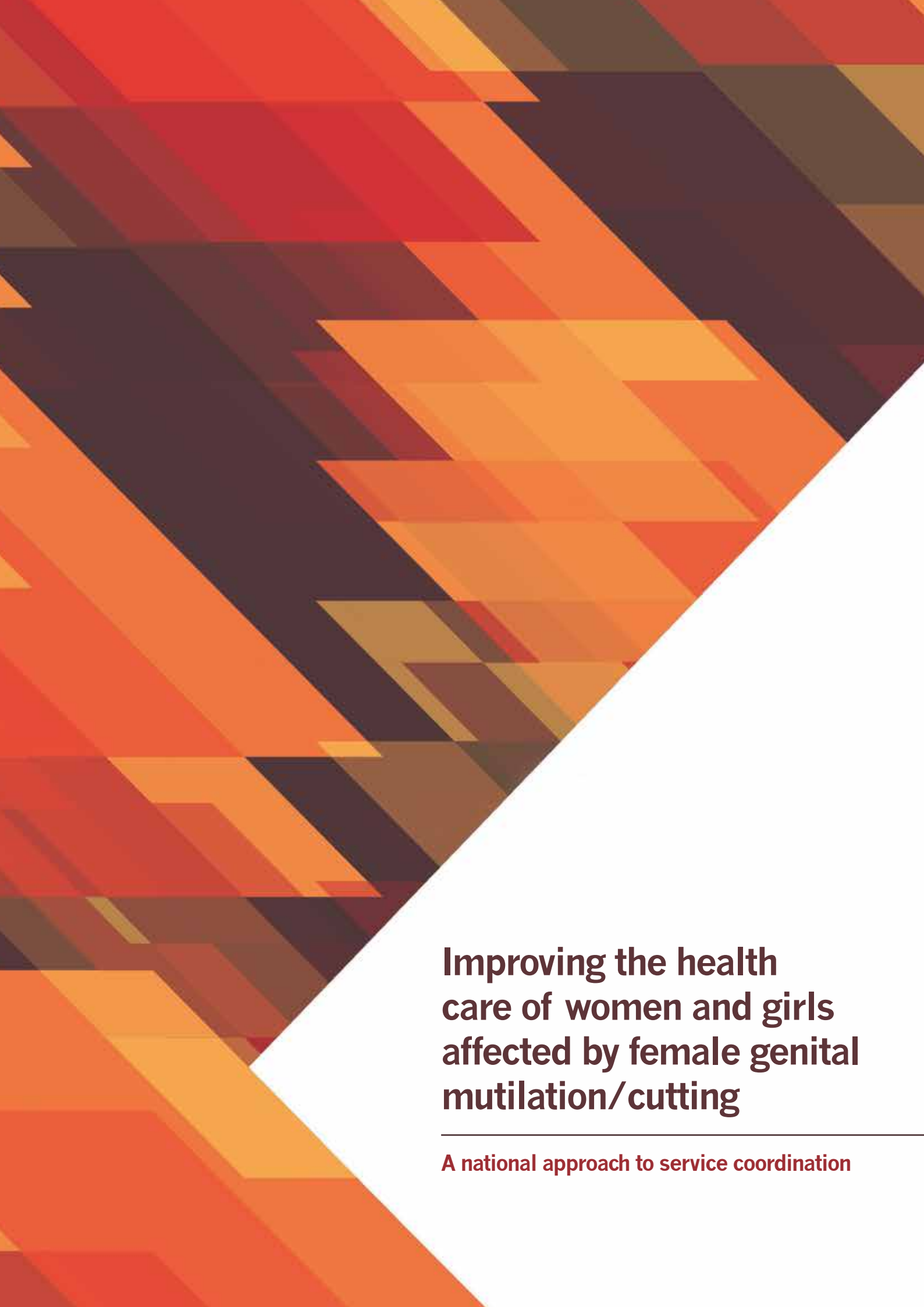

Improving the health care of women and girls affected by female genital mutilation/cutting

A national approach to service coordination

Improving the health care of women and girls affected by female genital mutilation/ cutting: A national approach to service coordination

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Contents

Using the resource

This national resource supports health and community service providers in all states and territories, who work with women and girls affected by female genital mutilation/ cutting (FGM/C). It provides them with the information they need to talk with women and girls about FGM/C and its potential impact on their health and wellbeing.

This national edition is based on a previous publication developed for Victorian health and community service providers. The information, strategies and practice described in this guide are based on the Victorian Service Coordination principles and practices. See <www.health.vic.gov.au/pcps/publications/sc_pracmanual.htm>.

Where they exist, information and references are included for each state and territory. When the information and/ or references are extensive, they have been loaded on a webpage and listed by state and territory. It may be helpful to print the pages relevant to your state or territory. See <www.fpv.org.au/a-national-approach-to-service-coordination>.

Introduction and policy context	Introductory information, including the purpose of this guide, an explanation of service coordination, guiding principles and relevant policy regarding FGM/C
Understanding female genital mutilation/ cutting	Information about FGM/C, including the different types, what is known, why it occurs and the health impacts for affected women and girls
Working with women and girls	Flow chart identifying key strategies and practice to support the care of women and girls, including initial needs identification and assessment, duty of care and case studies
Service coordination partnerships and training	Information to support agencies in working together, including developing local partnerships, identifying resource people and accessing training

Language used in this guide

FGM/C is also known as 'female circumcision' or 'female genital cutting'. The word 'mutilation' is used to emphasise both the severity and harmful effect of the practice and the violation of the rights of women and girls[1]. In 1990, this term was formally accepted by the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children.

When working with community members, it is recommended that service providers use more culturally sensitive language such as 'traditional cutting' or 'circumcision'. Appendix A provides a list of culturally specific terms used in reference to FGM/C.

Adding the word 'cutting' is intended to reflect the importance of using non-judgemental language with communities known to practise FGM/C. The term FGM/C is used throughout this document, except when referencing or quoting other sources.

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1 World Health Organization, 2008, Eliminating female genital mutilation: An Interagency statement, WHO, Geneva, viewed November 2011, <whqlibdoc.who.int/publications/2008/9789241596442_eng.pdf>.

...in 2011, there were 109,000 people living in Australia who were born in countries that practise female genital mutilation/ cutting.

Introduction and policy context

This resource provides the information health care professionals need to support the development of partnerships between services to respond to the health care needs of women and girls affected by female genital mutilation/ cutting (FGM/C).

Consultations conducted to inform the development of this resource indicate that although many professionals would ask the question about FGM/C, this does not reflect standard practice. These consultations also indicate that many professionals feel unsure or unprepared for asking the question and discussing FGM/C with women and girls from communities that practise FGM/C.

Aims of the resource

- To improve care and referral pathways for women and girls who come from communities known to practise FGM/C
- To improve the capacity of service providers to identify women and girls who are affected or are at risk of being affected by FGM/C

What is service coordination?

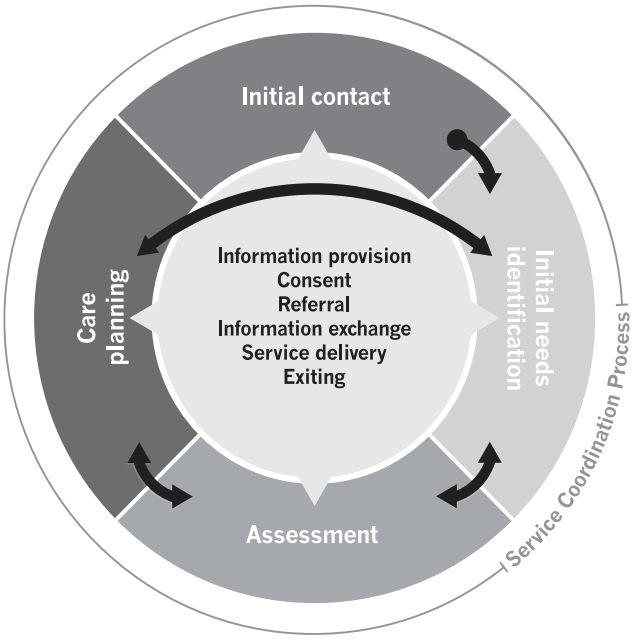
Service coordination places the client at the centre of service delivery, to ensure that they have access to the services they need, opportunities for early intervention, health promotion and improved health and care outcomes.[2]

Service coordination emphasises collaborative partnerships between services and organisations. A service coordination model sets out a multi-service response to assist organisations in working together to better meet the needs of clients, reducing service duplication and ensuring better coordination of referral and response.[3] The focus is on the client, with the model being driven by the needs of the client.

The key components of service coordination are initial contact, initial needs identification, assessment and care planning. Other elements include information provision, consent, referral, feedback, service delivery and exiting.[4]

Initial contact: first contact the client has with the service

Initial needs identification: broad screening to determine the best possible services, urgency and type of assessment required for the client



Assessment: the decision-making process that collects, weights and interprets relevant client information, using professional and interpersonal skills to uncover issues for informing the development of a care plan for the client[5]

Care planning: process of deliberation that incorporates care coordination, case management, referral, feedback, review, re-assessment, monitoring and the development of exiting plan

2 Victoria. Department of Health, 2009, Primary care partnerships: Service coordination, Department of Health, viewed November 2011, <www.health.vic.gov.au/pcps/coordination>.

3 Great Britain. Foreign and Commonwealth Office 2011, Multi-agency practice guidelines: female genital mutilation, HM Government, London, viewed November 2011, <www.homeoffice.gov.uk/publications/crime/FGM?view=Binery>.

4,5 Victoria, Department of Health 2009, op.cit.

What is female genital mutilation/ cutting?

The World Health Organization (WHO) states that the term FGM/C refers to all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.[6] FGM/C is a harmful practice and a violation of the human rights of affected girls and women. In 1997, the WHO issued a joint statement with the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA) against the practice of female genital mutilation (FGM).[7]

It is difficult to know the precise number of women and girls in Victoria who are affected by FGM/C. A demographic study of communities that have arrived in Australia from countries known to practise FGM/C[8] using census data from the Australian Bureau of Statistics, indicates that in 2011 there were 109,000 people living in Australia who were born in countries that practise FGM/C.

Policy context

Australian context

New South Wales, Victoria, Queensland, South Australia, Australian Capital Territory, and Northern Territory, have legislated against the practice of FGM/C and it exists in the Criminal Codes of Western Australia and Tasmania. There is no federal legislation regarding FGM/C.

New South Wales	*NSW Crimes Act 1900*
Victoria	*The Crimes (Female Genital Mutilation) Act 1996, Children, Youth and Families Act 2005*
Queensland	QLD Criminal Code: 323 B, 323 A
South Australia	*Children's Protection Act 1993, Criminal Law Consolidation Act 1935*
Western Australia	*Criminal Code Amendment Act 2004*
Tasmania	Criminal Code Amendment Act 1995 amendments not proclaimed
Austraian Capital Territory	*Victims of Crime (Financial Assistance) Act 1983, Crimes Act 1900 (ACT)* Part IV
Northern Territory	*Criminal Code Act.* Division 2 and Division 4A*, Care and Protection of Children's Act 2007*

International context

In international and human rights treaties, there is strong support for protecting the rights of women and girls by abolishing FGM/C. In some African countries, despite legislative measures outlawing the practice, more than half of all women and girls have undergone FGM/C.

Universal Declaration of Human Rights, 1948

In international and human rights treaties, there is strong support for protecting the rights of women and girls by abolishing FGM/C. In some African countries, despite legislative measures outlawing the practice, more than half of all women and girls have undergone FGM/C.

Convention on the Elimination of All Forms of Discrimination Against Women, 1979

This convention outlines the appropriate responses for government to eliminate the practice of FGM/C and other forms of discrimination against women.

Any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.

6, 7 World Health Organization 2010, Female genital mutilation, WHO, Geneva, viewed April 2012 <www.who.int/mediacentre/factsheets/fs241/en>.

8 Costello, S, Quinn, M & Tatchell, A 2012, Female genital mutilation/cutting (FGM/C): A tradition in transition: report to Family Planning Victoria on Victorian demographics and international program response to FGM/C, unpublished research paper, RMIT, Melbourne.

Convention On the Rights of the Child, 1989

One of the guiding principles of this convention is the consideration of the best interests of the child. Parents who submit their daughters to FGM/C believe that the benefits outweigh the risks. However, the convention states that FGM/C is a permanent and potentially life changing practice that violates the fundamental human rights of girls.[9]

Maputo Protocol, 2003

The Maputo Protocol, also known as The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, guarantees comprehensive rights to women including the right to take part in the political process, social and political equality with men, control of their reproductive health and an end to FGM. In 2003, the protocol was adopted by the 53 member countries of the African Union.[10]

In the development of this service coordination guide, Family Planning Victoria has drawn on the above policies and statements which reflect national and international positions on the practice of FGM/C. We also value and support:

- the upholding of zero tolerance of FGM/C
- the paramount importance of the safety of women and girls affected or at risk of being affected by FGM/C
- meeting the sexual and reproductive health care needs of affected women and girls
- the use of culturally sensitive and non-judgemental language
- an awareness that families that practise FGM/C do not see it as an act of abuse, but an act of love and cultural identity
- an understanding that the practice of FGM/C is embedded in cultural tradition
- an awareness that FGM/C is illegal.

9 United Nations Children's Fund 1989, Convention on the rights of the child, UNICEF, New York, viewed April 2012, <www.unicef.org.au/Discover/What-we-do/Convention-on-the-rights-of-the-child.aspx>.

10 African Union 2003, Protocol to the African charter on human and peoples' rights on the rights of women in Africa, African Union, viewed June 2012, <www.au.int/en/content/protocol-african-charter-human-and-peoples-rights-rights-women-africa>.

It is estimated that over 140 million women and girls worldwide have undergone some form of female genital mutilation/ cutting, with at least three million girls at risk of undergoing the practice each year.

Understanding female genital mutilation/ cutting

There are no known health benefits to be gained from female genital mutilation/ cutting (FGM/C). The practice is known to be extremely painful and has serious health consequences, both at the time of the procedure and in later life. FGM/C is a complex and sensitive issue embedded in cultural traditions. Communities that practise FGM/C believe doing so is important for preserving their cultural traditions. Many women who have undergone the procedure believe that they appear more attractive and desirable for marriage.[11] Women who resist undergoing FGM/C are at risk of being excluded and ostracised from their community, with their families believing that no one will want to marry their daughters.

FGM/C is known to be practised in 29 countries, 28 in Africa as well as Yemen. FGM/C is also reported to be practised among certain ethnic groups from parts of Asia and the Arabian Peninsula.[12]

It is estimated that over 140 million women and girls worldwide have undergone some form of FGM/C, with at least three million girls at risk of undergoing the practice each year. FGM/C is not confined to a specific population group and it is not sanctioned by any religious values.

Types of FGM/C

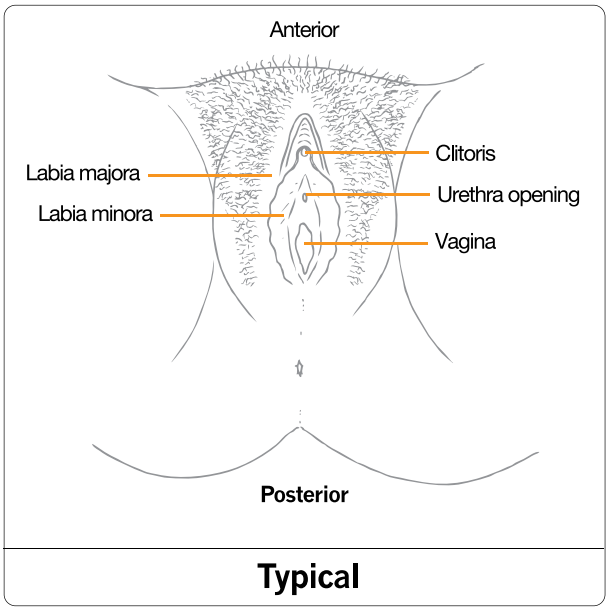
The World Health Organization identifies four types of female genital mutilation (FGM):

- Type I: Partial or total removal of the clitoris and/ or prepuce (clitoridectomy)
- Type II: Partial or total removal of the clitoris and labia minora, with or without removal of the labia majora (excision)
- Type III: Narrowing of the vaginal opening through the creation of a covering seal formed by cutting and re-positioning the labia minora and/ or labia majora, with or without removal of the clitoris (infibulation, the most common form of FGM)
- Type IV: All other harmful procedures to the female genitalia for non-medical purposes, including pricking, piercing, scraping, incising and cauterising

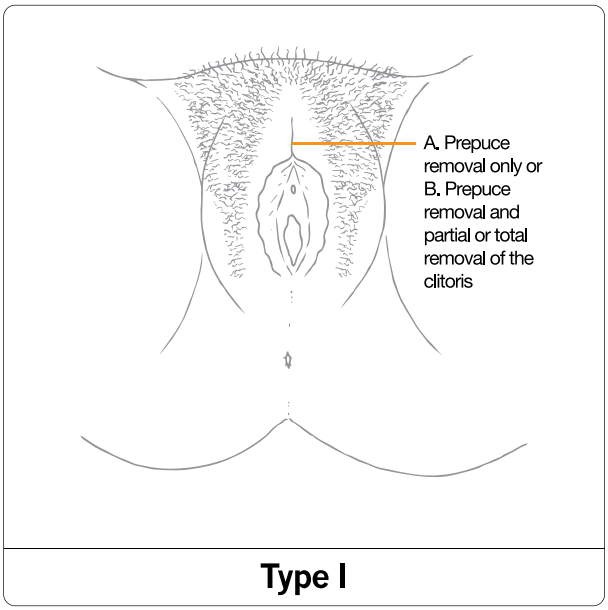
The age at which the procedure is carried out varies depending on the community the girls live in. It can be performed when the girl is newborn or during childhood or adolescence, though the most common ages are between five and eight years.

11 Great Britain. Foreign and Commonwealth Office 2011, Multi-agency practice guidelines: female genital mutilation, HM Government, London, viewed November 2011, <www.homeoffice.gov.uk/publications/crime/FGM?view=Binery>.

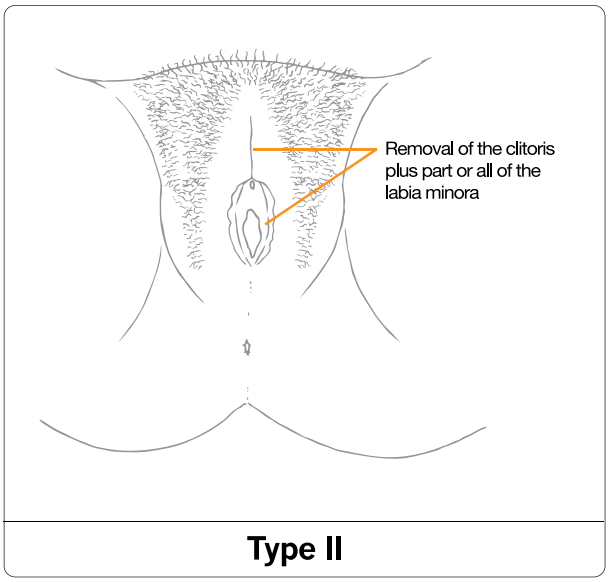
12 United Nations Population Fund n.d. Frequently asked questions on female genital mutilation/cutting, UNFPA< New York, viewed March 2012, <www.unfpa.org/gender/practices2.htm#7>.



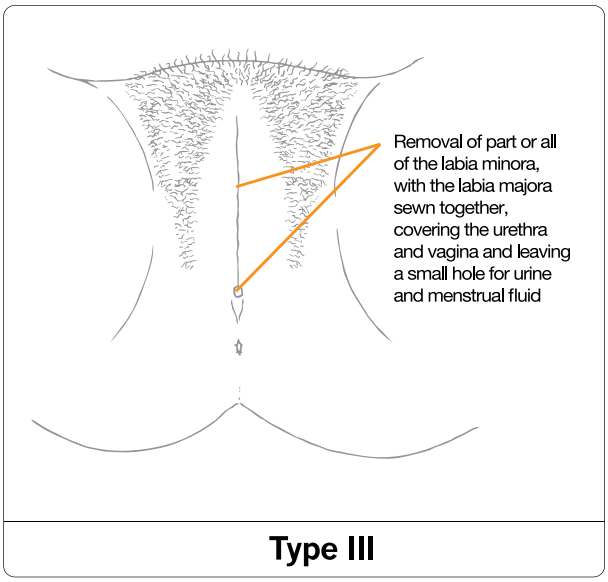
Typical



Type I



Type II



Type III

Why FGM/C occurs

In every society within which FGM/C is practised, it can be argued it is an expression of gender inequality deeply entrenched in the social, economic and political structures.[13] Like the now abandoned foot binding practice in China, FGM/C represents the control society has over women and their sexuality.

FGM/C is not sanctioned by any religion, with neither Islam, Christianity nor Judaism prescribing to the practice in their holy text. There is evidence that FGM/C practices predate both Christianity and Islam, with Egyptian mummies having been found with signs of FGM/C.

The reasons for the practice are to ensure marriageability, for cleanliness and/ or aesthetics and to control the sexuality of the woman. There are well established cultural and traditional beliefs among communities known to practise FGM/C that if girls do not undergo the procedure, they will not be considered suitable for marriage.[14] It is believed that FGM/C will prevent girls from being promiscuous and wives from 'straying' when their husbands are away for long periods of time.

[13,14] World Health Organization 2010, Female genital mutilation, WHO, Geneva, viewed April 2012, <www.who.int/mediacentre/factsheets/fs241/en/index.html>.

In communities known to practise FGM/C, FGM/C is widely supported and anyone who does not follow the norm by having their daughters undergo the procedure can face condemnation, harassment, threats that no man will want their daughter and the risk of being ostracised from their community.[15] When faced with these issues, it can be difficult for families to abandon the practice. In addition, social norms and conventions are a powerful tool, making abandonment difficult without wider community support. In some cases, the practice will often continue even when it is known to inflict harm on girls because the perceived social benefits are deemed higher than the harmful health effects.[16]

In some cultures, FGM/C is considered an important aspect of raising a girl and preparing her for adulthood and marriage. FGM/C may be embedded in 'coming of age' rituals, which are seen as an integral part of becoming a woman and member of society. Girls themselves may want to undergo the procedure as a result of peer pressure or fear of stigmatisation and rejection by their communities.[17] There may also be a celebration and public recognition for girls who undergo the procedure, which frames FGM/C as an important part of cultural identity and pride.

Harmful consequences of FGM/C

The health consequences for women and girls who undergo FGM/C are well documented. The procedure removes healthy female genital tissue, which can interfere with the natural function of the bodies of women and girls and lead to ongoing health complications.

It is reported that almost all girls who undergo FGM/C experience pain and bleeding as a consequence.[18] The process itself can be traumatic, with girls often having to be held down. If they have been infibulated, their legs are bound together for several days or weeks. Physical and psychological health problems can occur with varying frequency, though the true extent of these complications is unknown. The documented knowledge of immediate health consequences is based on those who seek hospital treatment after having the procedure.[19]

Some of the documented immediate health complications are:

- excessive bleeding/ haemorrhage
- difficulty passing urine
- severe pain
- infection
- shock
- death
- psychological consequences.

Long term health complications

The long term health complications which can eventuate following FGM/C include:

- vulval scaring and pain
- pelvic and urinary tract infection
- obstructed menstrual and urinary flow
- painful sexual intercourse (particularly with type III)
- childbirth complications
- danger to newborns (higher death rates and reduced Apgar scores)
- psychological stress (flashbacks, post traumatic stress disorder, trauma)[20 21 22]
- fistulae
- infertility
- HIV.

Child birth complications

The World Health Organisation conducted a multi-country study of 28,000 women who had undergone FGM/C and found they had significantly increased risks of adverse events during childbirth. Women who had undergone FGM/C types I, II and III had a higher incidence of caesarean section and post partum haemorrhage in comparison to those who had not undergone the procedure.[23] The study found death rates during or immediately after birth to be higher for women who had undergone FGM/C than those who had not.

The consequences for women affected by FGM/C who deliver their baby outside a hospital setting are even more severe, including a higher incidence of post partum haemorrhage, which can be a life threatening condition without medical assistance.[24]

15-20 World Health Organization 2010, Female genital mutilation, WHO, Geneva, viewed April 2012, <www.who.int/mediacentre/factsheets/fs241/en/index.html>.

21 Great Britain. Foreign and Commonwealth Office 2011, Multi-agency practice guidelines: female genital mutilation, HM Government, London, viewed November 2011, <www.homeoffice.gov.uk/publications/crime/FGM?view=Binery>.

22 Royal Australian College of Obstetricians and Gynaecologists 1997, Female genital mutilation: Information for Australian health professionals, RANZCOG, East Melbourne, Vic, viewed November 2011, <www.ranzcog.edu.au/publications/womens-health-publications/female-genital-mutilation-fgm-bookletet.html>.

23,24 World Health Organization 2009 'Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries', The Lancet, vol. 36, no.9525, pp. 1835-1841.

Female genital mutilation/ cutting is a complex and sensitive subject requiring service providers to engage in culturally appropriate conversations with women and girls.

Working with women and girls

Health and welfare service providers can assist in meeting the needs of women and girls affected by FGM/C and preventing its occurrence. Raising awareness among service providers of the issues confronting communities known to practise FGM/C will help services to better support women and girls affected by FGM/C, build the capacity of workers to engage in difficult conversations about FGM/C and establish collaborative partnerships to improve health outcomes.

FGM/C is a complex and sensitive subject requiring service providers to engage in culturally appropriate conversations with women and girls affected by FGM/C. There are a number of measures an organisation can implement to improve access to services and meet the needs of women and girls affected by FGM/C. Adopting a service coordination approach can facilitate information provision and referral processes and using this guide can assist service providers in streamlining assessment and referral pathways for women and girls.

Another important consideration when working with communities known to practise FGM/C is the journey of the families to Australia. Many families who have come to live in Australia as refugees may have experienced considerable suffering and trauma before their arrival. They may have experienced war, famine, violence, lost contact with or witnessed the murder of family and friends or spent time in refugee camps. Experiences such as these can have profound effects on health and wellbeing.

Why it is important to ask whether the woman or girl has been circumcised or cut

Asking women and girls whether they have been circumcised or cut will help ensure they receive the health care they need and assist in the prevention of FGM/C.

In some circumstances, pregnancy is the first time a woman comes into contact with the health care system. This can be the best time to discuss any health issues she has experienced as a result of FGM/C, as well as support she may require and whether de-infibulation will be required.

Women and girls affected by FGM/C may experience ongoing health complications such as chronic pelvic infections, sexual problems, vulval abscesses, infertility, cysts or menstrual problems. A well informed assessment of the health status of women and girls affected by FGM/C will result in referral to appropriate services, which can significantly improve their health and wellbeing.

Language may be a barrier to asking questions about FGM/C. In such cases it is important that there is an interpreter, preferably a female, present at the consultation. It is not appropriate for a family member (e.g. husband or child) to interpret for the woman or girl, as she may not feel comfortable discussing personal issues in their presence. Allowing family members to interpret assumes they will be able to interpret the complex issues associated with FGM/C. If a child of the woman interprets, pressure can be placed on them to talk about the health issues experienced by their mother or listen to adult health issues. Misleading information can be deliberately delivered by family members who may want their relative to submit to community or family wishes, rather than representing her true wishes if they go against cultural tradition. For information on accessing language services, see page 17.

When to ask the question

When taking client history during the initial needs identification process, consider asking about FGM/C. There will always be exceptions, however, depending on the reason why the woman or girl has made contact with the service. Country of birth is usually a good indicator that the woman or girl may have undergone FGM/C and as a result, may have ongoing health complications that need to be addressed. When starting a conversation about FGM/C, it is important to remember that it is a sensitive and private issue. It is important to explain the reasons for asking and how the information will be used. Some possible reasons include:

- as part of conducting a thorough health assessment
- to identify health complications that may need to be addressed by medical staff
- to develop a labour plan, particularly for women who have been infibulated, as they may require de-infibulation before labour and information regarding the legality of re-infibulation and the changes experienced as a consequence
- to assist with referral.

Talking about FGM/C with women and girls

Talking about FGM/C with women and girls can be uncomfortable for both the individual and the professional. It is important to include a question about the FGM/C status of the woman or girl in your assessment or first contact meeting.

When discussing FGM/C with the woman or girl, it is important to:

- avoid making assumptions and judgements
- be sensitive to the intimate nature of FGM/C
- use simple language and ask straightforward questions
- use value neutral non-judgemental language such
- as, 'have you been cut down there?', 'have you been circumcised?' or, 'do you have traditional cutting?'
- be direct when assessing its impact by asking questions such as, 'do you experience any pain or difficulties during intercourse?', 'do you have any problems urinating?' or, 'have you had any difficulties in childbirth?'[25]
- make the woman or girl feel comfortable and ensure she knows she can come back if she wishes
- inform the woman or girl that FGM/C is illegal in Australia and that the law is there to help women and girls
- use a female interpreter where possible and avoid using family members to interpret
- be aware of your own responses and reactions the first time you examine a woman or girl who has undergone FGM/C so she does not feel uncomfortable or different
- be aware of the potential risks to young women and girls
- understand that not all families want their daughters to undergo FGM/C
- record FGM/C status on the birth notification to ensure the maternal and child health nurse is mindful of any ongoing health concerns.

25 Great Britain. Foreign and Commonwealth Office 2011, Multi-agency practice guidelines: female genital mutilation, HM Government, London, viewed November 2011, <www.homeoffice.gov.uk/publications/crime/FGM?view=Binery>.

Assessment

Assessment is not an end in itself, but rather an ongoing investigative process between the individual and the professional. This process draws on the expertise and interpersonal skills of the professional to uncover relevant health and wellbeing issues for informing the development of a care plan.[26] The assessment builds on information obtained during previous contact with the woman or girl to develop an holistic understanding of their situation.

Obtaining information about whether the woman or girl is affected by FGM/C is important for informing care plans and referrals. Signs of FGM/C can be missed if the practitioner is not specifically looking for evidence of the procedure during examinations.

Ensuring the woman or girl is asked whether she has been circumcised or cut is of paramount importance, particularly when a woman is accessing services such as antenatal care or a Pap test. If a woman has been infibulated and is accessing antenatal services, de-infibulation and re-infibulation will need to be discussed. Women who have been infibulated may request to be re-infibulated post partum. In Australia, it is against the law to re-infibulate. This will need to be discussed with the woman, preferably on her own and with a female interpreter, where necessary.

Many hospitals have long waiting lists for obstetricians and making women who have been infibulated a priority is an important policy and procedural change. For more information regarding policy and procedural change, go to <www.ranzcog.edu.au/publications/womens-health-publications/female-genital-mutilation-fgm-booklet.html> Similarly for Pap test providers, conducting a Pap test for a woman who has been infibulated may be difficult and/ or uncomfortable for the woman. Knowing this information before the appointment will help with conducting the test.

Organisations need policies and procedures in place for FGM/C and to have staff trained and well informed about the procedure. The Royal Women's Hospital (the Women's) in Melbourne has useful examples of policies and procedures for working with women affected by FGM/C, which service providers can refer when developing their own policies and procedures. To access to these documents, go to <www.thewomens.org.au>.

Important points to remember

- Be aware of your own judgements and reactions.
- Families have their girls undergo the procedure out of love, not to harm them.
- Not all women or girls who are affected by FGM/C are aware that they are 'different' to other women and girls.
- Some women and girls do not realise that they have had the procedure.
- Not all families from communities known to practise FGM/C want to have their girls undergo the procedure.
- Be alert when families are planning a holiday with their girls for an extended period of time.
- Engage the person, not the issue, ensuring that the woman or girl feels important and heard.
- All women and girls, from countries known to practise FGM/C, should be asked at intake or initial assessment if they have been circumcised or cut.
- Referral may be necessary for women and girls who experience flashbacks during examinations.

Care planning

Partnerships are the key to care planning working effectively. Local networks can be used to discuss issues relating to FGM/C. Within your organisation, one or more staff members can be chosen to be responsible for providing support to other staff in relation to FGM/C. In addition, hospitals can explore the option of making women who are affected by FGM/C, in particular Type III (infibulation), a priority for obstetric and/ or gynaecological services.

Assisted referral is an integral part of care planning, as it can help families navigate the system and ensure they are referred to the appropriate service provider.

Providing the woman or girl with information about the appropriate service will ensure she is fully informed and aware of the reasons for referral. Before referral, her consent is needed and must be documented. For example forms and templates go to <www.health.vic.gov.au/pcps/sctt. htm>. The National Health Services Directory (NHDS) can be used for referral options. To access the directory, go to <www.nhsd.com.au>.

[26] Great Britain. Foreign and Commonwealth Office 2011, Multi-agency practice guidelines: female genital mutilation, HM Government, London, viewed November 2011, <www.homeoffice.gov.uk/publications/crime/FGM?view=Binery>.

Care plan flow chart

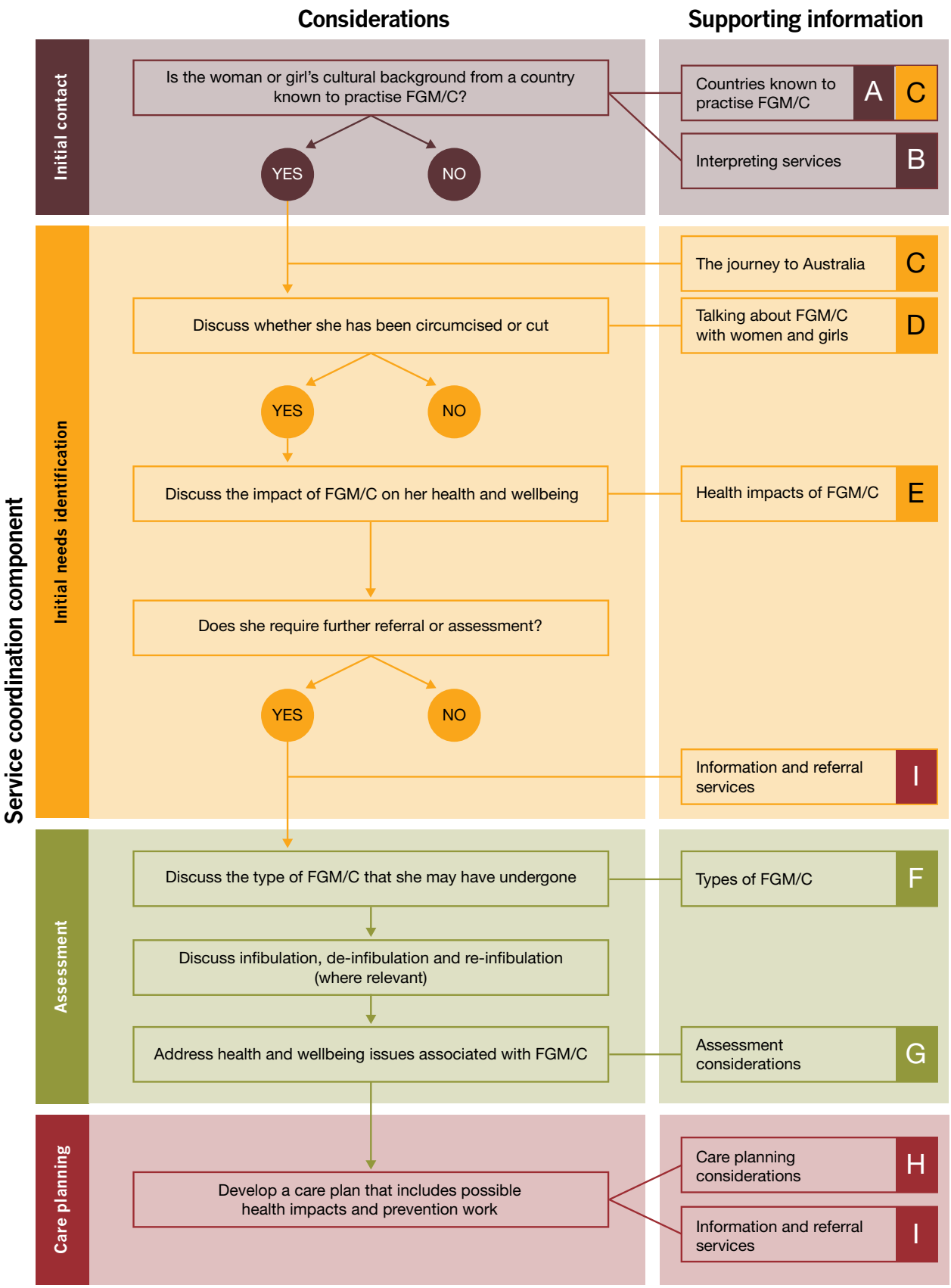
The following information outlines the steps in identifying and assessing the needs of women and girls who may be affected by female genital mutilation/ cutting (FGM/C). It is designed to assist health and community service providers in developing their understanding of the health impacts associated with FGM/C and suggest ways for talking to women and girls from communities known to practise FGM/C about whether they have undergone the procedure. It also provides the information to support referral pathways.

FGM/C is defined as all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.

It is important to ask whether the woman or girl has been circumcised or cut to:

- raise a topic the woman or girl might be reluctant to discuss
- ensure the she receives the best possible care
- prevent FGM/C occurring in the future to her daughters
- discuss de-infibulation and re-infibulation with her before labour
- ensure she has access to appropriate services
- enable families to receive information about the legalities and health consequences of FGM/C
- determine and document FGM/C status for assisting with care and follow-up
- enable her to receive information about changes she may experience after de-infibulation.

Flow chart


Considerations
Supporting information
Service coordination component
Initial contact
Is the woman or girl's cultural background from a country known to practise FGM/C?
YES
NO
Countries known to practise FGM/C
A
C
Interpreting services
B
Initial needs identification
The journey to Australia
C
Discuss whether she has been circumcised or cut
Talking about FGM/C with women and girls
D
YES
NO
Discuss the impact of FGM/C on her health and wellbeing
Health impacts of FGM/C
E
Does she require further referral or assessment?
YES
NO
Information and referral services
I
Assessment
Discuss the type of FGM/C that she may have undergone
Types of FGM/C
F
Discuss infibulation, de-infibulation and re-infibulation (where relevant)
Address health and wellbeing issues associated with FGM/C
Assessment considerations
G
Care planning
Develop a care plan that includes possible health impacts and prevention work
Care planning considerations
H
Information and referral services
I

Initial contact The first contact the woman or girl has with the service

In this step, the woman or girl is given information about the service, eligibility and the intake process, as well as other relevant information. The collection and recording of client information using the Service Coordination Tool Templates (SCTT) or similar, begins with client registration and consent obtained.

To access SCTT forms, go to <health.vic.gov.au/pcps/sctt.htm>.

The woman or girl will progress to initial needs identification if she needs further advice or support. In preparation for her next appointment, you can start to consider whether she has undergone FGM/C.

Key questions to ask yourself

- Is the woman or girl's ethnic background from a country known to practise FGM/C?
- Does she need an interpreter?

A Countries known to practise FGM/C

The table below lists countries known to practise FGM/C and the estimated prevelance among women and girls aged 15-49.

Country	Estimated prevalence (%)	Country	Estimated prevalence (%)
Benin	16.8	Liberia	45.0
Burkina Faso	72.5	Mali	91.6
Cameroon	1.4	Mauritania	71.3
Central African Republic	25.7	Niger	2.2
Chad	44.9	Nigeria	19.0
Côte d'Ivoire	41.7	Senegal	28.2
Djibouti	93.1	Sierra Leone	94.0
Egypt	95.8	Somalia	97.9
Eritrea	88.7	North Sudan	90.0
Ethiopia	74.3	Togo	5.8
Gambia	78.3	Uganda	.06
Ghana	3.8	United Republic of Tanzania	14.6
Guinea	95.6	Yemen	22.6
Guinea-Bissau	44.5		
Kenya	32.2		

Note: There is anecdotal evidence that FGM/C type IV occurs in parts of the Middle East and Asia, including Indonesia, India, Malaysia, Israel and Iraq.

B Interpreting services

Ensure you have an interpreter, preferably female, if required and avoid using family members to interpret. For contact details of translating and interpreting services in states and territories, please go to: <www.fpv.org.au/a-national-approach-to-service-coordination>

It may be helpful to print the information relevant to your state or territory.

Initial needs indentification	A broad screening of presenting and underlying issues by intake/ duty/ triage staff

This step allows for the woman or girl's health, social, emotional and wellbeing needs associated with FGM/C to be identified.

Key questions to ask yourself

- What are the health impacts associated with FGM/C?
- When should the woman or girl be asked the question?
- How should she be asked?

C The journey to Australia

Factors to consider when talking to women and girls who may be affected by FGM/C include the following:

- Refugee experience
- Grief and loss
- Trauma and torture
- Witnessing and/ or experiencing violence
- Refugee camps
- Social isolation or lack of family support
- Settlement issues or cultural shock
- Language barrier
- War
- Famine

When working with clients who have experienced any of the above, referral to counselling and support services may be helpful. For more information, see page 20.

D Talking about FGM/C with women and girls

The woman or girl will need to be told why the question is being asked and how the information will be used. For example:

- to conduct a thorough health assessment
- for referral purposes
- to develop a labour plan.

When asking the woman or girl about FGM/C, it is important to use value neutral, non-judgemental language, such as:

- Have you been cut down there?
- Have you had traditional cutting?
- Have you been circumcised?

Be direct by asking questions such as:

- Do you experience any pain or difficulties during sexual intercourse?
- Do you have any pain when urinating?
- Have you had any difficulties giving birth?

When having the conversation:

- use a female interpreter where possible and avoid using a family member to interpret
- inform her that FGM/C is illegal in Australia
- be aware of your own responses and reactions
- be aware of the potential risk to young women and girls
- understand that not all families want their daughters to undergo FGM/C
- record FGM/C status on her birth notification to inform the maternal and child health nurse.

E Health impacts of FGM/C

The health impacts associated with FGM/C include:

- Vulval scaring and pain
- Pelvic and urinary tract infection
- Obstructed menstrual and urinary flow (e.g. can take up to 20 minutes to urinate)
- Painful sexual intercourse
- Childbirth complications
- Fistulae
- Infertility
- Post traumatic stress disorder
- Flashbacks
- Trauma
- Psychological or emotional distress

Note: Assessing whether a pregnant woman is affected by FGM/C before birth is vital in her care preparations before and during labour. If she has been infibulated, de-infibulation will need to be discussed, options provided and consent obtained.

Assessment	An investigative and decision-making process to address issues relating to FGM/C, with the aim of developing a care plan

Assessment is an ongoing process where your professional skills are used to gather as much information as possible, with the aim of developing a care plan specific to the woman or girl.

Key questions to ask yourself

- What type FGM/C has the woman or girl undergone?
- Have I discussed infibulation, de-infibulation and re-infibulation with her?
- Have health and wellbeing issues associated with FGM/C been addressed?

F Types of FGM/C

The four types of FGM identified by the World Health Organization are as follows (*See page 9 for illustrations)*:

Type I: Partial or total removal of the clitoris and/ or prepuce (clitoridectomy)

Type II: Partial or total removal of the clitoris and labia minora, with or without removal of the labia majora (excision)

Type III: Narrowing of vaginal opening through the creation of a covering seal by cutting and re-positioning the labia minora and/ or labia majora, with or without removal of the clitoris (infibulation)

Type IV: All other harmful procedures to female genitalia for non-medical purposes including pricking, piercing, scraping, incising and cauterising

(WHO 2008)

G Assessment considerations

The assessment process enables:

- a more thorough investigation of the presenting issue/s
- the identification of relevant services to ensure the most appropriate referral for the development of a comprehensive care plan
- a more in-depth exploration of the impact of FGM/C on the health of the woman or girl
- any risk to her daughters and granddaughters to be discussed.

Use the National Health Services Directory <www.nhsd.com.au> to access further information on appropriate services for her referral.

Obtain consent from the woman or girl so she is part of the decision-making process.

If the woman has been infibulated, a childbirth plan will need to be developed and antenatal and post natal care discussed. It is important to determine:

  - what the woman expects to happen after childbirth
  - if she wants to be de-infibulated before childbirth
  - if she is expecting to be re-infibulated (due to the legalities of re-infibulation, this needs to be discussed before labour).

Note: To access an example of a childbirth plan template, see the Royal Women's Hospital flow chart at <www.thewomens.org.au/FemaleGenitalMutilationMaternity>.

Care planning	Referral, case management and coordination, reviews, re-assessment, monitoring and exiting

Care planning involves health practitioners and the client working together to ensure the planning and delivery of services meets the needs and circumstances of the client. For more information about care planning, go to <www.health.vic.gov.au/pcps/downloads/sc_pracmanual2.pdf>.

H Care planning considerations

- A care plan should include the possible health impacts and associated prevention work.
- Women and girls who have been infibulated should be fast tracked to medical services, gynaecologists and obstetricians, where appropriate.
- Partnerships and trained resource people should be used to assist in referral and care planning and for support.

I Information and referral services

Generic referral pathways are listed below. Details of information and services to assist in referral and care planning are listed by state and territory at <www.fpv.org.au/a-national-approach-to-service-coordination>. When working with women or girls who have experienced grief or trauma, referral to counselling and appropriate support services may be helpful. These service providers are included on the list. It may be helpful to print the page relevant to your state or territory.

Clinical care pathways

Family planning organisations

Maternal and child health services

Metropolitan/ regional community health services

Metropolitan/ regional GP services

Metropolitan/ regional hospitals

Women's hospitals

Refugee health services

Counselling and support services

AMES Settlement Services

Headspace

Metropolitan/ regional family services

Migrant resource centres

Rape crisis centres

Multicultural women's health services

Advisory service pathways

Medicare Locals

Royal Australian and New Zealand College of Obstetrics and Gynaecology (RANZCOG)

Women's health centres

Women's information and referral services

Child protection pathways

State and territory departments

State, territory and federal police

Duty of care

A 2011 report from Great Britain stated that there are four issues to consider in regards to duty of care when working with women and girls affected or at risk of being affected by FGM/C. These issues are as follows:

1. 1. FGM/C is an illegal act on a female, regardless of age.
2. Girls and young women at risk of FGM/C need to be safeguarded.
3. Female relatives of a girl or woman who has undergone FGM/C maybe at risk.
4. A girl may be removed from the country to undergo FGM/C.[27]

Although this report was in relation to health care workers in Great Britain, duty of care is similar for service providers in Australia who work with women and girls affected by FGM/C.

In New South Wales the *Civil Liability Act 2002* recognises a legal duty of care. Negligence is defined in section 5 of the Civil Liability Act as a 'failure to exercise reasonable care and skill'.

Duty of care in Victoria is addressed in the *Wrongs Act 1958* (Vic). Under common law principles of negligence and the *Wrongs Act 1958* (Vic), as amended by the *Wrongs and Other Acts (Law of Negligence) Act 2003* (Vic), care providers must exercise reasonable care to prevent service users and others from foreseeable injury.

In South Australia under common law principles of negligence and the *Civil Liabilities Act 1936* (SA), care providers have a duty to take reasonable care to protect users from foreseeable risk of injury.

In the Australian Capital Territory the *Civil Law (Wrongs) Act 2002* (ACT) in Parts 4.1 & 4.2 (sections 42 & 43) defines the common law principles of negligence and harm resulting from negligence in, and states that: For deciding whether a person (the defendant) was negligent, the standard of care required of the defendant is that of a reasonable person in the defendant's position who was in possession of all the information that the defendant either had, or ought reasonably to have had, at the time of the incident out of which the harm arose. The Act further considers that negligence has occurred if a person fails to take precautions to avoid risk of harm that was foreseeable, was likely to result in harm, and that would have been taken by a reasonable person in their circumstances, in possession of the information they had at the time.

In the Northern Territory, duty of care falls under the *Personal Injuries (Liability for damages) Act 2002*.

In Western Australia, Health workers have a duty of care to ensure that their clients do not come to reasonably foreseeable harm by their actions or failure to act, and must act with appropriate skill and judgment in their work. Health professionals (and/or their employer) may be liable for negligence where they do not take reasonable steps to prevent a reasonably foreseeable risk of harm to someone to whom they owe a duty of care. Negligence is addressed in *Civil Liability Act 2002* (WA). The Act sets out the standard of care for health professionals: "An act or omission of a health professional is not a negligent act or omission if it is in accordance with a practice that, at the time of the act or omission, is widely accepted by the health professional's peers as competent professional practice." (Section 5PB).

In Queensland, Sections 191-192 of the *Public Health Act 2005* (Qld) state that a professional (eg, doctor, registered nurse, school staff or a person employed in a departmental care service or licensed care service) becomes aware or reasonably suspects, during the practice of his or her profession, that a child has been, is being, or is likely to be harmed, the professional must immediately notify the chief executive (child safety) of the harm or likely harm. See <www.legislation.qld.gov.au/LEGISLTN/CURRENT/P/PubHealA05.pdf>.

All professionals have the responsibility to inform their client of the illegal and harmful aspects of FGM/C in a culturally sensitive manner, ensuring that the woman or girl does not feel threatened or frightened by what is being told to them.

Confidentiality and disclosure

The aim of service coordination is to improve communication between the client and the service provider and streamline referral and the sharing of client information. This requires the client to be informed that her personal information may be shared with other service providers. Obtaining client consent before sharing client information is of paramount importance. The client also needs to be aware that she has the right to withhold consent to the sharing of her personal information.

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27 Great Britain. Foreign and Commonwealth Office 2011, Multi-agency practice guidelines: female genital mutilation, HM Government, London, viewed November 2011, <www.homeoffice.gov.uk/publications/crime/FGM?view=Binary>.

Confidentiality and disclosure: Important considerations

- Service providers are encouraged to use the Service Coordination Tool Templates (SCTT) or similar.
  - A consistent approach like the Consent to Share Information template makes obtaining consent universal and transparent
- If the client does not have the capacity to consent, consent must be sought from a representative authorised by the client.
- If the client refuses consent to share information, a referral can still proceed, however the service to which the client is being referred will need to obtain the relevant information from the client.
- The SCTTs and supplementary information are available in 57 languages and can be downloaded at <www.health.vic.gov.au/pcps/sctt.htm>.

Mandatory reporting

In all states and territories, with the exception of Western Australia, professionals are required by law to report if they have reasonable concern that a child is at risk of significant harm.

New South Wales	The *Children Legislation Amendment Act 2009* mandates that people in occupations working with children report to the NSW Department of Community Services any 'current concerns' and/or reasonable grounds to suspect 'risk of harm' relating to children. People mandated to report such offences, or the suspicion of such offences having occurred, include health workers, teachers, childcare workers, disability workers and the NSW Police. Medical practitioners must report to the Director General of the Department of Health if FGM/C is carried out on a child who is under 16 years of age. See <www.community.nsw.gov.au/kts/guidelines/documents/mandatory_reporter_guide.pdf>.
Victoria	Section 183 of the *Children, Youth and Families Act* provides that any person who believes, on reasonable grounds, that a child is in need of protection may report to a protective intervener that belief and the reasonable grounds for it. This means that any person is voluntarily able to make a report to the Child Protection service when they believe a child is in need of protection. Under Section 184 doctors, nurses, teachers and police are required by law to report to Child Protection if, in the course of their professional practice, they form a belief, based on reasonable grounds, that a baby, child or young person is at risk of significant harm and is in need of protection from physical injury or sexual abuse. See <docs.health.vic.gov.au/docs/doc/A9B88A7B541AE7FCCA2579820012364D/$FILE/vulnerable_children.pdf>.
Queensland	Sub-section 76K of the *Health Act 1937* (Qld) requires medical practitioners, school staff, authorised officers, employees of the Department of Child Safety, a person employed in a departmental care service or licensed care service to notify one of the Director-General's designated officers (including representatives from the Department of Health, Family Services and the Queensland Police) if they suspects on reasonable grounds the maltreatment or neglect of a child in such a manner as to subject or be likely to subject a child to unnecessary injury, suffering or dangers. See <www.communities.qld.gov.au/childsafety/protecting-children/about-child-protection/mandatory-notifiers-and-reporting>.
South Australia	The *Children's Protection Act 1993* requires health professionals, police officers, community corrections officers, ministers of religion, approved family day care providers and any other employee or volunteer at organisations working with children (including teachers) to report to the Child Abuse Report Line (Department for Education and Child Development – Families SA) if they have a reasonable concern that a child is at risk of significant harm. It is then up to the department to determine whether there is reasonable grounds for investigation and further intervention. See <www.families.sa.gov.au/pages/protectingchildren/MandatoryNotificationObligations/?reFlag=1>.
Tasmania	The *Children, Young Persons and Their Families Act 1997* identifies mandatory reporters who are legally required to report when they believe, or suspect, on reasonable groups that a child has been or is being abused or neglected. Mandatory reporters include medical practitioners, nurses, health professionals, teachers, and police officers. See <www.dhhs.tas.gov.au/__data/assets/pdf_file/0020/63047/FINAL_-OTS_Mandatory_Reporters_Fact_Sheet.pdf>.

Australian Capital Territory	*Children and Young People Act 2008*(ACT) requires health professionals, teachers, childcare workers, police, public servants, and some other professions to report to ACT Care & Protection Services if, in the course of their professional work (whether paid or unpaid), they form a reasonable belief that a child or young person (from birth to 17 years) has experienced or is experiencing sexual abuse, emotional abuse, neglect or non-accidental physical injury. See <www.communityservices.act.gov.au/ocyfs/services/care_and_protection>.
Northern Territory	Northern Territory Section 26 of the *Care and Protection of Children Act* imposes a legal responsibility on every person in the Northern Territory to report a reasonable belief that a child has been or is likely to be abused or neglected, or has been or is likely to be, a victim of a sexual offence. Registered health practitioners have an additional responsibility to report to the Department of Children and Families or the Police if they believe on reasonable grounds that a child aged 14 or 15 years has been or is likely to be a victim of a sexual offence and the age difference between the child and the sexual offender is greater than two years. Registered health practitioners include Aboriginal health workers, chiropractors, dentists, dental hygienists, dental prosthetists, dental specialists, dental therapists, medical practitioners, midwives, registered nurses, occupational therapists, optometrists, osteopaths, pharmacists, physiotherapists, psychologists and radiographers. See <www.childrenandfamilies.nt.gov.au/Child_Protection/Child_Abuse/>

Case studies

These case studies sourced from a hospital in Victoria, provide examples of how health professionals can work in partnership to meet the health needs of women affected by FGM/C, ensuring they receive the best possible care.

Mrs A

22 year old woman, country of birth: Saudi Arabia

Mrs A arrived at the birthing unit with her husband in labour. It was not until she was in the second stage of labour that the Associate Midwife Unit Manager (AMUM) became aware that Mrs A had signs of FGM/C. The AMUM requested that the registrar on call attend, as she 'did not know what to do'. If Mrs A had been assessed in relation to FGM/C at the antenatal clinic, the staff involved would have been better prepared for de-infibulation either before or at delivery and there may have been the opportunity to arrange a female registrar or female obstetrician in advance.

When the clinical midwife followed up with Mrs A the next day, she explained her role and the role of the program. Mrs A was open to discussing female circumcision, which was important in helping to ensure her needs were met. Her husband, however, did leave the room before the discussion took place, highlighting the sensitive nature of the topic.

Mrs B

28 year old woman, country of birth: Sudan

Mrs B and her husband attended the hospital for a termination of pregnancy at 18 weeks gestation due to a severe congenital abnormality. Both Mrs B and her husband were most distressed about the loss of their baby. It was identified that Mrs B had undergone some form of FGM/C as a child and as a result, a referral was made to a clinical midwife and female obstetrician. Mrs B gave consent to assess her circumcision, with type III being noted. The clinical midwife and obstetrician discussed at length with the couple that due to female circumcision, de-infibulation would be necessary for the birth of the baby.

Assessing the circumcision of Mrs B ensured a detailed care and management plan for delivery could be discussed with Mrs B and her husband, then documented and conveyed to key clinicians involved in her care. Mrs B gave consent for de-infibulation at the time of delivery. Labour was induced and the baby was born without de-infibulation, but needing some assistance.

Mrs C

31 year old woman, county of birth: Sudan

A pregnant Mrs C arrived at the emergency department of the hospital after significant blood loss at home, which caused her to collapse. The decision was made to perform an emergency caesarean section. When the clinical midwife went to catheterise Mrs C, she found that Mrs C had undergone FGM/C type III (infibulation) and was unable to catheterise her.

The registrar who was to perform the caesarean had previous experience with women who had undergone FGM/C and was able to catheterise Mrs C. This caused a delay in performing the emergency caesarean, though the baby was born in good health.

The clinical midwife followed up with Mrs C the next day and arranged an Arabic interpreter. Through the interpreter, with a registrar present, the clinical midwife explained the reasons for the medical condition and caesarean section. A sensitive and detailed discussion then took place regarding FGM/C. Mrs C was aware that she had been circumcised as a young child, though could not remember the age at which it occurred or the reason. A note was made under 'Obstetric Alerts' in her clinical notes that for a subsequent pregnancy, Mrs C should be referred to the program which works specifically with women affected by FGM/C.

Mrs C asked, 'what if I had gone into labour…how would the baby have come?' She said the work that the clinical midwife was doing was, 'wonderful for the women like me,' and that, 'you will be helping many women.' Mrs C also said she would consider de-infibulation in the future.

After examining their statistical data, the hospital saw a rise in the number of women affected by FGM/C who were attending their antenatal and birthing clinics. As a result, the hospital established a clinic to work specifically with affected women. The program involves a number of health professionals, including a clinical midwife, a social worker, two educators, two female obstetricians, an antenatal clinical manager and a representative from an external health organisation. These professionals work as a team to meet the needs of women affected by FGM/C, ensuring they are assessed in relation to FGM/C at triage or at the antenatal clinic. They then ensure the woman is referred to a specialist service within the hospital which is able to work with her to ensure her health needs are met.

It is important for all potential partners to have a shared understanding and a commitment to supporting the issues faced by communities known to practise female genital mutilation/cutting. Identifying resources needed and the services each partner can provide is essential for ensuring the partnership is sustained and successful.

Service coordination partnerships and training

Mainstream services working with communities known to practise female genital mutilation/ cutting (FGM/C) need to be trained and well informed about FGM/C and FGM/C practising cultures. Forming collaborative partnerships in the relevant regional or local government areas can be the most efficient way to pool resources and support women and girls affected by FGM/C.

For the success and continuation of collaborative partnerships, there needs to be support from senior management. Policies and procedures need to be developed and there must be consistent and thorough communication between partners and clients. In addition, change management approaches need to be considered, resources need to be allocated to workers taking on extra responsibilities and all staff need to be provided with the necessary training and support.

The three stages involved in developing successful collaborative partnerships are outlined below:[29]

Problem setting

It is important for all potential partners to have a shared understanding of the issues relating to FGM/C and a commitment to supporting the issues faced by communities known to practise FGM/C. Identifying resources needed and the services each partner can provide is essential for ensuring the partnership is sustained and successful.

Reaching agreement

Partners will need to develop a working agenda, outlining roles and responsibilities, how frequently they will meet and an agreement on addressing the issues faced by communities known to practise FGM/C.

Implementation

At the implementation stage, partners need to reach an agreement on how to work together. Organisations can support the establishment of a pool of resource people to provide additional support to the work already being carried out in organisations such as hospitals, community health centres or local government offices. The role of these professionals would be incorporated into their existing responsibilities. As such, it is important that they receive the support and are allocated the time they need for the work to be carried out. It is recommended that there be more than one resource person in larger organisations, such as hospitals, for staff to call on when they need support.

The resource people need to be appropriately trained to ensure they have the necessary knowledge about FGM/C and communities known to practise FGM/C. This will help ensure they are well equipped to support staff and community members in their work. For service providers to be able to work effectively and collaboratively with these communities, whole agency training in FGM/C is essential.

The role of the resource person

- To provide support and information to colleagues about FGM/C and communities known to practise FGM/C as requested
- To provide assistance and knowledge in relation to referral pathways
- To provide training and information to all staff, including new staff members
- To support the work of the partnership and attend partnership meetings
- To be available to external organisations and community members for secondary consultation

Change management needs to be embedded as part of a whole staff training program. HealthWest Partnership has made available a number of change management techniques that can help ensure organisations are prepared and responsive to staff needs.[30]

Training

Health professionals must first develop a thorough understanding of FGM/C as a cultural practice and learn ways to work with and engage communities known to practise FGM/C. They then need to be trained in the clinical practice and health consequences of FGM/C.

If organisations are to meet the needs of both communities known to practise FGM/C and workers, they need to provide training to all staff, both clinical and non-clinical so they have a thorough understanding of the complexities, sensitivities and health consequences of FGM/C. FGM/C is a sensitive topic for both the professional and the client and with appropriate training, health professionals can become well equipped to raise the issue and ask the question.

Clinical training in FGM/C and how to assist women and girls who have undergone the procedures is vital. Currently, there is limited formal training available. The New South Wales Education Program for FGM provides clinical training. See <www.dhi.health.nsw.gov.au/NSW-Education-Program-on-Female-Genital-Mutilation/NSW-Education-Program-on-Female-Genital-Mutilation/default.aspx>. Major tertiary hospitals, for example The Royal Women's Hospital Melbourne and King Edward Memorial Hospital Perth, offer clinical training on request to medical practitioners.

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29 Victoria. Department of Health 2011, Health promotion: partnerships, Department of Health, Melbourne, viewed January 2012, <health.vic.gov.au/healthpromotion/stakeholders/partnerships.htm>.

30 HealthWest Partnership 2009, Refugee health service coordination guide for Victoria, Department of Human Services, Melbourne, viewed April 2011, <www.healthwest.org.au/images/stories/healthwest/pdf/resources/early_intervention/guide_refugee_service_co_101109%20pdf.pdf>.

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Appendix A

Terms used in reference to female genital mutilation/ cutting

Country	Terms used in reference to FGM/C	Language
Chad – the Ngama Sara subgroup	Bagne	
	Gadja	
Gambia	Niaka	Mandinka
	Kuyango	
	Musolula Karoola	
Guinea-Bissau	Fanadu di Mindjer	Kriolu
Egypt	Tahara	Arabic
	Khitan	
	Khifad	
Ethiopia	Megrez	Amharic
	Absum	Harrari
Eritrea	Mekhnishab	Tigregna
Iran	Xatna	Farsi
Kenya	Kutairi	Swahili
	Kutairi was ichana	
Nigeria	Ibi/ Ugwu	Igbo
	Didabe fun omobirin/ ila kiko fun omobirin	Yoruba

See over

Appendix A (continued)

Country	Terms used in reference to FGM/C	Language
Sierra Leone	Sunna	Soussou
	Bondo/ sonde	Mendee
	Bondo	Temenee
		Mandinka
		Limba
Somalia	Gudiniin	Somali
	Halalays	
	Qodiin	
Sudan	Khifad	Arabic
	Tahoor	
Turkey	Kadin Sunneti	Turkish

Source: UK report - languages from FORWARD <www.forwarduk.org.uk> and IKWRO <www.Ikwro.org.uk>.

Appendix B

A step-by-step guide to making a report to child protection services

Protective concerns

You are concerned about a child because you have:

- received a disclosure from a child about abuse or neglect
- observed indicators of abuse of neglect
- been made aware of possible harm via your involvement in the community external to your professional role.

At all times remember to:

- record your observations
- follow appropriate protocols
- consult notes and records
- consult with appropriate colleagues in necessary
- consult with other support agencies if necessary.

Please note: Steps 1 and 2 are the same for all states and territories.

Step 1	Responding to concerns	Step 2	Forming a belief on reasonable ground
1. If your concerns relate to a child in need of immediate protection; or you have formed a belief that a child is at significant risk of harm – Go to Step 4 2. If you have significant concerns that a child and their family need a child wellbeing referral – Go to Step 3 3. In all other situations – Go to Step 2		1. Consider the level of immediate danger of the child. Ask yourself: a. Have I formed a belief that the child has suffered or is at risk of suffering significant harm – YES/NO b. Am I in doubt about the child's safety and the parent's ability to protect the child? YES/NO 2. If you answered YES to (a) or (b) – Go to Step 4 3. If you have significant concerns that a child and their family need a child wellbeing referral – Go to Step 3	

Please note: Steps 3-4 differ from between states and territories.

	Step 3	Making a referral to child and family service	Step 4	Make a report to child protection
	Have notes ready with your observations and child and family details			
New South Wales	Contact local Family Referral Service <www.keepthemsafe.nsw.gov.au/initiatives/family_referral_services>		Contact Child Protection Helpline on 132 111 (TTY 1800 212 936 <www.keepthemsafe.nsw.gov.au/>	
Victoria	Contact local ChildFIRST provider <www.dhs.vic.gov.au/for-service-providers/children,-youth-and-families/family-and-parenting-support/how-to-make-a-referral-to-child-first>		Contact local Child Protection intake provider <www.dhs.vic.gov.au/for-individuals/children,-families-and-young-people/child-protection/child-protection-contacts>	
Queensland	Contact local Child Safety Service <www.communities.qld.gov.au/childsafety/about-us/contact-us>		Contact Regional Intake Service <www.communities.qld.gov.au/childsafety/protecting-children/reporting-child-abuse>	
South Australia	Contact › Child Abuse Report Line - 131 478 › Yaitya Tirramangkotti (Aboriginal child abuse report line) 8203 0470, 131 478 (after hours) <www.families.sa.gov.au/pages/protectingchildren/MakingAReport/?reFlag=1>		Contact › Child Abuse Report Line - 131 478 › Yaitya Tirramangkotti (Aboriginal child abuse report line) 8203 0470, 131 478 (after hours) <www.families.sa.gov.au/pages/protectingchildren/MakingAReport/?reFlag=1>	
Western Australia	Department for Child Protection district office closest to where the child lives <www.dcp.wa.gov.au/ChildProtection/Pages/IfyouareconcernedaboutachildaspxIfyouareconcernedaboutachild.aspx>		Contact › Department for Child Protection district office closest to where the child lives <www.dcp.wa.gov.au/Organisation/ContactUs/Pages/ContactUs.aspx> › Crisis Care Unit for after hours and on weekends 08 9223 1111	
Tasmania	Contact Gateway services 1800 171 233 <www.dhhs.tas.gov.au/disability/gateway_services>		Contact Child Protection Services 1300 737 639, after hours 131 278 <www.dhhs.tas.gov.au/children/child_protection_services>	
Australian Capital Territory	Contact › Child At Risk Health Unit 02 6244 2712 (specific forensic, medical and therapeutic intervention service for vulnerable children and families) <health.act.gov.au/health-services/canberra-hospital/our-services/division-of-women-youth-and-children/children-and-parenting> › Child, Youth and Family Gateway 1800 647 831 (generalist central contact and referral service for child, youth and family services) <www.thegateway.org.au>		Contact Care and Protection 1300 556 728 <www.communityservices.act.gov.au/ocyfs/services/care_and_protection>	
Northern Territory	Contact 1800 700 250. <www.childrenandfamilies.nt.gov.au/Child_Protection>		Contact 1800 700 250. <www.childrenandfamilies.nt.gov.au/Child_Protection>	


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