Public Health Association
AUSTRALIA

Female Genital Mutilation

Policy Position Statement

Key message: Worldwide more than 200 million girls and women are living with Female Genital Mutilation (FGM). FGM is strongly associated with adverse obstetric outcomes and serious immediate and long-term physical, sexual and psychosocial complications resulting in excruciating injuries, disability and death. FGM is a public health issue demanding attention in Australia given the increased migration of women and girls arriving as migrants or refugees from countries where FGM is prevalent.

Key policy positions: Priority policy changes required are:

1. Funding to support research on prevalence and prevention efforts.
2. Accessible and competent services to assist in the prevention and holistic management of FGM.
3. Health professional education and training to address gaps in FGM related knowledge skills and practice.
4. FGM community education and parenting programs that involve families, women and men.

Audience: Federal, State and Territory Governments, policy makers, program managers, other professional and non-government groups.

Responsibility: PHAA's Women's Health Special Interest Group (SIG).

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PHAA affirms the following principles:

1. The care of women with FGM must be guided by the World Health Organization's best practice recommendations on the management of health complications for FGM based upon sound practical judgement designed to ensure little to no risk of harm to health (2).
2. FGM prevention efforts must include primordial, primary, secondary, and tertiary interventions (6).
3. Educational interventions in clinical and community settings for parents reduce abuse and neglect and improve health outcomes for young children (7, 8).
4. Behavioural change leading to the abandonment of FGM is most successful when communities are engaged (9, 10) and health promotion for communities affected by FGM should be guided by the National Education Toolkit (11).
5. Comprehensive legislation and health professional and community education about the law is important to prevent FGM (6).

PHAA notes the following evidence:

6. FGM is a practice performed on infants and girls as young as two years that involves the partial or complete removal of the external female genitalia or other injury to the genitalia for non-therapeutic reasons.
7. FGM constitutes a form of gender-based violence and child abuse.
8. Worldwide more than 200 million girls and women are living with FGM and three million girls may be at risk of undergoing FGM every year (1).
9. FGM is strongly associated with adverse obstetric outcomes and serious immediate and long-term physical, sexual and psychosocial complications resulting in excruciating injuries, disability and death (2).
10. Sustainable Development Goal (SDG) target 5.3.2 focuses on the elimination of all harmful practices including FGM that is neglected in the Asia-Pacific region (3).
11. All States and Territories in Australia have passed criminal legislation prohibiting FGM (4).
12. FGM is a public health issue demanding attention in Australia given the increased migration of women and girls arriving as migrants or refugees from countries where FGM is traditionally practiced in Africa, the Middle East and Asia.
13. Despite a lack of national prevalence data the number of affected women in Australia has been estimated at 53,000 (5).

PHAA believes that the following steps should be undertaken:

14. Health professional education and training must be provided to address gaps in FGM related knowledge skills and practice (12, 13).
15. Specialist hospital services in maternity units that serve communities where there are women from FGM prevent countries should be provided to increase the detection rate of FGM and improve obstetric management of women with FGM (14).
16. FGM community education programs should be adequately resourced to deliver state and territory wide programs and involve men as well as women.
17. Parenting programs tailored to the needs of new mothers and fathers from FGM prevent nations should be co-produced to improve their social support, self-efficacy and prevent FGM (15).
18. A multi- sector, multiagency approach is needed to identify children at risk or those who have been cut, and co-ordinate appropriate response and rapid referral pathways and prevention programs (6, 16).
19. Data about FGM prevalence and frequency of service use should be routinely collected to inform health service planning (5).

PHAA resolves to undertake the following action:

20. Advocate for the following steps to be taken based on the principles in this position statement.
21. Development of a national comprehensive sexual and reproductive, health strategy that includes action on the prevention of FGM, and honours Australia's commitment to the SDGs and reports against agreed indicators.
22. Standardised education and in-service training for health professionals.
23. Improved data collection to inform the provision of specialist services, tailored primary care and clear referral pathways for women affected by FGM.
24. Comprehensive community-based health promotion and support for new parents from FGM prevalent nations.
25. Co-ordinated legal child protection actions to effectively identify children at risk or those who have been cut, and appropriate and rapid referral pathways to the appropriate agencies for investigation and protection.
26. Research collaboration between countries of FGM prevalence and migration should be fostered to improve training and prevention programs.

ADOPTED 2018, revised 2021

References

1. UNICEF. Female Genital Mutilation/Cutting: A Global Concern https://data.unicef.org/wp-content/uploads/2016/04/FGMC-2016-brochure_250.pdf. New York: United Nations Childrens Fund; 2016.
2. WHO. Guidelines on the management of health complications from female genital mutilation. 2016.
3. Dawson A, Rashid A, Shuib R, Wickramage K, Budiharsana M, Hidayana IM, et al. Addressing female genital mutilation in the Asia Pacific: the neglected sustainable development target. Australian and New Zealand Journal of Public Health. 2020;44(1):8-10.
4. Australian Government. Review of Australia's Female Genital Mutilation legal framework Final Report https://www.ag.gov.au/publications/pages/reviewofaustraliasfemalegenitalmutilationlegalframework-finalreportpublicationandforms.aspx. Canberra: Attorny General's Department 2013.
5. AIHW. Discussion of female genital mutilation/cutting data in Australia. Canberra: Australian Institute of Health and Welfare; 2019. Contract No.: Cat. no. PHE 253.
6. Njue C, Karumbi J, Esho T, Varol N, Dawson A. Preventing female genital mutilation in high income countries: a systematic review of the evidence. BMC J Reproductive Health. 2019;16(1):113.
7. Selph SS, Bougatsos C, Blazina I, Nelson HD. Behavioral interventions and counseling to prevent child abuse and neglect: a systematic review to update the US Preventive Services Task Force recommendation. Annals of internal medicine. 2013;158(3):179-90.
8. Vlahovicova K, Melendez-Torres G, Leijten P, Knerr W, Gardner F. Parenting programs for the prevention of child physical abuse recurrence: a systematic review and meta-analysis. Clinical child and family psychology review. 2017:1-15.
9. Berg RC, Denison EM. A realist synthesis of controlled studies to determine the effectiveness of interventions to prevent genital cutting of girls. Paediatrics and international child health. 2013;33(4):322-33.
10. Brown K, Beecham D, Barrett H. The Applicability of Behaviour Change in Intervention Programmes Targeted at Ending Female Genital Mutilation in the EU: Integrating Social Cognitive and Community Level Approaches. Obstetrics and gynecology international. 2013;2013:324362.
11. MCWH. NETFA Resource and Activity Guide for Working with Communities Affected by FGM/C http://netfa.com.au/national-education-toolkit-for-fgm-c-awareness-resource-activity-guide.php. Melbourne: Multicultural Centre for Women's Health; 2014.
12. Dawson A, Homer CS, Turkmani S, Black K, Varol N. A systematic review of doctors' experiences and needs to support the care of women with female genital mutilation. International Journal of Gynecology & Obstetrics. 2015;131(1):35-40.
13. Dawson A, Turkmani S, Fray S, Nanayakkara S, Varol N, Homer C. Evidence to inform education, training and supportive work environments for midwives involved in the care of women with female genital mutilation: A review of global experience. Midwifery. 2015;31(1):229-38.
14. Varol N, Dawson A, Turkmani S, Hall JJ, Nanayakkara S, Jenkins G, et al. Obstetric outcomes for women with female genital mutilation at an Australian hospital, 2006–2012: a descriptive study. BMC pregnancy and childbirth. 2016;16(328):doi.org/10.1186/s12884-016-1123-5.

15. Renzaho AM, Vignjevic S. The impact of a parenting intervention in Australia among migrants and refugees from Liberia, Sierra Leone, Congo, and Burundi: Results from the African Migrant Parenting Program. Journal of Family Studies. 2011;17(1):71-9.
16. Varol N, Hall JJ, Black K, Turkmani S, Dawson A. Evidence-based policy responses to strengthen health, community and legislative systems that care for women in Australia with female genital mutilation/cutting. Reproductive health. 2017;14(663):doi.org/10.1186/s12978-017-0324-3.