Resource 3: Activity materials, evaluation tools and handouts

Activity materials

Icebreakers

My name is…

Ask the women to introduce themselves by finishing the sentence however they choose: "My name is _____ and I am a woman who …" Answers can be about what they like, what they care about, where they are from, how they are feeling, absolutely anything. If you use this approach, you should begin with yourself, to start people off.

Getting to know you

Ask each member of the group to share something about themselves:

a. Favourite food?
b. Favourite place?
c. Most satisfying thing they have done this week?
d. Three words their friends would use to describe them?

First Names

Ask the women to break into pairs. Each person in the pair has to find out how the other person was given their first name.

a. Do they like their name?
b. Was their name passed down through the family?
c. Does their name have a special meaning?
d. Were they named after someone special?
e. If they could choose another name, what would it be?

Encourage each person to introduce their partner, and to tell us what they have learnt about their partner's name.

I'm here today because…

Ask the women to share what has brought them to the group or what they hope to gain from participating in the program or what has motivated them to participate. This activity can be used to collect evaluation material as well.

Activity 1A.2
Basic Needs cut-out cards

Rest	Clothing	Education
Protection from harm	Health care	Healthy food
Relaxation	Love	Religion
Cultural activities	Family	Clean water
Safety	Shelter	Freedom of speech

Activity 1A.3
Social determinants of health scenarios

"I work casual hours at a café but they don't always need me so some weeks I don't earn any money. I'm renting my house and it can be difficult to pay the rent every month."

"We migrated to Australia seven years ago because of conflict in our country. We don't speak about it but I know my husband has trouble sleeping. We still don't know if our relatives are alive."

"I had to stop working when I hurt my back and I couldn't afford to stay in my house. Sometimes friends let me sleep on their couch, but I usually sleep in my car. I'm too embarrassed to tell my family."

"I work a twelve hour shift four days a week and then I have to look after my children, while my husband goes to work. I don't have any time to myself and sometimes I feel like I can't cope."

"My husband has been unemployed for 12 months. He used to look for work every day but now he seems so down, and he's started drinking heavily. I worry about the future."

"I moved here three years ago, with my husband. I miss my parents so much, especially now that I have a baby. I don't speak English that well and I don't know anyone here."

"I have two small children, and I can't drive so it's hard to leave the house to shop without my husband to help. It's often easier to order takeaway instead."

"I work in hospitality but I find it really stressful. I can't miss a shift or I'll lose my job and my boss often makes racist jokes to the other workers at my expense."

"No one ever told me about my body or how to be healthy. I just take pain killers when I feel unwell. As long as I can look after my children I don't think about my health."

Activity 1B.1
Identifying human rights

Which of the following do you think are human rights and which do you think are not?

	Human Right	Other
The right to life, liberty and security of person		
The right to remain silent		
The right to bear arms		
The right to freedom of thought		
The right to freedom of speech		
The right to party		
The right to own property		
The right to assert authorship		
The right to drink alcohol		
The right to work		
The right to privacy		
The right to a nationality		
The right to your opinion		
The right to drive		
The right to freedom of religion or belief		

Activity 1B.1a
Identifying human rights: answers

Human right	The Universal Declaration of Human Rights Article
The right to life, liberty and security of person	Article 3: (1948) Everyone has a right to life, liberty and security of person
The right to freedom of thought	Article 18: Everyone has the right to freedom of thought
The right to freedom of speech	Article 19 Everyone has the right to freedom of opinion and expression.
The right to own property	Article 17: Everyone has the right to own property alone as well as in association with others.
The right to work	Article 23.1: Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment.
The right to privacy	Article 12: No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks.
The right to a nationality	Article 15: Everyone has the right to a nationality.
The right to your opinion	Article 18: Everyone has the right to freedom of thought, conscience and religion
The right to freedom of religion or belief	See Article 18 This right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance.

Activity 1B.2
Human Rights Case Studies

Mary's story

Mary was sacked from her job in airport security after she was refused counter-terrorism clearance. She had no idea why the airport might have thought she was a risk and she was not given any reasons.

What happened?

A human rights advocate helped Mary to challenge her sacking using the Human Rights Act. They argued that her employer had, among other things, not given Mary the right to a fair hearing, protected by Article 6. During the case, it became obvious that the decision to sack Mary had been made on flimsy grounds. The employer conceded that the process was flawed and paid Mary compensation. It has also altered its procedures.

Fatima's Story

Fatima was 23 and doing well in her job with a retail store. She was promoted to Store Manager by her Area Manager but when she had a disagreement with Helen, the store owner, she was dismissed. Helen told Fatima that she was too young to manage a store.

What happened?

Fatima contacted the Australian Human Rights Commission to complain. They contacted Helen and she denied making the comment about Fatima's age. So the commission held a conciliation meeting and Fatima's complaint was settled with a payment of $1,500 compensation.

Joseph's Story

Joseph is blind and uses a guide dog to get around. A caravan park refused to let him stay because they had a 'no pets' policy.

What happened?

Joseph contacted the Australian Human Rights Commission to make a complaint. When they contacted the caravan park, it claimed that it didn't know Joseph's dog was a guide dog and wanted to resolve the dispute. The caravan park agreed to apologise to Joseph, participate in training run by a guide dog organisation and include information on its website to say that assistance animals are welcome.

Hakim's Story

Hakim, who is of Lebanese/Armenian descent, received an email from his supervisor at work about Muslim women. Hakim found it offensive because his wife is Muslim. His supervisor also called Hakim an 'Arab' and a 'bomb thrower' in front of other staff and told him to 'speak English'. After Hakim complained about his supervisor to senior managers, his higher duties were removed, his work was over-scrutinised and his performance was unfairly criticised.

What happened?

Hakim contacted the Australian Human Rights Commission to make a complaint and the Commission held a conciliation conference to resolve Hakim's dispute. The supervisor verbally apologised to Hakim at a conciliation conference. The company said they had taken action on Hakim's complaint by moving the supervisor to another area and they had not discriminated against Hakim. The company agreed to pay Hakim's legal costs and contribute $10,000 towards Hakim's training and career development. The company also agreed to hold a staff meeting to ensure that staff are aware that racially offensive material or comment was unacceptable.

Sadiq's story

In 1998 Mr Sadiq Shek Elmi, a failed asylum seeker in Australia, lodged a complaint with the Committee against Torture. He claimed that his deportation to Somalia would constitute a violation of Article 3 of the Convention against Torture, because he was a member of a member of a minority clan which had a well-documented history of persecution in Mogadishu. There was evidence that other members of his family had been targeted by that clan.

What happened?

The Committee determined that Australia had an obligation to refrain from forcibly returning Mr Elmi to Somalia or to any other country where he runs a risk of being expelled or returned to Somalia because of the danger of him being subjected to torture in Somalia. The Committee noted that the majority clan in Mogadishu could be regarded as exercising de facto control, and was therefore responsible for any acts of torture for the purposes of the Convention. Mr Elmi was subsequently permitted to stay in Australia.

Faduma's story

Faduma and her children were fleeing domestic violence. Her husband was trying to track the family down; each time he discovered their whereabouts the family moved to a different area. The family eventually arrived in London and were referred to the local social services department. Social workers told Faduma she was an unfit parent and that by moving she had made the family intentionally homeless. Because of this, they said she was not eligible for housing. Faduma was told that her children had to be placed into foster care.

What happened?

An advice worker helped the mother to challenge this claim using the Human Rights Act. They argued that social services were not properly considering the rights of the woman and her children to respect for family life, protected by Article 8. Under this right, social services needed to consider the rights of the woman and her children and to take actions which are necessary and proportionate. As a result, the family were told that they could remain together and that the social services department would provide the deposit if they could secure private rental accommodation.

Activity 2A.2
Case studies concerning sexual and reproductive rights

Alicja

Part One:

Alicja's Story: When Alicja, a Polish woman with vision problems since childhood, became pregnant, she was advised by numerous doctors that her pregnancy and delivery posed the risk of

Part Two:

What Happened to Alicja? The birth resulted in further deterioration of Alicja's eyesight. She became unable to work, dependent on assistance for day-to-day activities and childcare, and wholly reliant on public assistance. Alicja's case was taken to the European Court of Human Rights, which found that governments have a duty to establish effective mechanisms for ensuring that women have access to abortion where it is legal. The court awarded her significant financial damages in recognition of her "anguish and suffering."

Amina

Part One:

Amina's Story: Amina was a divorced Nigerian mother of three. After she had been dating Mohammed for 11 months, he asked her to have sex with him, promising to marry her. She agreed and became pregnant. Mohammed, however, did not marry her, and she gave birth to a baby daughter out of wedlock. She was charged with adultery under religious law. Mohammed swore that he was not the father and was allowed to go free, but Amina was convicted of adultery and sentenced to death by stoning. She appealed but the verdict was upheld. Her execution was deferred for two years so that she could nurse her baby.

Part Two:

What Happened to Amina? Following another appeal, Amina was acquitted and the verdict of death by stoning was revoked. The judges agreed that she had not had sufficient opportunity to defend her case. The government denies that she had been condemned to be stoned to death. She has since remarried.

Matthew

Part One:

Matthew's Story: Matthew was a homosexual university student in the United States. One night, two young men pretended to be gay and offered him a ride home from a bar. Matthew went with them and they took him to a remote area, robbed him, tied him to a fence, beat him brutally with a gun, and tortured him. They left him there to die. Matthew was found 18 hours later, still tied to the fence, by a cyclist, who first thought that he was a scarecrow. Matthew was still alive, but in a coma.

Part Two:

What Happened to Matthew? Matthew's skull was shattered and his brain severely damaged. His injuries were too severe for doctors to repair. He never regained consciousness and died five days later. The murderers were arrested, and each eventually received two consecutive life sentences. Matthew's story drew national attention to hate crimes. A law was passed in Matthew's name that extends hatecrimes legislation to include hate crimes against gays and lesbians, women, and people with disabilities. Matthew's mother established the Matthew Shepard Foundation, which seeks to "replace hate with understanding, compassion, and acceptance" through education, outreach, and advocacy.

Lakshmi

Part One:

Lakshmi's Story: Lakshmi, a young girl from Nepal, was forced into marriage at the age of 12 and was exploited at her husband's house. Unable to bear her situation, she escaped and returned to her parents' home, but her parents forced her to go back to her marital home. "On the way, I managed to escape, and a kind lady helped me," Lakshmi said. "She said her sister was working for a factory in another part of Nepal and I could join and all that needed to be done was to sell the clothes from the factory." On the way, Lakshmi was drugged and taken to India. Lakshmi said, "It was then that I learned that I was sold for 15,000 Indian rupees. I was beaten when I refused to be a sex worker. For one year I was trapped in the brothel. Later the police raided the brothel and I was rescued and sent back to Nepal. By then I was 14 years old."

Part Two:

What Happened to Lakshmi? Upon Lakshmi's return her parents refused to accept her. She later married but has tested positive for HIV. Whether she contracted the virus when she was forced into sex work or after marrying is not clear.

Fatima

Part One:

Fatima's Story: Fatima, an 11-year-old West African girl, overheard her parents discussing her circumcision. She was frightened because she remembered how her elder sister had returned from the ceremony — in pain and miserable. She thought also about her best friend, who had been in and out of the local clinic with severe infections caused by her circumcision. She did not want to experience what she saw the other young girls around her go through, and she begged her parents not to force her to be circumcised. They were reluctant to listen to their daughter because they believed she would be unmarriageable if she were not circumcised, and they did not think the choice should be made by someone so young and inexperienced. Fatima's sister, however, had heard of an organisation in town that worked to educate local families about the dangers and health risks of female genital mutilation/cutting (FGM/C). She asked a staff member from the organisation to her family's hut to speak with her parents about Fatima's situation.

Part Two:

What Happened to Fatima: The aid worker convinced Fatima's parents that circumcision was dangerous to their young daughter's health and that there were other ways to mark the important rite of her passage into womanhood. Today Fatima is happily married and grateful that her parents were so openminded. She works for the same organisation that helped her avoid FGM/C, educating girls in school about how to talk to their parents about circumcision.

Activity 2B.1
The Story of Maya

Maya first had a boyfriend at the age of 16. Before that her two friends teased her that she had never had a boyfriend. She was curious, but mostly she felt pressured by her friends, so she asked a boy out. Almost everyone at school found out that Maya and the boy were together.

Over the next two years, Maya had four other boyfriends. She enjoyed herself with them but she knew that she did not want to marry any of these boys. She was nice to each boy at the time, and she never lied to them about her feelings. Having a boyfriend made Maya feel attractive and important.

Now Maya is in her twenties and she is engaged to a young man whom her family wants her to marry. She likes this young man, but she knows that she is expected to refrain from having sex with him until they marry in two years. Her fiancé encouraged her to have sex with him before they married and she finally gave in to his desires. She felt, “After all, two years with no sex is a long time.” Maya was careful about using condoms, but one time she became pregnant and decided to have an abortion. Her fiancé was supportive of her and after their two-year engagement, they married and started a family together.

After reading this story, think about these questions, then discuss them with your group:

1. What do you think Maya’s peers think about Maya? What “label” might they use to describe Maya?
2. How do you feel about Maya?
3. Generate a list of at least three or four adjectives that you think describe Maya. For example, is she happy or unhappy? Self-confident or insecure? Honest or dishonest? Realistic or unrealistic? Attractive or unattractive? Respectable or not respectable? Typical for a girl or atypical? Moral or immoral?

Activity 2B.1
The Story of Rasul

Rasul first had a girlfriend at the age of 16. Before that his two friends teased him that he had never had a girlfriend. He was curious, but mostly he felt pressured by his friends, so he asked a girl out. Almost everyone at school found out that Rasul and the girl were together.

Over the next two years, Rasul had four other girlfriends. He enjoyed himself with them but he knew that he did not want to marry any of these girls. He was nice to each girl at the time, and he never lied to them about his feelings. Having a girlfriend made Rasul feel attractive and important.

Now Rasul is in his twenties and he is engaged to a young woman whom his family wants him to marry. He likes this young woman, but he knows that he is expected to refrain from having sex with her until they marry in two years. His fiancé encouraged him to have sex with her before they married and he finally gave in to her desires. He felt, "After all, two years with no sex is a long time." Rasul was careful about using condoms, but one time his fiancé became pregnant and decided to have an abortion. Rasul was supportive of her and after their two-year engagement, they married and started a family together.

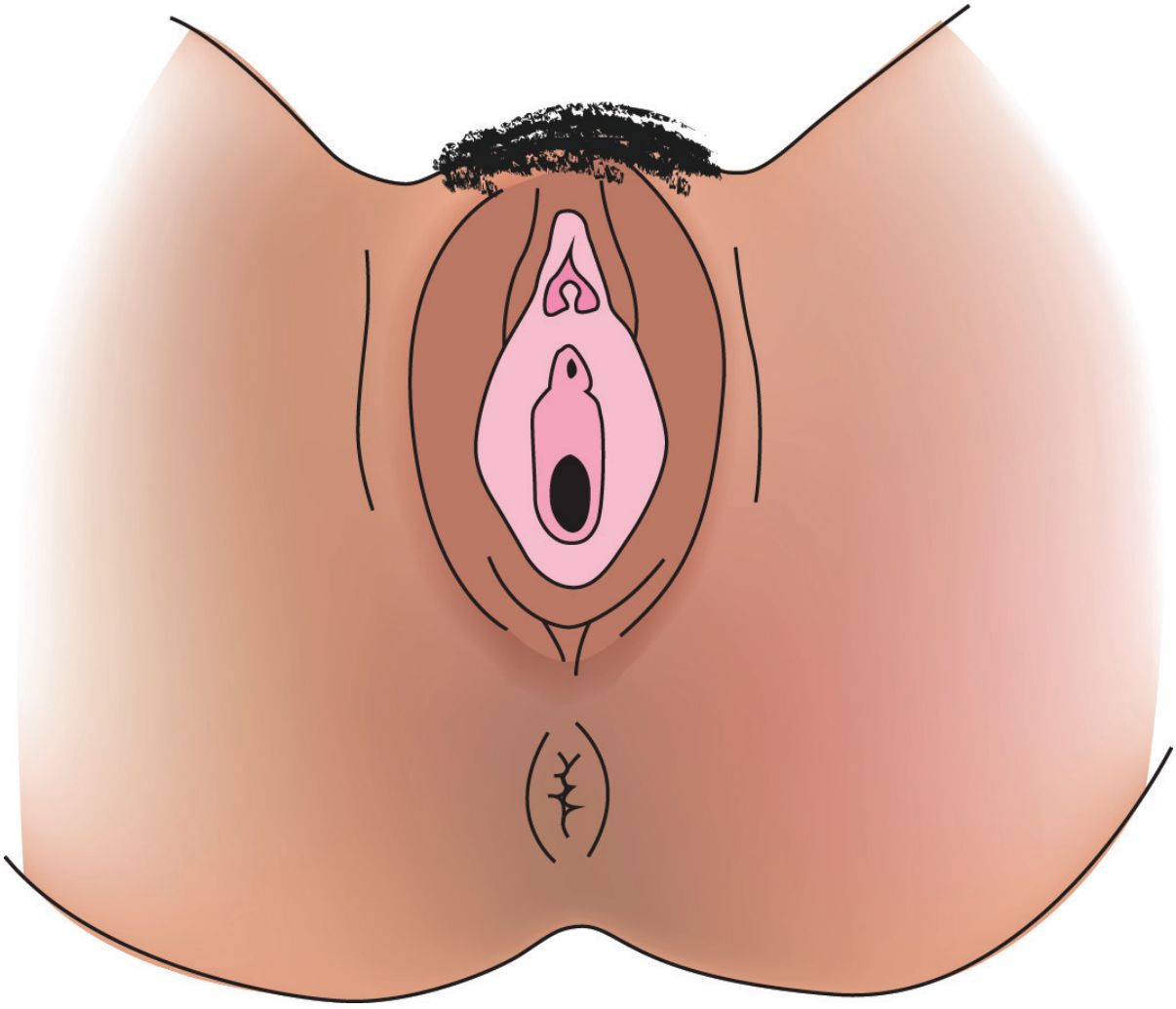
After reading this story, think about these questions, then discuss them with your group:

1. What do you think Rasul's peers think about Rasul? What "label" might they use to describe someone like Rasul?

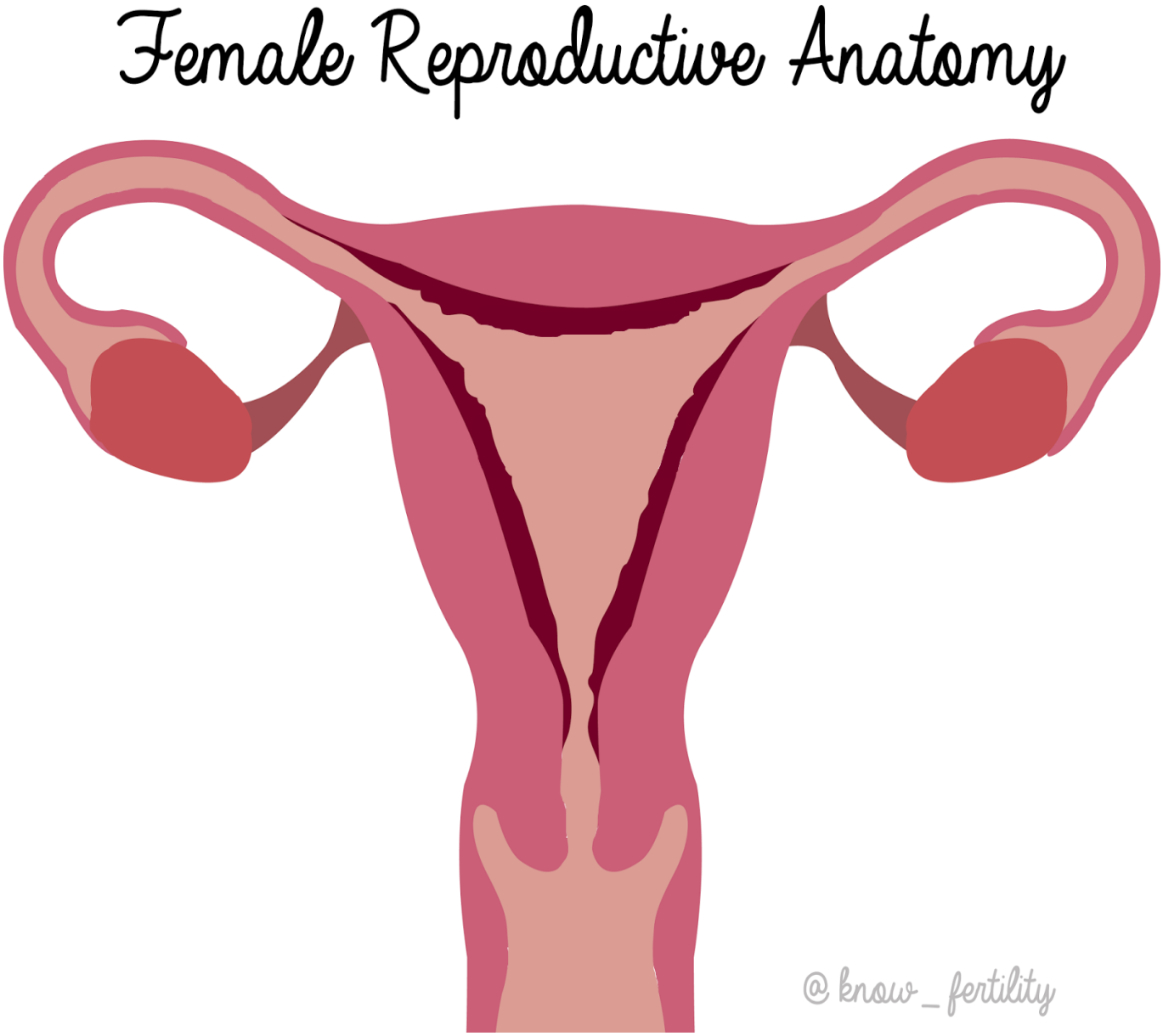
2. How do you feel about Rasul?

3. Generate a list of at least three or four adjectives that you think describe Rasul. For example, is he happy or unhappy? Self-confident or insecure? Honest or dishonest? Realistic or unrealistic? Attractive or unattractive? Respectable or not respectable? Typical for a boy or atypical? Moral or immoral?

Activity 2C.2 Women's reproductive system



Activity 2C.2 Women's reproductive system



Activity 2C.2a
Women's reproductive anatomy names cut-out cards

Uterus	Vagina	Labia majora	Anus	Clitoris
Endometrium	Cervix	Clitoris	Opening of urethra	Labia minora
Fallopian tube	Ovary	Vulva	Opening of vagina	Fallopian tube

Activity 3B.1 Myth or Fact cut out cards

Myth	Fact
If it is not cut the clitoris will continue to grow	The clitoris stops growing after puberty
Having FGM/C is more hygienic	FGM/C will not make the vagina more hygienic. In fact it can make it less hygienic
The clitoris will cause harm to a woman's husband during intercourse	The clitoris gives the woman pleasure and does not harm her partner
The practice of FGM/C is required by religion	FGM/C is not required by Islam, Christianity or Judaism and is not in the Bible or the Koran
An uncircumcised woman will miscarry her pregnancy	Some forms of FGM/C can cause foetal distress, and serious complications during delivery
FGM/C will control promiscuity	FGM/C does not stop women from choosing to be sexually active, but can inhibit sexual pleasure for a woman's entire life, cause pain during intercourse and can create problems within marital relationships
Without FGM/C the woman can be infertile	FGM/C can cause infertility
FGM/C is still acceptable in many countries where it has been traditionally practised	As of 2013, 24 African countries have legislations or decrees against FGM/C practice*
FGM is feminine and enhancing	FGM/C can cause pain and discomfort, bleeding, acute urinary retention, infection (wound, tetanus, urinary tract) and death

* Countries with legislations or decrees against FGM/C practice are: Benin, Burkina Faso, Central African Republic, Chad, Côte d'Ivoire, Djibouti, Egypt, Eritrea, Ethiopia, Ghana, Guinea, Guinea-Bissau, Kenya, Mauritania, Niger, Nigeria (some states), Senegal, Somalia, Sudan (some states), Tanzania, Togo and Uganda and Zambia and South Africa. (Female Genital Mutilation/Cutting UNICEF, July 2013)

Activity 4A.2
Ways to assert your rights

Match the problems to the solutions by drawing an arrow.

Problem	Solution
You don't think you will remember what the health worker is telling you.	Write out a list of questions to take with you.
You think you may forget what you want to ask the health workers.	Tell the doctor you need more time to talk about your situation.
The health worker is explaining something to you. You can't understand what's being said, but you feel that you would understand if you could see a picture.	Tell the health worker you need to see a woman. If he insists you stay with him, you can say, 'I'm sorry, but this is not OK for me.' If necessary, you can leave politely.
The nurse is talking to you very quickly, so you think you understood but you're not sure.	Write down what the health worker tells you.
You visit a health worker, but when you arrive you find the health worker is male. Your problem feels too personal to discuss with a man.	Tell the doctor that you need an interpreter.
Your doctor tells you about the treatment of your problem. You think there may be another way to treat the problem.	Ask the health worker to draw a picture to explain what he/she is saying more clearly.
You can't understand the doctor. There are too many medical words. You need to hear about your condition in your own language.	Ask the nurse to repeat what s/he said.
You are at the clinic seeing a health worker. You are talking about your situation. There is a lot to talk and ask about. You feel that you need more time to talk about the problem.	Ask the doctor to give you some different ways to treat your problem.

Activity 4A.3
Your rights to health services quiz

Tick Yes or No

In Australia, do you have the right to make your own decisions about your health and your body?	YES ❑ NO ❑
In Australia, do you have the right to ask a doctor to explain exactly what is wrong?	YES ❑ NO ❑
In Australia, do you have the right to find out about other kinds of treatment?	YES ❑ NO ❑
In Australia, do you have the right to ask the doctor lots of questions and to get answers you can understand?	YES ❑ NO ❑
In Australia, does a woman's husband or father have the right to make (or force) her to have an operation?	YES ❑ NO ❑
In Australia, do you have the right to get a second opinion from another doctor?	YES ❑ NO ❑
In Australia, do you have the right to keep your health problem a secret between you and your doctor?	YES ❑ NO ❑
In Australia, do you have the right to use a professional interpreter for free in certain situations?	YES ❑ NO ❑
In Australia, do you have to say 'yes' to a test, procedure or treatment the doctor wants to give you?	YES ❑ NO ❑

Evaluation Tools

Evaluation Tool 1:
Basic evaluation questionnaire for participants

(You can use this questionnaire template to adapt to your specific program or project. This questionnaire can be interpreted verbally by the bilingual community worker, or handed out to participants to fill in and return to the facilitator.)

We would like to find out what you thought about the session you have participated in for two main reasons:

- To find out how useful the sessions were for you
- To find out if there is anything we could do differently next time

This information is important to help us improve our sessions and support our community better.

1. Was there enough time for the sessions?	Yes	No	Not Sure
2. Would you like to join a group like this again?			
3. Would you recommend this program to a friend?			

4. How did you hear about this session?

_____

_____

5. Why did you come along today?

_____

_____

6. What did you enjoy most about the session?

_____

_____

7. What would make a group like this better next time?

_____

_____

8. Was there anything you heard today that you didn't know before?

_____

_____

9. Do you think differently about sexual and reproductive health

_____

_____

10. Do you think you will behave differently because of this session? If so in what way?

_____

_____

Evaluation Tool 2:
Evaluation ideas for large group sessions or groups with low literacy or reading difficulties

When conducting evaluation with a large group, or with a group that experiences reading or writing difficulties, either in English or in their preferred language, written surveys and questionnaires may not be effective. It is a good idea to adapt your expectations about what information you can collect and be strategic about how you collect it. Some ideas you might try are:

1. Use a ballot box system.
   Particularly for large groups it may be effective to ask just one question such as "Will you tell someone else about why FGM/C is wrong." Give each participant a piece of paper to mark with a cross or a tick and ask them to vote as they leave the session.

2. Use more visual evaluation tools. On the next page you will find a hand out for individual distribution that uses visual aids. Although the questions are still written down, the evaluator could ask each question aloud and get participants to mark along the scale with either previously distributed stickers or a simple cross or tick.

   You could also enlarge this sheet to poster size to attach to the wall and, in the same way, ask participants to mark their answers on the poster with a sticker. This would give a good visual representation of the whole group's feelings.

3. For some groups, or for people with limited mobility, a general verbal survey with raising of hands may work better if educators feel they are able to accurately record the outcomes. You may be able to do this in the form of a brainstorm by asking participants to describe the session in one or two words.

4. Asking individuals if you can contact them at a later time to ask for more detailed feedback may also be worthwhile for large group events.

In each case, knowing what you want to gain from evaluation will influence how and in what ways you will conduct evaluation.

Evaluation Tool 3:
Evaluation for peer educators and facilitators

As a peer educator or facilitator you play an essential role in the evaluation of sessions and the program or project as a whole. It is important that you are provided with training, resources and adequate time to conduct evaluation effectively and write it up.

It is likely that your organisation will have developed evaluation tools specific to the particular project or program. However, on the next page is a template you could adapt if needed.

Session Evaluation for Peer educators

Educator name: _____ Date: _____

Session: _____ Organisation: _____

Session venue: _____ Number of participants: _____

Average age group: _____

Relevant participant details (male, female, community):

Overall, how would you rate the session for the following:

Quality of group interaction

Not good at all	Not good	Average	Good	Very good

Group understanding of concepts

Not good at all	Not good	Average	Good	Very good

Usefulness of participant's handouts

Not good at all	Not good	Average	Good	Very good

Usefulness of resource materials for facilitator

Not good at all	Not good	Average	Good	Very good

Group satisfaction with the session

Not good at all	Not good	Average	Good	Very good

Overall, how did you feel about the session?:

Very unhappy	Unhappy	Neither happy nor unhappy	Happy	Very happy

Please answer the following questions:

What was most important thing participants seemed to take from the session?

During this session, what seemed to be the least satisfying thing for participants?

During this session, what seemed to be the most satisfying thing for participants?

If you could conduct this session again, is there anything you would do differently? What?

Did anything happen in this session that stood out for you?

Did anything difficult happen in this session? If so, how was it managed?

Any other feedback you want to share?

Handouts

1A
What are social determinants of health?

1A
Some Social Determinants of Health

Statements from Social Determinants of Health: The Solid Facts (WHO, 1998).

The social gradient "The social gradient in health reflects material disadvantage and the effects of insecurity, anxiety and lack of social integration … Poor social and economic circumstances affect health throughout life".

Stress "Stress harms health … Lack of control over work and home can have powerful effects on health".

Early life "The effects of early development last a life-time; a good start in life means supporting mothers and young children".

Social exclusion "Social exclusion creates misery and costs lives … People living on the streets, who may suffer a combination of ... problems, suffer the highest rates of premature death".

Work "Stress in the workplace increases the risk of disease … Jobs with both high demand and low control carry special risk".

Unemployment "Job security increases health, wellbeing and job satisfaction … unemployed people and their families suffer a substantially increased risk of premature death".

Social support "Belonging to a social network...makes people feel cared for … Friendship, good social relations and strong supportive networks improve health at home, at work and in the community".

Addiction "People turn to alcohol, drugs and tobacco to numb the pain of harsh economic and social conditions".

Food "Healthy food is a political issue … A good diet and adequate food supply are central for promoting health and wellbeing".

Transport "Cycling, walking and the use of public transport promote health … Healthy transport means reducing driving..."

1B
Summary of the Universal Declaration of Human Rights

The Universal Declaration of Human Rights was adopted by the United Nations on 10 December 1948. It represents “a common understanding of the peoples of the world concerning the inalienable and inviolable rights of all members of the human family and constitutes an obligation for the members of the international community.” (Proclamation of Tehran, 1968)

Human rights are universal, indivisible, interconnected and interrelated,
with equality and without discrimination for all women and men, youth and children.

Article 1	Article 2	Article 3	Article 4	Article 5	Article 6
All human beings are born free and equal.	Everyone is entitled to the same rights without discrimination of any kind.	Everyone has the right to life, liberty, and security.	No one shall be held in slavery or servitude.	No one shall be subjected to torture or cruel or degrading treatment or punishment.	Everyone has the right to be recognized everywhere as a person before the law.
Article 7	Article 8	Article 9	Article 10	Article 11	Article 12
Everyone is equal before the law and has the right to equal protection of the law.	Everyone has the right to justice.	No one shall be arrested, detained, or exiled arbitrarily.	Everyone has the right to a fair trial.	Everyone has the right to be presumed innocent until proven guilty.	Everyone has the right to privacy.
Article 13	Article 14	Article 15	Article 16	Article 17	Article 18
Everyone has the right to freedom of movement and to leave and return to one's country.	Everyone has the right to seek asylum from persecution.	Everyone has the right to a nationality.	All adults have the right to marry and found a family. Women and men have equal rights in marriage.	Everyone has the right to own property.	Everyone has the right to freedom of thought, conscience and religion.
Article 19	Article 20	Article 21	Article 22	Article 23	Article 24
Everyone has the right to freedom of opinion and expression.	Everyone has the right to peaceful assembly and association.	Everyone has the right to take part in government of one's country.	Everyone has the right to social security and to the realization of the economic, social and cultural rights indispensable for dignity.	Everyone has the right to work, to just conditions of work and to join a trade union.	Everyone has the right to rest and leisure.
Article 25	Article 26	Article 27	Article 28	Article 29	Article 30
Everyone has the right to a standard of living adequate for health and well-being, including food, clothing, housing, medical care and necessary social services.	Everyone has the right to education.	Everyone has the right to participate freely in the cultural life of the community.	Everyone is entitled to a social and international order in which these rights can be realised fully.	Everyone has duties to the community.	No person, group or government has the right to destroy any of these rights.

1C
Summary of the Convention on the Elimination of all Forms of Discrimination against Women

The Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) is an international treaty adopted in 1979 by the United Nations General Assembly. It has 30 articles.

Article 1: Discrimination
Discrimination against women is “any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.”

Article 2: Duty of States
States must ensure the elimination of discrimination in laws, policies and practices nationally.

Article 3: Equality
States must take measures to uphold women’s equality in the political, social, economic, and cultural fields.

Article 4: Temporary Measures
States may implement temporary special measures to accelerate women’s equality.

Article 5: Prejudice
States must abolish discriminatory cultural practices or traditions.

Article 6: Trafficking
States must take steps to suppress the exploitation of prostitution and trafficking in women.

Article 7: Political and public life
Women must have equal rights to vote, hold public office, and participate in civil society.

Article 8: Governmental Representation
Women have the right to work and represent their governments internationally.

Article 9: Nationality
Women have equal rights with men to acquire, change or retain their nationality as well as that of their children.

Article 10: Education
Women have equal rights with men in all aspects of education.

Article 11: Employment
Women have equal rights with men in employment, including without discrimination on the basis of marital status or maternity.

Article 12: Health
Women have equal rights to health care services with an emphasis on reproductive health services.

Article 13: Economic and social life
Women have equal rights to family benefits, financial credit, and participation in recreational activities.

Article 14: Rural women
Rural women have the right to adequate living conditions, participation in development planning, and access to health care and education.

Article 15: Equality before the law
Women and men are equal before the law. Women have the legal right to enter contracts, own property, and choose their place of residence.

Article 16: Marriage and family.
Women have equal rights with men in matters related to marriage and family planning.

Articles 17-24:
The Committee on CEDAW and reporting procedures.

Articles 25-30:
Administration of the Convention.

2A
Definition of reproductive health

From the Programme of Action of the International Conference on Population and Development, 1994

7.2. Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.

http://www.unfpa.org/public/lang/en/home/sitemap/icpd/International-Conference-on-Population-and-Development/ICPD-Program

2C
Women's sexual and reproductive organs

We have both internal and external sexual and reproductive organs. Some have functions related to sexual pleasure, some to reproduction and some to both. Internal organs have different functions which are best shown in the following picture.

Internal reproductive organs in the female

Vagina: The vagina is a canal that joins the cervix (lower part of uterus) to the outside of the body. It is also known as the birth canal.

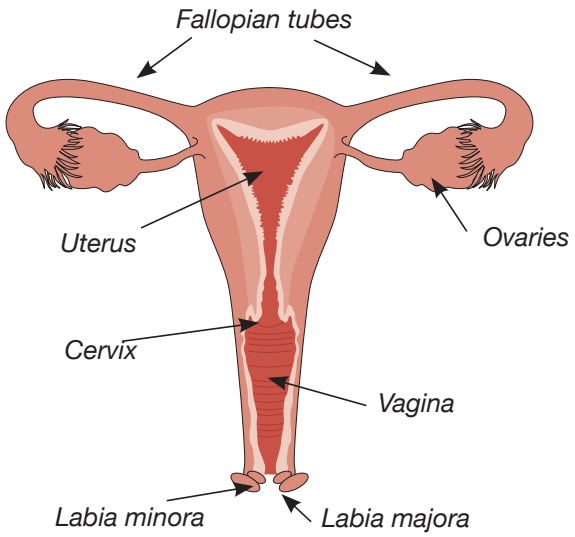
Cervix (neck): The cervix has strong, thick walls. The opening of the cervix is very small, which is why a tampon can never get lost inside a girl's or woman's body. During childbirth, the cervix can expand to allow a baby to pass.

Uterus (womb): The uterus is a hollow, pear-shaped organ that is the home to a developing foetus. The uterus is divided in two parts: the cervix, which is the lower part that opens into the vagina, and the main body of the uterus, called the corpus. The corpus can easily expand to hold a developing baby. A channel through the cervix allows sperm to enter and menstrual blood to exit.

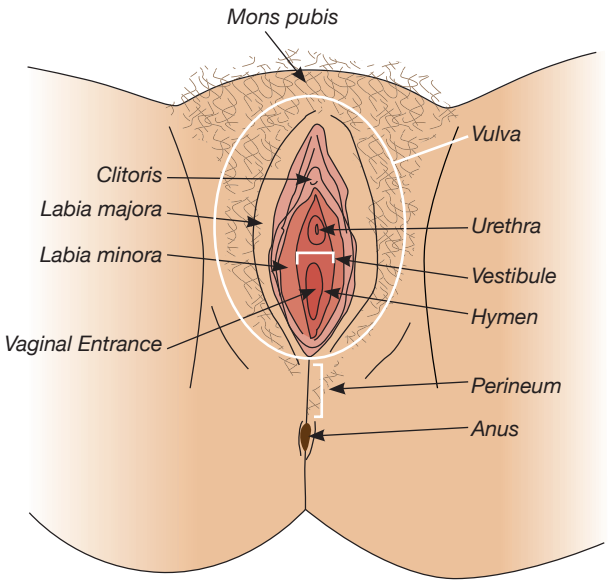
Ovaries: The ovaries are small, oval-shaped glands that are size of an olive and are located on either side of the uterus. The ovaries produce eggs and hormones, oestrogen and progesterone.

Fallopian tubes: These are narrow thin spaghetti-like tubes that are attached to the upper part of the uterus and serve as tunnels for the ova (egg cells) to travel from the ovaries to the uterus.

Endometrium: This is the lining of the uterus or the womb.



External female reproductive organs



The external female reproductive organs have two functions; one is to enable sperm to enter the system and the other is to protect internal reproductive organs from any infections. The main external reproductive organs are:

Labia majora: The labia majora is also called large lips. It is different in size and shape for every woman but is generally larger and contains sweat and oil secreting glands. After puberty, the labia majora are covered with hair.

Labia minora: The labia minora can be very small or up to 2 inches wide and are often called small lips. They lie just inside the labia majora, and surround openings to the vagina and urethra (the tube that carries urine from the bladder to the outside of the body).

Bartholin's glands: These glands are located besides the vaginal opening and produce a fluid (mucus) secretion.

Clitoris: The two labia minora meet at the clitoris, a sensitive protrusion. The clitoris has several parts. The glans (or tip, the part that you can see) attaches to the shaft, which runs along internally toward the vaginal opening. The clitoris connects to a branching interior system of erectile tissues that runs through the genitals. The clitoris is very sensitive to stimulation and can swell and change position.

Hymen: Is a thin sheet of tissue with one or more holes in it partially covering the vaginal opening. Hymens are often different from person to person. Some women stretch or ton them apart during first sexual intercourse, while some women have no changes in hymen after intercourse. Some women would have little or no beading and the others may complain they first intercourse was painful or not at all.

3A What is Female Genital Mutilation/Cutting (FGM/C)

What is FGM/C?

FGM/C is the deliberate cutting or excision of part of the female genitalia.

It is a social practice that has been customary for centuries in certain cultures and communities.

It performed on girls of different ages, most commonly around the ages of 7 - 10.

Who carries out the practice?

It is usually carried out by women without medical training, often using unsterile blades or knives and without using anaesthesia.

In some countries, such as Sudan and Egypt, it is also performed in private clinics by doctors and nurses.

Why does it happen?

The reasons given for the procedure vary but are often related to maintaining social acceptance, tradition and prevailing gender norms. Other specific reasons given include:

- The belief that it keeps young women pure and marriageable.
- The belief that it promotes cleanliness and inhibits sexual promiscuity
- The belief that it is a religious observance, although it is not required by any religion.
- To reinforce cultural identity or comply with local cultural attitudes about “beauty”

FGM/C is a practice reserved for women, and reflects a gender inequality that does not respect girls’ and women’s right to make independent decisions about their own bodies or about their sexual and reproductive health.

Where is FGM/C practised?

An estimate 100 to 140 million girls and women have undergone FGM/C, and about 2 – 3 million more girls are at risk each year.

FGM/C has been documented in 28 countries in Africa and several countries in Asia and the Middle East.

In Australia, New Zealand, Canada, Europe, the United Kingdom and the United States, some immigrant populations are considered to be at risk. While the main risk is when young girls return to their country of origin, there have been cases where FGM/C has been practised in destination countries.

What human rights does FGM/C violate?

FGM/C violates or jeopardises the enjoyment of the right to life; the right to physical integrity; the right to the highest attainable standard of health; the right to freedom from cruel, inhumane or degrading treatment, including physical or mental violence, injury or abuse; the right to live in dignity, free from gender discrimination; and the rights of the child to development, protection and participation.

How common is it in Australia?

Many women from affected countries have been subjected to FGM/C during childhood. It is assumed that the proportion of women coming from countries that practise FGM/C that have had the procedure is the same as the proportions in the general population of those countries, as estimated by WHO.

There is no evidence to suggest that the practice is being continued by immigrant populations in Australia. However, there have been a number of FGM/C related cases and in 2012 four people were charged with FGM/C related offences in NSW.

If it is part of our culture, what is wrong with it?

It is a painful practice that constitutes child abuse. It is an infringement on the basic human rights of children.

There can be immediate and long-term health complications for girls and women including death.

It alters the external genital organs and can reduce sexual enjoyment for women.

It can complicate childbirth and increases the need for a caesarean section.

It is against the law in Australia and many other countries.

What are the common medical complications of FGM/C?

The most common immediate complication is bleeding (which can be fatal) and extreme pain. The trauma of the experience can have long term psychological consequences.

Infection and inability to pass urine are common immediately after the procedure, and later on due to obstruction of the urinary tract and repeated infections.

Recurrent cysts and abscesses can occur in the area. These can lead to chronic pelvic inflammation and long term pain.

Pain during sex is common.

Childbirth is difficult, especially if the birth attendants are not experienced in dealing with the altered anatomy. A Caesarean birth is a common outcome in Australia and elsewhere.

There can be short and long term mental health effects for girls and women who experience FGM/C.

What does the practice involve?

There are different types of FGM/C, but all types involve altering a girl's genitalia in some way.

The World Health Organisation (WHO) has classified FGM/C into 4 types as follows:

Type I: removal of the clitoral hood, the skin around the clitoris, with partial or complete removal of the clitoris

Type II: removal of the labia minora (the inner lips that cover the vagina), with partial or complete removal of the clitoris and the labia majora (the large skin folds that cover the genital area)

Type III: removal of all or part of the labia minora and labia majora, with the stitching of a seal across the vagina (infibulation), leaving a small opening at the back for the passage of urine and menstrual blood and for sexual intercourse

Type IV: various other things done to the girl's genitals, including pricking, piercing, cutting or cauterisation of the clitoris, cutting of the vagina, and introduction of herbs or corrosive substances

What is infibulation?

The most destructive type of FGM/C in the WHO classification is Type III, which is also called infibulation. It is estimated that about 15% of all women who have undergone FGM/C have been infibulated. In order for infibulated women to give birth vaginally, the stitched area must be opened with a knife or scissors.

After the delivery it is illegal in Australia for the attendant to resew the labia together again, except in special circumstances. As such, the birth generally leads to the deinfibulation of the woman.

Can infibulation be reversed?

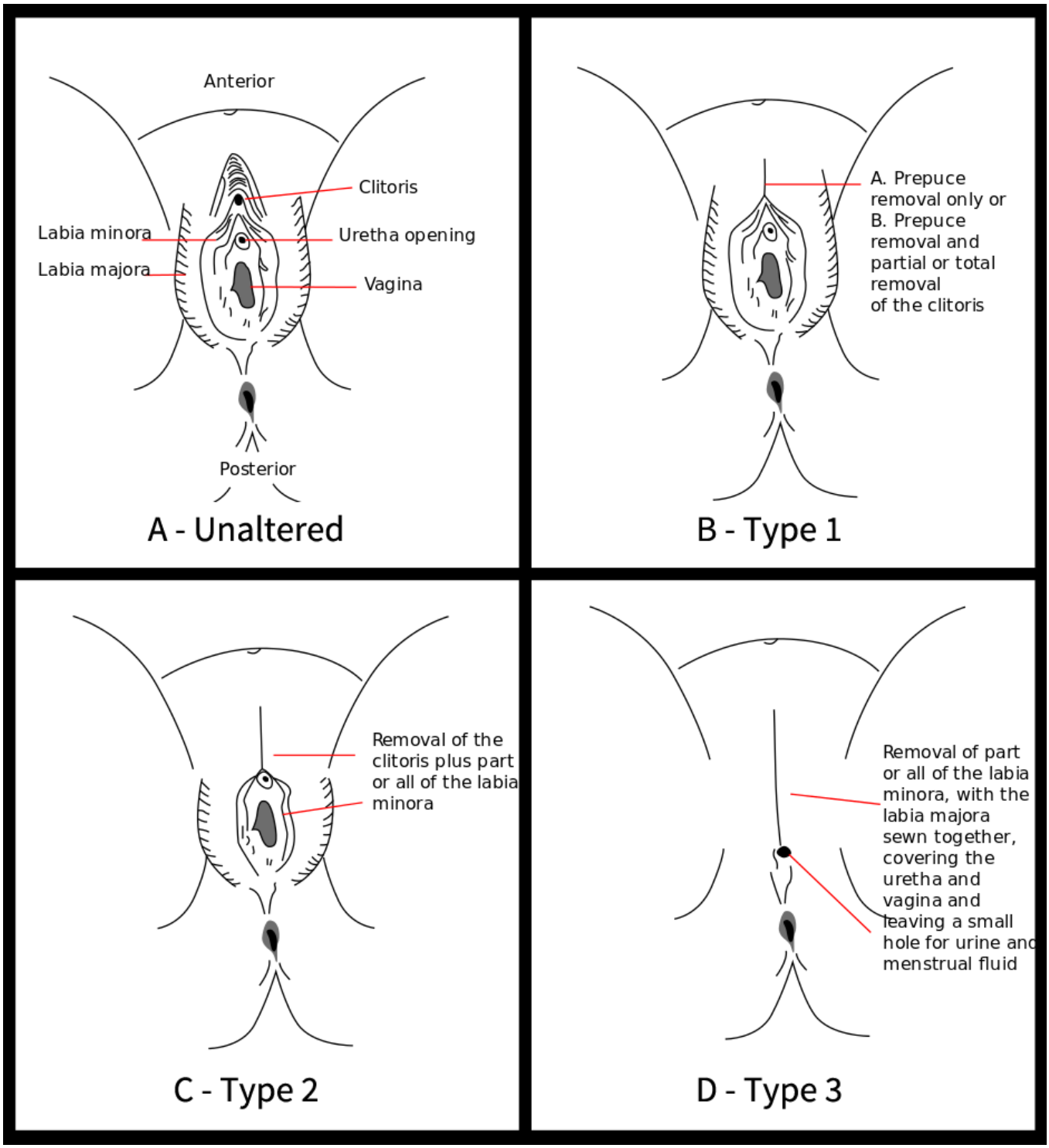
Yes. It is a simple medical procedure, carried out under anaethesia, to open the area that has been sewn up. This surgical reversal is called deinfibulation.

Deinfibulation can be requested at any time, but is commonly undertaken prior to marriage, before or during pregnancy or at childbirth.

Once the clitoris has been removed it cannot be restored.

3A
Types of FGM/C

NOTE: Type IV FGM/C is not shown here, but includes pricking, piercing or incision of the clitoris and/or the labia; stretching of the clitoris and or the labia; cauterisation or burning of the clitoris and surrounding tissues, scraping of the vaginal orifice or cutting of the vagina and introduction of corrosive substances or herbs into the vagina.



3C
Countries with legislation or decree against the practice of FGM/C

From UNICEF (2013) Female Genital Mutilation/ Cutting: A statistical overview and exploration of the dynamics of change, UNICEF: New York, pp. 8-9.

Twenty-six countries in Africa and the Middle East have prohibited FGM/C by law or constitutional decree. Two of them – South Africa and Zambia – are not among the 29 countries where the practice is concentrated (see Table 2.1). With the exception of Guinea and the Central African Republic, where bans on FGM/C were instituted in the mid-1960s, the process of enacting legislation or revising the criminal code to outlaw the practice began to take hold in Africa quite recently.

Legislation prohibiting FGM/C has also been adopted in 33 countries on other continents, mostly to protect children with origins in practising countries. Legislation on FGM/C varies in scope. In Mauritania, for example, the law is restricted to a ban on the practice in government health facilities and by medical practitioners. In Mauritania, the United Republic of Tanzania and some non-African countries, including Canada and the United States, FGM/C is illegal only among minors. Laws banning FGM/C at all ages have been passed in the majority of African countries.

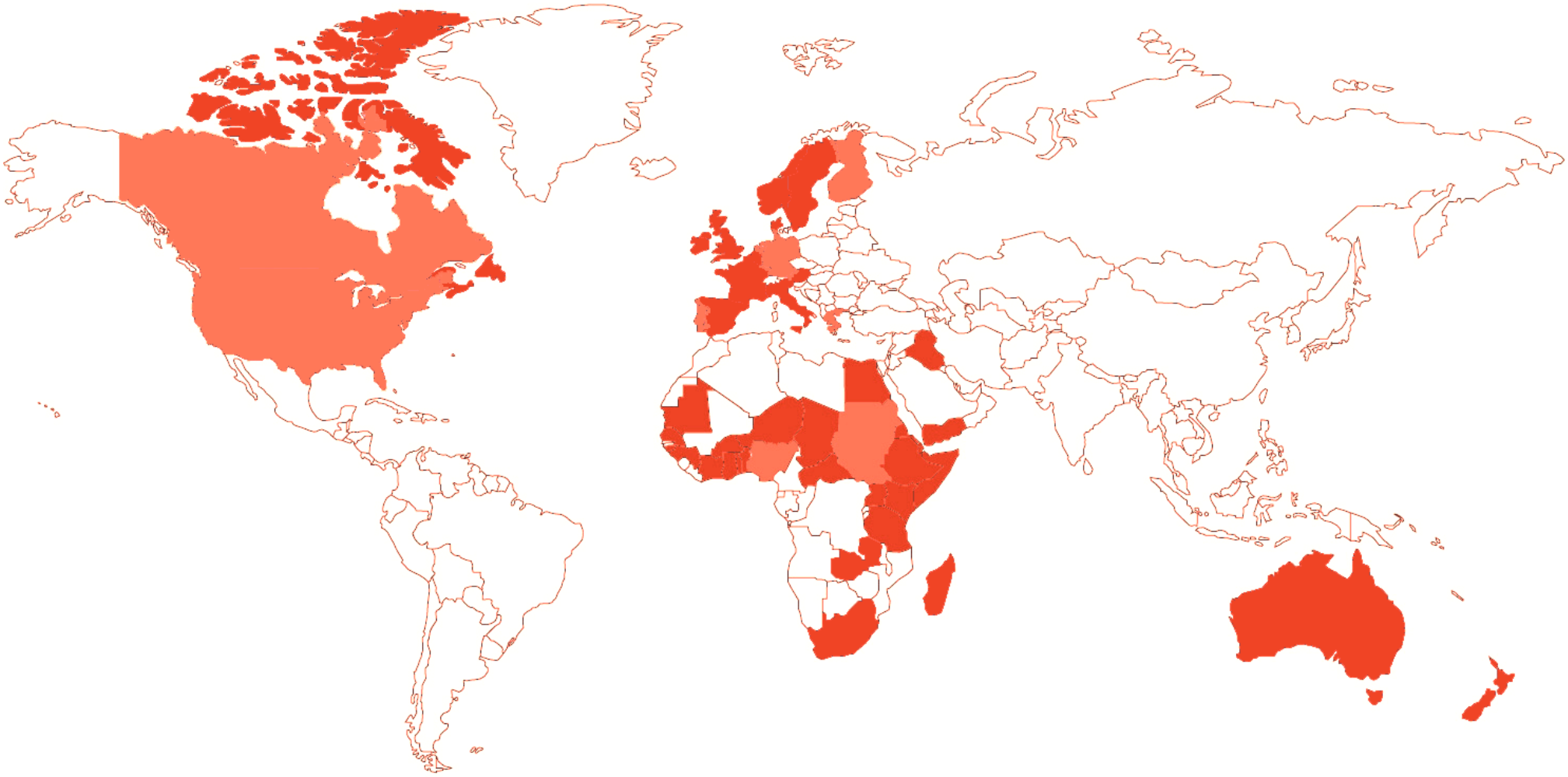
In Burkina Faso, fines can be levied not only against practitioners of FGM/C, but also against anyone who knows that the procedure has been performed and fails to report it. In 2011, Kenya expanded the 2001 ban on FGM/C among minors to apply to adult women and added an extraterritoriality clause, extending restrictions to citizens who commit the crime outside the country's border. Reports of prosecution or arrests in cases involving FGM/C have been made in several African countries, including Burkina Faso and Egypt.

Table 2.1 Twenty-four of the 29 countries where FGM/C is concentrated have enacted decrees or legislation related to FGM/C

Benin	2003
Burkina Faso	1996
Central African Republic	1966, 1996*
Chad	2003
Côte d'Ivoire	1998
Djibouti	1995, 2009*
Egypt	2008
Eritrea	2007
Ethiopia	2004
Ghana	1994, 2007*
Guinea	1965, 2000*
Guinea-Bissau	2011
Iraq (Kurdistan region)	2011
Kenya	2001, 2011*
Mauritania	2005
Niger	2003
Nigeria (some states)	1999-2006
Senegal	1999
Somalia	2012
Sudan (some states)	2008-2009
Togo	1998
Uganda	2010
United Republic of Tanzania	1998
Yemen	2001

Notes: Bans outlawing FGM/C were passed in some African countries, including Kenya and Sudan, during colonial rule. This table includes only legislation that was adopted by independent African nations and does not reflect earlier rulings. * Later dates reflect amendments to the original law or new laws.

3C: Countries around the world with specific laws ordecrees making FGM/C illegal



AUSTRALIAN CHARTER OF HEALTHCARE RIGHTS

The Australian Charter of Healthcare Rights describes the rights of patients and other people using the Australian health system. These rights are essential to make sure that, wherever and whenever care is provided, it is of high quality and is safe.

The Charter recognises that people receiving care and people providing care all have important parts to play in achieving healthcare rights. The Charter allows patients, consumers, families, carers and services providing health care to share an understanding of the rights of people receiving health care. This helps everyone to work together towards a safe and high quality health system. A genuine partnership between patients, consumers and providers is important so that everyone achieves the best possible outcomes.

Guiding Principles

These three principles describe how this Charter applies in the Australian health system.

1 Everyone has the right to be able to access health care and this right is essential for the Charter to be meaningful.

2 The Australian Government commits to international agreements about human rights which recognise everyone's right to have the highest possible standard of physical and mental health.

3 Australia is a society made up of people with different cultures and ways of life, and the Charter acknowledges and respects these differences.

For further information please visit
www.safetyandquality.gov.au

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTHCARE

What can I expect from the Australian health system?

MY RIGHTS	WHAT THIS MEANS
Access	
I have a right to health care.	I can access services to address my healthcare needs.
Safety	
I have a right to receive safe and high quality care.	I receive safe and high quality health services, provided with professional care, skill and competence.
Respect	
I have a right to be shown respect, dignity and consideration.	The care provided shows respect to me and my culture, beliefs, values and personal characteristics.
Communication	
I have a right to be informed about services, treatment, options and costs in a clear and open way.	I receive open, timely and appropriate communication about my health care in a way I can understand.
Participation	
I have a right to be included in decisions and choices about my care.	I may join in making decisions and choices about my care and about health service planning.
Privacy	
I have a right to privacy and confidentiality of my personal information.	My personal privacy is maintained and proper handling of my personal health and other information is assured.
Comment	
I have a right to comment on my care and to have my concerns addressed.	I can comment on or complain about my care and have my concerns dealt with properly and promptly.

References and further reading

Introduction

Setting ground rules for discussion

Rules closely adapted from 'Learning Agreement or Ground Rules' in the Forward FGM Lesson Plan (FORWARD, 2014) and the similar, 'K23 FGM Lesson' in SRE Covered: all you need to teach about sex and relationships in secondary schools (Islington Healthy Schools Team, 2014).

What to do in the event of emotional distress of a participant

Guidelines closely adapted from 'Recovery Goal 1: Restoring Safety, Enhancing Control and Reducing Fear and Anxiety' in Rebuilding Shattered Lives pp. 73 – 81. (Victorian Foundation for Survivors of Torture Inc., 1998) It is strongly suggested that facilitators read the Introduction and Chapter 2 of Rebuilding Shattered Lives in order to understand and apply guidelines appropriately.

Resource 1

Reaching Communities

Cultural Day aims, objectives and program content suggestions closely developed from Community Cultural Days November 2008- July 2009 Report (NSW Education Program on FGM, 2010). You can access the full report by contacting (02) 9840 3768.

Resource 2

Facilitating sessions

Parts of this section, including 'What is my role as a facilitator?' adapted from 'Delivering the Sessions' in Stepping out of the Shadows, Reducing Stigma in Multicultural Communities Training Package Community Trainer Manual (Multicultural Mental Health Australia, Queensland Transcultural Mental health Centre and the Commonwealth Department of Health and Ageing, 2008) pp. 78-83.

Module 1: Women's health and human rights

Key messages in this module are closely adapted from 'Unit 1: What are "human rights"?' and 'Unit 2: Defining gender' in It's All One Curriculum: Guidelines and Activities for a Unified Approach to Sexuality, Gender, HIV and Human Rights Education (The Population Council, 2011), pp. 24-27, 44-45.

Module 2: Everyone's right to sexual and reproductive health

Key messages in this module are selected and adapted from 'Unit 6: The body, puberty and reproduction', Unit 2: Gender and bodily autonomy' and 'Unit 1: Sexual and reproductive rights' in It's All One Curriculum: Guidelines and Activities for a Unified Approach to Sexuality, Gender, HIV and Human Rights Education (The Population Council, 2011), pp. 28-30, 64,156-178.

Module 4: Advocating for sexual health, rights and gender equality

Key messages in this module are selected and closely adapted from 'Unit 1: promoting human rights, including sexual and reproductive rights' and 'Unit 7: The right to health services' in It's All One Curriculum: Guidelines and Activities for a Unified Approach to Sexuality, Gender, HIV and Human Rights Education (The Population Council, 2011), pp. 32, 186-187.

Activities

'Altering bodies' taken from 'Activity 12' in It's All One Curriculum: Guidelines and Activities for a Unified Approach to Sexuality, Gender, HIV and Human Rights Education, Volume 2 (The Population Council, 2011), p. 45.

'Appreciating your own body' adapted from Mirror mirror off the wall blog, website (Kjerstin Gruys, May 1 2012): http://www.ayearwithoutmirrors.com/2012/05/best-positive-body-image-group-activity.html#sthash.8dLPXWcc.dpuf

'Basic Needs' from Sharing Our Stories Project: a woman to woman approach to human rights education 2011, final report (MCWH, 2011)

'Case studies concerning sexual and reproductive rights' from 'Activity 4: Case studies concerning sexual and reproductive rights' in It's All One Curriculum: Guidelines and Activities for a Unified Approach to Sexuality, Gender, HIV and Human Rights Education, Volume 2 (The Population Council, 2011), pp. 28-31..

'First impressions' adapted from Activity 18 in t's All One Curriculum: Guidelines and Activities for a Unified Approach to Sexuality, Gender, HIV and Human Rights Education, Volume 2 (The Population Council, 2011), pp. 56-58.

'Gender or Sex' adapted from A Model of Practice for the Empowerment of Muslim Women: The SILC—Self-esteem, Identity, Leadership and Community—Project (Islamic Women's Welfare Council of Victoria (IWWCV), 2005).

Human Rights Case Studies taken from the Australian Human Rights Commission website: OHCHR, 1996-2012 Accessed: http://www.ohchr.org/en/issues/pages/whatarehumanrights.aspx

'Faduma's Story' adapted from Our Human Rights Stories, website (London Irish Women's Centre, 6 Febraury 2010): http://www.ourhumanrightsstories.org.uk/case-study/domestic-violence-survivor-uses-human-rights-act-keep-her-children-and-get-safe-accomodation.

‘Mary’s Story’ adapted from Our Human Rights Stories, website (Liberty, 2 March 2010): http://www.ourhumanrightsstories.org.uk/organisation/liberty

‘Memory Journey’ adapted from ‘Activity 6: Memory journey: learning about gender as a child’ in It’s All One Curriculum: Guidelines and Activities for a Unified Approach to Sexuality, Gender, HIV and Human Rights Education, Volume 2 (The Population Council, 2011), pp. 26-27.

‘Power, privilege and equality’ adapted from ‘Activity 3: Power, privilege and equality’ in It’s All One Curriculum: Guidelines and Activities for a Unified Approach to Sexuality, Gender, HIV and Human Rights Education, Volume 2 (The Population Council, 2011), pp. 26-27.

‘Social Determinants of Health’ adapted from ‘Determinants of Health’ on Te Kete Ipurangi, website (New Zealand Ministry of Education, accessed 29 June 2013): http://health.tki.org.nz/Key-collections/Curriculum-in-action/Making-Meaning/Health-education2/Determinants-of-Health#2

‘Understanding and Identifying Human Rights’ from Understanding Human Rights: Human rights education resources for teachers (Australian Human Rights Commission, 2010) p. 19.

Other recommended resources

FORWARD (2014) Forward FGM Lesson Plan. FORWARD: London

‘K23 FGM Lesson’ in Janice Slough and Janine Killough (2014) SRE Covered: all you need to teach about sex and relationships in secondary schools. Islington Health Schools Team: London

Multicultural Centre for Women’s Health and Victoria University (2010) PACE Community Leadership Development Training Program, Victoria University. MCWH: Melbourne.

NSW Education Program on FGM (2011) Women’s Health & Traditions in a New Society - Community Education Program, NSW Department of Health: Sydney

Images

The paper factory. Michael Caven (Flickr: 2007).
A handful of drought tolerant maize seed. Anne Wangalachi/CIMMYT (Flickr: 2008).
Young mum. Lindsay Mgbor/Department for International Development (Flickr: 2012).
Australia-Bali Memorial Eye Centre. AUSAid/Australian Department of Foreign Affairs (Flickr: 2004).
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Flood evacuation. The U.S Army (Flickr: 2010).
Myanmar, monks and novices. Dietmar Temps (Flickr: 2012).
Female reproductive system. Adapted. Big hug little kiss (website accessed 1 June 2014): http://bighuglittlekiss.blogspot.com.au/2014/02/your-menstrual-cycle-explained.html.

Multicultural Women's Health Australia Contacts

State	Organisation	Representative(s)	Contact
ACT	Women's Centre for Health Matters	Marcia Williams (ED)	ed@wchm.org.au T (02) 6290 2166
NSW	NSW Education Program on FGM Women's Health at Work Program	Vivienne Strong (Manager)	vivienne_strong@swahs.health.nsw.gov.au T (02) 9840 4182
NT	Melaleuca Refugee Centre	Caz Coleman (A/g Director)	director@melaleuca.org.au T (08) 8985 3311
QLD	Immigrant Women's Support Service	Cecilia Barassi-Rubio (Director)	cecilia.barassi@iwss.org.au T (07) 3846 3490
SA	Migrant Health Service	Jan Williams (Clinical Services Coordinator)	Jan.Williams@health.sa.gov.au T (08) 8237 3912
TAS	Red Cross Tasmania	Al Hines (Manager Migration Support Programs)	ahines@redcross.org.au T (03) 6235 6083
WA	Ishar Multicultural Women's Health Centre	Andrea Creado (CEO)	andrea@ishar.org.au T (08) 9345 5335

Multicultural Centre for Women's Health Quality Standard

About our organisation

Multicultural Centre for Women's Health (MCWH) is a national, community-based organisation committed to the achievement of health and wellbeing for and by immigrant and refugee women.

Vision: The national voice for immigrant and refugee women's wellbeing in Australia.

Mission: To promote the wellbeing of immigrant and refugee women across Australia, through advocacy, social action, multilingual education, research and capacity building.

Our values

Leadership: We take the lead in immigrant and refugee women's wellbeing

Impact: We create opportunities for positive change.

Equity: We respect each woman's voice, culture, identity, rights and aspirations.

Dynamism: We actively engage with others, responding to changing environments.

Integrity: We follow our social justice principles consistently and in every circumstance

Learning: We actively engage with new knowledge and share our unique standpoint and expertise.

Our approach

Social Determinants Of Health

MCWH recognises that health and wellbeing is significantly affected by a range of social determinants, including gender, race, culture, class, employment status, sexuality, disability, age, and immigrant status.

Representation

MCWH is guided by the leadership of immigrant and refugee women in achieving equity and promoting their health and wellbeing. MCWH is committed to listening to, and representing, their voices in all their diversity, and in placing their issues at the centre of advocacy and policy development.

Education Exchange

MCWH learns from, and provides education to, immigrant and refugee women following a feminist peer education model where women' knowledge and experience is valued and respected, and education is delivered by respected and accredited bilingual educators.

Collaboration

MCWH works together with immigrant and refugee women, community organisations, health practitioners, employers, communities and governments to achieve equity and improve health and wellbeing for immigrant and refugee women.

Multilingual Health Education Programs

MCWH Multilingual Health Education Programs have been delivering important health information to women from immigrant and refugee backgrounds since 1978. Programs are conducted in industry and community settings by highly trained and qualified Bilingual Health Educators.
These programs are uniquely successful because health information is provided in:

- the preferred language of the women attending the program;
- location and at times that are most convenient for women; and
- ways which respect women's experiences and knowledge and understand their cultural context.

Health Education Programs are run by immigrant and refugee women for immigrant and refugee women. This woman-to-woman approach is our peer education model, and is based on the belief that sharing health information and experiences is the best way to increase women's health knowledge and wellbeing.

Educator Accreditation

All BHEs have completed a nationally accredited course, 10374NAT Course in Multicultural Women's Health Education for Bilingual Community Educators.

Quality Standards

Health Education Programs are underpinned by a set of Quality Standards which guide program development, implementation, delivery and evaluation. The standards can be summarised under seven general headings.

1. Women's Empowerment
2. Cultural and Linguistic Appropriateness
3. Accuracy of health information
4. Access and Equity
5. Confidentiality
6. Collaboration
7. Continuous Improvement

Each of the standards is inter-connected and essential to the maintenance of high quality standards in multilingual health education for immigrant and refugee women.

Standard 1: Women's Empowerment

All Health Education Programs adopt feminist approaches to the provision of health care. Programs empower immigrant and refugee women to take control of their own bodies and to make informed decisions about their own health and wellbeing.

Underpinning each Health Education Program is a holistic view of health that considers intersections between gender, health, disadvantage, migration and other variables that circumscribe immigrant and refugee women's experiences of health and wellbeing.

Indicators

a. Sessions are conducted according to the MCWH woman-to-woman approach, where health information is exchanged among women in a non-hierarchical manner. Women are active contributors to sessions and their knowledge, experiences and choices are respected.

b. Information shared increases women's knowledge about women's health and wellbeing and builds their capacity for making informed choices.

c. Sessions are conducted in small, women-only, language-specific groups.

d. Sessions are non-discriminatory, non-judgemental and conducted in a safe, non-threatening environment chosen by the women involved.

e. Uniqueness of women's experiences, needs and aspirations are acknowledged and respected.

f. Participants are actively involved in the planning, implementation and evaluation of sessions.

Standard 2: Cultural and Linguistic Appropriateness

Health Education Programs are responsive to immigrant and refugee women's cultural and linguistic needs, recognising the complex nature of women's multiple identities along with the impact of additional layers such as migration, settlement and socio-economic context.

Indicators

a. Sessions are conducted by trained Bilingual and Bicultural Health Educators who share the cultural and linguistic backgrounds of participants.

b. Sessions are conducted in language-specific groups and in the women's preferred language(s).

c. Multilingual health information is provided to the women and sessions are delivered using a variety of mediums such as written information, posters, DVDs, CD, charts and models.

Standard 3: Accuracy of Health Information

Health Education Programs offer accurate, up to date, relevant and culturally and linguistically appropriate information to immigrant and refugee women.

Indicators

d. All multilingual health information is screened for accuracy, appropriateness and relevance.

e. Bilingual Health Educators have appropriate qualifications, skills, competency and suitability for the delivery of education sessions.

f. Bilingual Health Educators are provided with individual and team support, and participate in ongoing performance assessments and professional development activities, including continuous training about women's health topics.

Standard 4: Access and Equity

Health Education Programs are accessible to all immigrant and refugee women, and can accommodate women's diverse needs.

Indicators

a. Sessions are provided in women's workplaces, community settings, homes, educational institutions and other locations suitable to participants, including in rural, regional and remote areas of Victoria.

b. Sessions are conducted on any day of the week, at any time that suits the particular group.

c. Sessions are tailored to accommodate the specific and diverse needs of all immigrant and refugee women, including

but not limited to women with disabilities, same-sex attracted women, GBLTIQ women, outworkers, shift-workers, mothers, carers, rural women, young women and newly-arrived women.

d. Sessions are offered in community languages which reflect those spoken by immigrant and refugee women around Victoria, including newly-arrived women.

e. Sessions are non-judgemental and non-discriminatory.

f. Sessions are promoted widely amongst immigrant and refugee women using a variety of media and methods.

Standard 5: Confidentiality

Health Education Programs respect and maintain the right of service-users to privacy and confidentiality. The assurance of confidentiality within Health Education Programs is essential (particularly within small and well-networked communities) to ensure that women's autonomy and freedom of choice is maintained. The assurance of confidentiality facilitates the development of trust and rapport and enables sensitive and complex issues to be openly discussed.

Indicators

a. Bilingual Health Educators maintain privacy and confidentiality on all matters discussed with women.

b. Policies pertaining to confidentiality of information (including entry of data) have been developed.

c. Information about women participants is retained so data can be utilised for evaluation, report writing and dissemination. Electronic data collection de-identifies women to protect confidentiality.

d. Where a woman's name has been noted for an information referral, it is blacked out at the end of each month.

Standard 6: Collaboration

MCWH collaborates with a range of agencies to ensure that sessions are well-organised, well-attended, delivered at a suitable venue and culturally and linguistically appropriate. Collaboration also ensures that women are well-linked with their local ethno-specific, health, welfare and women's services after sessions are completed.

Indicators

e. MCWH collaborates with workplaces, educational institutions, unions, local organisations and groups to organise, promote and evaluate sessions.

f. MCWH collaborates with ethno-specific, health, welfare and women's agencies to link and refer women to appropriate services and activities.

g. MCWH collaborates with ethno-specific, health, welfare and women's agencies to promote appropriate services among immigrant and refugee women.

Standard 7: Continuous Improvement

Health Education Programs are continuously evaluated in order to improve effectiveness and relevance for immigrant and refugee women's health and wellbeing. Participant assessments and recommendations for improvement are collected, analysed and utilised to make relevant changes.

Indicators

a. Each session is evaluated by participants and by Bilingual Health Educators.

b. An overall evaluation survey is completed by participants and by Bilingual Health Educators at the end of the program.

c. Evaluation findings are continuously collated, analysed and fed back to the program coordinator and Bilingual Health Educators, and an annual evaluation takes place so that appropriate changes are made to programs.

d. An independent evaluation is conducted periodically and findings inform MCWH strategic planning.

Further Information

For more information or to access a copy of the standards, go to www.mcwh.com.au or contact:

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Mandatory reporting of child abuse and neglect in Australia

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What is mandatory reporting?

Mandatory reporting is a term used to describe the legislative requirement imposed on selected classes of people to report suspected cases of child abuse and neglect to government authorities. Parliaments in all Australian states and territories have enacted mandatory reporting laws of some description. However, the laws are not the same across all jurisdictions. The main differences concern who has to report, and what types of abuse and neglect have to be reported. There are also other differences, such as the state of mind that activates the reporting duty (i.e., having a concern, suspicion or belief on reasonable grounds - see Table 1) and the destination of the report.

This sheet focuses on the major differences features of state and territory laws regarding who must report and what must be reported.

Table 1: Key features of legislative reporting duties: "state of mind" that activates reporting duty and extent of harm.

Jurisdiction	State of mind	Extent of harm
ACT	Belief on reasonable grounds	Not specified: "sexual abuse ... or non-accidental physical injury"
NSW	Suspects on reasonable grounds that a child is at risk of significant harm	A child or young person "is at risk of significant harm if current concerns exist for the safety, welfare or wellbeing of the child or young person because of the presence, to a significant extent, of ... basic physical or psychological needs are not being met ... physical or sexual abuse or ill-treatment ... serious psychological harm"
NT	Belief on reasonable grounds	Any significant detrimental effect caused by any act, omission or circumstance on the physical, psychological or emotional wellbeing or development of the child
QLD	Becomes aware, or reasonably suspects	Significant detrimental effect on the child's physical, psychological or emotional wellbeing
SA	Suspects on reasonable grounds	Any sexual abuse; physical or psychological abuse or neglect to extent that the child "has suffered, or is likely to suffer, physical or psychological injury detrimental to the child's wellbeing; or the child's physical or psychological development is in jeopardy"
TAS	Believes, or suspects, on reasonable grounds, or knows	Any sexual abuse; physical or emotional injury or other abuse, or neglect, to extent that the child has suffered, or is likely to suffer, physical or psychological harm detrimental to the child's wellbeing; or the child's physical or psychological development is in jeopardy
VIC	Belief on reasonable grounds	Child has suffered, or is likely to suffer, significant harm as a result of physical injury or sexual abuse and the child's parents have not protected, or are unlikely to protect, the child from harm of that type
WA	Belief on reasonable grounds	Not specified: any sexual abuse
Australia	Suspects on reasonable grounds	Not specified: any assault or sexual assault; serious psychological harm; serious neglect

Adapted from relevant state and territory legislation.

Who is mandated to make a notification?

The legislation generally contains lists of particular occupations that are mandated to report. The groups of people mandated to notify cases of suspected child abuse and neglect range from persons in a limited number of occupations (e.g., Qld), to a more extensive list (Vic.), to a very extensive list (ACT, NSW, SA, Tas.), through to every adult (NT). The occupations most commonly named as mandated reporters are those who deal frequently with children in the course of their work: teachers, doctors, nurses, and police.

What types of abuse are mandated reporters required to report?

In addition to differences describing who is a mandated reporter across jurisdictions, there are differences in the types of abuse and neglect which must be reported. In some jurisdictions it is mandatory to report suspicions of each of the four classical types of abuse and neglect abuse (i.e., physical abuse, sexual abuse, emotional abuse, and neglect). In other jurisdictions it is mandatory to report only some of the abuse types (e.g., Vic., WA). Some jurisdictions also require reports of exposure of children to domestic violence.

It is important to note that the legislation generally specifies that except for sexual abuse (where all suspicions must be reported), it is only cases of significant abuse and neglect that must be reported. Reflecting the original intention of the laws, the duty does not apply to any and all "abuse" or "neglect", but only to cases which are of sufficiently significant harm to the child's health or wellbeing to warrant intervention or service provision. However, reflecting the qualitative differences presented by sexual abuse as opposed to other forms of abuse and neglect, five jurisdictions apply the reporting duty to all suspected cases of sexual abuse without requiring the reporter to exercise any discretion about the extent of harm which may have been caused or which may be likely (ACT, NT, SA, Tas., WA).

In the other three jurisdictions, the practical application of the duty to report sexual abuse would still result in reports of all suspected sexual abuse being required, as sexual abuse should always create a suspicion of significant harm. Suspicions of more minor child abuse and neglect may be referred to child and family welfare agencies, especially where jurisdictions have made more extensive provision for this (e.g., Vic., NSW, Tas.). It is also important to note that the duty to report also applies to suspicions that significant abuse or neglect is likely to occur in future, not only suspected cases of significant abuse or neglect that have already happened.

Table 2 provides an overview of the key features of the legislation in each state and territory: who must report, and what must be reported.

Table 2: Mandatory reporting requirements across Australia

	Who is mandated to report?	What must be reported?	Abuse and neglect types which must be reported	Legal provisions
ACT	A person who is: a doctor; a dentist; a nurse; an enrolled nurse; a midwife; a teacher at a school; a person providing education to a child or young person who is registered, or provisionally registered, for home education under the EDUCATION ACT 2004; a police officer; a person employed to counsel children or young people at a school; a person caring for a child at a child care centre; a person coordinating or monitoring home-based care for a family day care scheme proprietor; a public servant who, in the course of employment as a public servant, works with, or provides services personally to, children and young people or families; the public advocate; an official visitor; a person who, in the course of the person's employment, has contact with or provides services to children, young people and their families and is prescribed by regulation	A belief, on reasonable grounds, that a child or young person has experienced or is experiencing sexual abuse or non-accidental physical injury; and the belief arises from information obtained by the person during the course of, or because of, the person's work (whether paid or unpaid)	Physical abuse Sexual abuse	Section 356 of the CHILDREN AND YOUNG PEOPLE ACT 2008 (ACT)
NSW	A person who, in the course of his or her professional work or other paid employment delivers health care, welfare, education, children's services, residential services or law enforcement, wholly or partly, to children; and A person who holds a management position in an organisation, the duties of which include direct responsibility for, or direct supervision of, the provision of health care, welfare, education, children's services, residential services or law enforcement, wholly or partly, to children	Reasonable grounds to suspect that a child is at risk of significant harm; and those grounds arise during the course of or from the person's work	Physical abuse Sexual abuse Emotional/psychological abuse Neglect Exposure to domestic violence	Sections 23 and 27 of the CHILDREN AND YOUNG PERSONS (CARE AND PROTECTION) ACT 1998 (NSW)
NT	Any person	A belief on reasonable grounds that a child has suffered or is likely	Physical abuse Sexual abuse	Sections 15, 16 and 26 of the CARE AND

Table 2: Mandatory reporting requirements across Australia

	Who is mandated to report?	What must be reported?	Abuse and neglect types which must be reported	Legal provisions
		to suffer harm or exploitation	Emotional/psychological abuse Neglect Exposure to physical violence (e.g., a child witnessing violence between parents at home)	PROTECTION OF CHILDREN ACT 2007 (NT)
	Registered health professionals	Reasonable grounds to believe a child aged 14 or 15 years has been or is likely to be a victim of a sexual offence and the age difference between the child and offender is greater than 2 years	Sexual abuse	Section 26(2) of the CARE AND PROTECTION OF CHILDREN ACT 2007 (NT)
QLD	A doctor or registered nurse	Awareness or reasonable suspicion during the practice of his or her profession of harm or risk of harm		Sections 191-192 and 158 of the PUBLIC HEALTH ACT 2005 (Qld)
	School staff	Awareness or reasonable suspicion that a child has been or	Sexual abuse	Sections 364,365,365A, 366,

Table 2: Mandatory reporting requirements across Australia

	Who is mandated to report?	What must be reported?	Abuse and neglect types which must be reported	Legal provisions
		is likely to be sexually abused; and the suspicion is formed in the course of the person's employment		366A of the EDUCATION Z(GENERAL PROVISIONS) ACT 2006 (Qld)
	An authorised officer, employee of the Department of Child Safety, a person employed in a departmental care service or licensed care service	Awareness or reasonable suspicion of harm caused to a child placed in the care of an entity conducting a departmental care service or a licensee	Physical abuse Sexual abuse or exploitation Emotional/psychological abuse Neglect	Sections 9, 148 of the CHILD PROTECTION ACT 1999 (Qld)
SA	Doctors; pharmacists; registered or enrolled nurses; dentists; psychologists; police officers; community corrections officers; social workers; teachers in educational institutions including kindergartens; family day care providers; employees/volunteers in a government department, agency or instrumentality, or a local government or non-government agency that provides health, welfare, education, sporting or recreational, child care or residential services wholly or partly for children; ministers of religion (with the exception of disclosures made in the confessional); employees or volunteers in a religious or spiritual organisations	Reasonable grounds to suspect that a child has been or is being abused or neglected; and the suspicion is formed in the course of the person's work (whether paid or voluntary) or carrying out official duties	Physical abuse Sexual abuse Emotional/psychological abuse Neglect	Sections 6, 10 and 11 of the CHILDREN'S PROTECTION ACT 1993 (SA)

Table 2: Mandatory reporting requirements across Australia

	Who is mandated to report?	What must be reported?	Abuse and neglect types which must be reported	Legal provisions
Tas	Registered medical practitioners; nurses; midwives; dentists, dental therapists or dental hygienists; registered psychologists; police officers; probation officers; principals and teachers in any educational institution including kindergartens; persons who provide child care or a child care service for fee or reward; persons concerned in the management of a child care service licensed under the CHILD CARE ACT 2001; any other person who is employed or engaged as an employee for, of, or in, or who is a volunteer in, a government agency that provides health, welfare, education, child care or residential services wholly or partly for children, and an organisation that receives any funding from the Crown for the provision of such services; and any other person of a class determined by the Minister by notice in the Gazette to be prescribed persons	A belief, suspicion, reasonable grounds or knowledge that: a child has been or is being abused or neglected or is an affected child within the meaning of the FAMILY VIOLENCE ACT 2004	Physical abuse Sexual abuse Emotional/psychological abuse Neglect Exposure to family violence	Sections 3, 4 and 14 of the CHILDREN, YOUNG PERSONS AND THEIR FAMILIES ACT 1997 (Tas.)
Vic	Registered medical practitioners, midwives, registered nurses; a person registered as a teacher under the EDUCATION, TRAINING AND REFORM ACT 2006 or teachers granted permission to teach under that Act; principals of government or non-government schools; and members of the police force	Belief on reasonable grounds that a child is in need of protection on a ground referred to in Section 162(c) or 162(d), formed in the course of practising his or her office, position or employment	Physical abuse Sexual abuse	Sections 182(1)(a)-(e), 184 and 162(c)-(d) of the CHILDREN, YOUTH AND FAMILIES ACT 2005 (Vic.)
WA	Doctors; nurses and midwives; teachers; and police officers	Belief on reasonable grounds that child sexual abuse has occurred or is occurring	Sexual abuse	Sections 124A and 124B of the CHILDREN AND COMMUNITY SERVICES ACT

Commonwealth law

In addition to state and territory laws, the Family Law Act 1975 (Cth) creates a mandatory reporting duty for personnel from the Family Court of Australia, the Federal Magistrates Court and the Family Court of Western Australia. This includes registrars, family counsellors, family dispute resolution practitioners or arbitrators, and lawyers independently representing children's interests. Section 67ZA states that when in the course of performing duties or functions, or exercising powers, these court personnel have reasonable grounds for suspecting that a child has been abused, or is at risk of being abused, the person must, as soon as practicable, notify a prescribed child welfare authority of his or her suspicion and the basis for the suspicion.

What protections are given to reporters?

In all jurisdictions, the legislation protects the reporter's identity from disclosure. In addition, the legislation provides that as long as the report is made in good faith, the reporter cannot be liable in any civil, criminal or administrative proceeding.

About whom can notifications be made?

Legislation in all jurisdictions except New South Wales requires mandatory reporting in relation to all young people up to the age of 18 (whether they use the terms "children" or "children and young people"). In New South Wales, the legislative grounds for intervention cover young people up to 18 years of age, but it is not mandatory to report suspicions of risk of harm in relation to young people aged 16 and 17.

What type of concerns must be reported, and what may be reported?

Mandatory reporting laws specify those conditions under which an individual is legally required to make a report to the relevant government agency in their jurisdiction. This does not preclude an individual from making a report to the statutory child protection service if they have concerns for the safety and wellbeing of a child that do not fall within mandatory reporting requirements. All statutes enable people to report concerns for a child's welfare even if they do not compel such reports. Any voluntary non-mandated reports will receive the legal protections referred to above regarding confidentiality and immunity from legal liability.

Although particular professional groups (such as psychologists) or government agencies (such as education departments in some states) may have protocols outlining the moral, ethical or professional responsibility or indeed the organisational requirement to report, they may not be officially mandated under their jurisdiction's child protection legislation. For example, in Queensland, teachers are required to report all forms of suspected significant abuse and neglect under school policy, but are only mandated to report sexual abuse under the legislation.

In what cases can child protection and welfare agencies respond?

A common assumption is that mandatory reporting requirements, the legislative grounds for intervention, and research classifications of abusive and neglectful behaviour are the same. In fact, mandatory reporting laws define the types of situations that must be reported to statutory child protection services. Legislative grounds for government intervention define the circumstances and, importantly, the threshold at which the statutory child protection service is legally able to intervene to protect a child. Researchers typically focus on defining behaviours and circumstances that can be categorised as abuse and neglect. These differences arise because each description serves a different purpose; the lack of commonality does not mean that the system is failing to work as policy-makers had intended.

What are the benefits of mandatory reporting requirements?

Mandatory reporting is a strategy which acknowledges the prevalence, seriousness and often hidden nature of child abuse and neglect, and enables early detection of cases which otherwise may not come to the attention of helping agencies. Mandatory reporting requirements reinforce the moral responsibility of community members to report suspected cases of child abuse and neglect. The laws help to create a culture which is more child-centred, and which will not tolerate serious abuse and neglect of vulnerable children. The introduction of mandatory reporting and accompanying training efforts aim to enable professionals to develop an awareness of cases of child abuse and create conditions which require them to report those cases and protect them as reporters. Research has found that mandated reporters make a substantial contribution to child protection and family welfare.

Are there challenges with the introduction of mandatory reporting?

As the introduction of mandatory reporting requirements within a jurisdiction tends to increase reporters' and the community's awareness of child abuse and neglect, it can result in a substantial increase in the number of reports being made to child protection departments. If there are inadequate resources available to the responsible department to respond to the increased demand, then the increasing number of reports may result in services being overwhelmed with cases to investigate and lacking sufficient staffing to do so. It is important that mandated reporters receive training and accurate information to ensure they know what cases they have to report, and what cases they should not report. Since non-mandated reporters make a large proportion of all reports, it is also important for the public to be made aware of the appropriate extent of their responsibility. It is also essential that child and family support services be adequately resourced to respond to children and families in need of protection and assistance.

Further details and information about mandatory reporting can be obtained from the relevant statutory child protection authority in each jurisdiction. Contact and other details for each state and territory office can be found in Reporting Abuse and Neglect: State and Territory Departments Responsible for Protecting Children.

Further reading

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Footnote

[1] There may also be legal requirements for various professionals to report other child related conditions to various authorities (i.e., certain diseases, the occurrence of injuries in children attending schools or day care, and incidents of domestic violence related to adult victims). This sheet does not relate to those circumstances but is specific to the reporting of child abuse and neglect to child protection authorities.

FGM/C related Health Promotion Programs and Contacts in Australia

Most of the programs established in Australia's states and territories were initially established under the National Program for the Prevention of FGM, which was developed in 1995 through a specific Commonwealth funding arrangement and was managed nationally through the Australian Health Minister's Council Sub-committee on Women and Health. Although these programs are no longer supported by direct Commonwealth funding, many have continued on to become a service backbone for women and communities affected by FGM/C and related health outcomes.

Western Australia (WA)		
FGM Program		
Established as part of the King Edward Memorial Hospital, The WA program is a state-wide service which delivers training on request to health providers, organisations and other relevant health and support agencies. The program also advocates for communities' access to health services and support, and has developed some key FGM/C education and information resources (accessible online).		
Contact	Carol Kaplanian (FGM and FDV Research Project Officer, Education and Training)	carol.kaplanian@health.wa.gov.au

Queensland (QLD)		
Family Planning Queensland: Multicultural Women's Health (FGM)		
Founded as part of Family Planning, Queensland, in 1997, the Queensland program, Multicultural Women's Health (FGM) has received multiple National and State awards, and provides professional bilingual peer education and support to communities (for both men and women) through community media, newsletters and community leaders to increase health literacy. The program also provides cultural awareness training and education on FGM/C to relevant service providers, working in partnership with other departments and health services in order to meet its goals. Multicultural Women's Health (FGM) undertakes advocacy, promotes public awareness and has produced a broad range of free resources including DVDs (accessible online).		
Website	www.FPQ.com.au	
Contact	Odette Tewfik (Project Coordinator)	otewfik@fpq.com.au Mobile 0422 113 118
Phone	+61 (07) 3250 0250	

New South Wales (NSW)

New South Wales Education Program on FGM (NSWFGM)

Founded in 1995 under the Sydney West Area Health Service, the NSW program has a strong community education focus. It provides formal training to bilingual community workers and professional development workshops to health and other professional sectors working with FGM/C affected communities. Its education program for women, 'Women's Health and Traditions in a New Society' (WHATINS), began in 1999 and is run by bilingual community workers over 11 sessions. The success of WHATINS has led to a complementary program for men. As a state-wide service, NSWFGM undertakes a yearly rural outreach program, holds 'Cultural Day' health promotion events and has developed a number of comprehensive resources (accessible online).

Website	www.dhi.health.nsw.gov.au/NSW-Education-Program-on-Female-Genital-Mutilation	
Contact	Linda George (Community Education and Development Officer)	linda.george@.health.nsw.gov.au
	Shairon Fray (Professional Education Officer)	shairon.fray@health.nsw.gov.au
	Vivienne Strong (Program Manager)	Vivienne.strong@health.nsw.gov.au
Phone	+61 (02) 9840 3910	

Tasmania (TAS)

Red Cross Tasmania Bi-cultural Community Education Program (FGM)

Initiated by the Tasmanian Department of Health and Human Services in 2005 and more recently established as part of the Red Cross Bicultural Community Health Program in 2008, the Tasmanian program provides training for bilingual community workers, community education for those affected by FGM and training for health service providers across the state.

Contact	Rebecca Eli (Community Link Worker)	reli@redcross.org.au
	Ashley Mattson (Team Leader)	amattson@redcross.org.au
	Al Hines (Manager)	ahines@redcross.org.au

Northern Territory (NT)

Everybody's Business Subcommittee (EBS)

There are no funded programs or services related to FGM/C in the Northern Territory. Everybody's Business Subcommittee (EBS) was founded in 2011 as part of the Refugee Health/ Sexual and Reproductive Health Service initiative called "Everybody's Business". Despite limited capacity and resources, the EBS was able to conduct a series of one-off FGM workshops for the Somali community in Darwin over 4 weeks in 2011. The workshops were conducted following requests by the Somali community for education on FGM. EBS has mapped all local NT services and resources regarding sexual and reproductive health for migrant and refugee communities, including the clinical and legal aspects of FGM/C, to be used as a resource for health and community service providers and relevant community members.

Contact	Dr Nader Gad (Obstetrician and Gynaecologist, Royal Darwin Hospital) Kirsten Thompson (Nurse)	nader.gad@nt.gov.au Kirsten.thompson@fpwnt.com.au
Phone	+61 (08) 8948 0144	

Australian Capital Territory (ACT)

ACT Health, Women's Health Service

First founded under the National Program for Prevention of FGM in 1996 by the Australian Health Minister's Council (AHMC) in the Migrant Health Unit of ACT Health, the original ACT FGM/C program lapsed after 2007.
Responsibility for the program was given to the Women's Health Service in early 2013, including a CALD women's health education program and training for health professionals.

Contact	Deborah Colliver (Manager) Esther Lam (CALD Liaison Nurse)	deborah.colliver@act.gov.au esther.lam@act.gov.au
Phone	+61 (02) 6205 1078	

South Australia (SA)

Women's Health Statewide

Initially federally funded and founded in 1995, the FGM/C program in South Australia was later absorbed by Women's Health Statewide. In 2012, it grew to incorporate refugee women's safety at all levels and was re-named the 'Refugee Women's Health and Safety Program'. The Program includes community engagement in collaboration with key refugee and immigrant services, counselling services, support (including home visits), advocacy and hospital referral services for women affected by FGM/C. Women's Health Statewide also runs workforce development for relevant professionals across sectors, and has begun peer educator training for women in relevant communities.

Contact	Gillian Kariuki (Project Coordinator) Rowena Leunig (Nurse)	gillian.kariuki@health.sa.gov.au +61 (08) 8239 9600
	Jan Williams (Migrant Health Clinical Services Coordinator)	jan.williams@health.sa.gov.au +61 (08) 8237 3912

Victoria (VIC)

Family and Reproductive Rights Program (FARREP)

Founded in 1995, the FARREP Program employs a regional model of service delivery channelled through organisations across Victoria in order to cover different regions. While FARREP Programs are independently run within each lead organisation, all programs use bilingual health workers and community workers to provide education and activities to raise awareness about FGM/C across a wide range of communities, ages and situations. FARREP workers also provide consultation, education and training for service providers, offer referrals and support for women directly affected by FGM/C, and undertake specific projects in partnership with relevant organisations (e.g. schools, research organisations, etc.) Both Mercy Hospital For Women and Royal Women's Hospital have a FARREP Program, and at the Royal Women's, clinical services are now explicitly available to women affected by FGM/C through the Well Women's De-infibulation Clinic, established in 2010.

Contact	Multicultural Centre for Women's Health (Statewide Service) Medina Idriess	 +61 (03) 9418 0913 medina@mcwh.com.au
	Banyule Community Health Amina Hussein	+61 (03) 9450 2063 amina.hussein@bchs.org.au
	Darebin Council Youth Services Fowzia Issa	+61 (03) 8470 8001 fissa@darebin.vic.gov.au
	Mercy Hospital For Women Wemi Oyekamni	+61 (03) 8458 4150 woyekanmi@mercy.com.au
	North Yarra Community Health Maria Ibrahim	+61 (03) 9349 7304 maria.ibrahim@nych.org.au
	Royal Women's Hospital Medina Idriess Egi Chaniyalewand Zeinab Mohamed	+61 (03) 8345 3058 farrepprogram@thewomens.org.au
	Southern Health Faduma Salah Musse Wudad Salim	+61 (03) 8558 9333 musse@southernhealth.org.au wudad.salim@monashhealth.org.aut
	Women's Health in the North Munira Adam Chamut Abebe Kifetew	+61 (03) 9484 1666 muniraa@whin.org.au chamutk@whin.org.au
	Women's Health in the West Intesar Homed	+61 (03) 9689 9588 intesar@whiw.org.au
	Doutta Galla Community Health Aisha El-Hag	+61 (03) 8378 1600 aisha.elhag@dgchs.org.au

Women's Health Topics

Summary of multilingual women's health information topics available in different languages from the multilingual catalogue at Multicultural Centre for Women's Health (go to www.mcwh.com.au)

Breast Health (Breast Screening/Breast Awareness/ Breast Cancer)

Cervical Health (Pap smears/ Abnormal Pap Tests/HPV/ Cervical Cancer/Ovarian Cancer)

Endometriosis

Menopause

HRT

Menstruation (PMS)

Osteoporosis

Pelvic Floor

Polycystic Ovarian Syndrome (PCOS)

Health Rights

Heart health

Cardiovascular Disease

Diabetes

Exercise

Nutrition

Alcohol

Smoking

Arthritis

Occupational Health & Safety

Asthma

Discrimination

Dust

Heat

Hygiene

Machinery

Manual Handling

Paternity Leave

Noise

Occupational Overuse Syndrome

Sexual Harassment

Stress

Varicose Veins

Workplace Violence

Workplace Bullying

Mental Health

Drug use (Prescription/Non-prescription/Illicit)

Alternative Therapies

Pain Management

Relaxation

Depression

Stress

Mental Illnesses

Better Sleep

Reproductive Health

Infertility

Family planning

Natural Methods

Pregnancy Choices

Pregnancy and Birth

Pregnancy: Effects of Alcohol and Drugs

Health consequences related to Female Genital Mutilation/ Cutting (FGM/C)

Sexual Health

Safer Sex

Sexually Transmitted Infections

HIV/AIDS

Cystitis

Vaginal Health and Hygiene

Sexuality and (Sexual Identity)

Healthy Relationships (Negotiating sex)

Women's Safety and Wellbeing

Sexual Assault

Family Violence

Legal Rights & Services

Problem Gambling

Some traditional and local terms for FGM/C

Country	Term used for FGM	Language	Meaning
Egypt	Thara	Arabic	Deriving from the Arabic word 'tahar' meaning to clean / purify
	Khitan	Arabic	Circumcision - used for both FGM and male circumcision
	Khifad	Arabic	Deriving from the Arabic word 'khafad' meaning to lower (rarely used in everyday language)
Ethiopia	Megrez	Amharic	Circumcision / cutting
	Absum	Harrari	Name giving ritual
Eritrea	Mekhnishab	Tigregna	Circumcision / cutting
Kenya	Kutairi	Swahili	Circumcision - used for both FGM and male circumcision
	Kutairi was ichana	Swahili	Circumcision of girls
Nigeria	Ibi / Ugwu	Igbo	The act of cutting - used for both FGM and male circumcision
	Sunna	Mandingo	Religious tradition / obligation - for Muslims
Sierra Leone	Sunna	Soussou	Religious tradition/ obligation - for Muslims
	Bondo	Temenee	Integral part of an initiation rite into adulthood - for non Muslims
	Bondo / Sonde	Mendee	Integral part of an initiation rite into adulthood - for non Muslims
	Bondo	Mandingo	Integral part of an initiation rite into adulthood - for non Muslims
	Bondo	Limba	Integral part of an initiation rite into adulthood - for non Muslims
Somalia	Gudniin	Somali	Circumcision used for both FGM and male circumcision
	Halalays	Somali	Deriving from the Arabic word 'halal' ie. 'sanctioned' - implies purity. Used by Northern & Arabic speaking Somalis.
	Qodiin	Somali	Stitching / tightening / sewing refers to infibulation
Sudan	Khifad	Arabic	Deriving from the Arabic word 'khafad' meaning to lower (rarely used in everyday language)
	Tahoor	Arabic	Deriving from the Arabic word 'tahar' meaning to purify
Chad - The Ngama	Bagne		Used by the Sara Madjingaye

Sara Subgroup	Gadja		Adapted from 'ganza' used in the Central African Republic
Guinea-Bissau	Fanadu di Mindjer	Kriolu	'Circumcision of girls'
	Fanadu di Omi	Kriolu	'Circumcision of boys'
Gambia	Niaka	Mandinka	Literally to 'cut/weed clean'
	Kuyango	Mandinka	Meaning 'the affair' but also the name for the shed built for initiates
	Musolula Karoola	Mandinka	Meaning 'the women's side' / 'that which concerns women'

Other FGM/C-related terms and definitions

Angurya cuts: A form of FGM type 4 that involves the scraping of tissue around the vaginal opening.

Clitoridectomy: Refers to excision of the clitoris.

De-infibulation: (sometimes known as or referred to as deinfibulation or defibulation or FGM reversal): The surgical procedure to open up the closed vagina of FGM type 3.

Excision: Refers to removal of the clitoral hood, with or without removal of part or all of the clitoris.

Infibulation or Pharaonic circumcision: Refers to FGM type 3 (see above), the most extensive form of FGM.

Re-infibulation: (sometimes known as or referred to as reinfibulation or re-suturing): The re-stitching of FGM type 3 to re-close the vagina again after childbirth (illegal in the UK as it constitutes FGM).

Sunna: the traditional name for a form of FGM that involves the removal of the prepuce of the clitoris only. The word 'sunna' refers to the 'ways or customs' of the prophet Muhammad considered (wrongly in the case of FGM) to be religious obligations. Studies show however, that the term 'sunna' is often used in FGM practicing communities to refer to all forms of FGM, not just FGM that involves only the removal of the hood of the clitoris.

Forward, 2006.