

# Chapter 10

## Healthcare Provision for Refugees and Immigrant Women with FGM Living in Australia



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### 10.1 Introduction

It is estimated that more than 200 million girls and women alive today have been subjected to female genital mutilation (FGM) in the world, mainly in 31 countries across three continents, with more than half living in Egypt, Ethiopia and Indonesia (UNICEF 2021). There is evidence from small-scale research studies that the practice also occurs in communities in 20 countries in Eastern Europe, Latin America, the Middle East, and South-eastern Asia, as well as North America, Australia and New Zealand (Cappa et al. 2019).

As a result of migration, FGM has become a transnational public health, human rights, and gender injustice issue. FGM violates many human rights, including the human right of the child, the human right to life, the human right to be free of torture or cruel, inhumane or degrading treatment, the human right to equality and non-discrimination on the basis of gender, the human right to a standard of living adequate for the health and well-being of a person and her family. No religion condones or mandates it. FGM has deeply entrenched sociocultural roots, the main propagators being social obligation and pressure for families to conform, marriageability for economic security or survival, and fear of exclusion from resources and opportunities as young women (Darkenoo 1994; UNICEF 2005). FGM is closely linked to child marriage, as girls may be taken from school after the cutting to be married. FGM is ultimately a symptom of poverty and gender inequality. It is important to remember that these women were children when the cutting was done to them; they did not have any say in it; they were not able to consent. It is hence the dignity of these women and girls which we must foremost protect and respect on our path to helping communities abandon this practice.

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141

The physical and psychological suffering for many of these children and women can be enormous, often lifelong and irreversible. A World Health Organization (WHO) study estimated that 2.8 million 15 year-old girls in six African countries would lose about 130,000 years of life due to obstetric complications from FGM. It is estimated that up to I\$ 5.82 (international [purchasing power] dollars adjusted for the cost of living in each country) are required to fund prevention programs for the more severe FGM types. These costs would be offset by the economic saving of preventing and managing obstetric complications from FGM (Bishai et al. 2010).

Male partners of women with FGM experience physical and psychological complications as well (Almroth et al. 2001). A Sudanese study of men married to women with FGM most notably revealed that they felt responsible for their wives' pain and suffering and experienced their continuing suffering as their own (Almroth et al. 2001). In contrast to the social norms and expectations, most of the young men in the study stated they would have preferred to be married to uncut women (Almroth et al. 2001). Men are critically part of the solution towards abandonment of FGM.

Analogous to FGM was the practice of foot binding that originated in Imperial China from the tenth century until the establishment of the People's Republic of China in 1949. It had similar sociocultural underpinnings, determining status and controlling women's sexuality, and was eventually abandoned, with advocacy by men having played a crucial role (Broadwin 2020).

Global efforts for the abandonment of FGM over the last three decades have significantly reduced the prevalence of this practice, especially with the contribution of the UNFPA-UNICEF Joint Programme on the Elimination of FGM (UNFPA and UNICEF 2021). Today, girls are one third less likely to have undergone the cutting, especially those aged 15–19. More women, girls, as well as men, are opposed to the practice than in the past, and more men and women understand the health complications (UNFPA and UNICEF 2021; Gele et al. 2013b). In countries with data on FGM prevalence, 63% of men and 67% of women want the practice to end (UNICEF 2016). However, due to population growth, if FGM continues to be performed at the current rate in countries of prevalence, the WHO predicts 68 million girls and women will have been subjected to this practice by 2030 (WHO 2020).

The WHO's modelling predicts an annual global economic cost of USD 1.4 billion if all the health complications of FGM were to be treated (WHO 2020). This translates to 10–30% of a country's annual health budget. If FGM were to be abandoned, the savings in health costs would be more than 60% by 2050. However, the reality is that as the practice continues and more children are being cut, the costs will double over the same time period (WHO 2020).

Australia is home to more than 83,000 women and girls with FGM who were born in African countries and the Middle East (Australian Bureau of Statistics 2011). There are more than 140,000 people with ancestry from these regions living in Australia, comprising about 1.5% of the total population (Australian Bureau of Statistics 2011). We do not have information on women and girls with FGM from Asian countries, such as Indonesia, where FGM is also prevalent. The Royal Hospital for Women in Melbourne alone reports caring for 600–700 women with FGM per year (Bourke 2010). Women who have been subjected to FGM as children in their country of

origin require specialised healthcare to treat and prevent further complications and suffering.

This chapter explores what is known about the burden of complications from FGM in Australia, the scope of healthcare provision for these women and what kind of evidence-based policy responses are needed to strengthen health, community, and legislative systems to provide optimal care and to help communities abandon this harmful practice.

## 10.2 Burden of Complication of FGM in Australia

In countries where FGM is prevalent, girls are usually subjected to FGM between infancy and age 15 (WHO 2008). The WHO describes four types of FGM (WHO 2022). Type III, also known as infibulation, is the most severe with various degrees of cutting and removing of the external genitalia and then suturing the vaginal opening to create a seal, which allows a slow release of menstrual blood and urine only.

Girls may die from infection and/or haemorrhage or experience a long list of well-known acute and chronic physical, psychological, and sexual complications, as outlined in Table 10.1. (Almroth et al. 2005; Elnashar and Abdelhady 2007; Matanda et al. 2019; Sarayloo et al. 2019; Talle 2007; WHO 2008).

Whilst sub-Saharan Africa continues to have some of the world's highest maternal and infant mortality rates, FGM causes the additional deaths of ten to 20 babies per

**Table 10.1** Complications of FGM

Immediate complications	Long term complications
Death	Vulval abscess, ulcer, cyst, neuroma, keloid scar
Haemorrhage	Vaginal obstruction with haematocolpos, haematometra, dysmenorrhoea
Infection (HIV, hepatitis, other organisms, wound, septicaemia)	Apareunia, dyspareunia, vaginismus
Shock from haemorrhage or sepsis	Sexual dysfunction, anorgasmia
Acute severe pain	Relationship problems
Psychological trauma	Urinary incontinence, urinary tract obstruction, urinary tract infection, voiding difficulties
Fracture of bones or dislocation of joints from force of being held down	Pelvic inflammatory disease
Acute urinary retention	Chronic vulval and/or pelvic pain
Damage to urethra, anus, rectum and/or perineum	Vesicovaginal or rectovaginal fistula
	Post-traumatic stress disorder
	Depression, anxiety
	Infertility

1000 births (UNFPA 2009). The WHO initiated a landmark collaborative prospective study of 30,000 women across 28 obstetric centres in six African countries. The study centres varied from isolated rural healthcare centres to tertiary teaching hospitals in capital cities. It revealed that obstetric complications increased with the severity of FGM type. FGM type III was associated with a 30% higher caesarean section and 70% postpartum haemorrhage risk compared to women without FGM. Perinatal mortality rate was 15%, 32% and 55% higher for women with type I, II and III, respectively. Moreover, newborns of mothers with FGM type III were 66% more likely to require resuscitation (Banks et al. 2006, June 3).

There is limited data on the burden of disease and complications from FGM in Australia. There is only one study on maternal and neonatal outcomes of women with FGM. This retrospective study at a metropolitan Australian hospital analysed data on women with and without FGM who gave birth over a seven-year period (Varol et al. 2016). This hospital is a multicultural centre of excellence for the provision of maternity and neonatal care services for women with low-risk births, of which there are approximately 1500 per year. At the time the hospital's patients spoke 17 languages and more than two thirds had a non-English speaking background. It was one of only three hospitals in Australia that had established a specialised FGM clinic with obstetricians and midwives trained to follow the guidelines for optimal maternity care of women with FGM by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists. The clinic had counselling, psychological and translation services. The maternity care involved establishing a clear plan for antenatal care, labour and birth for each woman. The benefits of de-infibulation were explained, and the procedure was offered preferably in the second trimester, so that vaginal examinations could be performed as normal during labour. De-infibulation was also done during labour (Varol et al. 2016).

Importantly, this hospital provided training on FGM for obstetricians, midwives, general practitioners, and nurses specialising in reproductive health. The curriculum covered the sociocultural underpinnings of FGM, cultural competence, identification of FGM types, de-infibulation surgical competence, recognition of FGM complications, and legal framework around this practice. It also conducted education sessions for migrant women and their partners on FGM (Varol et al. 2016).

The prevalence of FGM in women who gave birth at this hospital was 2–3%. The measured maternal and neonatal outcomes were caesarean section, instrumental birth, episiotomy, genital tract trauma, postpartum haemorrhage of more than 500 mls, low birth weight, admission to special care nursery, and stillbirth. Women with FGM had similar obstetric outcomes to women without FGM, except for a significantly higher risk of first and second perineal tears and of caesarean sections. The former was more common with FGM type III. It was noted that none of the caesarean sections, however, had FGM indications (Varol et al. 2016).

The authors of the Australian study (Varol et al. 2016) showed that their results were in keeping with those of other high-income countries. Provision of high-quality obstetric care with expertise in FGM seems to be able to minimise obstetric complications (Abdelshahid and Campbell 2015; Amusan and Asekun-Olarinmoye 2006; Essen et al. 2005; Wuest et al. 2009). Having the skill to perform de-infibulation is a

very important aspect of care for these women. The reason for emergency caesarean sections in a study in Switzerland was that vaginal examinations were not able to be performed in labour for women with FGM type III who had not been de-infibulated (Wuest et al. 2009). A study from Saudi Arabia showed no difference in obstetric and neonatal outcomes. All their patients underwent de-infibulation at vaginal delivery, and there were no FGM indications for their caesarean sections (Brown et al. 2010). Similarly, studies from the United Kingdom and Sweden supported the benefit of de-infibulation with regard to caesarean sections. The latter also showed that de-infibulation was associated with lower risk of prolonged labour (Essen et al. 2005; Hernandez 2007).

In contrast to the findings of the Australian study and in keeping with the WHO study in the six African countries (Banks et al. 2006, June 3), obstetric complications are reported to be higher in African countries as well as hospitals in high-income countries that do not have high-quality obstetric care and/or specialised FGM knowledge (Frega et al. 2013; Herral et al. 2004; Johnson et al. 2005; Small et al. 2008; Vangen et al. 2002).

Cultural factors and poor cultural competence, as well as language barriers, adversely affect health outcomes as shown by studies of Somali-born women receiving care in high-income countries compared to locally-born women (Herral et al. 2004; Johnson et al. 2005; Small et al. 2008; Vangen et al. 2002). A meta-analysis in six countries revealed that these women were more likely to labour without analgesia or epidural and to undergo a caesarean section (Small et al. 2008) despite their aversion to this operation (Brown et al. 2010; Hernandez 2007; Vangen et al. 2002).

The Australian study also evaluated data collection and accuracy in identifying the correct type of FGM diagnosis by their midwives, by comparing two databases, i.e., one used by all midwives and doctors and one by the midwives that specialised in FGM (Varol et al. 2016). Through formalised training and education by the Clinical Midwife Consultant and an obstetrician, data collection increased from only 14 to 90% over the six years. Accuracy was low at 35%. The Australian study highlights the importance of integrating a specialised FGM unit in hospitals that care for women with FGM and fostering training and education of their midwives and doctors to provide the best care for women with FGM.

### 10.3 Knowledge and Training of Health Care Workers

FGM and its associated complications are generally not the primary concern of women who migrated to Australia. They have multiple and complex immediate challenges that need to be acknowledged and addressed. These women usually come from countries where they experienced war or conflict, poverty, malnutrition, health issues, lack of access to education and healthcare (Women's Refugee Commission 2009). Many refugees and migrants experience significant obstacles to finding healthcare services and affordable accommodation, due to language barriers, limited education

and finances, loneliness and isolation from lack of social support, as well as domestic violence (Comas-Diaz and Jansen 1995; Dona and Berry 1999; NSW Government Department of Health 2018). A community-based participatory study of 619 women in Australia and New Zealand confirmed these findings; these women's main concern was not that they had undergone FGM but the financial difficulties of resettlement, discrimination and social integration of their children, and their families remaining in conflicted countries (Guerin et al. 2006). All these factors make the usual work of healthcare providers more challenging, requiring cultural competence, knowledge and training in the management of FGM complications, and established referral pathways to other community and health specialists. For example, perinatal outcomes of refugee and migrant women from low- to middle-income countries, especially from African countries, have been reported to be poorer (Belihu et al. 2016; Gibson-Helm et al. 2014). Cultural competence is a very important aspect of healthcare to be included in curricula in nursing and medical institutions and their governing colleges. It delivers better healthcare as it is respectful of and responsive to health and cultural beliefs as well as the language needs of patients (Beach et al. 2005; Truong et al. 2014).

### **10.3.1 Doctors**

A systematic review of doctors' experiences and needs concerning the care of women with FGM, evaluated data derived from ten studies from Australia, New Zealand, United States, Belgium, UK, Sweden, Egypt, and Sudan (Dawson et al. 2015a). The UK study identified gaps in knowledge on the type of FGM (Zaidi et al. 2007) and the importance of identifying women with FGM as high risk for obstetric complications on the first antenatal visit. Moreover, a caesarean section was considered the best delivery method if vaginal examination was not possible (Zaidi et al. 2007). Another UK study identified lack of knowledge on the prevalence of psychological complications and half of the doctors expressed concern about how to access referral pathways to specialist services (Purchase et al. 2013). A third of them did not know about antenatal de-infibulation and a fifth were not aware that FGM was illegal (Purchase et al. 2013). Only 1% of Flemish gynaecologists were aware of hospital guidelines or information on FGM, and more than half expressed the need for access to technical guidelines on the medical management of women with FGM (Leye et al. 2008). Clinical guidelines and education on FGM led by professionals with experience in this area were also requested by Swedish doctors (Tamaddon et al. 2006).

An audit of two hospitals in Western Australia had a prevalence of pregnant women with FGM of 0.3 and 2.2% (Shukralla and McGurgan 2020). Documented compliance with the hospital's FGM Clinical Guideline was found to be poor. Documentation of discussions between patients and healthcare workers on the maternal complications of FGM was non-existent in one hospital, and 18% at the other site. The authors postulated that this was most likely due to the lack of confidence in

their knowledge on FGM (Shukralla and McGurgan 2020). Similarly, a survey of Australian child health specialists showed that 10% (n = 50) acknowledged they had cared for a child with FGM but only a minority had clinical experience or formal education in this field (Sureshkumar et al. 2016).

### **10.3.2 Midwives**

With regard to the experience of midwives caring for women with FGM, there was one study which evaluated data from focus group discussions of 48 midwives in three Australian urban hospitals (Dawson et al. 2015a, b, c). Many midwives lacked the surgical skills of de-infibulation and had little confidence in their knowledge of FGM types and data collection. Moreover, they expressed fear of having to care for these women due to a lack of experience. Other issues were: difficulty in establishing rapport with their patients, lack of availability of interpreters and misunderstanding of cultural values.

A review of the global experience of midwives involved in the care of women of FGM (Dawson et al. 2015b, c) showed similar results to the one on doctors (Dawson et al. 2015a). Ten papers were included in this review, with eight being from high-income countries. The review again identified a lack of technical knowledge and training opportunities and limited cultural competency. Midwives expressed their need for professional education and training, a working environment supported by guidelines, responsive policy, and community education (Dawson et al. 2015b, c).

Two studies of midwives from Sudan and Somaliland reported a different problem (Berggren et al. 2004; Isman et al. 2013). While acknowledging its illegality some of them still performed FGM, as well as re-infibulation after childbirth (either in hospital, the woman's house or their own home). The main reasons were to supplement their low salaries and pressure from the community. Midwives in the Sudanese study said they were not afraid of prosecution as the law was rarely enforced (Berggren et al. 2004). Some midwives disliked carrying out re-infibulation but performed it anyway, and maintained that the women would otherwise have it done by someone else without the same experience and skill they had (Berggren et al. 2004). Somaliland midwives were confident in counselling women regarding FGM as they had experienced it themselves. They felt their work was honourable, beneficial to women, and that they were supported by their community (Berggren et al. 2004). Midwives reported challenges in convincing families to abandon FGM and expressed the need for community education and health promotion as well as providing midwives with alternative employment (Isman et al. 2013).

### **10.3.3 Women with FGM as Healthcare Recipients**

It is essential to hear the voices of women as recipients of care when we are designing and implementing maternity services for them. Otherwise these may be inappropriate

for their needs and/or the women may not use them. A very insightful Australian study from Western Sydney involved in-depth interviews and focus group discussions involving 23 migrant and refugee women with a history of FGM who had given birth in Australia within ten years or were pregnant at the time of the study (Turkmani et al. 2020). These women appreciated their meaningful involvement in the care design and delivery, and regarded the time taken to build trust between healthcare provider and recipient as a crucial factor. Overall, they appreciated the high standard of maternity care they received in Australia. They mentioned respectful care, a feeling of safety, receiving required information, access to skilled healthcare providers, being able to have a care plan and family support, and the midwifery continuity care (Turkmani et al. 2020).

Most women described feeling embarrassed and uncomfortable with their bodies after de-infibulation and wished re-infibulation had been done (Turkmani et al. 2020). One can postulate that there may not have been adequate antenatal counselling and explanation regarding FGM, its complications, the benefits of de-infibulation, and the appearance and function of the vulva after de-infibulation. Receiving knowledge through words, diagrams and photos would be empowering and perhaps have allowed them to appreciate the changes to their bodies. This may be inferred from these quotes from two women in the study:

“Sometimes they don’t even talk about FGM with us and just write everything down and say all is good without giving us the details. I think it is mostly because they don’t know anything about FGM, and they just look at you and they have no idea.”

“If these midwives and doctors know where to cut (de-infibulation), how to cut and when to cut it will be so helpful for us and for them because we will not have a problem and they will be relaxed and confident in what they do. Now, as soon as they see us, they are shaking ... Oh my God. They can get advice from doctors and midwives who worked in our country and have real experience of treatment of women with FGM.” (Turkmani et al. 2020)

For these women, developing trust was directly associated with the healthcare provider’s competence in FGM. A show of surprise or shock at their FGM made the women feel anxious and lose confidence that they would receive the appropriate care. They wished to be treated the same as women without FGM but with a tailored approach to appropriately manage the implications of their FGM (Turkmani et al. 2020).

The women were motivated to be involved in the decision-making regarding their care but struggled with the language barrier and lack of health literacy. Sometimes they were bypassed and husbands and mothers-in-law were consulted instead. Many requested psychological services, as pregnancy and birth bring up traumas of the past related to the FGM (Turkmani et al. 2020).

There was a belief that FGM may be continuing in their communities, even in Australia. The women emphasized the importance of community- and school-based interventions with media and education campaigns, involving not only women but also men and young people. The women believed that men are a crucial part of the abandonment process. However, they emphasized the challenge of this, as they believed men supported the cultural obligation and gave licence for the practice to continue. They maintained men lacked knowledge on the health complications of



FGM and would not be interested in supporting change (Turkmani et al. 2020). A quote from one of the participants underlined the importance of finding ways to include men in the conversation:

“At the moment, most of the trainings are for women. We need men to talk to men so we can engage them otherwise you cannot force them to sit in a class. You need to train more men to open up and talk about this issue with other men in the community and engage them at the same level as women. Men are still looking at it as a good thing.” (Turkmani et al. 2020)

Women explained that the cultural taboo around FGM made it difficult to discuss it even with male members of one’s family. They suggested facilitating workshops in the community in Australia to foster an environment where men and women can receive education on this issue and debate it amongst themselves (Turkmani et al. 2020).

## 10.4 Men and FGM

A systematic review of the role of men in the abandonment of FGM (Varol et al. 2015) supported the pertinent comments regarding men by the women in the Australian study (Turkmani et al. 2020). It included 25 studies from 15 countries, i.e., Egypt, Yemen, Oman, Nigeria, North Sudan, Senegal, Guinea, Somalia, Gambia, Sierra Leone, Ghana, USA, Norway, Sweden and Spain. Somali men in Oslo acknowledged that it continued due to social pressure and obligation (Gele et al. 2012). Fathers in Egypt believed uncut women to be promiscuous (Abdelshahid and Campbell 2015), and men in Guinea considered FGM important in preventing premarital sex in women (Gage and Van Rossem 2006). In a study of 993 men in Gambia 72% did not know FGM had negative health consequences (Kaplan et al. 2013). Men complained about the effect of FGM on their marital sexual relationships and found the lack of sexual response in their wives disturbing or inconvenient (Abdelshahid and Campbell 2015; Fahmy et al. 2010). Almost all 99 men and Christian and Muslim religious leaders, acknowledged a women’s equal right to enjoy sex (Fahmy et al. 2010). However, despite this belief and their relationship problems, some men remained staunch supporters of FGM due to their fear of loss of control over their sexual relationship (Fahmy et al. 2010) and their wives’ fidelity (Abdelshahid and Campbell 2015).

On the other hand, the systematic review also revealed that many men want the practice to end but feel unable to voice their concerns. In some countries, i.e., Guinea, Sierra Leone and Chad, more men than women want FGM to end (UNICEF 2013, July). The women in the Australian study recommended enabling conversation between men and women (Turkmani et al. 2020). This is supported by DHS data that there may be limited dialogue on FGM between the genders and that many women and men did not know the opinion of the opposite sex regarding FGM (UNICEF 2013, July). Communication would allow a debate on the validity of this practice in a culturally sensitive way (Varol et al. 2015). A family planning study showed just

how essential communication is for change (Shattuck et al. 2011). Teaching men communication skills to discuss contraception with their partners not only increased contraception use but also improved spousal relationships (Shattuck et al. 2011).

The women in the Australian study maintained that sustainable change needed to start within the family (Turkmani et al. 2020). Similarly, the systematic review (Varol et al. 2015) showed that men also believed that change should come from within the community rather than be imposed by government or non-government organizations (Gele et al. 2013a). Support for abandonment of FGM by men was directly related to level of education, higher socio-economic class and urban living (Varol et al. 2015). Each additional year of schooling significantly increased the odds of supporting abandonment of the practice (Gage and Van Rossem 2006). Education is the most crucial factor in helping communities end FGM. Studies have shown that men do want to be involved in health promotion programs addressing the welfare of families, and respond positively to them (Baylies and Bujra 2000; Drennan 1998). Generally, involvement of men in reproductive health services places men in secondary roles only as supporters for the benefit of women (Kululunga et al. 2012; Sternberg and Hubley 2004). The systematic review suggested the possibility of the provision of reproductive health services specific to men where a man-to-man strategy would facilitate discussion and management of their private and sensitive health and personal issues (Varol et al. 2015).

Migration to countries where FGM is not prevalent seems to be a catalyst for change (Varol et al. 2015). The systematic review cited three studies examining attitudes of men from Somalia living in Norway (Gele et al. 2012) and the USA (Johnson-Agbakwu et al. 2014), and men from Ethiopia and Eritrea living in Sweden (Johnsdotter et al. 2009). It was found that men had very good knowledge of the complications of FGM and almost all of them strongly rejected this practice (Gele et al. 2012; Johnsdotter et al. 2009; Johnson-Agbakwu et al. 2014). They found it had neither meaning within their cultural framework, nor a religious mandate (Gele et al. 2012; Johnsdotter et al. 2009). This supports the view that social obligation and pressure are the most prominent propagating factors of FGM. When people move to another country away from their community and extended families, not only is social pressure for conformity relieved, but the benefits and positive reinforcements are also removed (Varol et al. 2015). As an example, uncut Somali girls in Norway were more likely to attract boyfriends and get married as compared to girls who had undergone FGM (Gele et al. 2012). Even moving to another country within Africa where FGM remained prevalent was associated with anti-FGM attitudes. Eighty-nine percent of Somali male refugees in Ethiopia welcomed the usefulness of interventions to abandon this practice (Mitike and Deressa 2009). These findings support the belief by women and men (Gele et al. 2013a; Turkmani et al. 2020) that, in the absence of migration, change needs to come from within the communities, as the need to conform overrides any other outside intervention and influence.

## 10.5 Policy Responses in Australia

Between 2011 and 2019, Australia received about 100,000 migrants and refugees from Sub-Saharan Africa (Australian Bureau of Statistics 2019, November). Some of these countries have FGM prevalence rates of between 74 and 98% (UNICEF 2013, July). Whilst it is inaccurate to extrapolate prevalence of FGM data from country of birth, there would be a significant number of women and girls who would have FGM and hence require healthcare in Australia that is specific to their needs. The Australian study on obstetric outcome showed that 2–3% of all women delivering their babies at a metropolitan hospital had FGM and that with high-quality obstetric care and specialised FGM expertise, the outcome was similar for them compared to women without FGM (Varol et al. 2016). There are only three hospitals in Australia with FGM clinics, i.e., in Sydney, Melbourne and Perth. There are other hospitals in Victoria within which the Reproductive Rights Program provides education and training for healthcare providers and support for women affected by FGM (Multi-cultural Centre for Women's Health). Moreover, the New South Wales Ministry of Health has developed clinical guidelines for maternity care of women with FGM (NSW Government Department of Health Kids and Families 2014, September).

There is no other data on the prevalence of FGM in Australia on which to base policy development and resource allocations. Information on the prevalence of FGM and maternal and neonatal complications can be included in the National Perinatal Data Collection of the Australian Institute of Health and Welfare. This would also be a prerequisite for monitoring and evaluating health and community intervention programs. Accurate data collection and the ability to ask about and discuss FGM with women requires an improvement in current education and training programs for doctors, midwives and nurses (Dawson et al. 2015a, b, c). We need to incorporate teaching on FGM in curricula of under- and postgraduate medical, midwifery and nursing colleges (Varol et al. 2017). Furthermore, to improve the healthcare for these women and reduce healthcare costs for the government, there is a need to establish other FGM clinics in hospitals where women with FGM present for maternity care (Varol et al. 2017). These clinics need to be holistic with gynaecological, urological, paediatric, psychological, social work and interpreter services (Varol et al. 2017). We also need to establish a directory with easily accessible referral pathways for clinicians and other government and non-government community services involved in the care of women with FGM (Varol et al. 2017).

Programs aimed at multiple levels of intervention have been shown to be effective in the abandonment of FGM (Varol et al. 2017). The largest decline globally has been in Kenya and Burkina Faso with a combination of legal and community education responses (Rahman and Toubia 2000; Shell-Duncan et al. 2013; UNICEF 2013, July). In Australia, FGM was first made illegal in New South Wales in 1994 and the other states and territories soon followed. Penalties vary for performing or helping to perform FGM, ranging from seven to 21 years imprisonment (Australian Government Attorney General's Department 2013). Three cases of successful prosecution have been seen in Australia to date, which sent strong messages to people. It also

allowed members of a particular community to speak out about FGM and sparked an international campaign to end it (Tavawalla 2016). Legislation and prosecution are most effective within a framework of community culturally-affirming interventions (Costello et al. 2013). The legal profession in Australia, like in the European Union, has limited tools for education and training in this practice (European Institute for Gender Equality 2013). As with the needs of healthcare workers, training should include a multidisciplinary national program for child protection professionals to understand the sociocultural underpinnings, to identify children at risk of FGM, and access pathways for appropriate referral (Varol et al. 2017).

The Australian Government has been addressing violence against women in a National Plan, focusing on domestic and family violence, prevention and intervention programs involving women, men and communities, provision of support services for women, and research and evaluation programs to inform policy (Australian Government Department of Social Services 2011). This Plan also addresses other national reforms on children, settlement services for refugee and migrant women, human trafficking and slavery, disability and homelessness. It has been suggested that all professionals involved in the care of women with FGM and protection of girls from FGM, form a network of experts within this National Plan to coordinate research, training and intervention programs, and inform policy (Varol et al. 2017).

## 10.6 Conclusion

Girls and women will continue to be subjected to FGM in the world as long as there is systematic gender inequality, a lack of empowerment and voices of women, poverty, the need to conform to customs concerning marriageability for economic survival, and lack of access to education for girls and women, preventing them from being able to earn their own living. FGM is a global concern due to migration and refugee-seekers from countries of conflict and war. It is a moral, health and human rights imperative to protect children from this trauma by addressing the underlying causes. Migration to countries such as Australia where FGM is not prevalent, provides a catalyst for change within communities, as underlying propagators are no longer present. Australia has world-class legal, health and education systems which we can leverage, in consultation with affected women, men and their families, to form a national network of experts to develop, implement and evaluate national policy and guidelines on healthcare provision, protection of girls, and prevention of FGM. This may be placed within the broader program which already addresses gender-based violence. We are more likely to see the end of FGM if there is global collaboration on research, training, and prevention programs.

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