2014

NETFA Resource and Activity Guide for working with communities affected by FGM/C

The National Education Toolkit for Female Genital Mutilation/Cutting Awareness

www.netfa.com.au

An electronic version of this publication can be found on the NETFA website.

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The 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. The mission of MCWH is to promote the wellbeing of immigrant and refugee women across Australia, through advocacy, social action, multilingual education, research and capacity building.

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About this Guide

The NETFA Resource and Activity Guide has been developed for use by bilingual peer educators working to support women who may have experienced or been affected by FGM/C. Peer educators or facilitators are community members who share similar social and cultural backgrounds or life experiences with their audience and who have professional training and support in delivering and facilitating education sessions.

This Guide is based on a review of national and international literature related to best practice in working with communities affected by FGM/C. The review led to the development of the 'NETFA Best Practice Guide for Working with Communities Affected by FGM/C', which should be read in conjunction with this Resource and Activity Guide.

Although this Guide has been specifically developed for working with immigrant and refugee women in a community setting, many of the resources and activities provided can also be adapted for working with men on this issues, and could be developed to engage various audiences in a range of settings, including the workplace or the classroom.

Important note to the Guide

The resources and activities provided in this Guide help to raise awareness about the human rights and health impact of FGM/C. However, before you begin planning or delivering health education sessions on this topic it is strongly advised that you contact the coordinator of the FGM/C program operating in your state or territory. At the very least you should be aware that:

- The coordinator of the FGM/C project in your state or territory should be able to help you in planning suitable training for your group and may already be conducting programs which meet your needs.

- You can access the latest news and resources relating to FGM/C prevention and health support by visiting the national website for community education: http://www.netfa.com.au.

You will find the contact details for current Australian FGM/C prevention programs in Resource 3 of this Guide.

Who can use this Guide

The resources and activities in this Guide have been developed for use by peer educators and facilitators, bilingual educators, health educators and community educators, with the support of their relevant health and community organisations. These different terms for community educators are used interchangeably in the Guide, however a more detailed discussion about the importance of using peer educators, and what constitutes a peer educator, can be found in the 'NETFA Best Practice Guide'.

The resources and activities in this Guide have been developed with the expectation that they will be used and delivered by peer educators who have received professional training in facilitation and session delivery.

If you are seeking professional training or development in this area, many state and territory FGM/C programs have training programs specifically designed for peer educators or bilingual health educators. You can also access resources for bilingual health educators across Australian through the Multicultural Centre for Women's Health.

In all cases, the implementation of the resources and activities provided by educators should be underpinned by NETFA Best Practice Principles and professional standards of facilitation and education. As a reference, the Multicultural Centre for Women's Health has developed a set of Quality Standards which guides its bilingual program development, implementation, delivery and evaluation. These 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

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

You will find a copy of the Quality Standards in Resource 3: References and Further Reading.

How to use this Guide

This Guide has been divided into 3 main resources, to provide flexible support to trained peer educators and organisations that deliver FGM/C education and prevention information to women and other members of their community.

i	Introduction	An introduction has also been provided with important general information about preparation, evaluation and delivery of education sessions and events.
1	Resource 1	Resource 1 provides suggestions for reaching or approaching women and other members of communities who may benefit from health information or support relating to FGM/C, or could be recruited as peer educators.
2	Resource 2	Resource 2 is a health promotion program designed for women from communities who may benefit from health education, information or support relating to FGM/C.
3	Resource 3	Resource 3 is a compilation of relevant fact sheets, handouts and activity materials and references to help bilingual health educators in their session preparation.

Introduction

Before you use the resources in this Guide

Please read this section before you use the resources in this Guide. It covers some important issues to consider when planning and implementing a program or event.

Creating a safe and open environment
1. Practical considerations when planning a session
2. Setting ground rules for discussion

How to manage risks
1. What to do in the event of emotional distress of a participant
2. Supporting participants who have experienced trauma
3. What to do in the event of a disclosure
4. Caring for yourself as a peer educator

Creating a safe and open environment
1. Introducing a session
2. Concluding a session
3. Evaluating a session

Creating a safe and open environment

Practical considerations when planning a session

There are a number of practical issues that should be taken into consideration when planning a session or event. Some factors to consider include:

- An appropriate venue: venues should be safe, comfortable and accessible for participants and provide privacy and adequate space for the group
- Disability access
- Childcare options: whether you decide to make the session or event child free because of the nature of some of the discussions, providing childcare for the event will make it more accessible for women
- Availability and easy access to transportation: including consideration of parking fees, parking availability and access to public transportation
- Possible schedule clashes with other community events: religious days, community commitments and parental or work commitments can pose challenges to participants' ability to attend sessions
- If catering for an event, give consideration to cultural and dietary requirements and preferences relating to food (if applicable)

Depending on the size of your group and the availability of additional bilingual peer educators, you may consider the need for qualified interpreters at your event, and the additional time requirements that would be needed for interpreting. If you do need to engage interpreters, make sure you brief them carefully about the nature of the event. Try to ensure that they are culturally and gender appropriate and clarify their attitudes to and understanding of FGM/C.

Setting ground rules for discussion

Openly discussing some ground rules for participation can help to encourage respectful discussion and promote a safe and open environment. Reassuring participants about confidentiality may be particularly important given the personal nature of some of the topics being covered. Some points you may want to raise include:

- Respect people and their diverse backgrounds and lifestyles
- Listen to each other
- Everyone has the right to their own opinion – the goal should not be to agree but to gain a deeper understanding
- Be conscious of body language and non-verbal responses – they can be just as expressive as words
- Participants should take responsibility for the quality of discussion and participate to the best of their ability, including encouraging others and being good listeners
- The facilitator's role is not necessarily to be an expert, or have all the answers, but to guide participants through a discussion in which sharing their own knowledge and experience is important and valuable
- No one has to disclose personal information if they don't want to
- Don't disclose someone else's personal information to the group without permission. If you want to ask about or share a personal story or experience that involves someone you know, don't use their name. You can discuss them in the third person 'someone I know', 'a friend', 'something I heard about'
- You can use stories to maintain confidentiality and to facilitate openness
- You do not have to share information if you don't feel comfortable and you can leave the room or the session at any time
- It is important to reassure participants that as a facilitator you take privacy and confidentiality very seriously. Depending on your obligations, you may need to be clear about any exceptions to confidentiality where required by law (See 'What to do in the event of a disclosure')
- If anyone has personal questions or concerns they do not wish to share they are always welcome to approach the facilitator during a break or at the end of the session

NOTE: At this time you may also want to agree on preferred terminology in the group when talking about FGM/C. Otherwise, you could raise this before delivering Module 3.

Terminology

There are a number of different terms that can be used to describe female genital mutilation/cutting (FGM/C).

The slightly shorter term 'female genital mutilation' (FGM) is sometimes used in Australian and international legislation. The use of the word 'mutilation' is intended to highlight the seriousness of the harm done by the practice to girls and women.

However, many who have undergone the practice prefer terms like female genital cutting (FGC) or female circumcision (FC) because these descriptions are less isolating and stigmatising for women. Of course, in languages other than English the practice is not described in these terms at all.

In line with many international organisations, this resource uses the term 'female genital mutilation/cutting' or 'FGM/C' to reflect the importance of using non-judgemental language that is respectful of individuals who have undergone the practice. Inclusion of the term 'cutting' is not an attempt to excuse or diminish the impact of the practice, but to acknowledge the different ways girls and women might identify or interpret their experience.

Particularly in countries of destination like Australia, best practice health promotion and community development programs have shown that using appropriate language to ensure that communities are not marginalised or stigmatised is more effective in engaging communities and facilitating dialogue.

As a bilingual peer educator, the terminology you use will be influenced by your community. It may be important to discuss and clarify what language the group wants to use when talking about FGM/C. Keep in mind that the language you use to talk about FGM/C is important. Don't be afraid to challenge participants to reflect on their use of terminology, if it is appropriate to do so.

You will find an information sheet about other terms related to FGM/C in Resource 3: References and further reading.

Considering and managing risks

Most bilingual health educators will already be aware of possible risks for participants and for themselves during education sessions. However, given the complex and sometimes difficult emotions and experiences that can surround sexual and reproductive health, it is important and helpful for facilitators to plan in advance how they will manage possible outcomes of sessions. Some issues to consider include:

- What happens if a participant becomes emotionally distressed?
- What happens if the discussion triggers trauma for a participant?
- What if I have concerns that a girl is at risk of FGM/C either in Australia or overseas?

The topic of FGM/C can produce strong emotional responses and opinions among participants. One of the best ways that a bilingual educator can prepare themselves to facilitate difficult discussions safely and responsibly is to be confident and familiar with the material that they are presenting. Being prepared is just as important for the wellbeing of the educator as for participants. Take the time to prepare information and activities and ensure that enough time is allowed in each session to cover the key messages and invite questions and discussion.

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

It is possible that during discussion a participant may become distressed. It is helpful to have a plan in place for responding to their needs including:

- Identifying nonverbal and verbal signs and symptoms of distress and providing appropriate support
- Ensuring that there is a quiet place that the participant can retreat to if they choose
- Ensuring that participants know they can leave the conversation or the room at any time
- Ensuring there is a trained team member available during the session for the purpose of providing support to the participant if needed
- Knowing where you can refer the participant for further counselling if they choose
- Noticing if an individual's distress has affected others in the group, acknowledging the situation if appropriate and, if needed, working through any issues raised with participants

Supporting participants who have experienced trauma

It is possible that discussion may bring up a traumatic experience or event for a participant, which they may or may not choose to discuss.

In many cases a participant may not discuss the cause of their anxiety, even if a memory of past traumatic events has been triggered. They may even hide their anxiety, or it may not be easy to identify through their behaviour.

It is important to recognise that little can be done to prevent certain triggers occurring because they are beyond one's control. However, many things can be done to prevent or reduce likely triggers such as:

- Being honest and upfront about the content you are planning to deliver
- Being clear in your introduction that the information you intend to cover might trigger emotional responses in participants
- Providing a safe and consistent environment
- Using a collaborative and respectful facilitation manner
- Explaining the purpose of activities
- Setting realistic expectations for participation
- Acknowledging and accommodating the barriers to participation
- Creating opportunities to set individually appropriate goals which are attainable
- Providing a quiet place as an alternative to the session
- Providing information about the causes and symptoms of trauma to remove stigma around mental health issues that are often common to, and exacerbated by, settlement and migration

If a participant chooses to talk about their experience it is advisable to:

1. Acknowledge the participant's experience without judgement and without trying to change their feelings or 'make things better'.
2. Recognise that even if the participant raised the experience it may not be possible for that individual to speak further about what happened or acknowledge painful feelings.
3. Offer comfort if intense emotion is expressed.
4. Be sensitive to an individual's sense of what is frightening or overwhelming for them: the elements of a traumatic experience are highly personal and can never be assumed.
5. Ask the participant if they need anything that you can help them with. It is important to demonstrate sensitivity and choose to speak to them at the end of the session.
6. Check in with the rest of the group. Ask them for permission to move on.
7. Ensure that the participant has supports in place (family, friends, community, etc.) outside the session and be ready to provide information about where they can seek further support.

What to do in the event of a disclosure

If you have concerns that a girl is at risk of FGM/C either in Australia or overseas, you may have a legal obligation to report this to child protection services, depending on your profession, and/or an ethical obligation to ensure the safety and protection of any girls or women involved.

Be aware that different legislation applies in different states and territories in relation to mandatory reporting requirements. In general, health professionals and professionals who work with children have a legal obligation to report situations where they consider there is a clear risk to a person's health or safety. As a community worker or peer educator you may not necessarily have a legal mandate to report a situation you consider to

You can find a summary of Mandatory Reporting requirements for each State and Territory in Resource 3. However, it is your responsibility to ensure that you are aware of any changes or updates to relevant legislation.

Depending on the context in which a facilitator is working, it is important to:

- Know and understand any mandatory reporting requirements that relate to your profession
- Know and understand relevant national legislation and legislation in your state/territory
- Know and understand any relevant policies of your organisation
- Discuss issues with colleagues and/or make an agreement about a plan of action to take as a group/ organisation/program

Caring for yourself as a peer educator

Most bilingual health educators will already be aware that it is important to take care of their own health and emotional wellbeing in responding to and facilitating discussions with participants.

Your organisation should have clear procedures in place to support educators in their professional practice and personal development, and it is important to make sure you are aware of the support that is available to you. In particular, a regular debriefing process and support network are invaluable tools for helping facilitators to reflect on challenges and strengths and to use their experiences to constructively inform future sessions.

Conducting and evaluating a session

Introducing a session

As a facilitator, how you conduct an introduction is up to you. However, as a general rule, important information to cover includes:

- Introducing yourself: your name, the name of your organisation, project or program and your role in it
- Providing some general information or background about your organisation, project or program
- Ground rules for the session(s) (see 'Setting ground rules for discussion')
- Introducing the purpose of the session(s)
- Providing an outline of the session, project or program
- Covering any housekeeping issues related to the venue (eg. toilets, security, parking, etc.)
- Discussing your role as a facilitator: it may be important to explain your role as a peer educator and emphasise the participatory nature of the session(s)

It is equally important to introduce participants to one another. This usually involves asking each member of the group to introduce themselves although, depending on the size of the group, you may need to divide participants into smaller groups to save time and make the process more meaningful. The introduction of participants can be conducted in many ways and is often valuable for establishing rapport within the group.

You will find some suggested 'Icebreakers' in Resource 3:
Activity materials, evaluation tools and handouts.

Concluding a session

The end of a session can be a good opportunity to:

- Check that participants have understood material covered during the session
- Collect information that will help you to evaluate a session
- Inform participants about what to expect from the next session

Participants should be given the opportunity to provide feedback about the session or ask further questions. Depending on the number of participants, try to allocate enough time at the end of the session to recap key messages and invite participant feedback.

Some questions to guage participants' responses might be:

- How did you find today's session?
- Is there anything that stood out for you in today's session?
- What are you going to take home with you from this session?
- What will you share with other women from today's session?
- Could you think about anything you would like me to change, modify, and do differently?

Always thank participants for attending and encourage them to come back for the next session.

Evaluation and Forward Planning

Many people think of evaluation as something that happens after a session or event. However, evaluation is an ongoing process and facilitators should think about evaluation at the beginning of planning a project, program, session or event, in order for it to be effective.

Knowing what you want to achieve is essential for effective planning and for evaluation. Consider what specific goals you could set for the session based on your aims and think about how you might test them.

Here is an example of how you might start to think about evaluation and planning:

Goal	How will I achieve this?	How will I test this?
To raise awareness about the health risks of FGM/C	Give a talk for 15 mins and have a brochure available (in community language)	• Count how many women took brochures • Provide an anonymous survey for feedback
To makes sure that participants understand how gender inequity can impact on their health	Deliver three sessions with participants on gender inequity using Resource 2	• Write down comments and feedback from participants. • Ask participants to talk about whether their ideas have changed about gender and health.
To find participants for a health education/ training program	Give a talk about the program and invite people to participate	• Count how many women signed up • Ask for feedback from participants

There are many different methods of planning and evaluation. Choose a method that suits you, your organisation and your initiative. Goals can be short-term or long-term or both.

Methods of collecting evaluation can depend a lot on the capacity of the organisation, peer educators and participants. Be realistic about what information you can collect and then try to be clear about why you are collecting it, how it will help you to evaluate your program and how you will use the information you collect.

If you decide to collect personal information, stories or photographs that you intend to share or publish, it is important that you ask participants' permission. It is equally important to not compromise participants' right to privacy. Make sure that participants are comfortable with the information you collect and provide informed consent before you use it.

Some additional considerations when implementing evaluation with specific communities

Evaluation is extremely important for measuring the success of your program or project, building on successes and future planning. However it can be a time consuming and complex process that can present many challenges, especially for non-English speaking groups. If not effectively managed, these challenges can result in negative outcomes for participants, facilitators and sessions. Some possible challenges may include:

- Difficulty in translating or adapting evaluation tools that have been written for an English speaking audience
- Mistrust or fatigue with evaluation processes such as questioning, form-filling, providing feedback, etc.
- Lack of knowledge or confusion about evaluation processes or about the concept of evaluation in general
- Time constraints for participants and facilitators
- Inadequate (paid) time or resources provided to facilitators to conduct evaluation
- Difficulties in adapting evaluation tools for participant groups with low literacy levels
- Cultural differences in the type of collection process or feedback that is appropriate (for example in some communities providing negative feedback is considered culturally inappropriate)

You will find some suggested evaluation templates in Resource 3: Evaluation Tools

Resource 1
Reaching Communities

About this resource

Because of the privacy surrounding the practice of FGM/C and the health consequences experienced by women who have undergone the practice, it can be very difficult to begin a conversation about the topic without having established rapport with members of a community. Concerns about confidentiality, personal sensitivities around discussing sexual and reproductive issues, fear of stigma or judgement and emotional trauma can all serve as barriers to starting open dialogue about FGM/C. These concerns may be heightened in settings such as Australia where the practice is illegal and unfamiliar to the wider population and where the community is itself dispersed or isolated, such as can be the case in rural settings and among recently arrived migrant groups.

This resource aims to provide some practical suggestions related to reaching communities and recruiting bilingual peer educators. The suggestions are based on international literature and the successes and experiences of Australian FGM/C prevention programs. In line with the recommendations of the 'NETFA Best Practice Guide', this resource has been developed with the expectation that community members would necessarily play a leading role in the process of initiating a conversation about FGM/C among the community. This resource covers:

Where to start	Holding a Cultural Day	Planning your Cultural Day	Promoting and managing your Cultural Day
Designing Cultural Day Program Content	Evaluation and Forward Planning		

Where to start

Across Australia there is a diverse range of health resources and programs available to support and educate new and established migrants about FGM/C. However, for many reasons it can be difficult to reach individuals and develop networks within immigrant communities.

Providing ongoing professional training and development for peer educators has been shown to be one of the most effective ways to raise community awareness about FGM/C as a harmful practice and support lasting change among community members.

Finding and recruiting women and men who want to raise FGM/C awareness in their community may seem like a daunting task if you do not already have connections within that community.

Some things that you can do to start the process might be:

- Get in touch with FGM/C programs operating in your state or territory
  If you are a service provider that thinks a group in your local area may benefit from information about FGM/C, your first step should be to get in touch with current FGM/C programs in your region. Many of these programs already provide free bilingual education on FGM/C, professional training and multilingual resources. They may also have data and suggestions about the audience you may want to target. You will find a list of current programs around Australia in Resource 3.

- Check your demographics
  There is often data available on the size of migrant communities in your region. While these figures do not reflect the prevalence of FGM/C, they can indicate communities that may potentially benefit from education about the risks of FGM/C and information about where to access support. Knowing which countries and ethnic groups have previously practiced FGM/C will be instructive in choosing potential groups to target, but it is important not to make assumptions about prevalence of the practice in any community or cultural group. FGM/C can cross religious, geographic and cultural boundaries and can occur in communities where it has not been a traditional practice, just as it can be an abandoned practice in communities where it was once widely accepted.

- Speak to community leaders, both female and male
  Be aware that not all community leaders may feel comfortable talking about FGM/C or necessarily support its prevention. Make sure you clarify your views and establish their position to ensure a good working relationship.

- Speak to women's organisations
  State and regional women's organisations may have contact with women in emerging communities or be aware of activities or groups you could link with.

- Speak to multicultural and ethno-specific organisations
  Ethno-specific and multicultural organisations are likely to be well connected and well informed about the issues affecting their local community and be aware of activities or groups you could link with.

- Speak to migration and settlement services
  If you are finding it difficult to reach a new community, migrant and settlement services may provide a good point of contact or be aware of activities or groups you could link with.

- Speak to schools and other educational settings
  TAFEs, language schools and universities might be able to link you to relevant student groups.

- Speak to school nurses, social workers and other community health professionals who engage in outreach.
  Local and community health professionals may also be able to identify groups or individuals you could link with.

Holding a Cultural Day

Once you have made some initial contacts, you may still be unsure about how to generate interest in starting a discussion about FGM/C prevention within a particular community.

One successful strategy employed by the NSW Program in Australia has been to hold Cultural Days. Developed in consultation with bilingual peer educators, Cultural Days are designed to enable women in specific communities to come together to celebrate their communities and cultural identities and to raise awareness about human rights and Australian legislation against FGM/C. The Cultural Day is also an opportunity to promote an extended education program about women's health and FGM/C and to invite women to sign up.

A Cultural Day should be thoughtfully tailored to suit each specific community and should be designed in close consultation with community leaders, community organisations, bilingual peer educators and community members. Ideally, it would be beneficial to collaborate with organisations that have specific expertise in FGM/C.

Depending on the community, facilitators may begin by holding a Cultural Day for families, or choose a significant cultural event or international day to use as a focus for activities (e.g. International Day of the Child; International Women's Day). There may also be different communities that feel culturally connected and could participate in the same event (for example, NSW has held an Ethiopian and Eritrean day). However, in most cases it is more effective to hold events that are community and gender specific, particularly if the topic of FGM/C will be raised. Decisions such as these are best made by or in close consultation with the community.

Aims of the Cultural Day

- To reaffirm cultural or ethnic identities and positive cultural traditions and practices
- To celebrate the community in your local area in a fun and dynamic way
- To bring community members together to further develop links and support networks
- To raise awareness about the health risks associated with FGM/C and available support
- To raise awareness and support for the global campaign to end FGM/C
- To raise awareness about the human rights and Australian legal position on FGM/C
- To get feedback and ideas about effective ways to engage the community
- To identify potential champions of ending FGM/C among the local community
- To identify community members who are interested in becoming peer educators

Planning your Cultural Day

See the introduction to this Guide for detailed information on planning a session or event.
The 'NETFA Best Practice Guide' can help you to plan your event based on the following Best Practice principles:

1. Community engagement: Consider the audience you would like to engage: would you like the day to be culturally specific in its focus? Would you like it to be gender specific or to include the whole community? Would you like to focus on youth? Tailor your activities appropriately, and as much as possible, enlist community members who belong to the demographic you are interested in inviting to the Cultural Day.

2. Community leadership: Consider your capacity to plan the event. Engage community members to assist in identifying local needs and to implement an appropriate program for the day.

3. Holistic and integrated education: Think about how you can best communicate your messages about FGM/C to your audience on the day. Introducing FGM/C under a broader theme of human rights, women's rights, gender equality and/or sexual and reproductive health may be less confronting for some participants.

4. Peer education and training: If you are not a peer educator from the community you would like to invite, consider linking with trained peer educators or with other organisations that can provide this service. When selecting people to speak or facilitate the event, consider their familiarity with the community they will be addressing and their understanding of the topic.

5. Cultural dignity: When developing your day, it is important to ensure that public forums have clear and understood rules for participation and facilitators maintain individuals' right to privacy and respectful treatment.

6. Building the capacity of relevant professionals: Relevant professionals from various sectors can benefit from understanding cultural and social attitudes related to FGM/C. If appropriate for the event, invite relevant professionals (e.g. general practitioners, school nurses, teachers, or local government workers) to take part in the day's activities and hear the voices of their local community.

7. Women's empowerment: Ensure that the day focuses on women's and girls' empowerment. The program should promote immigrant and refugee women's achievements and/or help to build the capacity of women's community organisations.

8. Collaboration: Maximise opportunities to work in collaboration with multiple stakeholders during the planning and/or delivery of the event. Involve relevant community groups and individuals, health services, refugee support and settlement services and other non-government services to be part of the organising committee.

9. Research and evaluation: Ensure evaluation is part of the event planning. Establish a process for collecting participants' feedback before, during or after the event.

Cultural Day Program Content

Cultural content

The Cultural Days are intended to attract as many community members as possible, so including fun social events that connect them as a community is key.

Some of the cultural activities developed in consultation with each community have included:

- Traditional dancing
- Traditional stories and jokes
- Fashion parade of traditional costumes
- Singing or music traditional to the culture
- Other cultural traditions (e.g. Coffee ceremony and hair plaiting for Ethiopians and Eritreans)

Educational content

The Cultural Days are an opportunity to introduce women to your program or organisation and to raise awareness about FGM/C prevention. Try to incorporate information throughout the program, without overwhelming participants. Information could be related to:

- Reflecting on what culture is
- Discussing challenges of migration
- Presenting information about gender inequality around the world and encouraging women to speak out
- Discussing FGM/C and the efforts to prevent the practice around the globe, including in their home region
- Introducing the work of your organisation and links to further education, information and support
- Inviting participants to attend a more detailed education program (See Resource 2)

NSW program Egyptian cultural day program	
Saturday 1 November 2008	
9:30	Registration
10:00	Welcome (with interpreter)
10:20	Housekeeping
10:30	Talk about Egyptian culture
11:00	Jokes
11:15	Global issues affecting women
11:30	Egyptian belly dancer
11:45	FGM/C and human rights
12:00	Lunch
1:00	Introduction to film
1:10	Film screening: “Season of planting girls”
1:50	Focus group discussion
2:15	Exercise session
2:30	About the NSW Program
2:45	Music and dancing for all
3:30	Raffle

The NSW Program held Cultural Days for 8 communities: Egyptian, Kurdish, Sierra Leonean and Liberian (together), Ethiopian and Eritrean (together), Sudanese and Somali. You can read more about the specific cultural activities chosen, event promotion and feedback from the Cultural Days in the NSW Report.

Resource 2
Facilitating a health promotion program with an FGM/C focus

About this resource

Resource 2 is a flexible tool for planning and delivering a health promotion program of education sessions that are designed to encourage thinking and discussion about FGM/C.

The program provided in this resource was written with a focus on educating and empowering groups of women from communities who may benefit from health information or support relating to FGM/C (See NETFA Best Practice Principle 3: Empowering Women). Although this program is designed to be delivered specifically to women, it can also be adapted for men's groups or a wider audience.

The program has been developed for use by bilingual peer educators, working in close consultation with members of their community (See NETFA Best Practice Principle 2: Community Leadership). It is assumed that peer educators using this resource have prior training in facilitation and have read the Introduction to this Resource and Activity Guide and the 'NETFA Best Practice Guide for Working with Communities Affected by FGM/C.'

Although this program can be delivered as a whole, it has been structured in a way that may also be adapted to suit educators who need to develop shorter programs or conduct stand-alone sessions. The program covers essential topics related to health and human rights but can be complemented by other topics that educators want to include which are not covered in this resource.

Although not all of the learning modules in this program refer explicitly to FGM/C, the discussion points, key messages and activities are designed with the intention of creating opportunities for discussion and education about the issue of FGM/C as a serious risk to women's sexual and reproductive health; as a violation of human rights; and as a practice which can be ended if women take an active role in leading change.

Program Aims	Program Approach	How to use this resource	
Module 1: Women's health and human rights	Module 2: Everyone's right to sexual and reproductive health	Module 3: Female Genital Mutilation/ Cutting	Module 4: Advocating for health, rights and gender equity

Program aims

1. To discuss the ways in which female genital mutilation/cutting (FGM/C) impacts women's health and rights
2. To discuss ways to support and promote the global abandonment of the practice of FGM/C
3. To learn about women's sexual and reproductive health and how understanding sexual and reproductive health supports women to make informed decisions about their health and the health of their family
4. To learn about women's sexual and reproductive rights and how knowing these rights can empower women to make informed decisions about their wellbeing

Program approach

"Successful programs and initiatives show that the most appropriate and effective way to engage the community on the issues about FGM/C is to introduce the topic within a wider context. Approaching the topic directly can be confronting and unproductive for participants who may never have discussed the issue before and who may consider the subject taboo.

The topic is most effectively integrated within programs as part of a holistic approach to increasing women's and girls' health, wellbeing and independence."

(NETFA Best Practice Principle 4: Holistic and Integrated Education)

Unless you have already established a relationship of trust with your group, or have been specifically invited to speak on the topic of FGM/C, best practice literature suggests that the topic of FGM/C should be framed within a wider context relating to women's health and/or human rights. Raising the issue of FGM/C without established trust or proper context has been widely recognised as ineffective and can potentially have negative consequences for participants. For this reason, the health education program provided in this resource has been developed to address the topic of FGM/C from a number of perspectives including gender equity, human rights and sexual and reproductive health.

For many women who have undergone FGM/C, that experience is not the sole defining feature of their sexual and reproductive health or their wellbeing. Not all women who have undergone FGM/C will have experienced negative health outcomes. Contextualising the issue of FGM/C within the larger issues of sexual and reproductive health and human rights allows women to reflect on their individual experiences and empowers them to make informed decisions about their health and wellbeing, which includes reflecting on the impacts of FGM/C for themselves and for their community.

How to use this resource

Before you use this resource, please read the introduction to this Guide for important information about preparing and managing your program.

Program structure

The program suggested in this resource consists of 4 modules, which can be delivered over a number of separate sessions, or combined into a full day or weekend.

Each module is divided into 3 main topics, which can be delivered together or separately depending on the time available and how peer educators choose to run sessions.

Module 1: Women's health and human rights
a. What do we need to be healthy? b. What are human rights? c. Gender and human rights
Module 2: Everyone's right to sexual and reproductive health
a. What is sexual and reproductive health? b. Cultural expectations about sexual and reproductive health c. Knowing about your sexual and reproductive body
Module 3: Female Genital Mutilation/Cutting
a. What is FGM/C? b. What are the causes of FGM/C? c. What are my rights in relation to FGM/C?
Module 4: Advocating for sexual health, rights and gender equality
a. Your right to health information and services in Australia b. What health services are available to me and how can I access them? c. How can I advocate for women's sexual and reproductive rights?

The length of each module is intended to be flexible, and can be adjusted depending on the activities selected by the peer educator and the time available (as a guide, we suggest allocating at least 2 hours for each module).

Although the program has been designed to be delivered in sequence, it can also be used as a guide for peer educators developing their own programs or facilitating individual sessions.

Module Structure

The 4 modules in this program are designed to be flexible for educators. At the beginning of each module, you will find:

General aims: To guide facilitators in developing session goals and objectives for themselves and participants	**Aims relating to FGM/C:** To guide facilitators in helping participants to make connections between general material and FGM/C	**Module topics:** A brief summary of module topics to help facilitators to contextualise sessions	**Suggested session plan:** Provided as a guide only

Suggested audiovisual resources for educators are provided at the end of each module where available.

For each topic you will find:

Discussion points

The discussion points in this resource provide a focus for each topic and can be used as a way of facilitating discussion among the group, communicating key messages and signposting what is coming ahead. Many discussion points do not have simple or single answers and are designed to provoke participants to think through issues for themselves. Choose activities that help to trigger discussion like brainstorming, case studies, agree/disagree exercises or short films.

Key messages

The key messages in this resource are not exhaustive and are not intended to be prescriptive. They provide information which will help the peer educator to guide discussion, based on the discussion points. Key messages might be used to punctuate a relevant discussion or activity, or to bring a new perspective to the discussion.

Activities

The activities in this resource have been selected in order to support discussion and encourage participants to think through the discussion points. Peer educators may prefer to design their own activities, or adapt these activities to suit their group.

Program Topics

Module 1: Women's health and human rights

1A: What do we need to be healthy?

This topic encourages participants to think about health more broadly and understand the ways in which health is influenced by many social, political, economic and cultural factors.

1B: What are human rights?

This topic introduces the concepts and principles behind human rights and encourages participants to see the ways in which these rights help us to enjoy health and wellbeing.

1C: Gender and human rights

This topic leads on from the discussion of human rights to further consider the way that perceptions of gender can be a barrier to women sharing equal rights to health and wellbeing.

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

2A: What is sexual and reproductive health?

This topic introduces sexual and reproductive health and encourages participants to see the connection between sexual and reproductive rights and our ability to experience health and wellbeing.

2B: Cultural expectations about sexual and reproductive health

This topic encourages participants to consider the ways in which cultural expectations and attitudes to gender can impact sexual and reproductive health.

2C: Knowing about your sexual and reproductive body

This topic covers basic information about women's sexual and reproductive organs and functions.

Module 3: Female Genital Mutilation/Cutting

3A: What is FGM/C?

This topic introduces the discussion of FGM/C by covering the different types of FGM/C that women may have experienced and covering the health risks and health consequences of FGM/C.

3B: What are the causes of FGM/C?

This topic broadens the conversation about FGM/C to consider why there is social pressure to practice it in some cultures and encourages participants to see the relationship between FGM/C and gender expectations.

3C: What are my rights in relation to FGM/C?

This topic encourages participants to understand FGM/C as a violation of girls' and women's sexual and reproductive rights, covers Australian and international laws and considers strategies and examples of positive change.

Module 4: Advocating for health, rights and gender equity

4A: Your right to health information and services in Australia

This topic covers every Australian's right to access health services.

4B: What health services are available to me and how can I access them?

This topic provides information about local health services, navigating the health system and where to find resources relating to their sexual and reproductive health.

4C: How can I advocate for women's sexual and reproductive rights?

This topic encourages participants to consider ways they can advocate for improved gender equality and support women's sexual and reproductive rights in their community.

Facilitating sessions

This resource is based on the understanding that learning is an active and ongoing process. Learning is not something that happens to people and learners are not simply empty containers that can be filled up with new information. Learning comes from experiencing, thinking and reflecting. Each participant will bring their own ideas, values, beliefs, knowledge, personal experiences and learning style to sessions. Equally, each participant will take something different from sessions, and will develop their own understanding and point of view.

In order to allow for flexibility and to cater for a wide range of contexts and learning styles, discussion points have been provided to assist you in facilitating the sharing of stories, starting discussions and communicating the key messages.

There are many effective techniques for encouraging and supporting interactive learning. Using diverse methods will allow you to reach a wider range of participants with different learning styles. Some of the methods that you might choose to use in your sessions are:

Sharing stories

Telling stories can help participants to understand and relate to a particular experience, idea or perspective. Sharing narratives can be a good way of relating concepts to lived experiences, as well as encouraging participants to reflect on and share their own experiences. Stories help us connect with each other.

Screening videos

If you have the technology and equipment available to show participants a short video, this can be a very effective way to trigger discussion or reflection on topics.

Conducting activities

The activities presented in this resource cover a wide range of different learning methods. They can be useful for triggering group discussion and, depending on the activity, can allow group participants to interact more closely in pairs or smaller groups. Activities that get participants moving around can also be a great way to energise the group.

Using visuals

Using visual aids wherever possible can be an important and interesting way to help communicate your messages, particularly for communities who have experienced disrupted education or have low literacy levels.

Being flexible and taking opportunities

Although it is important to aim to meet the objectives of the session, don't be afraid to be flexible if the group discussion takes an interesting turn. Listen to the group and feel free to ask them for feedback about ways they would like to approach the material.

What is my role as a facilitator?

As the facilitator it is your role to support participants to build on their existing knowledge and experience and to encourage them in their learning.

You should aim to:

- Build rapport between you and the participants
- Build trust and respect between participants and to ensure that everyone feels comfortable and safe
- Support participants in handling any problems that may arise during the course of sessions
- Ensure that privacy and confidentiality are understood and respected by the group
- Create an environment for learning, sharing and growth
- Provide focus and encourage the participation of all members
- Provide information and resources necessary for the participants to build on and use
- Monitor group dynamics and progress and ensure that the group reaches its goals

Keep in mind that a lot of the content covered in this resource touches on issues that can be very personal and may not have been discussed by participants before. Equally, participants could bring views, perspectives and experiences that they have never critically reflected on, and they might find parts of the program challenging. As a facilitator, it is not your role to judge, but to foster an environment in which participants feel safe to challenge themselves, be open to new information and express themselves without fear.

Module 1:
Women's health and human rights

General aims

- To encourage participants to think about health as central to our everyday lives
- To explain how social, economic, political and cultural factors influence our health
- To provide an overview of human rights and they ways in which they are protected as legal rights in national and international laws
- To introduce the topic of gender and identify ways in which gender inequality can impact on women's health and human rights
- To encourage participants to see the connection between rights and our capacity to experience health and wellbeing
- To provide an overview of human rights that specifically protect women and why they exist

Aims relating to FGM/C

- To encourage participants to recognise the ways in which FGM/C can impact women's health throughout her life
- To raise awareness about human rights that are relevant to the practice of FGM/C
- To encourage thinking about the way that gender norms can negatively impact women's health and wellbeing, including perpetuating the practice of FGM/C
- To encourage women to recognise that gender norms around FGM/C can be challenged and changed

Module Topics

1A: What do we need to be healthy? This topic encourages participants to think about health more broadly and understand the ways in which health is influenced by social, political, economic and cultural factors.

1B: What are human rights? This topic introduces the concepts and principles behind human rights and encourages participants to see the ways in which these rights help us to enjoy health and wellbeing.

1C: Gender and Human Rights This topic leads on from the discussion of human rights to further consider the way that perceptions of gender can be a barrier to women sharing equal rights to health and wellbeing.

Example session plan

Activity	Time
General introduction and icebreaker activity	10 minutes
Setting ground rules and housekeeping (see the introduction to this resource)	5 minutes
Topic 1A: What do we need to be healthy? Suggested Activities: • Activity 1A.1 What do we need to be healthy and well? • Activity 1A.2 Basic Needs • Activity 1A.3 Social determinants of health	20 minutes
Topic 1B: What are human rights? Suggested Activities • Activity 1B.1 Understanding and Identifying Human Rights • Activity 1B.2 Human rights case studies	20 minutes
Break	15 minutes
Topic C: Gender and Human rights Suggested Activities • Activity 1C.1 Gender or sex? • Activity 1C.2 Power, privilege, equality • Activity 1C.3 Memory Journey	40 minutes
Evaluation, outline of next session and close	10 minutes
Total time	2 hours

1A: What do we need to be healthy?

Discussion Points

- What does it mean to you to be healthy?
- What basic needs does every person need to experience health and wellbeing?
- What factors can influence our health and wellbeing over the course of our lives?

See Resource 3 Handout 1A: 'What are social determinants of health?'

Key messages

1. **Being healthy means more than not being injured or unwell.**
   In the past, being healthy was often thought of in terms of being free from illness, injury or pain. The World Health Organisation (WHO) defined health in its broader sense in 1946 as "a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity…"

2. **Health is influenced by biological, psychological and social factors.**

3. **Cultural and social attitudes and beliefs can have a strong influence on the way we envision and understand our health.**
   Many of our ideas, beliefs and attitudes about our health come from the culture and society in which we grow up and live. Culture is more than our customs, language or traditions. Culture is a shared system of meaning built on a changing mixture of values, beliefs, ideas and attitudes that we learn from our family; education; work; and economic, social and political frameworks and institutions.

4. **All over the world both men and women experience barriers to enjoying good health.**

5. **Some barriers to health are connected to the economic and social conditions in which people grow up. These conditions are sometimes called the social determinants of health.**
   The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. (WHO, 2014)

Activity 1A.1
What do we need to be healthy and well?

Objective: To encourage participants to understand that there are many aspects in our lives that directly or indirectly impact on our health and wellbeing and that health is not only about feeling good physically, but also about our mental, emotional and spiritual states.

Duration: 15 minutes

Preparation and materials: Whiteboard and markers, or butcher paper and pens.

Instructions:

1. This brainstorming activity can be conducted all together or in smaller groups. Ask participants: 'What do we need as humans to be healthy and well?'
2. Allow 5-10 minutes for discussion and jotting down ideas. Then ask participants to report back to the rest of the group on their ideas.
3. Write the answers on the board. Educators may ask participants to explain why the things they need are important for their health. Educators can use participants' feedback to discuss the importance of understanding health more broadly.

Activity 1A.2
Basic Needs

Use Resource 3 Activity 1A.2: Basic Needs cut-out cards

Objective: To introduce participants to human rights by allowing them to reflect on some basic human needs and reflect on their fundamental importance for every person's health and wellbeing.

Duration: 20 - 40 minutes depending on the size and number of the group(s) and how much time you want to allow for discussion. This could be a longer activity if you have time.

Preparation and materials: A set of 'Basic Needs' cut-out cards for each group. (See Resource 3). These cards need to be prepared in advance and are easier to work with when laminated.

Instructions:

1. To prepare participants for the activity you may begin by quickly brainstorming the question: 'What are our basic needs for living?' or using Activity 1A.1: What do we need to be healthy and well? Otherwise, you can simply introduce the activity by explaining that we all have basic needs and this activity will consider the importance of these needs for each of us.
2. Ask participants to move into small groups and give each group a set of the pre-prepared 'Basic Needs' cards. If you have a small group, you can run this activity as one group, but it may help to make larger cards.
3. Ask participants to organise the cards in order of importance and discuss why they chose this order.
4. You can bring the groups back together to share and compare their decisions and discuss basic needs further if time allows. You can conclude the activity and lead into a discussion of human rights by asking participants if they think everyone should have the right to these basic needs.

Activity 1A.3
Social Determinants of Health

Use Resource 3 Activity 1A.3: Social determinants of health scenarios

Objective: To encourage participants to identify some of the ways that social, economic and cultural factors can influence their health.

Duration: 30 minutes

Preparation and Materials: Whiteboard and markers, or butcher or poster paper and pens.

Instructions:

1. Explain to participants that they will be moving into groups or pairs to discuss the question: 'How might aspects of your daily life affect your health?'

2. Divide participants into pairs or small groups and provide each group with some pens and a piece of butcher paper. Ask each group to write a different theme in the centre of their piece of paper. Themes you could use are: your job; your house; your education; your access to transport.

   Ask each group to consider the main question in relation to their theme. Some other questions you might ask are:

   a. What factors might mean that this aspect of your life is a hazard to your health?

   b. What factors might mean that this aspect of your life is a benefit to your health?

   c. What difference might it make to your health to not have a job/a house/an education/access to transport?

3. Allow 10-15 minutes for discussion and putting down ideas and ask them to report back to the rest of the group. Another way you could structure this activity is to hold a 'Conversation Café.' Each group nominates a 'writer' or 'facilitator' for their theme. The groups discuss their theme for 5 minutes. Then each group moves to the next theme, leaving the facilitator behind. The facilitator summarises what has been discussed for the next group who can add their own views and ideas to the discussion. The process continues until every group has looked at each theme.

4. As an extension of this exercise, you may choose to provide some scenarios to the group using the 'Social Determinants of Health scenarios' (see Resource 3). Ask a participant to read out one of the quotes. Then ask participants to nominate which social determinants or other factors could be affecting this person's health and why. This extension exercise is designed to demonstrate how the social determinants often overlap or intersect with one another, showing that there are many factors that influence our health.

1B: What are human rights?

Discussion points

- What are human rights?
- Who has human rights?
- Why are human rights important?
- What stops people from living with all the human rights to which they are entitled?

See Resource 3 Handout 1B: Summary of the Universal Declaration of Human Rights

Key messages

1. **Human rights are the basic freedoms and protections we are all fundamentally entitled to as human beings. These rights include, but are not limited to:**
    - Equal treatment under the law
    - Food, water, shelter, and clothing
    - Being treated with respect and dignity
    - Freedom from torture
    - Freedom of expression
    - Freedom of thought, conscience and religion
    - The right to assemble and participate in society
    - The right to education
    - The right to health, including accessing health information and services
2. **Human rights are universal.**
   Human rights apply to all human beings, regardless of sex, race, age, colour, ethnicity, gender identity, marital status, sexual identity, physical or mental ability, social or economic status, political beliefs, religious beliefs, citizenship status, country of origin or health status. It doesn't matter where you live or have lived in the world for human rights to apply to you.
3. **Basic human rights are often protected as legal rights in national and international law.**
   The Universal Declaration of Human Rights (UDHR) was established by nations of the world in 1948. It sets the basic rights and freedoms of all women, men and children, and forms the basis of many legally binding international and national laws. Some of these are:
    - The International Covenant on Economic, Social and Cultural Rights (ICESCR, 1966) recognises socio-economic rights such as the right to education, housing and to health.
    - The International Covenant on Civil and Political Rights (ICCPR, 1966) which ensure rights such as freedom to speech and freedom from torture.
    - International Convention on the Elimination of All Forms of Racial Discrimination (ICERD, 1969) undertakes to eliminate racial discrimination in all of its forms.

4. Although everyone is entitled to basic human rights, not everyone can access them.
   Part of the responsibility for protecting, respecting and fulfilling human rights rests on governments. In reality, however, countries vary in the degree to which they fulfil this responsibility. For example, some governments have passed laws that restrict the rights of certain people, for example:

   - Outlawing political protest
   - Prohibiting labour-union organisation
   - Criminalising same-sex sexual activity between consenting adults
   - Pardoning or treating lightly the murder of a girl or woman in cases which are perceived to relate to a matter of 'honour'

   An individual's social and economic status may also limit their ability to enjoy their rights.
   For example, a person's nationality, sex, race, religion, sexual identity, age, caste or class, political view, health status or physical or mental ability can influence their opportunity to:

   - Get an education and earn a living
   - Live free from violence
   - Be treated with dignity
   - Access basic needs

5. The government has an obligation to make sure our human rights are protected by implementing appropriate laws.
   Human rights involve both rights and obligations. States assume obligations and duties under international law to respect, to protect and to fulfil human rights.

   - The obligation to respect means that States must refrain from interfering with or curtailing the enjoyment of human rights.
   - The obligation to protect requires States to protect individuals and groups against human rights abuses.
   - The obligation to fulfil means that States must take positive action to facilitate the enjoyment of basic human rights.

6. Just as we are each entitled to human rights, we have an individual responsibility to respect the rights of others equally.
   Human rights are only effective when they are supported by the law and enforced by our own awareness and support for them.
   Often when we have grown up learning to hold negative attitudes towards a certain group of people, we may treat them unfairly or unequally and deny them their rights.

   Some ways in which people are unfairly treated include:

   Stereotyping: When people attach a set of characteristics to a certain group of human beings. Stereotypes are typically inaccurate or distorted. Stereotyping makes us less able to see others as fully human or as individuals. It makes us more likely to condone unfair treatment of others.

   Stigma: When people are subject to severe social disapproval because of their personal characteristics, or because of presumed character traits or behaviour. Stigma sets individuals apart and can lead to discrimination and prejudice. (e.g. stigma around mental health)

   Discrimination: When people are treated unfairly because of their presumed or actual membership in a certain group or category. People have a right to live free from discrimination.

Activity 1B.1
Understanding and Identifying Human Rights

Use Resource 3 Activity 1B.1: 'Identifying human rights' worksheet
Use Resource 3 Activity 1B.1a: 'Identifying human rights' answer sheet

Objective: To encourage discussion about human rights concepts and identify a number of fundamental human rights.

Duration: 10 - 15 minutes

Preparation and materials: Butcher paper, markers, copies of the 'Identifying human rights' worksheet for each participant and a copy of 'Identifying human rights' answer sheet for your reference (see Resource 3).

Instructions:

1. As a group or in pairs, ask participants to categorise the 'rights' outlined in the worksheet and identify which of them are human rights. Use the answer sheet as a guide.
2. Go through the sheet as a group and invite participants to discuss what distinguishes human rights from others, why some rights are human rights and why some are not.

Activity 1B.2
Human rights case studies

Use Resource 3 Activity 1B.2 ‘Human rights case studies’

Objective: To enable participants to identify and discuss real examples of instances involving violations of human rights.

Duration: 30 - 60 minutes

Preparation and materials: Whiteboard, copies of the case studies you want to use (see Resource 3).

Instructions:

1. Using the case studies provided in Resource 3, or using your own, ask one of the participants to read aloud the first part of the case study.
2. Ask participants to discuss the case study, using the following questions as a guide:
    a. How does the story make you feel?
    b. What human rights relate to this case?
    c. Do you think this represents a human rights violation? Why?
    d. Who is responsible? Consider everyone who bears some responsibility for what happened.
3. Ask the same participant to read the second part of the case study “What happens next?”
4. Ask participants to discuss the second part of the case study, using the following questions as a guide:
    a. How do you feel about the outcome?
    b. What attitudes need to change to protect this human right?
5. You might choose to conclude by asking:
    a. Do you know of other cases or examples like these? Which rights were violated?
    b. What must be done to stop such violations?

1C: Gender and Human Rights

See Resource 3: Summary of the Convention on the Elimination of Discrimination Against Women

Discussion points

- What is gender?
- How does gender affect the way people behave and are treated in societies?
- Do you think these issues would be considered a human right?
- What challenges or dangers do you think women face in Australia or elsewhere? Are these challenges different for men?

Key messages

1. **In every society, gender norms and gender roles influence people's lives, including their sexual and reproductive lives.**

2. **Gender roles are socially constructed and learned. They are not innate or 'natural' or fixed.**

3. **Within any culture or society, people have varying attitudes about gender roles and gender equality.**

   Apart from the fact that every individual is entitled to their own opinion, factors that can influence people's attitudes about gender include their level of education, religious beliefs, political beliefs and upbringing. Beliefs about gender also vary from one culture (or society) to another and between ethnic and religious groups within cultures.

4. **Rigid gender roles affect how people treat each other and contribute to discrimination, violence and many other social problems.**
   - People who do not conform to dominant gender norms may be isolated or suffer threats or violence.
   - People who identify with a gender identity different from the one with which they were assigned at birth, or who feel ambiguous about their gender identity may be subject to stigma.
   - Women around the world are known to suffer discrimination on the basis of gender, which disadvantages them in many ways.

5. **All human rights are important and relevant, but there are specific human rights issues relevant to women.**
   Due to stereotypes, social structures, traditions and beliefs about women's role in society, many women do not have the same opportunity as men to enforce their equal rights. Issues which affect women include:

Discrimination: Treating a person unfairly or differently. People are discriminated against for many reasons including their gender: also race, pregnancy, disability, religious beliefs, sexual orientation and other statuses.

Violence: Domestic or family violence can include verbal or physical abuse, including sexual abuse, social isolation, financial abuse, emotional abuse, intimidation, or any other behaviour that causes fear.

Sexual harassment: Unwanted or unwelcome sexual behaviour that makes a person feel intimidated, humiliated, offended or uncomfortable.

Unequal participation in the workforce: unequal pay, on average women have lower earnings than men all over the world. In Australia, women earn 17.4% a week less than men (ABS, 2009). Globally, women make up half the world's population, work two thirds of the world's working hours, yet earn only 10% of the world's income (World Development Indicators, 1997, Womankind Worldwide)

Unequal participation in education: many women have less opportunity to receive an education due to social and gender roles.

Sexual and reproductive health (bodily autonomy): lack of access to contraception, lack of education about sexual and reproductive health, forced or early marriage, sexual assault within marriage, and practices affecting sexual and reproductive health like FGM/C.

Access to goods and services: Some examples include discrimination faced by newly arrived immigrants seeking rental accommodation; no access to interpreters in health care services

The violation of rights can occur anywhere and everywhere:

- Workplace
- Home – in families, between husband and wife, ageing parents and adult children
- Goods and services such as hospitals, banks, shops
- Educational or religious institutions

6. **Because of the need to address gender inequality, there are legally binding human rights specifically related to women and girls.**

    - The Convention on the Elimination of Discrimination Against Women (CEDAW, 1979); and

    - The Convention on the Rights of the Child (CRC, 1989)

    Australia recognises the need for full gender equality. The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) recognises that discrimination and inequality against women exists, and therefore protects a broader range of human rights.

    By following CEDAW, Australia has committed to promoting policies, laws, organisations, structures and attitudes that ensure women have equal rights as men.

Under CEDAW, women have the right to participate in politics and public life, to equal opportunities in education and training, to employment without discrimination, to equal access to health services and financial credit, and to freedom from violence.

The Equal Opportunity Act 2010 (EOA) helps to identify and eliminate discrimination, sexual harassment and victimisation. It does this by making reasonable adjustments in the areas of employment, education and service provision to eliminate discrimination.

"The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence…" (Beijing Platform for Action, 1995. Paragraph 96)

7. Globally, achieving gender equality is recognised as a matter of human rights.

Gender equality benefits everyone, regardless of their gender.

Activity 1C.1
Gender or sex?

Objective: To differentiate between sex (biological) and gender (socio-political) differences between men and women and emphasise the changeability of gender roles and responsibilities.

Duration: 20 - 40 minutes

Preparation and materials: White board or butchers paper, pens or markers.

Instructions:

1. Ask the participants to quickly brainstorm words or characteristics that are generally associated with men and then repeat for women. This can be done either in small groups using butcher paper or with the whole group using a white board. If it is a large group, make sure both lists are visible for comparison.

2. As a group, draw two columns for “men” and “women” and divide the columns into two parts labelled “biological” and “social”.

3. Using the list of brainstormed words for men, ask the group to indicate which words relate to a biologically determined traits and which relate to a characteristics that are socially determined. Repeat this with the list of brainstormed words for women.

4. Discuss the outcomes as a group. While some characteristics are biologically determined, most are socially determined.

5. Explain that gender refers to socially assigned roles and expectations. These roles are not determined by any natural or biological necessity but have become accepted or ‘normalised’. Some people challenge these social roles either by choice or by necessity.

6. Ask the group to think of a couple of examples of changing gender roles.

7. If appropriate, you may also want to compare the lists and discuss the different associations given to men and women.

Activity 1C.2
Power, privilege and equality

Objective: To enable participants to discuss power arrangements in society, to identify how holding power relates to the experience of privilege, discrimination and oppression, and to relate these issues to their own lives.

Duration: 20 - 40 minutes

Preparation and Materials: Whiteboard or butcher paper, markers. Add any groups to the following list that may be relevant to your particular community. Complete this list before the session begins:

- Groups that tend to have unequal power in society:
- Rich people / Poor people
- Men / Women
- Heterosexual / Homosexual
- Boss / Worker
- Politician / Community Worker
- Citizen / Refugee
- People without disabilities / People with disabilities
- Majority ethnic groups / Minority ethnic groups
- Majority religious groups / Minority religious groups
- People considered attractive / People considered unattractive

Instructions:

1. Draw a chart with two columns. Label the first column 'greater power/privilege' and the second column 'less power/privilege'. Explain that participants will be discussing concepts of power, privilege and equality in their own lives and in society.
2. From the list 'groups that tend to have unequal power in society', read the first example (rich people and poor people) and ask, which column ('less' or 'greater' power) does each group belong to? Remind participants that these characterisations (or labels) are not always true or absolute.
3. Record participants answers in the appropriate column. Ask participants:

    a. Look at the list of groups that tend to have more privilege. Can you identify with any of the groups? Do you agree that this group generally enjoys more power? Can you share an experience that illustrates this power difference?

    b. Look at the list of groups that often have fewer privileges. Can you identify with any of the groups? Do you agree that this group tend to have fewer privileges? Can you share an experience that illustrates this power difference?

    c. Raise your hand if you found that you identified with at least one group on each list. Do most of us know what it's like to enjoy greater privilege AND to have less privilege?

4. Close with a discussion of the following question (or simply encourage participants to ponder the question): What must happen for everyone to enjoy equality and the right to dignity?

Activity 1C.3
Memory Journey

Objective: To allow participants to reflect on their own experiences of being treated differently because of their sex and how they felt about it.

Duration: 20 - 40 minutes

Preparation and Materials: Peer educators are advised that this activity may trigger powerful memories for some participants. See the Introduction to this Guide for information about creating a safe environment and managing risks.

Instructions:

1. Divide the group into pairs.
2. Ask each person to think back to a time when they realised that they were being treated a certain way because of their sex. Then ask them to think about how they felt, being treated in that way.
3. Ask each person to share their stories and experiences with their partner, if they feel comfortable to do so.
4. Bring the group back together. Some questions you might ask are:

    a. What do these experiences tell us about the social attitudes and norms concerning the value of women and girls? Of men and boys?

    b. Thinking back to what has been discussed about human rights, do these attitudes and norms seem fair?

    c. What are some changes that would need to be made to achieve equity between males and females?

Audiovisual resources for educators

Video clip:
Making the Connections: Our City, Our Society, Our Health (3:45 minutes)

This short video discusses the social determinants of health for a Canadian audience. However, it is equally relevant to people living in Australia. The video is in English and may not be appropriate for audiences who prefer to speak in their first language. Educators should ensure that the video is appropriate for their group and that they have the correct audio-visual equipment to play the clip.

Access this video clip on YouTube:
http://www.youtube.com/watch?v=-kEqFiq11CE

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

General aims

- To define sexual and reproductive health.
- To encourage participants to see the connection between rights and our ability to experience health and wellbeing
- To encourage participants to recognise the relationship between gender perspectives and their sexual and reproductive health
- To initiate discussion about women's bodies and sexual and reproductive health
- To share different experiences of learning, understanding, and caring about our bodies
- To provide an opportunity for women to learn about the function of our internal and external sexual reproductive body
- To facilitate shared understanding about the importance of knowledge gained in this session in relation to women's whole health and wellbeing

Aims relating to FGM/C

- To 'normalise' the discussion about FGM/C and by placing it within the context of women's health
- To provide information about the health consequences of FGM/C and to encourage participants to discuss FGM/C as a risk to sexual and reproductive health
- To provide space for women to ask questions about FGM/C and its health consequences
- To provide a space for women to share their experiences of FGM/C and its health consequences
- To support and reassure women about the diversity of women's bodies and experiences of sexual and reproductive health

Module Topics

2A: What is sexual and reproductive health?
This topic introduces sexual and reproductive health and encourages participants to see the connection between sexual and reproductive rights and our ability to experience health and wellbeing.

2B: Cultural expectations about sexual and reproductive health
This topic encourages participants to consider the ways in which cultural expectations and attitudes to gender can impact sexual and reproductive health.

2C: Knowing about your sexual and reproductive body
This topic covers basic information about women's sexual and reproductive organs and functions.

Suggested session plan

Activity	Time
Introduction and icebreaker activity	15 minutes
Topic 2A: What is sexual and reproductive health? Suggested Activities • Activity 2A.1 Sexual and Reproductive Health • Activity 2A.2 Case Studies concerning sexual and reproductive rights	20 minutes
Topic 2B: Cultural expectations about sexual and reproductive health Suggested Activities • Activity 2B.1 First impressions • Activity 2B.2 Appreciating your own body • Activity 2B.3 Altering bodies	20 minutes
Break	15 minutes
Topic 2C: Knowing about your sexual and reproductive body Suggested Activities • Activity 2C.1 Are bodies embarrassing? • Activity 2C.2 Women's sexual and reproductive organs	45 minutes
Evaluation, outline of next session and close	5 minutes
Total time	2 hours

2A: What is sexual and reproductive health?

Discussion Points

- What is sexual and reproductive health?
- What sort of barriers to sexual and reproductive health do people experience?
- How important is it to to have control over your own body and decisions made about it?
- What sorts of actions violate our sexual and reproductive rights?

See Resource 3 Handout 2A: Definition of reproductive health

Key Messages

1. **Sexual and reproductive health is not just the absence of disease or illness.**
   The term 'reproductive health' was defined by the United Nations (UN) in 1994 at the Cairo International Conference on Population and Development as "… 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." An essential part of sexual and reproductive health is having sexual and reproductive rights

2. **We all deserve to have basic control over our own bodies.** This includes being free from violence and sexual abuse and from pressure to engage in violence toward others. Control over one's body also refers to deciding whether and when to have sex and with whom, when to become pregnant, whether to continue a pregnancy, and even whether and how to alter one's appearance.

3. **When human rights relate to people's sexuality or reproduction, we call them "sexual rights" or "reproductive rights"**
   Sexual rights and reproductive rights sometimes overlap. However, sexual rights generally include an individual's control over his or her sexual activity and sexual health. Reproductive rights usually concern controlling decisions related to fertility and reproduction.

4. **Sexual and reproductive rights apply to people of all ages, including girls**
   Children have the right to obtain information to protect their health, including their sexual and reproductive health.

   Younger children may need help in making decisions. The direction and guidance provided by caring adults must take into account the best interests of children. It must also take into consideration the capacity of children to exercise rights on their own behalf.

5. All over the world, both men and women face barriers to exercising their sexual and reproductive rights. The consequences of these barriers are often serious.

    - Sexual violence: millions of people are affected by sexual violence, both men and women of all walks of life.

    - Poverty: poverty can lead to increased risk of experiencing unwanted sex, unwanted pregnancy, forced marriage and sex trafficking.

    - In some areas, female genital mutilation or cutting is practised on girls, which can have severe and lifelong health consequences.

    - Some people suffer fear, shame, stigma, threat of violence and in some cases threat of arrest because their sexual identity does not fit in with local social norms.

6. Unfortunately, violations to sexual and reproductive rights are so common that they are often excused, overlooked or seen as culturally normal. These violations take different forms all over the world, but girls and women are disproportionately affected.

7. To control and protect our own bodies, we all need to be treated with dignity and respect. This is everyone's right as a human being.

8. Learning about our rights and being able to exercise them can have a profound effect on our sexual and reproductive health and wellbeing.

9. Our sexual and reproductive rights often play an important role in our ability to prevent and treat sexual and reproductive complications to our health.
   In some countries, women do not have the right to access some forms of contraception, abortion or pregnancy.

10. One of our sexual and reproductive rights is to access health services.
    (This will be discussed in more detail in Module 4)

Activity 2A.1
Sexual and Reproductive Health

Objective: To encourage participants to think holistically about sexual and reproductive health and the ways in which social determinants can impact on health and wellbeing.

Duration: 20 - 30 minutes

Preparation and materials: Whiteboard and markers or paper and pens

Instructions:

1. Divide participants into two or three groups. Give each group the name of a different woman (for example, group 1 is 'Vanessa', group 2 is 'Maria' and group 3 is 'Lia'). Explain that each group must imagine their woman is pregnant.

2. Now describe briefly three or four points about each woman, which may affect her pregnancy. For example:

   Vanessa:
   Vanessa is 18 years old. She became pregnant the first time she had sex with her boyfriend, who pressured her into sex. Her boyfriend doesn't want to support her and her parents have disowned her. She has nowhere to go.

   Maria:
   Maria is 42 years old. She has 3 children and lives in an exclusive suburb. She suffered postnatal depression with all three children. Her husband has always been very supportive.

   Lia:
   Lia is 25 years old and has just arrived in Australia as a refugee. She doesn't speak English well and she has no family here. Her husband is trying to get a job.

3. Ask participants to consider the specific situation of the woman they were assigned and to discuss her pregnancy as a group. Some questions they might consider include:
   - What do you imagine will be her greatest challenges?
   - What things might you be worried about in her situation?
   - What things do you think would help her in her situation?
   - What things related to her pregnancy are in her control? What things are not in her control?

4. After 10 minutes discussion ask the groups to compare their women. What challenges are the same? What challenges are different? What factors affected each woman and how concerned you are for her health during her pregnancy?

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

Use Resource 3 Activity 2A.2: 'Case studies concerning sexual and reproductive rights'

Objective: To enable participants to identify and discuss real examples of instances involving violations to sexual and reproductive health.

Duration: 30 - 60 minutes

Preparation and materials: Whiteboard, copies of the case studies you want to use (see Resource 3).

Instructions:

1. Using the case studies provided in Resource 3, or using your own case studies, ask one of the participants to read aloud the first part of the case study.
2. Ask participants to discuss the case study, using the following questions as a guide:
    a. How does the story make you feel?
    b. What sexual or reproductive rights relate to this case?
    c. Do you think this represents a human rights violation? Why?
    d. Who is responsible? Consider everyone who bears some responsibility for what happened.
3. Ask a participant to read the second part of the case study.
4. Ask participants to discuss the second part of the case study, using the following questions as a guide:
    a. How do you feel about the outcome?
    b. How might the case have been different if the victim had been wealthy (or male)?
    c. What attitudes need to change to protect this sexual right?
5. Facilitators may choose to conclude by asking:
    a. Do you know of similar cases? Which rights were violated?
    b. Have you heard of any other kinds of sexual rights violations in Australia or other places?
    c. What must be done to stop such violations?
    d. What do stories like this tell us about the relationship between our sexual and reproductive health and human rights?

2B: Cultural expectations about sexual and reproductive health

Discussion Points

- What social and cultural ideas influence your body image or your behaviour?
- What social expectations have you noticed that relate to women's bodies or to women's sexual and reproductive health?
- Do you think these expectations are fair?

Key Messages

1. Girls and women often feel pressure related to their physical appearance.
2. Girls and women often feel pressure related to their sexual and reproductive decisions.
3. Sometimes cultural or social ideas about sexuality and gender shape people's attitudes to particular parts of the body and can lead to myths.
4. Individuals and communities from migrant backgrounds can experience competing pressures from different cultural perspectives; can feel isolated and even stigmatised; and can experience racist attitudes which impact their sexual and reproductive health.
5. Cultural expectations and attitudes to sexual and reproductive health can change. Sometimes change happens gradually over time, or happens from necessity. Sometimes change happens because as a community, we make a choice.

Activity 2B.1
First impressions

Use Resource 3 Activity 2B.1: 'The Story of Maya' and 'The Story of Rasul'

Objective: To increase participants' awareness of the assumptions and judgements we often make about a person based on that person's sex.

Duration: 40 minutes

Preparation and Materials: Whiteboard, copies of the 'Story of Maya' for half the group, copies of the 'Story of Rasul' for half the group.

Note: This story should be adapted to suit the culturally specific situation and the dynamics of the group. If your group is comfortable talking openly about sexuality, then you can make the story a bit more explicit. If you think more detail in the story would be confronting for the group, you should be less explicit. Remember that the point of the exercise is to identify the different, gendered cultural expectations that we have about behaviour relating to sexual and reproductive health.

Instructions:

1. Divide the group in half. Distribute the 'Story of Maya' to one group and the 'Story of Rasul' to the other. Do not explain anything about the stories, and make sure that neither group can hear the other. Give the groups time to read the story and answer the questions provided on the sheet.
2. After 15 minutes ask the group that read about Rasul to share briefly its response to each of the questions at the end of the story, without explaining their reasons for their answers. Write the key responses on the board.
3. Do the same for the group that read the story of Maya.
4. At the top of the list of words generated from the 'Story of Rasul', write 'Rasul' and at the top of the list of words generated from the 'Story of Maya' write 'Maya.'
5. Reveal that the two stories are identical, except for the sex of the person. Then ask:
    a. What do we notice about the responses for Maya compared with those for Rasul?
    b. What does this tell us about the standards for girls as compared with the standards for boys?
    c. How do you feel about this double standard?

Activity 2B.2
Appreciating your own body

Objective: To allow participants to appreciate and celebrate what makes their own bodies unique, and to see the diversity in others. This activity is designed with a women's group in mind, but may be equally effective with men.

Duration: 20 - 30 minutes

Preparation and materials: Paper, coloured pencils, pens or markers.

Instructions:

1. Provide each participant with some paper and a pen or pencil. You may also choose to provide coloured pencils and markers.

2. Ask each participant to draw a picture of his/her body on the piece of paper. Assure participants that it doesn't matter how realistic or artistically appealing the picture is.

3. After drawing the picture, ask each participant to make a list of all the things he/she likes/loves/appreciates about his/her body. This "things I like" list can be as long as they like, but must contain at least 5 things. Each participant can also list one (but not more than one) thing he/she doesn't like about his/her body.

4. After 10 - 15 minutes of artistry and list-making, ask each participant to share his/her drawing with the group, and explain what he/she has listed. It is important that each thing on the "like" list is explained, instead of just stated. (i.e., "I like my eyes because they are the same color as my mother's eyes...")

5. After each participant has shared, you could conclude the activity by asking participants how they felt sharing positive feelings about their body with other people. Particularly if working with a group of women, the facilitator may conclude by discussing how, as women, we're often trained from childhood to believe that it's socially inappropriate to love our bodies, or at least, to admit that we love them. For a wider audience, the facilitator might discuss how we are often trained, from a young age, to speak a certain way about our own bodies and perceive certain attributes as positive or negative. Everyone is unique and everyone deserves to feel good about their own body

Activity 2B.3
Altering bodies

Objective: To help participants to identify what is considered to be 'ideal appearance' for males and females in their culture; discuss practices people engage in to make their appearance conform to this ideal; consider the pressures to conform to the ideal; and recognise the health consequences of such practices.

Duration: 20 - 40 minutes

Preparation and materials: White board and markers

Instructions

1. Introduce the topic with the following questions:
    - What are some of the pressure that girls and boys or men and women feel to look a certain way?
    - Are these desired appearances relistic for most of us, or how are they idealised?
    - How do people feel if they do not meet the ideal?
    - What are some of the things people do (or have children undergo) to conform to idealised images of attractiveness or acceptability? For example, with hair? Skin? Body shape?

    Write down participants' responses on the board.

2. Add any additional practices you wish to discuss from the following list:
    - Fattening or extreme dieting
    - Extreme bodybuilding
    - Tanning or skin whitening
    - Applying makeup, henna, or nail polish
    - Piercing, scarification, or tattooing
    - Shaving or removing hair
    - Straightening, curling, or dyeing hair
    - Cosmetic surgery
    - Female genital mutilation/cutting
3. Encourage discussion about these types of practices. Some questions you could raise include:
    - How do you feel about the practices on this list?
    - Which are playful or expressive and which can be harmful?
    - What might people in other cultures think about the practices listed here?
    - Are women under greater pressure than men to conform to a idealised body type?
    - Who benefits and who is harmed by this process?
    - How important is it to end harmful practices involving alterations of the body?
    - As you were growing up did anyone tell you that this practice is dangerous and should be stopped?
    - Have you shared your own knowledge and feelings about it with anyone else?
    - How might you do that?

2C:Knowing about your sexual and reproductive body

The primary focus in this topic is to provide information to participants about the female sexual and reproductive system.

See Resource 3 Handout 2C: Women's Sexual and Reproductive Organs

Discussion Points

- What do you know about the female reproductive system?
- Can you name any parts of the female reproductive system?
- How does the reproductive system work?
- Have you ever talked with other women about your female reproductive system?
- Do you have any beliefs about your reproductive system?

Key Messages

1. Knowing about your body has many benefits for your sexual health and wellbeing.
2. There is no shame in talking about your sexual and reproductive health.
3. People's bodies differ in appearance. There is no "perfect" or "normal" body type or appearance.

Activity 2C.1
Are bodies embarrassing?

Objective: To prepare participants for a discussion about the sexual and reproductive organs.

Duration: 15 - 20 minutes

Preparation and materials: Paper for participants, pencils or pens, and a ballot style box or container. Facilitators should be aware that this exercise could trigger difficult memories for some participants. When facilitating discussion, make sure you are non-judgmental and reassure participants that talking about bodies can be difficult for everyone. Some participants may never have had the opportunity to discuss or learn about their sexual and reproductive organs before and some participants may find it difficult.

Instructions:

1. Explain that this exercise will involve reflecting on personal experiences of being taught about our bodies when they were younger. Were some things never talked about? If they have children, how do they talk about the human body with their children? Why do they think some things are more difficult to talk about than others?

2. Depending on the group dynamic, ask women to get into pairs to talk to each other about their experiences and feelings. Make sure that both participants in each pair take turns in listening to one another. Ask women to write down a few words that describe how they feel when talking about the sexual and reproductive parts of their body, and why they think they feel that way.

3. Once the pairs have had enough time to talk, bring the group back together and ask one member of each pair to volunteer to share what has been written down. To encourage discussion, the facilitator may wish to share their own experiences as well.

4. If participants seem to find this exercise difficult an alternative might be to ask each participant to write down three words individually that describe how they feel about their bodies, particularly in relation to their sex. Ask the women to put their words into a box at the front of the room. The facilitator could read out the words from the box and ask participants as a group to discuss why people may feel that way.

5. Another variation on this activity could be to use it as an icebreaker by asking women if they have a slang term for their genitals or getting women to brainstorm names they have heard or used for their genitals. Facilitators may ask why participants think there are so many names for women's sexual organs and why women often choose not to use the proper names.

Activity 2C.2
Women's sexual and reproductive organs

Use Activity 2C.2: 'Women's reproductive system'
Use Activity 2C.2a: 'Women's reproductive anatomy name cut-out cards'

Objective: To consolidate information participants have learned about their sexual and reproductive organs.

Duration: 20 minutes

Preparation and materials: A large unlabelled chart of the 'women's reproductive system' and a set of the 'women's reproductive anatomy name cut-out cards'. Both the cards and the chart will need to be prepared in advance and preferably laminated. Be sure to enlarge the women's reproductive system diagram provided (see Resource 3). Facilitators may also choose to write the corresponding anatomy names in the preferred language of the group on the other side of each cut-out card. This activity should be conducted after the relevant material on women's sexual and reproductive organs has been covered. It may also be used as a tool to help facilitator's in delivering information.

Instructions:

1. Display the enlarged photocopy of the unlabelled women's reproductive system diagram. (This could also be distributed as an individual handout if it cannot be sufficiently enlarged).
2. Distribute laminated cut-out cards among the participants, so that each participant has at least one each. Ask the group to explain the function of each organ drawn on the chart.

Module 3:
Female GenitalMutilation/Cutting

Aims

- To talk about FGM/C as a violation of rights and provide further information about the cultural, religious and social perceptions that perpetuate the practice of FGM/C
- To dispel any myths and misunderstandings about the practice of FGM/C
- To provide space for women to ask questions about the practice of FGM/C
- To provide a space for women to share their experiences of FGM/C, if they choose to
- To empower women to feel comfortable speaking about FGM/C
- To inform or remind participants of the international and national laws prohibiting FGM/C
- To encourage participants to see the relationship between gender roles and FGM/C
- To show participants examples of positive change
- To end the practice of FGM/C worldwide

Module Topics

3A: What is FGM/C?
This topic introduces the discussion of FGM/C by covering the different types of FGM/C that women may have experienced and discussing the possible health risks and health consequences of FGM/C.

3B: What are the causes of FGM/C?
This topic broadens the conversation about FGM/C to consider why there is social pressure to practice it in some cultures and encourages participants to see the relationship between FGM/C and gender expectations.

3C: What are my rights in relation to FGM/C?
This topic encourages participants to understand FGM/C as a violation of women's sexual and reproductive rights, covers Australian and international laws and considers strategies and examples of positive change. It also introduces participants to their right to access health services which is covered in Module 4.

Note to facilitators

As a peer educator, how you conduct this module will be influenced by the specific dynamics and needs of the group.

Suggested session plan

Activity	Time
Introduction and icebreaker activity	10 minutes
Topic 3A: What is FGM/C?	50 minutes
Break	15 minutes
Topic 3B: What are the causes of FGM/C? Suggested Activities • Activity 3B.1: Sorting myth from fact	20 minutes
Topic 3C: What are my rights in relation to FGM/C?	15 minutes
Evaluation, outline of next session and close	5 minutes
Total time	2 hours

3A: What is FGM/C

Discussion Points

- What is FGM/C?
- What are the health consequences of FGM/C?

See Resource 3 Handout 3A: Female Genital Mutilation/Cutting

Key Messages

1. FGM/C is a tradition that has many names and is practised in many different communities in different ways around the world.
2. It is estimated that 100 to 140 million women and girls worldwide have undergone the practice and 3 million girls are at risk of undergoing FGM/C every year.
3. FGM/C is commonly practised in parts of Africa, Asia and the Middle East. Forms of FGM/C have also been reported in Central and South America.
4. The practice is mostly carried out on young girls between infancy and 15 years of age. Occasionally, it is carried out on adult women.
5. FGM/C 'comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons' (WHO definition).
6. There is no one type of FGM/C. But all types can lead to many short and long term health complications, both physical and mental, and no type has any health benefit.
7. Not every woman may experience the same complications.

3B: What are the causes of FGM/C?

Discussion Points

- Why is FGM/C performed on girls and women?
- What types of ideas about women and girls does the practice rest on?
- What do you know or have you been told about FGM/C?
- Why do you think women traditionally perform the practice?
- What keeps the practice going?

Key Messages

1. The reasons given for the practice of FGM/C are often related to fixed perceptions of gender roles and misconceptions about women's bodies.

2. There is no religious basis for the practice of FGM/C.

3. Individuals and families can sometimes feel strong social pressure to continue the practice.

Activity 3B.1:
Sorting myth from fact

Use Resource 3 Activity 3B: Myth or fact cut-out cards

Objective: To give participants the opportunity to learn about myths and facts that surround the practice of FGM/C.

Duration: 15 minutes

Preparation and materials: A set of the 'myth or fact' cut-out cards for each group. The cards will be easier to use if laminated. A small prize for the winning group.

Instructions:

1. Explain to participants that there are many myths that surround the practice of FGM/C, and it is important to sort out the myth from the fact.

2. Ask participants to move into two or three groups and provide each group with a set of 'Myth or fact' cut-out cards. Ask participants not to look at the cards yet, but to put them all face down on a table so that each participant in the group can access them.

3. Explain that on your signal, each group will turn over the cards and must match each 'myth' to its 'fact'. You may choose to offer a prize to the fastest group for fun. This activity could be run a number of other ways. With a smaller group, you could give one card to each participant and ask them to find the person with the corresponding card. Once participants have found their pair, ask them to form a line with 'myth' holders standing on one side and 'fact' holders on another.Ensure that participants agree and understand which cards are facts and which are myths. Questions you could ask are:
    a. Were there any myths or facts that surprised you?
    b. Are there any other myths that you have heard said about FGM/C?
    c. Are there any questions you have about any of the myths or facts?

3C: What are my rights in relation to FGM/C

Discussion Points

- What human rights does FGM/C violate?

See Resource 3: 'Countries with legislation or decree against the practice of FGM/C'

Key Messages

1. FGM/C is internationally recognised as a violation of human rights.
2. There is legislation all over the world which prohibits the practice, including 24 of the 29 countries where the practice is concentrated.
3. In every state and territory of Australia, the practice of FGM/C is illegal. This includes taking a child overseas to have FGM/C performed.
4. Girls and women who have undergone FGM/C have the right to appropriate health services, to accurate health information and education, and to be treated with respect and dignity.
   (To be discussed in detail in Module 4)

Audio Visual resources for educators

Video Clip: Empowering Change, 2013 (13:41 minutes)

This video features a group of women based in Melbourne speaking candidly about some of the common misunderstandings that lead communities to practise FGM/C and ways that they are working towards change. The video features Victorian FARREP educator Faduma, as well as a Sheik Issa Musse speaking about FGM/C in relation to the Koran. Produced by Genetic Circus productions for Monash Health.

You can access this video clip on YouTube:
http://www.youtube.com/watch?v=UfIyjonVCR0

Video Clip: Angelique Kidjo speaks out about female genital mutilation/cutting, 2013 (2.54 minutes)

This short video clip featuring UNICEF Goodwill Ambassador Angelique Kidjo is positive and upbeat. Angelique speaks briefly about the need to involve both men and women in the campaign for change.

You can access this video clip on YouTube:
https://www.youtube.com/watch?v=LS5mWchCtlE#t=13

Video Clip: Female Genital Mutilation / Cutting: a UNICEF Innocenti documentary, 2010 (5.34 minutes)

In this video, women who have experienced FGM/C and activists share their insights and personal stories from Africa and Europe and make a compelling case for the abandonment of FGM/C.

You can access this video clip on YouTube:
http://www.youtube.com/watch?v=MsdeI5JkbEo

Module 4: Advocating for health, rights and gender equity

General Aims

- To empower women to share what they have learned about sexual and reproductive health with families and friends
- To provide women with information about how to effectively access local health services and relevant health education and information
- To encourage women to advocate for women's sexual and reproductive rights
- To provide information and strategies for maintaining sexual and reproductive health
- To empower participants to see how the promotion of gender equality will benefit their community
- To encourage participants to consider specific ways they can advocate for women's rights in their everyday lives
- To empower individuals to exercise and respect their rights as citizens

Aims related to FGM/C

- To encourage participants to share information they have learned about FGM/C with others in their community
- To show participants that effective change is already happening around the world
- To empower women to feel comfortable raising FGM/C with health professionals
- To end the practice of FGM/C around the globe

Module Topics

4A: Your right to health information and services in Australia.
This topic covers every Australian's right to access health services.

4B: What health services are available to me and how can I access them?
This topic provides information about local health services, navigating the health system and where to find resources relating to their sexual and reproductive health.

4C: How can I advocate for women's sexual and reproductive rights?
This topic encourages participants to consider ways they can advocate for improved gender equality and support women's sexual and reproductive rights in their community.

Activity	Time
Introduction and icebreaker activity	10 minutes
Topic 4A: What are my rights to access health services in Australia? Suggested activities • Activity 4A.1: Going to see your doctor • Activity 4A.2: Ways to assert your rights • Activity 4A.3: Your rights to health services quiz	20 minutes
Topic 4B: What health services are available to me and how can I access them? Suggested activities • Activity 4B.1: Invite a guest speaker	15 minutes
Break	15 minutes
Topic 4C: How can I advocate for women's sexual and reproductive rights? Suggested activities • Activity 4C.1: Changing the future for women	30 minutes
Evaluation, outline of next session and close	30 minutes
Total time	2 hours

4A: Your right to health information and services in Australia

Discussion Points

- What obstacles can stop you from accessing health services?
- What is your experience of health care services in Australia?
- What could improve your access to health services?
- Do you know all your rights to health services in Australia?

Key Messages

1. Every person needs access to health services as part of having a safe, responsible and healthy sex life.

2. All people have the right to health services that are safe, accessible, affordable and of good quality. People have the right to be treated respectfully and to maintain their privacy.

3. Unfortunately many barriers keep people from obtaining the health services they need and deserve. Sometimes these barriers arise from discrimination and stigma. Sometimes these barriers are part of an institutional policy or culture.
    - Governments may not provide free or affordable health services in all areas.
    - Governments, providers, or pharmacies may withhold access to certain health services and medications. Their actions may be influenced by political or religious beliefs.
    - Pharmaceutical companies may charge unaffordable prices for drugs and supplies.
    - Some health programs may require young people, particularly girls, to obtain adult consent before receiving contraceptive services.
    - Some health services or providers may be less accommodating of language or cultural differences than they are professionally required to be.
4. Poor quality of care may discourage people from going to available health services.

5. Other barriers can relate to gender norms, language proficiency, cultural expectations, access to transportation, and working hours.
    - Some cultures have prohibitions against being alone with members of the opposite sex.
    - Some women may not want to be examined by a male doctor.
    - Some people may prefer to speak in a language other than English.
    - Some people may find health professionals intimidating or have had bad experiences with health professionals in other countries.
    - Some people may work long hours or have job insecurity, and find it difficult to physically access health services during normal opening hours.
    - Some people feel many competing pressures (caring for family, work, housing, finances) and do not prioritise their health.
6. Despite obstacles, there are many men, women and children who use health care and interact well with health service providers.

7. The Australian Charter of Healthcare Rights describes the rights of patients, consumers and other people using the Australian healthcare system. It was adopted by federal government in 2008.

Activity 4A.1
Going to see your doctor

Objective: To encourage participants to reflect on some barriers people experience in accessing health professionals and ways these could be overcome.

Duration: 20 - 30 minutes

Preparation and materials: paper and pens, theatre props.

Either brainstorming with the whole class or in smaller groups, ask participants to discuss the following questions.

1. What makes it difficult to see a doctor about your sexual and reproductive health?
   Some reasons why it is difficult to see a doctor or health professional may include:
   - Sex of the health worker
   - How a woman might feel about herself (physical characteristics including weight, body hair)
   - Feelings of embarrassment, having to be naked in front of a stranger
   - Language barriers – not knowing the words in English to describe parts of sexual/reproductive system
   - Fear of not being able to understand health worker (not just verbal)
   - Embarrassment about lack of knowledge about how her body works
   - Fear of having a serious illness

2. What would make it easier to communicate our questions or issues to health professionals?

   Some factors that would make it easier to communicate questions to health professionals may include:
   - Less embarrassed to talk to a health worker
   - Knowing the words to describe parts of her body and their function
   - Better understanding of what the health worker is talking about
   - Feelings of confidence, and feeling more positive about her body
   - Having a better understanding about changes in the body and what is normal etc.

After 10 minutes of group discussion, bring participants together to report their answers.

If you have more time, you could conduct this activity differently by dividing the group in half and asking participants to develop a 1 or 2 minute role play, with one group depicting what a bad experience with the doctor might be, and one depicting what an excellent experience at the doctor might be.

After 20 minutes of preparation, bring the groups together to act out their role plays and discuss some of the points that came out of each.

Activity 4A.2
Ways to assert your rights

Use Resource 3 Activity 4A.2: 'Ways to assert your rights' handout

Objective: To encourage participants to identify their rights in a health service setting and consider strategies they could use to assert these rights.

Duration: 15 minutes

Preparation and materials: A copy of 'Ways to assert your rights' for each participant (see Resource 3), pens.

Instructions:

1. Provide each participant with a copy of the 'Ways to assert your rights' handout.
2. Explain that the activity involves matching a problem or barrier you might face at the doctor with a possible solution to that problem. Participants can simply draw a line to match one to the other.
3. You could offer a prize to the participant who finishes first if you choose.
4. Once participants have completed matching up each problem with a solution, go through the answers as a group. You may conclude this activity by asking participants if they have ever experienced any of the problems described on the handout? If so, how did they overcome these problems? Do they think that knowing their rights will help them next time they go to see a health professional? If so, in what ways?

Activity 4A.3:
Your rights to health services quiz

Use Resource 3 Activity 4A.3: 'Your Rights to health services quiz' sheet

Objective: To help participants to identify their rights to health services in Australia.

Duration: 10 - 15 minutes

Preparation and materials: A copy of the 'Your rights to health services quiz' and a prize or prizes for participants. Make sure that you know the answers.

Instructions:

1. Explain to participants that you will be quizzing them about what they know or have learned about their rights to health services in Australia. The questions are all yes or no, and you can add more if you choose to.
2. Read the questions aloud one at a time and ask participants to answer as quickly as possible, either by hand raising or calling out. You can manage this differently depending on the size and dynamics of the group. In very large groups, you may choose to make people stand up for yes and sit down for no, eventually thinning out the competition. However, in that case you may need to thin of some more tricky quiz questions.
3. You can give a prize to the overall winner or a prize to each correct answer, depending on how you run the quiz.

4B: What health services are available to me and how can I access them?

Discussion Points

- What health services are available to me?
- What factors can make it difficult to access and use health services?
- What are my rights while I am using a health service?
- What can I do if I'm not happy with a health service?

See Resource 3: Multicultural Women's Health Australia Network Contacts

Key Messages

Note: Key messages in this section will depend, to a certain extent, on the health services specific to the group's local region and state or territory in Australia. Emphasis should be given to empowering participants, answering questions and clarifying uncertainties they may have about accessing services. This section should have a practical focus on services available.

1. Free interpreting services can be arranged for appointments.
    - You are entitled to a professional interpreter whenever and wherever possible. It is usually important to let the health service know that you want an interpreter well in advance.
    - Interpreting can be done over the phone.
    - Patients have the right to know the name of the interpreter and to request another if they perceive a conflict of interest/confidentiality. (This can sometimes be a concern in small, emerging communities)
    - Professional interpreters are highly trained and are subject to strict rules of confidentiality.
2. You have the right to ask questions.
3. You have the right to ask for a second opinion.
4. Services are available in every state and territory that have been established to specifically respond to the ethno-specific needs of women.

- For women who have experienced FGM/C, there are currently two defibulation clinics in Australia.
- Many hospitals have a cultural liaison, who can help to support you and advocate on your behalf.

5. You have the right to complain if you are not happy with a service.
6. Learning more about your health can help you to make informed decisions.
    - You can access free sexual and reproductive health information in many languages through local community health, ethno-specific and women's organisations.

Activity 4B.1
Invite a guest speaker

Objective: To introduce participants to someone who is working in local health services and provide opportunities for local health services to meet and hear members of the community.

Duration: 15 - 40 minutes

Preparation: Invite someone to speak to the group from a key health service provider in the group's local area. Fully brief the speaker about the aims of your session and useful information about the group. If needed, arrange for a culturally and gender appropriate professional interpreter and fully brief the interpreter as well.

Instructions:

1. Prepare participants by informing them that a guest speaker will be attending the session, preferably at the previous session. Be clear with the guest speaker about what you would like them to discuss in terms of available services. Ask the guest speaker beforehand if they are happy to field questions from participants.

2. Be prepared to have a back-up plan in case there the guest speaker is unable to attend. Provide participants with useful take-home material about local services and contacts.

3. Always be prepared to have a back-up plan in case the guest speaker is unable to attend on the day. Provide participants with useful take-home material about local services and contacts.

4. Another way of approaching this activity would be to take participants on a short excursion to a health service. This would require careful preparation, close collaboration with the health service and appropriate allocation of time.

4C: How can I advocate for women's sexual and reproductive rights?

Discussion Points

- What type of discrimination (injustices) have you encountered in your life?
- What can you do to help bring about social change?

Key Messages

1. Reflecting on our own attitudes to gender, class, race, religion, sexual identity, age and physical or mental ability can help us to recognise stereotypes or inequities that we may have accepted as true or acceptable in our own lives.

2. We can promote fairness and human rights in everyday life, including in sexual and reproductive life.
    - We can stand up for a friend or colleague who is being treated unfairly
    - We can defend someone who is ridiculed because he/she is ridiculed for their race, culture, perceived sexuality, or sexual choices
    - We can help others realise that they have opportunities or choices in life other than the ones that are being presented to them
    - We can identify trusted individuals or organisations who can help respond to incidents of discrimination
3. We can also promote fairness and human rights in our communities, including sexual and reproductive rights. Sometimes we can do this on our own; other times we can do this within an organisation.
    - We can accompany a friend on a visit to an official, the police, a health clinic or another service
    - We can ask a local leader to speak out on an issue such as FGM/C.
    - We can make sure that everyone in the community (including ourselves) knows about human rights and understands that everyone in the community matters
    - We can talk to people we know in the community about human rights and about the issues we care about
4. Sharing our own experiences relating to sexual and reproductive health can help other women to feel supported and to learn about their own sexual health and rights to health.

5. Sharing what we have learned about possible risks to sexual and reproductive health with our friends and family can help to create greater community awareness.

6. Supporting women and working to improve gender equity in all aspects of women's lives can have a positive effect on women's sexual and reproductive health.

7. Working to end practices and behaviors that are harmful to women's health is fundamental to improving women's health and wellbeing.

Activity 4C.1
Changing the future for women

Objectives: To encourage participants to focus on issues that they would like to see change for women, and to imagine their role in that change.

Duration: 10 minutes

Preparation and materials: Paper and pens or craft paper, coloured pencils and markers.

Instructions:

1. Ask participants to imagine they could change one thing for women in Australia or all over the world. Then ask participants to answer these two questions:
    - What would that one thing be?
    - What can you do now to start the change?
2. Ask participants either to write them down or to share them with the person next to them. If you wanted to extend this exercise you could ask participants to make a poster that represents what they want for women in the future.

3. Ask the group to share their wishes. You may also want to collect the wishes and display them.

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.

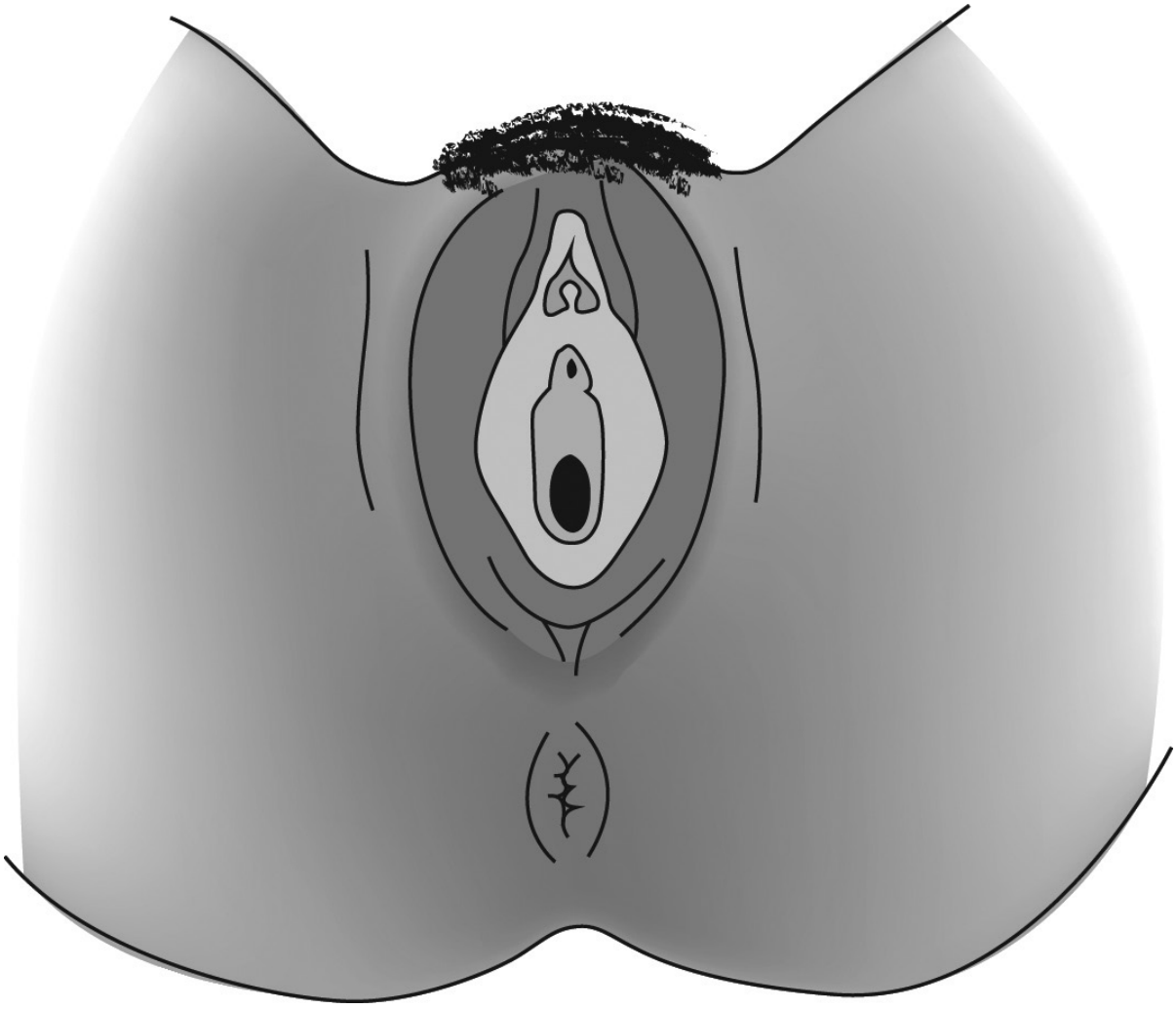
After reading this story, think about these questions, then discuss them with your group:

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

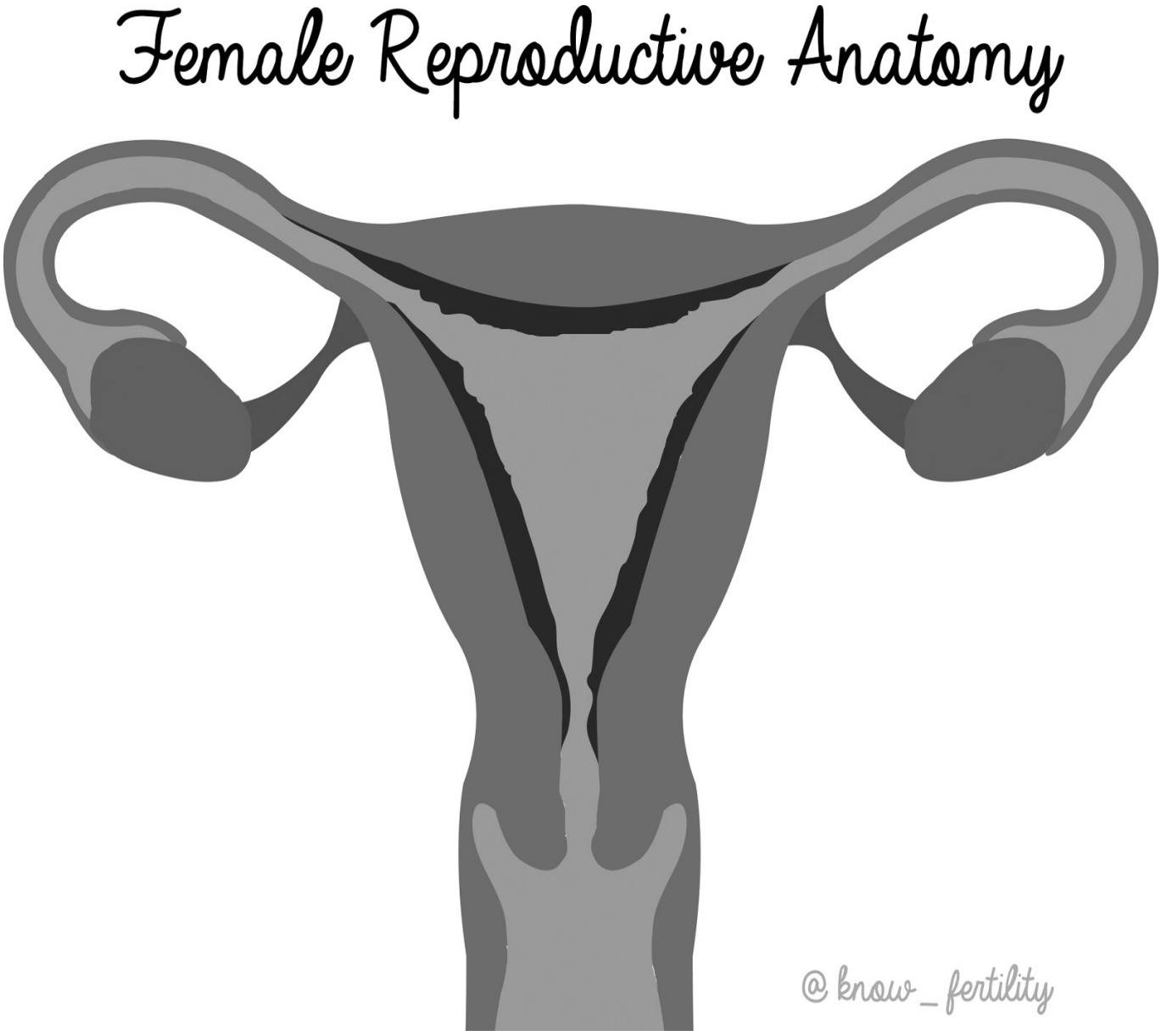
2. How do you feel about Rasul?

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

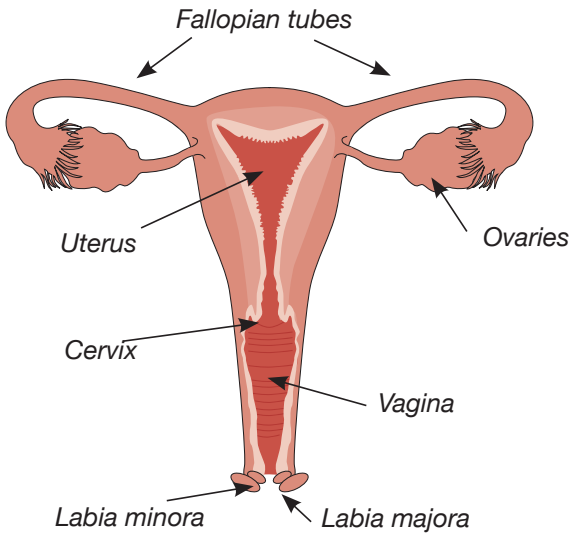
Cervix (neck): The cervix has strong, thick walls. The opening of the cervix is very small, which is why a tampon can never get lost inside a girl's or woman's body. During childbirth, the cervix can expand to allow a baby to pass.

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.

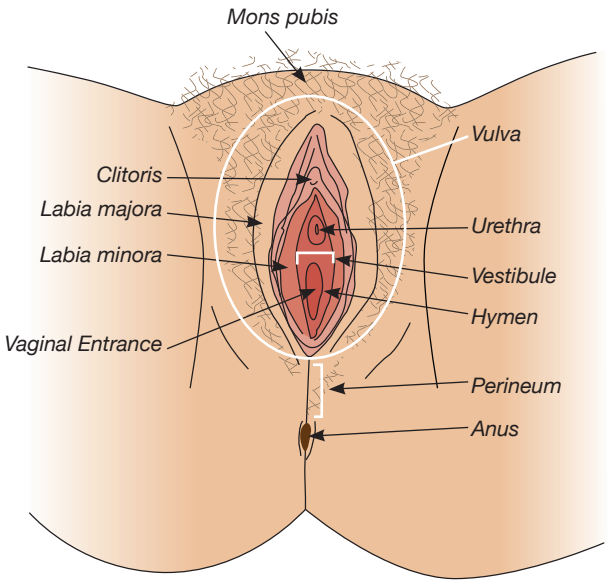
Ovaries: The ovaries are small, oval-shaped glands that are size of an olive and are located on either side of the uterus. The ovaries produce eggs and hormones, oestrogen and progesterone.

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?

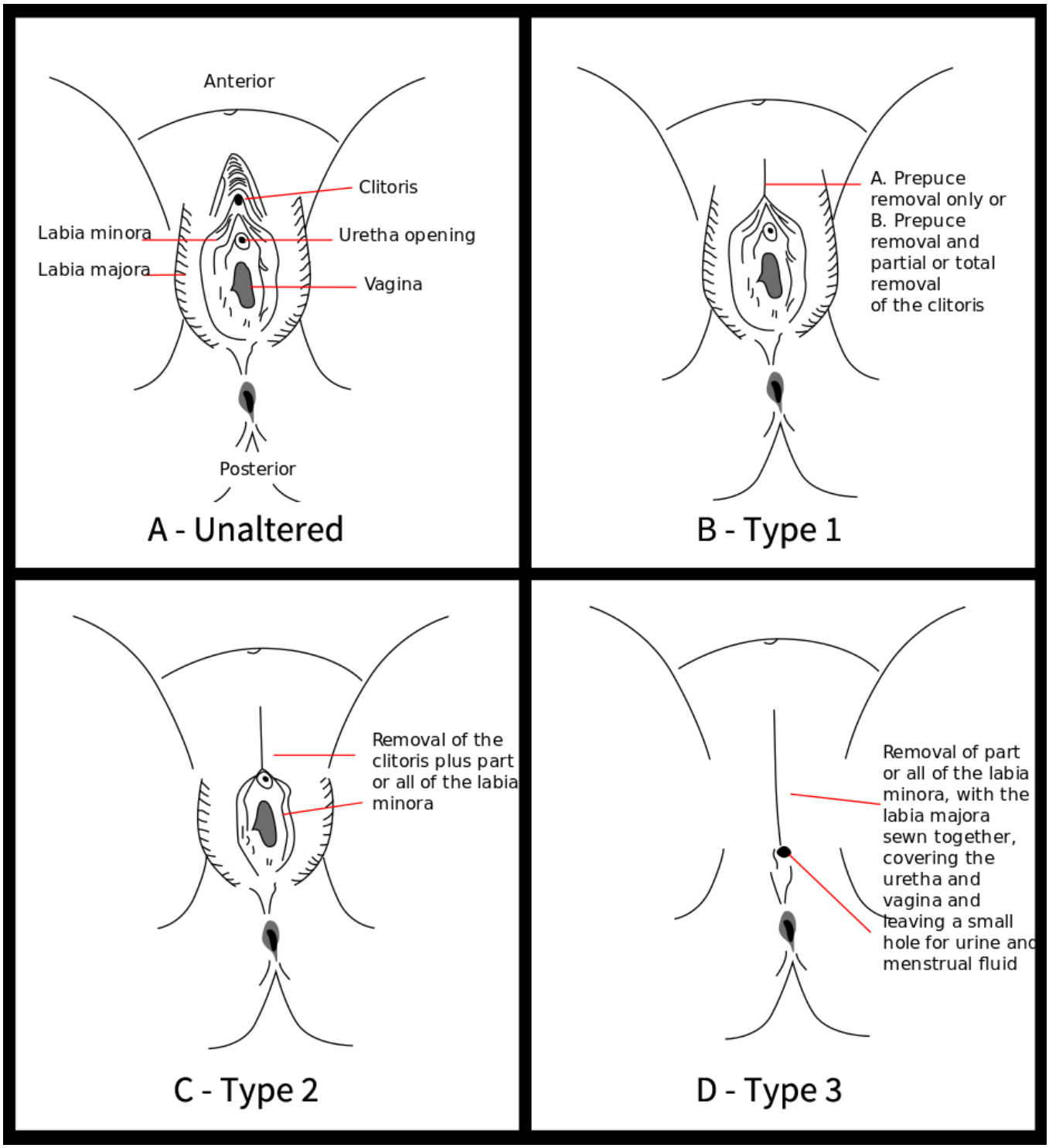
Yes. It is a simple medical procedure, carried out under anaethesia, to open the area that has been sewn up. This surgical reversal is called deinfibulation.

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

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'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..

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‘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

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‘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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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	Gudiniin	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.