

FARREP and the African Women's Clinic

Nigisti Mulholland and Marie Jones

“Three million girls per year are subjected to FGM. ”

Transcribed directly from MOGCAST Episode 27. Listen here:

<https://open.spotify.com/show/6dtXQ6jLjAlI7lHtP71cYe?si=7671224caacc4f4a>

My name is Nigisti Mulholland, and I'm the coordinator of FARREP at the Women's. FARREP stands for Family and Reproductive Rights Education Program. Today, I'm talking about the invisible public health issue of female genital mutilation, referred to as FGM.

FGM is the partial or total removal of the external female genitalia or any other injury to the female external genitalia conducted for non-medical reasons. FGM has no health benefit, and there is no medical justification for it. There are many serious short, medium, and long-term consequences of the practice.

FGM has been practiced in many communities over thousands of years. We do not know when it started. Why it's done? The reasons for performing FGM is both cultural and historical.

FGM is carried out for a number of reasons. Some of those are false medical beliefs that FGM might enhance hygiene, that FGM might increase fertility, or that FGM improves child survival by stopping miscarriage. Other reasons have more to do with controlling women's behavior.

There are beliefs that FGM is a rite of passage to womanhood, reinforces cultural identity, prevents sex before marriage, ensures fidelity within marriage. FGM can also comply with local cultural issues about beauty. Some believe it makes the genitalia more beautiful.

Some believe FGM is a religious observance despite not being required by any religion. Many see it as confined to Muslim societies, but it is not. It was done in some Western countries in the past to cure sexual expression in young girls. For example, it was performed in some communities in the USA until the 1970s.

Who does it? FGM is usually done by a woman without medical training, using unsterile equipment and no anaesthetic.

How to speak about FGM? There is different terminology to describe FGM that's used by different groups.

The term female genital mutilation, or FGM, is used by advocacy groups and the World Health Organization to emphasize its severity. Affected communities refer FGM to circumcision in their language. UNICEF and non-government organizations who work with affected communities use FGM/C or female genital mutilation/cutting.

Some women's health advocacy groups just refer to FGC, female genital cutting. It's important to remain nonjudgmental using neutral language when asking your patient about FGM. How common is it? It's estimated that 200 million girls and women worldwide are affected.

Three million girls per year are subjected to FGM. Most are from one of the 30 countries in Africa, mainly the Sahel Belt. Some affected women also live in Asia and the Middle East.

Many affected women have now migrated to Western countries, including Australia. The UN has a very clear position on FGM. Under Sustainable Development Goals, Target 5.3, eliminate FGM/C by 2030.

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“The role of FARREP is to support affected women and address their health needs.”

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In Australia, FGM emerged as a problem in the 1990s with the arrival of refugee women from the Horn of Africa who were affected by FGM. Health professionals were confronted with women presenting to pregnancy care in Melbourne. Today, over 34,000 people living in Victoria are from countries where FGM is practiced.

Most are from Egypt, Sudan, Ethiopia, Somalia, Kenya, and Eritrea. Recent new arrivals from West Africa are also affected. The prevalence of FGM among different communities range from 27% in Ethiopia to 98% in Somalia.

There is still little evidence of the practice in Victoria, but some girls living in Australia have been taken to their country of origin for FGM to be performed.

About FARREP, Family and Reproductive Rights Education Program, FARREP was established in 1997. Workers are distributed among hospitals and women's health NGOs.

The role of FARREP is to support affected women and address their health needs, including deinfibulation, to provide relevant information about FGM for community and health care workers, to promote the elimination of FGM within Australia and globally. FARREP works with all levels of the health service community, with nurses, midwives, paramedics, social workers, with medical practitioners at all levels, and with students of medicine, nursing, midwifery, and allied health professions. FARREP also works with community organizations, police, child protection service, teachers, community groups.

One word about human rights. The practice of FGM is recognized as a violation of human rights. Although FGM is a harmful and abusive practice, some people from affected communities do not see this from that point of view.

While many women are suffering with memories of the painful procedure, other affected women may not recall the incidents or even associate it with their current physical symptoms. For example, a newly married young woman presenting with an issue of painful intercourse may not recognize her symptoms as due to FGM. In fact, she may even be unaware that she has been subjected to FGM.

In many cases, it's a shock for them to hear that their loving parents have put them through such a painful experience that will lead to ongoing problems. Although this is a human rights abuse, it's undertaken by families wanting to do the right thing for their daughters. It's done out of love, a point often forgotten by health professionals.

What does the law say about FGM? The practice of FGM is illegal in Australia. All Australian states and territories have laws prohibiting FGM with mandatory reporting requirements for both clinicians and other service providers. In Victoria, the performance of FGM and/or the removal of a child from Victoria to have FGM performed are specifically prohibited under the Crime Female Genital Mutilation Act 1996.

More recently, under the Children, Youth, and Families Act 2005, health practitioners are required to report concerns about possible FGM if they think a child is in a danger of having their genitals cut, either in Australia or overseas, or if they believe this may have been performed since a child was living in Australia. Now, Marie, my

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colleague, who is the African Women's Coordinator, will talk to you about the management of women affected by FGM. Thank you for listening.

Hello, I am Marie Jones. I am a nurse practitioner and a midwife. I work at the Royal Women's Hospital in Melbourne and I am the coordinator of the African Women's Clinic.

The African Women's Clinic is a nurse midwife-led outpatient clinic set up in 2010 to care for women affected by female genital mutilation. I prefer to use the term FGM when I am giving a presentation or talking to health professionals. This is because I do not want to minimise the harm of FGM.

It is recognised as a violation of human rights as it occurs mainly in underage girls without their consent. The World Health Organisation says the majority of girls are cut before they turn 15 years old. In my experience, FGM occurs mainly pre-puberty.

However, I speak of traditional cutting when I am with women affected by FGM and with their family and friends. This is a more respectful terminology. When a woman presents to the African Women's Clinic, we have a multidisciplinary team approach in the consultation.

We have a FARREP worker in the consultation, an interpreter if required, and any other person that the woman would like in the room. At least one of our FARREP workers would have already had a conversation with the woman and will have explained their role. This often makes the woman feel more comfortable coming to the clinic, especially when she meets the FARREP worker she has been talking with over the phone.

Time is something we have in our clinic unlike most clinics. The consultations are not hurried. Women can self-refer to the clinic.

If the woman has been referred by a health professional, we ask her if she knows why she was referred to the African Women's Clinic. We take a general health history and a sexual and reproductive health history. We describe the types of FGM and have various visual aids to help in this discussion.

We also give the woman written information in her preferred language about the clinic, the law on FGM in Victoria, the deinfibulation procedure and post-procedure care if this is required.

According to the World Health Organisation, FGM is classified into four types. Type 1 is partial cutting of the clitoris or complete removal. Some women call this sunna. Type 2 is when the clitoris may or may not be cut or removed, the labia minora cut, and there may be some cutting of the labia majora. Type 3 is when the clitoris and or labia minora may be cut and the labia minora or labia majora are sewn, sealed together so that there is a small vaginal opening for the passing of urine and menstrual fluid. Type 4 is all other procedures performed to the genitalia for non-medical reasons such as piercing, scraping or cauterisation of the vagina.

We examine the woman with permission. If she is comfortable, we use a mirror as we describe what we think has happened when she was cut. This can be very confronting for the woman, especially if she has type 3 infibulation. After the examination, we sit down and discuss the type of FGM that has been identified and what

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“Please ask the question.”

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this may mean for the woman. We refer the woman to other clinics at the women's if required or requested.

This may include referral to our psychologist or sexual counsellor. The pelvic floor unit will take over the care of women with complications of FGM or if a woman needs or requests to have their deinfibulation in theatre. This may be due to difficulty of the procedure or the psychological trauma such as flashbacks.

If the woman has type 3 FGM, there is a discussion around deinfibulation. Deinfibulation is the opening of the vagina. This procedure is performed in clinic by the nurse midwife in a procedure room under local anaesthetic and the woman goes home soon afterwards.

Anaesthetic cream is applied over the area to be deinfibulated about 40 to 60 minutes before the procedure begins. Using an aseptic technique, we clean the vulval area with chlorhexidine with sterile drapes around the area to be de-infibulated. Local anaesthetic, Lignocaine 1%, is used on and around the area to be de-infibulated.

We often find that one side of the labia will need more Lignocaine than the other. The infibulation is cut with straight scissors up until urethra can be seen. The labia are sutured back so that it does not anastomose.

Blood pressure and heart rate are taken before and after the deinfibulation. If the woman is pregnant, we do the deinfibulation until 34 weeks gestation. If the woman is over 34 weeks pregnant, we discuss a plan with her around the birth of her baby and inform her antenatal team of the need for deinfibulation in labour.

The woman is given a sachet of urinary alkaliniser in water and one gram of paracetamol if needed to take after her procedure. She is given a strip of 10 paracetamol to take home, with six sachets of urinary alkaliniser. We have a small room for her to sit and relax with the FARREP worker before going home.

We ring the woman a few hours after her procedure. Most women tell us in their review appointment if this is all they need. One of the most important messages I can give to all health professionals is please ask the question.

It can be as simple as saying, I see you were born in or come from a country that has or does practice traditional cutting. Have you been affected by this? If the answer is yes, please inform the woman of the African Women's Clinic and the FARREP program. My contact details are marie.jones@thewomens.org.au or the FARREP phone number contact is 0383453058.

Thank you for listening.