnic background, and from the woman of having to raise the question in an unfamiliar setting. It may also uncover other significant problems for non-infibulated women.

### Terms used for circumcision

<table>
<thead>
<tr>
<th>Country</th>
<th>Language</th>
<th>Transliteration</th>
<th>Meaning</th>
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<tbody>
<tr>
<td>Egypt</td>
<td>Arabic</td>
<td>Tahara</td>
<td>From the Arabic word “tahar” which means to clean or purify. Circumcision (used for both male and female circumcision).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Khitan</td>
<td>From Arabic word “khafad” which means to lower. Refers to lowering of the height of the clitoris by cutting (rarely used in colloquial language).</td>
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<td></td>
<td></td>
<td>Khifad</td>
<td></td>
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<tr>
<td>Ethiopia</td>
<td>Amharic</td>
<td>Megrez</td>
<td>Circumcision/cutting</td>
</tr>
<tr>
<td></td>
<td>Harrari</td>
<td>Absum</td>
<td>Name giving ritual</td>
</tr>
<tr>
<td>Eritrea</td>
<td>Tigregna</td>
<td>Mekhnishab</td>
<td>Circumcision/cutting</td>
</tr>
<tr>
<td>Kenya</td>
<td>Swahili (national language)</td>
<td>Kutairi (wasichana)</td>
<td>Kutairi literally means circumcision for boys and girls. When Wasichana is added it becomes’ circumcision of girls’.</td>
</tr>
<tr>
<td>Nigeria</td>
<td>Igbo</td>
<td>Ibi/Ugwu</td>
<td>The act of cutting. It is used for circumcision for boys and girls (the Igbo language has several dialects. Other dialects may have a different term for circumcision).</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>Mandingo</td>
<td>Soussou</td>
<td>Sunna refers to a range of practises that follow the teachings of Islamic religion. This term is used by different groups of people of the Muslim faith in different countries to refer to female circumcision based on their understanding that the practice is recommended in the religion. The Soussou and Mandingo people are predominantly Muslim.</td>
</tr>
<tr>
<td></td>
<td>Mendee</td>
<td>Bondo</td>
<td>An initiation/training which is an integral part of the passing to adulthood. Those who participate in the training are considered initiated once they have been circumcised.</td>
</tr>
<tr>
<td></td>
<td>Mendee</td>
<td>Sonde</td>
<td>Same as Bondo</td>
</tr>
<tr>
<td>Somalia</td>
<td>Somali</td>
<td>Gudinin</td>
<td>Circumcision used for boys and girls. From the Arabic word ‘halal’ which means ‘sanctioned’. Used to imply purification or purity. Used mostly by people of Northern Somalia or by Arabic speaking Somalis. Stitching, tightening or sewing. Used to refer to infibulation</td>
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<td></td>
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<td>Sudan</td>
<td>Arabic</td>
<td>Tahoor</td>
<td>From the Arabic word ‘tahar’ which means to purify. From the Arabic word ‘khafad’ which means to lower. Refers to lowering of the height of the clitoris by cutting (rarely used in colloquial language).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Khifad</td>
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</tr>
</tbody>
</table>

### Reference

NSW Education Program on Female Genital Mutilation, 2000, *Clinical Management Guidelines – A self directed learning package for health professionals*, NSW College of Nurses.
**Counselling concerning deinfibulation and not reinfibulating**

Women’s life experiences, and that of their female relatives and friends, determine perceptions of what is “normal”. The literature on FGM suggests that many women welcome information about their bodies and how they function to aid their understanding about the need for deinfibulation prior to birth, and reasons for not reinfibulating postnatally. In order for women to give informed consent, it is important that they are given information in an appropriate manner, in consultation with FGM liaison officers and interpreters.

For any infibulated women who are attending for antenatal care, there is a need for appropriate information regarding deinfibulation, which is offered electively in pregnancy, or intrapartum, to allow for delivery.

The information provided to women about the process and management of deinfibulation should include the following:

- an explanation/description of the deinfibulation procedure
- pain relief options post deinfibulation
- wound care, including keeping the genital area clean, and techniques for keeping the skin flaps apart to prevent reformation of the scar
- Physiological changes following the procedure including
  - Voiding - pattern-faster, stronger stream, noisier
  - Menstruation - blood loss may appear heavier and more intense, clots.
  - Intercourse - may be less painful, feeling of looseness, due to wider introitus
  - appearance of the genitalia may be significantly altered
  - vaginal mucous - may appear more copious.

Some women may feel anxious about touching their genitals, or about infecting or harming themselves. It is important that medical and midwifery personnel are able to lead the discussion in a sensitive way in order to address women’s concerns, and ensure that women understand how to take care of themselves.

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Women may have experienced the initial genital mutilation procedure in clinical or non-clinical circumstances, with or without anaesthesia or pain relief, and with varying degrees of trauma. Any discussion of deinfibulation may uncover emotional and psychological sequelae for women, which will require sensitive support.
Caesarean Birth

Caesarean birth is often not welcomed nor readily agreed to by women who have FGM or their husbands for a number of reasons.

In many countries where FGM is performed, caesarean birth is rare and is often only performed when the mother’s life is in danger. It is generally not performed to save the baby as perceptions of foetal mortality are different from our own.

Suggestion of this procedure may create a fear that the woman’s death is imminent. The woman may also be concerned about future pregnancies and the inability to have another child.

If reasons for caesarean are understood and accepted, an elective procedure may still not be acceptable with some women insisting on waiting for the onset of labour. The cultural or social significance of this should be acknowledged, respected and accommodated if reasonably and safely possible. Practitioners should conscientiously explain risks and reasons for recommended interventions, using interpreters where necessary.

There may be a fear of being practised on by ‘junior staff’ and it may be necessary to explain their roles and supervision.

Informed Consent and Privacy

In the RDH there are limited opportunities for health practitioners to observe deinfibulation procedures and it is important to teach the method of deinfibulation to medical and midwifery practitioners.

If it is likely that another health practitioner will be present at the time of the deinfibulation procedure or at the birth of the baby, this should be discussed with the women and informed consent obtained during the antenatal period if possible. An interpreter is required to obtain consent if the woman does not speak or understand English.

The privacy of the woman should be respected at all times and informed consent gained for observing staff members, excess to required numbers, except in the case of emergency.
Teaching Case Study
Waris Mohamud is a 19-year-old African woman who presents in the antenatal clinic. Her partner speaks some English and accompanies her. He tells you that she has been seen by a GP, who confirmed her pregnancy six weeks ago. This is her first baby.
• how will you assess this woman’s antenatal care needs?
• what resources might you need to give this woman optimal care?
• are you aware of any particular obstetric needs she may have?
• are you aware of any information needs she may have?

In going through her history, Waris appears very shy, and lets her partner do the talking. Her partner tells you that Waris has only been in Australia for six months, having arrived via a refugee program from Kenya, where she lived for three years. He tells you that she is originally from Somalia, like himself.

• how will you assess her social supports and language needs?
• are you aware of any appropriate programs or agencies to refer her to?
• how might her refugee experience impact on her health and pregnancy?

As you go through the medical history, it appears uneventful – no surgical or medical procedures. Waris appears to be a healthy young woman, with a straightforward pregnancy. Her partner seems attentive, and only asks that, if possible, Waris been seen by women doctors and carers.

• what birthing care options might be available to Waris?
• how might you present these options to her?

Waris leaves the clinic after you have outlined the routine of future clinic visits. A few weeks later you attend an in service by two of the FGM liaison officers at RDH, who explain that their role is to support women affected by FGM. They give you some information about FGM, and about some of the cultural issues for women in their communities.

You next encounter Waris in the clinic, at 36 weeks. She is on her own, as her partner is working, but you are able to contact the interpreter and FGM liaison officer to assist with the consultation. It emerges that Waris is well, but concerned about the delivery, as she is infibulated, and has not had the opportunity to discuss what this means, beyond listening to some of the older women in her community.

• what strategies might you use to assist her?
• are you aware of particular health needs at this stage?
• what steps might you put in place to support Waris at this stage?
My Preferred Birth Plan At The RDH – One Woman’s Story

My name is Sagal and I am originally from Somalia. I came to Australia in 2002 under the Refugee and Humanitarian Program and married in January 2003. My first contact with the Australian health system was my attendance to the RDH antenatal clinic. In the clinic a very friendly midwife took my medical history with the use of a qualified Somali interpreter. I was asked if I ever had genital surgery or traditional circumcision when I was young.

I told her yes and she referred me to the FGM liaison officer. I was also told about the different options of birth care available at the hospital and I chose the normal antenatal clinic. An interpreter was available for each of my visits. At the antenatal clinic I met with a female doctor, with interest in female circumcision. She was guided by an experienced male doctor. She assessed my circumcision degree, which was infibulation, and developed a birth plan for the safe birth of my baby.

She discussed the deinfibulation process and gave me the option to get deinfibulated at 20 weeks of pregnancy or during the birth. I chose the latter. If I had known that information earlier I would have chosen to get deinfibulated before I got pregnant. She also spoke to me about not being reinfibulated.

For the rest of my pregnancy I came to the routine antenatal visits where I was given time to ask questions and discuss important issues for my pregnancy and birth. I also discussed my social situation, circumcision status and admission and discharge procedures.

My labour started spontaneously at home and my husband drove me to hospital. In the birthing suite I showed the midwife my birth plan and she called a doctor who is experienced in deinfibulation of circumcised women.

After the birth I was transferred to the postnatal ward with my baby. In the first hours after the delivery the midwife looking after me was constantly monitoring our health and was helping me with breast-feeding. The next day I was shown how to bath my baby. The staff made every effort to make me ready to look after my baby independently when I went home. I was offered a referral to the Community Health Clinic after discharge to check on my baby’s and my health.

I was allowed to have visitors and access to an interpreter during my stay. I chose to go home two days after the birth and the Community Health midwife visited me the next day. I was linked to the Maternal and Child Health nurses in my area. I feel positive about my experience of the hospital. I was given lots of information, different options of care were presented to me, and I was able to make good decisions about my care. I also felt treated with dignity and respect even though I know that some people are shocked by the practice of female circumcision.

I had a baby daughter and someone in the postnatal ward spoke to me about the law in Australia on female circumcision. It is not my intention to perform that procedure on my daughter as I am now informed about both the long and short-term harmful effects of the procedure.
Working With Interpreters

To ensure that women and workers are able to communicate optimally, it is essential to use interpreters who are professionally qualified, who are fluent in the appropriate languages and dialects, and who are female.

Professional interpreters should:
- understand and observe rules of confidentiality
- be fluent in the language of medical jargon as well as English
- assist with clear communication process
- be fluent in the language specified
- have undertaken FGM training.

The gender of the interpreter is of particular importance for women and families seeking care for sexual and reproductive health issues, so information can be appropriately shared between health providers and women. It is more appropriate for the interpreter to be females, especially when discussing sexual and reproductive health.

The role of the interpreter is to verbally convey as accurately as possible the meaning of the exact words of worker and client to each other. The interpreter, the worker and the client may ask for clarification of a word or phrase during an interaction, to ease communication, but it is the responsibility of the worker to check their own understanding as well as that of the woman. This can be done by summarising and reflecting the points made back to the woman, or by checking her understanding by asking her to do the same.

The roles of cultural advocate may be to support the work of interpreters, by supplying contextual information to women and workers. However, the cultural advocates working within the hospital should not be used as interpreters, rather as facilitators to enable women and workers to work together appropriately.

Care must be taken to try and ensure that the interpreter speaks the same or similar dialect as the woman, or that her accent is comprehensible. For example, Arabic speaking Eritrean women may have difficulty understanding Lebanese Arabic speakers; preferred language backgrounds would be Arabic speakers from Sudan or Egypt.

It is preferable not to use family members of friends for the following reasons:
- loss of confidentiality
- lack of knowledge of medical language and jargon
- cultural beliefs about what are acceptable to discuss with foreigners or strangers, eg. FGM status.

However, some women may prefer the support of a partner, friend, or family member as their interpreter, feeling more comfortable with someone whom they feel understands and advocates for them. Workers may be able to clarify the woman’s understanding of the interpreter role, so that she understands the choices available.
to her. It may also be possible to involve family members in other ways, for example encouraging their presence as support people.

Workers may be concerned that women are reluctant to ask for an interpreter due to the perception that it may be seen as a slur on their English language skills, their ability to participate in Australia society, or their class or educational background. Some workers find it helpful to say that it would assist them in the interaction to use an interpreter, so that the woman is not made to ‘lose face’.

Supports For Good Practice With Interpreters

There is a range of resources to support good practice with interpreters in the Royal Darwin Hospital including the following:

- *Working with Interpreters – A short guide* pamphlet available from Royal Darwin Hospital Cultural Consultant or NT Interpreter and Translator Service (NTITS)
- *Working with Interpreters NT Interpreter and Translator Service*, Office of Multicultural Affairs, Northern Territory ph 89994302.

### How To Arrange An Interpreter (for languages other than Aboriginal)

**NT Interpreter and Translator Service (NTITS)**

**Mon-Fri- 0830-1600**

- phone NTITS (94302) stating clearly the language required, and date and time of the appointment. It is important to specify you require a *female* interpreter
- if no onsite interpreter available you will receive a job number and advised to arrange telephone interpreting
- phone the Commonwealth Translating and Interpreting Service TIS (131 450)
- quote the job number and RDH client code (C107588). Telephone interpreters are usually available within a few minutes.

**After Hours, Weekends and Public Holidays**

- phone TIS (131 450) and quote RDH Client Code (C107588).

**Pre Booking Telephone or on-site Interpreters**

- follow steps as for weekday interpreting above. You will be given a job number and a faxed request form. Complete details and fax back. You will be notified of booking confirmation
- for telephone interpreter. When ready to use Interpreter phone TIS (131 450) advising of booking and quote job number
- TIS will connect you with the interpreter.
Languages of countries that practice FGM
We describe the countries in the Horn of Africa, which includes communities outside the Horn and throughout Africa, Somalia, Ethiopia, and Eritrea. All these countries are home to culturally and linguistically diverse communities, as outlined in the reading *The Horn of Africa* produced by VICSEG, and referred to in the bibliography of this manual.

When booking in interpreter, the main language groups are listed below. However, where possible it is important to check with the woman as to which language may be the most appropriate for her.

**Somalia**  
Somali  
- Point of interest: The history of white colonisation in Africa includes the roles played by Italy and Britain in annexing parts of Somalia. Therefore, some Somali women may speak English and/or Italian as well as Somali.

**Ethiopia**  
Amharic (Official language)  
Harari  
Oromo  
Tigrinia  
- Point of interest: There are more than 70 languages in Ethiopia, and numerous ethnic groups. Whilst the official language is Amharic, women may prefer to speak their own first language if given a choice.

**Eritrea**  
Arabic (Sudanese or Egyptian)  
Tigre  
Tigrinya  
- Point of interest: there are many languages spoken in Eritrea, reflecting its cultural diversity and history. When booking an interpreter, it is important to know that the Arabic spoken by Sudanese and Egyptian interpreters is easier to understand than the Arabic spoken in other countries, including Lebanon.

**Sudan**  
- Point of interest: The majority of Sudanese in Darwin are from the South who have suffered oppression by the dominant Northern Sudanese Arabs for the past four decades. The Northern Sudanese are Muslims while the Southerners are mostly Christians.

References:  
- VICSEG *The Horn of Africa*  
- EYIN “Refugees from the Horn of Africa Information File, 1994 Women’s Health West; Profile” – *A profile of settlers from the Horn of Africa living in the Western Region, 1999.*
Annotated Bibliography

FGM Resources
There are ranges of articles about FGM available, most of which can be located within the following categories:

- the prevalence of the practice worldwide
- cultural and traditional values underlying the practice
- adverse health effects, both physical and psychological and short and long-term
- elimination of the practice through legislation and education
- clinical management.

The following is a selection of articles and resources which reflect these concerns, and which summarise the ethical and clinical dilemmas for health professionals caring for childbearing women from affected communities, and wishing to provide culturally sensitive care.
Articles

1. Bayly, C
   *Female Genital Mutilation: Responding to health needs*
   This editorial summarises the benefits of a culturally sensitive approach to health issues related to FGM. The author emphasises the opportunities for doctors and other healthcare personnel to empower women, and to respect culture and support cultural identification while discouraging accompanying harmful practices.

2. Craig T & Kinson R
   *Women affected by old customs require sensitive support*
   Post Migration Jan 1996 : 6-11
   This article is a commentary on the effects of legislation to outlaw FGM in Victoria, and on the effectiveness of education in preventing the practice, and in developing our understanding of the cultural imperatives underlying the practice.

3. Dahlen H, Nanayakkara S & Bullivant V
   *Female Genital Mutilation: care of the childbearing woman*
   Midwifery Matters NSWMA Dec 1999 Col 12 6 12-14

4. Dahlen H, Nanayakkara S & Bullivant V
   *Female Genital Mutilation: Postpartum care of the Childbearing woman*
   Midwifery Matters NSWMA Mar2000 Vol 14 1 18-19
   These articles address issues of identification of affected women, appropriate history taking and assessment, clinical details of deinfibulation and resuturing, and post natal care needs, all within a framework of holistic care

5. Eyega Z & Conneely E
   *Facts and fiction regarding Female Circumcision/Female Genital Mutilation: A pilot study in New York City*
   JAMWA. Vol 52. 4 1997 174-8, 187
   This article reports on the health and social service needs of African immigrant women and the training and information needs of their health providers. Conclusions and recommendations include that quality services for women affected by genital mutilation can be fostered in the following ways:
   - care is provided in a sensitive and culturally appropriate manner
   - there is thorough training and education of health care providers on the physical and mental health consequences including the clinical management of FGM
   - there are counselling guidelines for health workers
   - there are interdepartmental linkages, referrals and integrated service delivery
   - there are interpreters available and information in relevant languages.
6. Gibeau, A  
*Female Genital Mutilation: When a cultural practice generates clinical and ethical dilemmas*  
JOGNN Jan/Feb 1998 27 (1) 85-91  
This article provides a wide-ranging discussion of the ethical and clinical dilemmas confronting health professionals, promoting a model of care, which is culturally competent and ethically grounded, respectful and effective.

7. Knight R, Hotchin A, Bayly C & Grover S  
*Female Genital Mutilation – The experience of The Royal Women’s Hospital, Melbourne*  
Aust NZ J Obstet Gynaecol 1999 39 1:50-4  
This article reports the findings of an observational study of women from countries with a high prevalence of FGM who presented to RWH over a 15-month period in 1995-7. The study uncovered the complications for women affected by FGM, and outlined recommendations for effective antenatal and gynaecological care.

8. Lightfoot – Klein H & Shaw E  
*Special needs of ritually circumcised women patients*  
JOGNN March/April 1991 20 (2) 102-7  
The authors discuss the care of women affected by FGM within the context of the prevalence of the tradition and women’s experiences of traditional and Western health systems.

9. McClear P  
*Female Genital Mutilation and Childbirth: A case reports Birth*  
21:4 December 1994 221-3  
This case report describes the pregnancy and birthing care of an infibulated woman in a Western Health care setting. The author discusses some of the cultural and medical implications and sequelae of FGM, and emphasises the importance of the education of perinatal health professionals in caring for women from affected communities.

10. Newman M  
*Midwifery care for genitally mutilated women*  
Modern Midwife June 1996 20-2  
This article outlines the cultural and clinical training required to provide adequate midwifery care for women affected by FGM, including discussion of the role of the midwife during the different stages of antenatal and intrapartum care. Recognition is given to the importance of the role of the midwife in the provision of holistic, individualised, non-judgmental clinical care.

11. Omer-Hashi K  
*Commentary: Female Genital Mutilation. Perspectives from a Somali midwife*  
Birth 21: 4 December 1994 224-5  
The author of this article has practiced as a midwife in Somalia and Canada. This article stresses the need for health professionals to display sensitivity and cultural awareness as well as clinical expertise in their work with women.
12. Royal College of Midwives
Female Genital Mutilation and the role of the midwife. Position Paper
RCM Midwives Journal July 1998 1:7 218-9
This paper presents midwives with a discussion of their roles and responsibilities with regard to the care of women affected by FGM, with an emphasis on the following:
- being aware, being informed
- assessing individuals needs
- involving partners and families
- involving and informing other health care professionals
- being sensitive, not superior
- informing and explaining

13. Royal College of Midwives
Female Circumcision: Understanding special needs Holistic Nursing Practice
1995 9 (2) 66-73
This article discusses the provision of appropriate care that is sensitive to the special physical and psychosocial needs of the circumcised patient seeking midwifery services in Australia. Aspects addressed include the prevalence of the practice globally; potential problems for the prenatal, intrapartum and postnatal periods; and implications for the midwife caring for women during these periods.

14. Toubia N
Female circumcision as a public health issue
The New England Journal of Medicine
331 (11) September 1994 712-6
This article outlines the need and rationale for the prevention of FGM, as well as a review of the types of circumcision, their complications, and the challenges in giving appropriate care to circumcised women.

15. VICSEG
The Horn of Africa
Undated
This paper provides an overview of the history, demographics and customs of the countries of the Horn of Africa, with particular reference to Somalia, Ethiopia and Eritrea. VICSEG is a Melbourne based agency which promotes childcare options to migrant and newly arrived communities, and cross cultural information to mainstream organisations.
Other Resources

Publications

Gilbert E (Ed)
Female Genital Mutilation: Information for Australian Health Professionals
RACOG Melbourne 1997

The definitive resource for health professionals working with women affected by FGM, developed with significant input from senior clinicians from RWH, as authors, advocates and advisors. This booklet covers all aspects of FGM, including demographics, sociocultural information, discussions of ethical and legal dilemmas, and clinical care for affected women.

Videos

Amina's Stories

Introducing women from Somalia, Ethiopia and Eritrea to some of the women’s health services in Melbourne, using scenarios developed in consultation, with women and workers from African communities and hospital and community based services playing the roles.

Well Women’s Services, RWH, 1999, in collaboration with Doutta Galla Community Health Service, Western Region Health Centre Inc, and Women’s Health West, with support from Victoria University Dept of Health Science and DHS.

Female Genital Mutilation – Issues For Clinical Practice

Useful information for health professionals as they follow a woman through pregnancy and birth care services in the Royal Women’s Hospital.

Websites

Amnesty International FGM Package
http://www.amnesty.org/ailib/intcam/femgen/fgm1.htm

IPPF: Female Genital Mutilation: A list of selected resources
http://www.ippf.org/fgm.index.htm

Australian Government Population Health Division National Education Program on Female Genital Mutilation

World Health Organisation
http://www.who.int/frh-whd/topics/fgm.htm

Royal Australian College of Obstetrics and Gynaecology booklet; Female Genital Mutilation – Information for Australian health professionals

www.nt.gov.au/health
Community Support Services

Melaleuca Refugee Centre
Ph 8985 3311
Melaleuca Refugee Service offers a culturally sensitive counselling, information, advocacy and support service to refugee women and their families. Our staff recognise the special psychological issues surrounding genital mutilation together with social, familial, cultural and religious sensitivities and offer an informed, objective and confidential service. Trained interpreters with gender considerations, support the counselling service with the client’s permission.

Anglicare NT
Refugee and Migrant Settlement Services program
Ph 8985 0000
Anglicare NT Refugee and Migrant Settlement Services program is funded by the Department of Immigration and Multicultural Affairs (DIMA) to provide settlement information and referral services to refugees and migrants from non-English Speaking Backgrounds who have been in Australia for the last five years. Refugees access this service after they have completed the initial settlement program with Melaleuca Refugee Centre’s Integrated Humanitarian Settlement Services (IHSS) program.

Anglicare NT supports refugee women by assisting them with individual and family needs including, medical and general health care, childcare and family planning. Anglicare NT works closely with other specialist services to enable appropriate referrals and obtain accurate information on how to access services.

The Refugee and Migrant Settlement Services program provides information sessions and advocacy to target groups. Anglicare NT also provides cross-cultural sessions and training on how to work with refugees and migrant people, to mainstream service providers including workers in the health, child protection and legal sectors.

Anglicare works closely with the Cultural Consultant at Royal Darwin Hospital and other services with regard to FGM issues.

Family Planning Welfare Association Northern Territory (FPWNT)
Ph 8948 0144
FPWNT recognises that accurate information and education is key to making healthy choices and informed decisions. The FPWNT provides immigrant and refugee women and girls with accurate information on sexual and reproductive health and rights, including FGM, as well as an orientation into the healthcare and social service systems with expected outcomes regarding good health care in this country.

FPWNT uses the RANZCOG guidelines and the Royal Women’s Hospital (Melbourne) pathways specific to Sexual and Reproductive Health for women with FGM issues.
Clinical Services
All clinical staff at FPWNT are experienced in providing an array of services to women who have undergone female circumcision. Advice is available for women needing ongoing care with long or short-term problems arising from FGM or referral to specialist services.

Young People & Reproductive Health
Young women are encouraged to access the clinics during the week, rather than on weekends, because weekend clinics may have an extended waiting times. FPWNT does not do outreach work in schools or other organisations due to the stigma that may be attached to this for the young women concerned. FPWNT would prefer the girls to be referred for sexual and reproductive health services.

Sexual Assault Referral Centre
Ph 8922 7156
Provides a confidential counselling service to both adults and children who may have experienced (recently or many years ago) any form of sexual assault. Sexual assault can range from verbal harassment, unwanted touching or exhibitionism, to a violent attack and can include genital mutilation.

For recent assault victims we provide 24-hour access to information regarding the medical, legal and counselling / support options available

We also provide counselling for partners, family members and significant others, support through the legal process and have an Aboriginal sexual assault counsellor available.

Acknowledgements
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Sharon Haste  Manager  Women’s Health Strategy Unit
Sujatha Thomas  O&G Consultant  Royal Darwin Hospital

www.nt.gov.au/health
Training Exercises

Exercise 1
After the birth of her baby a woman asks her doctor to stitch her up again as she was before the birth. The doctor is unsure about the legal position, so tells the woman she cannot do this as FGM is against the law. The woman becomes very upset and says her husband will not accept her in this new state and may want to divorce her. She is afraid that women in her community will gossip about her and call her a loose woman. She also feels very uncomfortable as her body now feels very strange to her. The doctor is concerned about her duty of care to her client, but she is also worried that she will be performing an illegal act if she agrees to the woman’s request.

What should the doctor do in this situation?
The doctor should:
- ask the woman to meet with both her husband and herself to discuss the woman’s situation and the health aspects of female genital mutilation, including benefits of not reinfibulating
- discuss the legal situation
- explain his or her duty of care
- explain the nature of the physical changes after deinfibulation and discuss these with the woman
- give reassurance to the couple and ask the husband to reassure his wife she will not be rejected
- offer referral for the couple to attend counselling
- reassure the woman of the confidentiality of this conversation and her health status.

How could this situation have been avoided?
The doctor may have:
- investigated the law before the birth
- requested to meet with the woman and her husband (with her permission) in the antenatal period to discuss the situation, bodily changes, law and improved health for the woman.

Exercise 2
A woman approaches a General Practitioner (GP) to circumcise her baby daughter. She tells him that it is a traditional practise in her culture and doesn’t do any harm, as it only involves a pricking of the baby’s clitoris to draw a drop of blood. She reassures him that it is not like other bad kinds of circumcision where they cut away the girl’s genitalia. In her culture, circumcision is called Sunna and is really only symbolic. The GP can’t see any harm in what the woman is asking for, so he tells her he will refer her on to a specialist he has heard about who may help her out. He makes a phone call and a professional colleague carries the procedure out the next day.

What is the GP’s position under the law?
- the doctor has broken the law and could face up to seven years in prison if convicted.
Could he have decided on a different course of action to help the woman?

- the doctor might have discussed the law with the woman and explained that it meant no difference in the type of circumcision carried out, as all types of circumcision are against the law. He might also have explored the reasons the woman uses to justify the practice and address these sensitively
- The doctor needs to explain his obligation to notify the Department of Community Services.

Exercise 3
Parents bring their 5 year-old daughter to their family doctor requesting that he circumcise her according to their tradition. The doctor refuses and advises the parents about the law in Australia. The parents tell the doctor that, in that case, they will have no choice but to take their child back to their home country to have the procedure carried out there, as the practice is required by their culture and religion.

What are the doctor’s responsibilities in this situation and how should he act?
The doctor will need to discuss the law again, pointing out that it is illegal to take the child out of the country. After spending some time in discussion, if the doctor feels that the parents may still do this, then he must tell them he is concerned for the child and will need to notify the authorities and the child will be monitored.

Exercise 4
A medical practitioner refuses a client’s request to perform FGM on his 6 year-old daughter. The doctor explains that female circumcision is against the law in Australia. The patient becomes angry and claims that the Australian government is racist and hypocritical in its attitude towards FGM, in that it permits male circumcision and also body piercing and forms of cosmetic surgery such as breast implants and trans-gender surgery.

How should the doctor respond to these arguments?
- the doctor might respond by pointing out that the law is to protect the child from the considerable health risks that may result from being circumcised. Although neither male nor female child has a choice, unlike the adult who submits to body piercing or other forms of body-shaping surgery, the procedure is different from male circumcision in that female circumcision usually involves the removal of a healthy organ
- the doctor may need to acknowledge that the laws against female circumcision may appear racist, as they are about other people’s cultural practises, and explain why these laws have been developed to protect children.

Reference
NSW Education Program on Female Genital Mutilation, 2000, Clinical Management Guidelines – A self directed learning package for health professionals, NSW College of Nursing.