



Mercy Health

Care first

SUPPORTING YOUNG WOMEN WHO HAVE EXPERIENCED FEMALE GENITAL MUTILATION/CUTTING (FGM/C)

PROJECT REPORT

June 2014

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ACKNOWLEDGEMENTS

The *Supporting young women* who have experienced FGM/C project team would like to acknowledge and thank:

- Young women who participated in interviews and focus groups and shared their experiences and expectations
- Key stakeholders who participated in interviews
- The Project Steering Group: Assoc Prof Sonia Grover, Mercy Hospital for Women; Ms Fowzia Issa, Darebin City Council; Ms Elizabeth Murdoch, Mercy Public Hospitals Incorporated; Dr Jane Yelland, Murdoch Childrens Research Institute
- Leadership Team at Mercy Public Hospitals Inc. for their ongoing support in the development and delivery of culturally responsive services
- and the Australian Government, Department of Health for making this project possible through the FGM Support Grants.

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FOREWORD

Our commitment to culturally responsive care

Our guiding principle at Mercy Health is “care first”. This means we put caring for people above all else. Providing compassionate care which respects the dignity and sanctity of each and every human being is central to our reason for being. To achieve this we must have a thorough understanding of an individual’s needs as well as their personal and cultural experiences.

The Supporting young women who have experienced female genital mutilation/cutting (FGM/C) project is an example of how we are obtaining information to improve care for those in need. This report presents the key findings of the project and proposes recommendations for the future that are relevant to all who are working with this group of women.

We commend this initiative for the way it recognises a specific care need, acknowledges women’s experiences and seeks better ways to provide support. By expanding our understanding and knowledge, not only will we be better equipped to serve women who have experienced FGM/C but we can assist them, their families and their communities to understand the effects of FGM/C and empower them to manage this issue in a manner which is respectful to their own cultural beliefs.

We extend our sincere thanks and appreciation to all project participants who shared their experiences and insight. Our gratitude also goes to the Australian Government, Department of Health for funding this important work.

On behalf of Mercy Hospital for Women and the leadership team of Mercy Health Services we are pleased to commend this report.



Dr Linda Mellors

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EXECUTIVE SUMMARY

A growing number of migrants and refugees who come from countries that practise female genital mutilation/cutting (FGM/C) have settled in Australia over the last few decades. FGM/C includes “procedures that intentionally alter or cause injury to female genital organs for non-medical reasons. The procedure has no health benefits for girls and women” (World Health Organization (WHO), 2014).

Since 1998, Mercy Hospital for Women, through its Family and Reproductive Rights Education Program (FARREP), has been working with women from affected communities. It was through this work that the need for this study was identified.

The *Supporting young women who have experienced FGM/C* project was funded through the FGM Support Grant from the Australian Government, Department of Health. The overall aim of the project was to explore experiences of young women (18-25 years old) from FGM/C affected communities to determine ways to develop, improve and deliver support services that are culturally and age appropriate, and increase understanding of FGM/C and its consequences.

Semi-structured interviews and focus groups were conducted with twelve young women and three key stakeholders who work with young women who have experienced FGM/C. Data acquired underwent thematic analysis from which the following findings emerged:

- The young women who participated in the project experienced a lack of awareness and understanding of services that may be available to them.
- They expressed an expectation that general practitioners (GPs) and other health professionals will offer support when required.
- Access to appropriate, relevant information about FGM/C and supports available was noted by participants as a challenge. They recommended delivering information in a variety of modes including online and through information sessions.
- Participants in the project have identified a number of features that would be important to them if they were to access services and support. Apart from practical features such as hours of operation and location, the participants highlighted the need for person-centred, culturally responsive care; access to bi-cultural workers; and emphasis on privacy, confidentiality and trust.

To support development and improvement of services for young women who have experienced FGM/C, this report proposes a range of future considerations for all those who work with this group of women.

1. INTRODUCTION

“Female genital mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. FGM is recognized internationally as a violation of the human rights of girls and women. The practice of FGM has no health benefits, causes severe pain and has several immediate and long-term health consequences” (WHO, 2014).

Terminology surrounding FGM has been widely debated. In our experience, generally the term mutilation is not well received by women who have experienced it. Whilst there are many culturally specific terms used to describe the practice, frequently used alternatives are ‘female circumcision’ or ‘female genital cutting’. For the purposes of this report the term female genital mutilation/cutting (FGM/C) is used. In practice, we strongly encourage service providers to identify and use the term that each woman is most comfortable with.

WHO (2014) estimates that more than 125 million girls and women alive today have undergone FGM/C in 29 countries in Africa and the Middle East where the practice is concentrated. Over the past few decades a growing number of migrants and refugees who come from communities that practise FGM/C have settled in Australia. However, there is no reliable data on the prevalence of FGM/C in Australia. In addition, “there is currently limited evidence to suggest that the practice is being continued by migrant communities in Australia” (Multicultural Centre for Women’s Health (MCWH), 2013). A survey of health care providers, mostly gynaecologists and cultural health care workers, failed to identify any direct evidence of FGM/C being undertaken in Australia (Moeed & Grover, 2012).

1.1. Background

Mercy Hospital for Women is a tertiary hospital based in Heidelberg, Melbourne, Victoria. We provide maternity, neonatal, gynaecological and gynaecological oncology services. We have a long tradition of caring for women and families from various cultural and linguistic backgrounds. Today, 37% of our patients are born overseas and 17% speak a language other than English at home.

Since 1998 Mercy Hospital for Women has run FARREP, a Victorian Department of Health initiative that funds a range of services to work with communities that practice FGM/C. The program at Mercy Hospital for Women provides direct care support to women and their families and also implements some health promotion activities in relation to FGM/C.

It was through this work that we were starting to see the younger generation of women who have experienced FGM/C and have been living in Australia for a significant part of their lives. Anecdotal evidence indicated services have not yet adapted to best meet the needs of these young women. There were interesting debates in our office as to how we should appropriately support this generation of women.

An FGM Support Grant received from the Australian Government Department of Health enabled us to conduct a qualitative review of the experiences of young women from FGM/C affected communities to determine ways to develop, improve and deliver FGM/C support services that are culturally and age appropriate, and enhance women's understanding of FGM/C and its consequences.

This report provides information on the methodology and findings of this project, *Supporting young women who have experienced FGM/C*, as well as future considerations for those who are working with this group.

2. METHODOLOGY

The *Supporting young women who have experienced FGM/C* project was designed as a descriptive study to enable exploration of young women's views and experiences of accessing FGM/C related health and support services.

The project was initiated by the Multicultural Services Manager and the FARREP worker at Mercy Hospital for Women. Funding received through the FGM Support Grants enabled employment of two project staff:

- Community Engagement Officer (0.6EFT) who was culturally and generationally matched to the target group, and
- Research Project Officer (0.2EFT) who had experience in conducting qualitative research.

This group formed the project team.

A Project Steering Group was established with membership reflecting relevant expertise, including a health services researcher, a clinician who works with women who have experienced FGM/C, a community worker and a representative from Mercy Public Hospitals Inc.

2.1. Aims

The project was conducted in the period July 2013-June 2014 and aimed to answer the following questions:

- 1) Are current models of service delivery accessible and applicable to the younger generation of women who have experienced FGM/C and have grown up in Australia?
- 2) What is the experience currently of this group and what are the key issues in accessing appropriate support?
- 3) How can the current state be improved from the point of view of a patient-centred paradigm, and how could this inform how young women who have experienced FGM/C are treated?
- 4) What are the key components of a successful model from the health worker's point of view?

To meet these aims, the project was designed around two main components: semi-structured interviews with young women from FGM/C affected communities and interviews with key stakeholders who are already working with this group.

2.2. Research ethics

Ethics approval was obtained from the Mercy Health Human Research Ethics Committee in September 2013.

2.3. Study participants

For the purposes of the *Supporting young women who have experienced FGM/C* project, the target group was identified as young women between 18 and 25 years of age, born overseas, who have experienced FGM/C or are from a community that practises FGM/C and have lived in Australia for a significant part of their life.

The recruitment period was between November 2013 and March 2014. In total 12 participants were recruited. Five individual interviews and two focus groups, consisting of three and four participants respectively, were conducted. Characteristics of the participants are outlined in section 3.1.

Three key stakeholders were also interviewed: an African youth worker, an African community worker, and a GP Liaison Officer.

2.4. Recruitment and consent

The process to ask women from FGM/C affected communities to participate in the study was complex. Due to the sensitivity of the topic, it was decided that the FARREP worker would initially approach her clients to gain interest for participation in the project. Once this was done, further information about the project was provided by the Community Engagement Officer. Verbal consent was obtained by the Community Engagement Officer at this time and the interview was scheduled. At the time of the interview the written consent was obtained following provision of *Participant Information and Consent Form* as well as a plain English verbal overview.

Focus group recruitment occurred through an existing network of workers. Women who participated in each respective focus group already knew each other through social and community contacts and were happy to participate in the focus group discussion. The focus group interviews were conducted by the Community Engagement Officer with support from the Research Project Officer.

In addition to information outlined in the *Participant Information and Consent Form*, participants also received additional verbal assurance from the Community Engagement Officer that their details and responses would be kept anonymous, and results only used in the final report. No individuals participating in the study could be identified by the rest of the project team.

2.5. Interviews

Due to our extensive experience in working with women who have experienced FGM/C, as well as advice received from the Project Steering Group, a face-to-face interview was considered to be the most effective method of data collection in this project.

Five individual interviews and two focus groups were conducted with young women. The interviews were semi structured, allowing open discussion. The interview questions were designed by the research team with input from the Project Steering Group.

2.6. Designing the interview questions

The topic of FGM/C is of a very sensitive nature and when designing the survey, care was taken to ensure that appropriate questions were asked to elicit the most diverse responses. The revision of questions was undertaken in conjunction with the Project Steering Group as well as the research team, to ensure all appropriate areas were being included in the survey. Diversity of expertise within the Project Steering Group allowed for qualitative research methods and culturally appropriate issues to be considered in the survey design. This included reviewing the terminology surrounding female genital mutilation/cutting, and replacing it with more appropriate wording, such as 'female circumcision/cutting'. The interview questions also had to allow for open discussion, and care was taken to ensure that the questions reflected the aims of the project.

All women were asked the same questions. Women who had accessed services were asked some additional questions. The questions are listed in Appendix 1. A separate questionnaire was created for key stakeholders and included questions exploring their experience and learnings from working with young women who have experienced FGM/C. The questions are listed in Appendix 2.

2.7. Data management and analysis

Interviews were recorded for consenting participants using an application on a smart phone. The recording was used solely for transcription purposes and destroyed once the interview was transcribed. For participants who did not consent to audio recording, interview responses were hand written and then typed. De-identified demographic data was entered into an Excel spread sheet.

Transcripts and notes from the interviews were analysed using content analysis and then coded into themes that best described the data (Liamputtong & Serry, 2010). When quotes are given, they are identified by participant type, e.g. Participant #1 or Focus group #1 participant.

Data obtained from service providers was used to clarify and reinforce issues raised by the participants.

2.8. Strengths and limitations

Conducting cross-cultural research, particularly in relation to sensitive cultural practices is a challenge. Over the course of this project we identified strengths and limitations, and gained important learnings that we believe would be useful to others who are considering doing this kind of work.

Funding obtained for this specific project assisted in building on the foundations of the work that we have been doing for nearly two decades. The grant allowed employment of a culturally and generationally appropriate worker, which was an important factor in engaging with the participants and making them feel at ease during interviews. Our existing working relationship with a network of community workers enabled us to recruit participants outside our immediate setting, and to survey a broader demographic sample.

Development of a culturally appropriate research methodology, particularly in relation to such a sensitive issue, was crucial. The expertise of the team and the members of the Project Steering Group was invaluable in this process.

Due to the sensitive nature of the topic, language and terminology had to be reviewed by the research team in consultation with the Project Steering Group to optimise maximum number of participants. An example includes using the term 'female circumcision or cutting' in interactions with women instead of 'female genital mutilation/cutting (FGM/C)'. In addition, after the initial two interviews, we identified a significant lack of understanding of service provision, and questions had to be reviewed to contain examples and further explanation of what is meant by health or support services.

One of the participants was aged just over 25 at the time of the interview, which was outside of the selection criteria. However, her experience of services relating to FGM/C occurred earlier in life, so her participation in the project was approved.

Two women who were born in Australia and did not experience FGM/C, but who strongly identified as being from an affected community, were interested in participating in one of the focus groups. Whilst the other participants sought their presence in the group, their views had to be excluded as they did not meet the selection criteria.

A number of issues were raised during the course of the project that were outside of the scope of the project. These are listed here as they may be considered in future studies:

- Role of the GP in supporting women with FGM/C
- Implementation and evolution of education programs in schools for girls who have experienced FGM/C, for example through sexual and reproductive health education
- Exploration of models of care to enable delivery of hospital-run FGM/C services in the community.

3. KEY FINDINGS AND DISCUSSIONS

3.1. Characteristics of participants

Twelve young women participated in the interviews or focus groups. Five women were past or current Mercy Hospital for Women patients. Seven women were recruited through the community workers and they had no previous contact with the hospital.

Table 1 outlines some of the key characteristics of participants. From the 12 young women who participated in this project, 67 per cent were born in Somalia, where the prevalence of FGM/C is high. The rest of the participants were born in Kenya, Sudan and Syria. Two thirds of participants arrived in Australia as children and the rest arrived as teenagers. In addition, most participants resided in another country (different to their country of birth) immediately before coming to Australia.

All except one participant indicated that they spoke a language other than English at home, namely Somali and Arabic. The majority said that they speak and write English very well.

Seven out of 12 participants identified as single. These women were recruited from the community. The remaining five participants were married with children and were recruited through the hospital.

Table 1: Characteristics of participants (n=12)

	Number		Number
AGE OF PARTICIPANTS		MARITAL STATUS	
18-20	6	Single	7
21-23	3	Married	5
24 +	3	HOUSEHOLD COMPOSITION	
LENGTH OF RESIDENCE IN AUSTRALIA		Nuclear	10
6-9 years	4	Extended	1
10-14 years	2	Did not answer	1
15 years and more	6	HEALTH CARE CONCESSION CARD	
PROFICIENCY IN ENGLISH		Yes	12
Spoken:		No	0
Very well	9		
Well	3		
Written:			
Very well	7		
Well	3		
Did not answer	2		

3.2. Experience of services

All participants in the project reported the lack of awareness and understanding of services, but had high expectations that their GPs and other health professionals will offer support when required.

“Most women don’t really access services relating to circumcision until they need it.” (Participant #4)

3.2.1. Lack of awareness and understanding of services

Various Australian and international studies have found that migrants and refugees experience a lack of awareness and understanding of services available (Kelaheer et al 1999; Allotey et al 2004). Our project also confirmed this knowledge. However, a significant finding is that the majority of the participants, who accessed a range of services in our hospital, did not acknowledge these as services. Hospital appeared to be a place where women go to have a baby, but there was very little acknowledgement of the support they received from allied health and other professionals, particularly in relation to FGM/C.

This presented a challenge. Before commencing the interviews we assumed that women who accessed our hospital would have at least a basic understanding of services and what is meant by that term. However, after conducting the first two interviews we decided to provide a definition of the term “services” in case this term was confusing for participants. Examples such as “hospital, GP, community health centre” were included in the definition.

When similar issues regarding services were raised in our second focus group, which was organised with the assistance of a local African youth worker, the interviewer asked *“How about <the worker>? Do you see her as a service provider or as someone in the community?”* One of the participants answered *“I see her as my sister.”* The worker explains this:

“To be honest when it comes to services, their main belief is that it is either Centrelink, doctors or those places... If I look at myself they don’t think I am a service provider. They will probably put it as a community worker or youth worker. Parents would say she is a community worker...or the young people will say she is a youth worker, she is a social worker. But they would still not think to relate that as a service provider.” (African worker #2).

This finding is an important one for any service provider who is trying to reach into these communities. It is imperative to identify appropriate ways to communicate and explain what services can offer. Even with this younger generation, where English is seemingly not a barrier, there are additional cultural issues that need to be considered. This once again demonstrates the need to improve cross-cultural understanding, because what is of value to the consumers may not be aligned to service providers’ expectations and values.

Many studies have identified the importance of providing culturally appropriate, patient-centred care (Williamson & Harrison, 2010). Practitioners are encouraged to “learn from patients in order to understand their beliefs and the way they wish to be treated” (Chang, Simon, & Dong, 2012, p. 273).

3.2.2. Women's expectations of support from general practitioners and other health professionals

"To me it's important that the professionals are aware of the needs of women who have undergone circumcision and to help them understand and explain to them about issues and what is available to them." (Participant #1)

All participants stated that they would access their GP for health information and expect the GP to organise referrals as necessary.

"I just access information from my local GP, I don't go anywhere else. But if there is other need, the GP will then refer me." (Participant #2)

"I have been seeing my GP for almost two years now, so it's easier to talk to him than actually going to another doctor where you feel like that you can't tell him anything; I don't know if I can trust him." (Focus group #2 participant)

The key stakeholders interviewed for this project expressed concerns with the varied knowledge and experience of GPs and other health professionals in this field.

"If a girl complains about period pains and she goes to see a local GP, the local GP will see it as a normal period pain... So it just depends on what their GP understanding is... I don't believe that any young person will just go and say 'I am circumcised'; it's very rare." (African worker #2)

This information demonstrates there is a need for GPs and other health professionals to understand the needs of women who have experienced FGM/C and know where to refer them for appropriate support. Our consultations with key stakeholders confirmed the knowledge of GPs and health professionals in this area would vary significantly from one individual to another.

3.3. Access to information and support

Access to appropriate, relevant and sensitive information about FGM/C can be a challenge. Most participants stated that they are not aware of FGM/C specific supports available, but thought that these are important. In addition to this, sexual and reproductive health issues are often not talked about in the family or the community.

“The health of women is always important and being able to be provided with support regarding our health is very important.” (Participant #2)

“Often, young women don’t realise that some of their issues, like painful periods, are related to circumcision. Some young women don’t know about their sexual and reproductive health. They are still thinking like their parents, because it is very important to keep the culture.” (African worker #1)

“...it’s just that we don’t know how to access [services]. We know that they are out there but we just don’t know how to get in contact with them.” (Focus group #1 participant)

From the five participants who accessed the hospital’s maternity care, only two reported knowing that the hospital provides help for women with circumcision:

“I am not aware of any services other than the hospital that would help them with that kind of issue. But I have heard that the hospital does help women who have been circumcised.” (Participant #3)

3.3.1. Online information

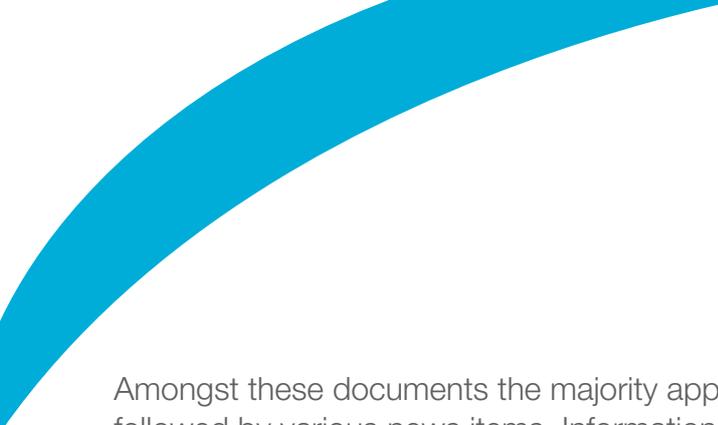
All participants offered suggestions on how information could be delivered to young women who have experienced FGM/C. Although there were some similarities in responses amongst all the participants, e.g. benefits of accessing online information, there were also some suggestions that appear to be more relevant to the subgroup of young single women.

All young single women stated that they would search for information online, most often using a Google search.

“If you know what kind of health problem you have, you can search it up.” (Focus group #2 participant)

The project team ran a very basic Google search, which came up with the following:

Term searched	Number of results
Female cutting	152 million
Female circumcision	1.63 million
FGM/C	14.9 million



Amongst these documents the majority appear to be policy and advocacy related documents, followed by various news items. Information that would assist women to find an appropriate local support service seems to be buried in these other documents.

Accessing information online also offered privacy which was important to all participants:

“...because it is easy and private. I think this is something that young women are already doing in the comfort of their home.” (Participant #5)

“It’s easier. You have more access to it and it gives you a variety of answers and you can access stuff without people knowing it’s you.” (Focus group #1 participant).

The young single women also talked about the potential role that social media, such as Facebook and Twitter, could play in raising the awareness of FGM/C and the supports available for young women who have experienced it. However, there were some concerns expressed within the group relating to privacy. This project acknowledges more work is required to test the appropriateness of using social media to deliver information on sensitive health issues that apply to a small proportion of the population.

3.3.2. Information sessions

There was a strong consensus amongst all participants that specific individual issues should be dealt with individually to ensure privacy and respect. This is explored in more detail in the next section. However, most participants suggested that community information sessions should also be conducted. These suggestions included:

- Peer-led information sessions: information sessions on sexual and reproductive health delivered by young women for young women. This was particularly strong amongst the young single women participants.
- General health and wellbeing sessions delivered at community gatherings. This was seen as a good way to improve the knowledge of the community and encourage preventative action.

Opinion on whether these sessions should involve men varied and the project team concluded this would need to be explored with individual groups before organising any such sessions.

3.3.3. Other suggestions

People search for and obtain information in various ways and this was also reflected amongst our participants. Apart from the relatively uniform responses regarding the need for online information and community sessions, other suggestions were provided by our participants:

- Four of the five women with children have expressed a need for information to be provided over the telephone to enable access to information and support for women who are busy with family and work commitments.
- Young single women in focus group #2 also discussed the need for broader community campaigns and advertising, which would allow community members to gain confidence to speak about the issue.

3.4. Important aspects in service delivery

Participants in the project identified a number of features that would be important to them if they were to access services and support.

“Better understanding is important; sometimes it is difficult for professionals to understand you. It is also important to be treated like an individual rather than being put in a group because you are from a particular community. We all don’t have the same experiences or facing the same issues so it’s important to me to be treated like an individual with her own needs and issues rather than for professionals to assume that I have the same experience or facing the same issues to that of my community.” (Participant #4)

3.4.1. Person-centred, culturally responsive care

The need for person-centred, culturally responsive care was identified as one of the most important aspects of care amongst all the participants:

“It is important to get a good health service and be able to understand others’ cultural needs. We Africans did not all come from one country. We are all different from different cultural background, so it’s important for health workers to understand us and our needs” (Participant #3)

“To help them [young women] come out of their comfort zone. Then they would be more able to get help.” (Participant #5)

3.4.2. Bi-cultural workers

The second important element identified by all the participants was the need to have workers with a similar background involved in service delivery. Similarity was described as having experience of the issue and being of the same cultural background, but also being of similar age. A few participants commented that it is very difficult to speak to older women in the community about sexual and reproductive health because it is like “*speaking to my mother.*”

“If you are going through something and someone else has suffered from it, you can relate to them and you would feel more confident and comfortable talking to them more about it rather than someone who has never gone through it.” (Focus group #2 participant)

“This would benefit women. They [bi-cultural workers] have similar experiences and would allow you to be more open and get the right support that you need.” (Participant #2)

This is also confirmed by the African worker #1: *“The younger girls, they need someone they can relate to, who talks the same way they talk and be able, I guess, to understand them.”*

3.4.3. Privacy, confidentiality and trust

Ability of health professionals to relate to women, establish a rapport and ensure privacy and confidentiality featured strongly in all responses.

“It’s embarrassing...to talk about or what they [service providers] are going to ask you.” (Focus group #2 participant)

Interestingly, most of the young women who used the maternity care at the hospital were reluctant to disclose that they also received support relating to FGM/C during their care. However, their feedback on the overall experience of care offers a useful insight:

“For me everything worked well. I have no issues with the services or the support I have received. I would say it has benefited me, because I received support and also gained knowledge from them. Knowledge about my health, my rights and the support that is available to me.” (Participant #1)

“The only health service I have used is at Mercy. My experience was good; they have the highest respect and understanding for patients.” (Participant #3)

All of the participants have talked about the need for privacy and confidentiality across the spectrum of service delivery. An interesting point was also raised by the African worker #2:

“Young girls believe that the women’s hospital is not for them. They believe that is only for babies and... older women. And the problem is also within our community if they see a young person at the women’s hospital, there are also questions around if like, is she pregnant, did she get married. So there is always that issue.”

This presents a significant challenge for services such as ours which are based in a hospital setting. However, exploration of this issue was outside the scope of this project.

3.4.4. Features of services

In addition to specific elements already explored in this section, participants also offered suggestions on how services could be made more accessible to young women who have experienced FGM/C. These included:

- After hours services, both evenings and weekends
- Preference for services based in local areas
- Access to information and support over the telephone.

4. FUTURE CONSIDERATIONS

This project has identified a number of issues that need to be considered by those who are working with young women who have experienced FGM/C.

Our participants identified GPs as the first port of call for support and referral regarding FGM/C. Hence there is a need to ensure all GPs have access to ongoing education, as well as information on relevant local services that women can be referred to. This may be a particular challenge in areas where there are very small numbers of people who come from communities where FGM/C is practised.

The role of bi-cultural workers has been identified as another significant part of delivering culturally responsive care. For organisations looking to develop or enhance service delivery to young women, consideration should be given to investing in capacity building and skill development of bi-cultural workers who generationally match the target group.

Despite the fact that most of our participants were educated in Australia, and had good proficiency in English, many did not know how to access reliable information and appropriate services in relation to FGM/C. Our findings indicate there is a need for a multipronged awareness raising strategy that would include:

- Peer led information sessions for young single women, e.g. through community gatherings or universities
- A broader community awareness strategy
- Access to online information that is easy to find, relevant to local needs and culturally sensitive.

It is crucial to involve the community in developing such a strategy.

Overall comments from the participants demonstrate that what they most value in health professionals is provision of person-centred, culturally responsive care. Whilst this is not a new finding, our experience tells us that there is still a way to go to ensure that this is consistently practised. Apart from more training, finding other innovative ways to improve delivery of person-centred, culturally responsive care is necessary.

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APPENDIX 1: QUESTIONS FOR PARTICIPANTS

Common questions:

- Can you tell me about your experience of using women's health and support services in Australia?
- Are you aware of any women's health/support services?
- As an African woman, what aspect of health service is important to you?
- Sometimes women feel that it's important to have somebody who has similar experiences working within the health service; in your opinion, do you think this would benefit the women?
- There are a number of women living with circumcision in Australia. If you are/were aware of support available to these women, do you think it would be beneficial?
- How do you access information about your own health?
- Some women would prefer to get their information from online sources, or via phone, or the social media. Is this something that you would use?
- What would be the best way to advertise services to young women such as you?

Specific questions for women who know of services and have used them:

- Which services have you used?
- How did you first find out about the services?
- Do you think these services meet or are applicable to your needs?
- What has worked well for you in this service?
- What has not worked well for you?
- Did you have an input into the services you have received? Did you feel that your concerns were listened to? Did you feel that you were involved in your care? Were your worries/concerns taken seriously?
- Did you feel that what you told the health professional was kept confidential?
- What barriers were you faced with when trying to access these services?
- How could the services be made better?
- Would you recommend the services that you have used to your family/friends?

APPENDIX 2: QUESTIONS FOR KEY STAKEHOLDERS

- What is your current role/position?
- Can you give us an overview of the services you provide to women who have experienced FGM/C?
- Is this service accessed by the target group, i.e. young women (18-25 years old) who have experienced FGM/C?
- Can you tell us about your experiences with the target group?
- Do you think the current services are meeting these needs?
- Have you identified any barriers/gaps in the services for the target group?
- In our consultations, we identified that women don't know what we mean by the term "services". E.g. they don't consider GP or hospitals as services. What is your experience with this?
- In your opinion what do you think would be a good model of care (service) for the target group?
- Do you think such a service should include workers from the community?
- What recommendations would you make to improve services, particularly for younger women?

