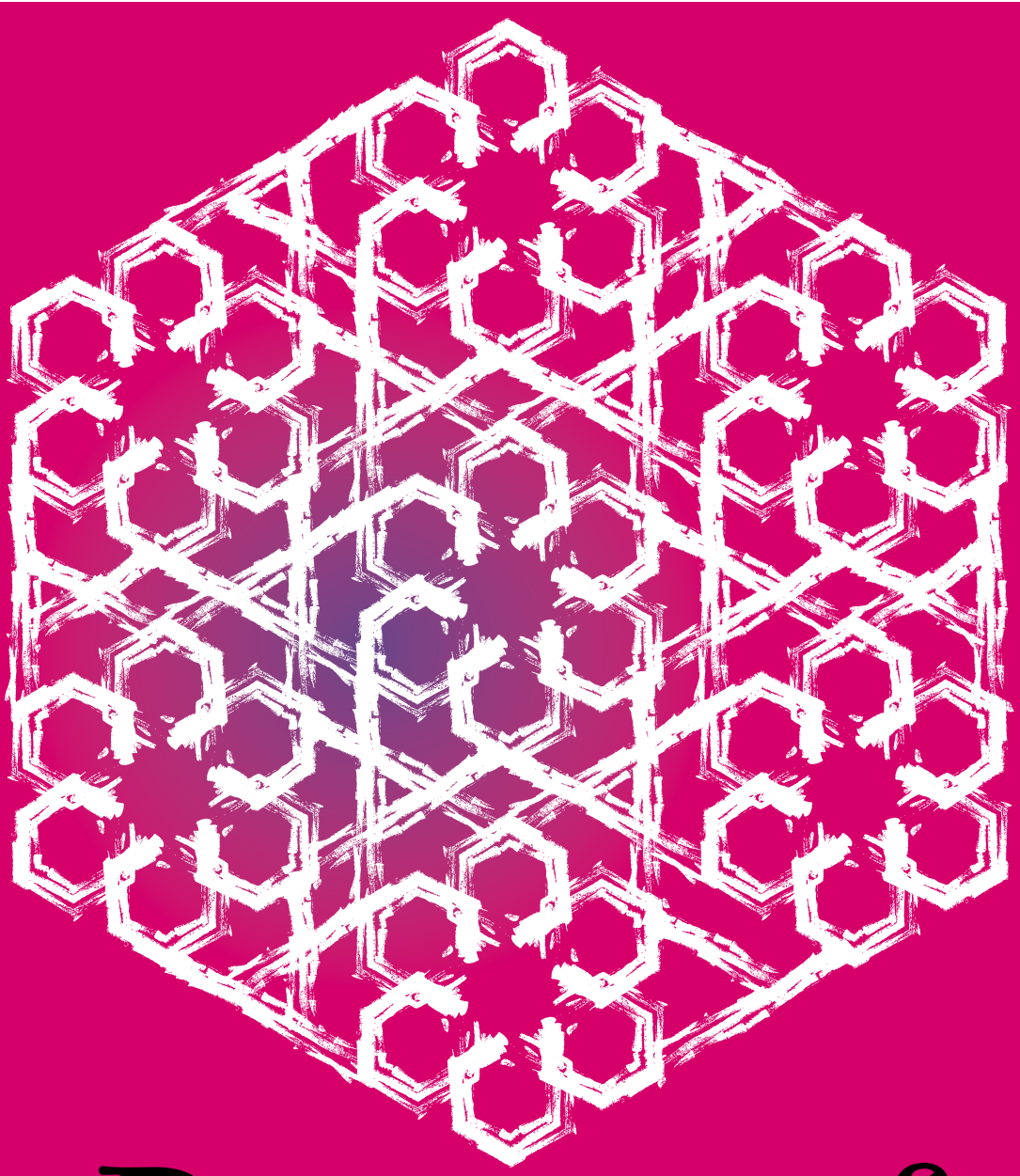

Respectful Dialogue

A guide for responsible reporting on Female Genital Cutting

Australian Muslim Women's Centre for Human Rights
Equality without Exception

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Published by:
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Australian Muslim Women's Centre for Human Rights

Equality without Exception

Who we are

The Australian Muslim Women's Centre for Human Rights (AMWCHR) is an organisation of Muslim women working to advance the rights and status of Muslim women in Australia.

We believe that Muslim women must be the impetus for change in their status as citizens.

The Australian Muslim community is characterised by diversity and hybridity; there is not a binding vision of Islam or what it means to be Muslim. We are a non-religious organisation reflecting the cultural, linguistic and sectarian diversity within the Muslim community.

As an organisation committed to Muslim women and human rights, we will not remain silent when Islam is used to undermine the status of Muslim women. We will intervene in these instances with facts and informed analysis.

Our framework of understanding is the international Muslim women's movement for equality and dignity. But our action and concern are focused on the local communities in Australia where Muslim women live.

We work for the rights of Muslim women by:

- empowering women's self-determination
- bringing a human rights approach to bear on issues of inequality and disadvantage
- working with individuals, the community, and government to advocate for equality within the Australian context.

We aim to inspire positive action by others and aspire to continuously enhance the quality, impact and effectiveness of our work.

Our Principles

The one foundational principle that informs our approach to our work is that Muslim women's equality is:

- without exception
- without qualification
- without threat

What are the core areas of work we undertake?

We prioritise very practical work for women that improves the quality of their lives in tangible and measurable ways. We work with individuals, groups and service providers in the following areas:

- case work, referrals, secondary consultation and outreach,
- advocacy,
- community-based programs and service delivery,
- capacity building,
- leadership development,
- policy development, and
- partnership projects.

We have recently established the Australian Institute for Minority Women (the Institute) to operate as the research and consultancy arm of the AMWCHR. The experience of Muslim women as a minority has much in common with women's experiences from other minority groups. The Institute was created so that the expertise we develop working with Muslim women might be shared with other minority women. As well as providing an insight into the conditions and situations of minorities in Australia generally, the Institute seeks to build an alliance with other minority women in Australia as a gesture of solidarity.

The Institute undertakes the following activities:

- research,
- training development and delivery,
- publications, and
- consultancy services.

Project Contributors

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Respectful Dialogues Project

In 2013, the Australian Muslim Women's Centre for Human Rights was awarded a grant by the Australian Government's Department of Health to develop a guide for all media professionals reporting on Female Genital Cutting (FGC).

This guide has been based primarily on the views and input of women from affected communities. We have consulted with women from diverse cultural communities on their views of the current media coverage of FGC. We have also consulted experts in FGC, including doctors and health workers, community educators, relevant community leaders, media experts and journalists currently reporting on this complex area.

We have relied extensively on the feedback provided to us in forming this guide, particularly in the recommendations we have developed.

Purpose of this Guide

This is a resource guide for professionals working in all aspects of the media on the issue of Female Genital Cutting (FGC). It aims to equip media professionals with an understanding of the practice of FGC, and provide recommendations on ethical reporting from the perspective of affected communities and experts working on FGC.

There is a great deal of material already available on FGC. This guide is not intended to be a comprehensive account of the issue, but is rather designed to be an introductory and quick reference guide. There are a number of other guides to assist media professionals reporting on sensitive issues, as well as a number of resources to assist journalists who wish to report on culturally and linguistically diverse communities. We have included some of these guides in the Appendices list.

In addition to basic contextual information on FGC and providing guidelines on sensitive reporting, this guide provides a list of services and community contact people for journalists or other professionals seeking information on FGC.

Ultimately, this guide is about assisting media professionals to report on a complex, and at times highly emotive, provocative and controversial issue. Affected communities, as well as communities who are perceived to be affected, feel directly impacted by reportage or media coverage of FGC. This guide has therefore been written to support media professionals to avoid alienating, stigmatising or racialising these communities. It is also designed to reinforce and support the good work that is already being done by some media professionals when reporting on FGC.

Community feedback on current reporting on Female Genital Cutting

Feedback from affected communities was gathered through focus groups and one-on-one interviews in which affected women and community members were asked about current media representations of FGC. They were also asked about what information should be included in such a guide to assist media professionals in reporting on FGC in a balanced manner that is representative of the reality on the ground.

As with many sections of Australian society, affected communities viewed media reportage as skewed, unfair and insufficiently cognisant of its power to influence the social attitudes towards minority communities in Australia. While a number of participants identified examples of good reporting and significant improvements in the reporting on FGC, many nonetheless felt that there was still a long way to go.

One of the most significant concerns among communities, particularly affected women, was that journalists were unable to overcome their own biases, reactions and judgments when reporting on FGC. This inability to overcome personal reaction to FGC, particularly in its severe forms, generally led to stories that were inaccurate, unfair in their representation of the community, and lacking meaningful objectivity. For example, women affected by FGC are always represented as victims, when the reality is far more complex.

Community members stated that the media often focused on problematic and controversial practices within immigrant communities and this resulted in a skewed and prejudicial view of communities among the Australian public. The consequences of this, such as intolerance of the community, were made much worse by the fact that such stories were the only time that communities received any media attention. Some were of the view that the focus on FGC is sometimes used to sell papers.

Women struggling with the effects of FGC and those within the community working hard towards its eradication, felt that the issue was at times trivialised, sensationalised and represented in very stereotyped ways.

Additionally, the media's focus on finding victims and reporting on only the most severe forms of FGC – such as Types III and IV (see explanation following), when they were the least practised types of cutting – greatly concerned many community members. This generally resulted in communities being apprehensive and at times unwilling to help journalists seeking to develop a story on FGC.

Finally, despite the strong views articulated above, those consulted did not feel that journalists intentionally sought to vilify their communities or actively misrepresent the issue of FGC. Hence they provided a great number of recommendations which we have used in the design, content and recommendations of this guide. Like the women we consulted, we hope that this guide is of great use to you.

Summary of Recommendations for Responsible Reporting on FGC

When reporting on the practice of female genital cutting, keep in mind that FGC:

- is not practised across all African countries,
- is not practised by all African communities or cultures,
- is not a religiously-based practice.

When approaching affected women:

- do not assume you are speaking to a victim,
- respect the affected girls and women you are reporting about.

In your report:

- avoid being sensationalist – with words and pictures,
- put your story in its national and international context,
- avoid being judgemental or stereotyping certain ethnic groups,
- acknowledge the work that's being done to eradicate the practice that has been spearheaded by members of affected communities themselves,
- acknowledge that there is no accepted explanation about how, why, when and where the practice came about – only many theories,
- acknowledge that FGC is first and foremost an issue of reproductive health,
- source information from reputable health professionals (see Appendix),
- seek interviews with community members who are knowledgeable about the topic, and use an interpreter where necessary (see the protocols in the guide),
- be sensitive in your approach to community members and explain to them who will make the final editorial decisions on your published story,
- be balanced and fair in the face of your copy deadlines,
- be aware of your own views, how they might impact on your telling of the story, as well as how preparing the story might impact on you.

Language (Terms and Descriptions) Used

The term *Female Genital Mutilation* replaced the terms *cutting* and *circumcision* in 1979 as a conscious effort to stress its severity, to differentiate it from traditional male circumcision and to place it on the global human rights agenda. Ultimately, the shift in language was designed to assist efforts to eradicate the practice and women from affected communities spearheaded the movement to change the language used. This effort has had mixed results, with different societies using different terms. Despite efforts since 1979, many communities – especially those affected by the practice – continue to use the term cutting rather than mutilation.

In our work we prefer to use the term cutting as it is the term used by women, communities and community leaders. This is not because they endorse the practice, but rather because the term mutilation makes communities feel stigmatised and condemned, and tends to curtail both discussion and attempts to eradicate the practice.

An important consideration is the fact that the vast majority of women affected use the term *cutting*. Even affected women who consider the act to be one of mutilation, do not regard themselves as 'mutilated', 'deformed' or inferior to normal women. Whatever we might feel about the practice, one of the most fundamental of our rights is the right to self definition, and the right to use terms to refer to ourselves in a manner that does not demean us or allow us to be demeaned by others. While there are certainly women who call themselves mutilated, in our experience of reviewing the literature and speaking to women, this is exceptionally rare. Additionally, while woman may wish to express anger at the violence committed against them, they will not accept being labelled as mutilated by others. **Ultimately, it is difficult to call the practice mutilation without calling the woman mutilated.**

It is worth noting that language and culture are always in a state of mutability and change. Culture changes our use of language all the time, and as cultures seek to improve their understanding of the human condition, the language we use to describe others is an attempt to reflect this refinement. For example, we no longer consider it acceptable to refer to a person with a disability as 'handicapped' or 'retarded', and we do not speak about people who have a mental illness as 'crazy' or 'demented'. Currently we are in the process of changing our language around how we speak about women who have experienced domestic or sexual violence; for example, women and advocates encourage us to use the term 'survivor' rather than 'victim'.

For the reasons outlined above, we have decided to use the term Female Genital Cutting (FGC). We think that ultimately the use of language when speaking or reporting on Female Genital Cutting or Mutilation is an ethical consideration that media professionals must resolve for themselves. We have decided to use the language used by those affected, and again we come back to the reality that one can't call the act mutilation without calling the woman mutilated.

Section 1

What do we know about Female Genital Cutting?

Culture is not static and neither is it monolithic. Cultures are dynamic and evolving. It is a constantly shifting product of internal struggles, interaction with other cultures, social, economical and technological change (Abu- Lughod, 1991).

What is FGC?

The World Health Organization (WHO) defines Female Genital Mutilation (FGM) - also known as Female Genital Cutting (FGC) and sometimes female circumcision – as "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, 2013)

Four types of FGC have been identified by WHO, which are:

Type I

Clitoridectomy – partial or total removal of the clitoris and clitoral head or, in rare cases, only the prepuce which is the fold of skin *surrounding* the clitoris;

Type II

Excision – partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora;

Type III

Infibulation – cutting and repositioning the inner or outer labia, often also removing the clitoris, in order to create a seal and narrow the vaginal opening; the fusion of the wound is opened for intercourse and child birth, leaving a small hole for urine and menstruation

Type IV

refers to all other procedures, such as piercing of the clitoris or labia, cauterisation and cutting into the vagina.

Types I and II are the most commonly practised.

The procedure is often performed without anaesthesia by a traditional circumciser using a knife, razor or scissors. More recently, it may also take place in a hospital or clinic, performed by medical practitioners in countries where it is legal (WHO, 2013).

Who does it affect and where does it take place?

Typically, the procedure is performed on girls between 4 years of age and puberty, but it may also be carried out on infant girls or adult women before marriage.

Female Genital Cutting has been documented in 28 countries in Africa, as well as in some countries in Asia and the Middle East. As a result of immigration and refugee movements, FGC also exists in minority populations in the USA, Canada, Europe, Australia and New Zealand. However, while the practice exists around the globe, it would be more accurate to view it as being practised by specific ethnic groups and communities rather than by a whole country.

The following countries are commonly cited as having practising communities (WHO, 2014; Foundation for Women's Health Research and Development, 2014; Stop FGM in the Middle East, 2014):

1. Benin
2. Burkina Faso
3. Cameroon
4. Central African Republic
5. Chad
6. Côte d'Ivoire
7. Djibouti
8. Egypt
9. Eritrea
10. Ethiopia
11. Gambia
12. Ghana
13. Guinea
14. Guinea-Bissau
15. India
16. Indonesia
17. Iraq
18. Kenya
19. Liberia
20. Malaysia
21. Mali
22. Mauritania
23. Niger
24. Nigeria
25. Pakistan
26. Senegal
27. Sierra Leone
28. Somalia
29. Sri Lanka
30. Sudan, northern
31. Togo
32. UAE
33. Uganda
34. United Republic of Tanzania
35. Yemen

The list above is not exhaustive; it is commonly accepted that there are many more countries with small communities living within that practise FGC.

According to the World Health Organization (WHO), it is estimated that FGC is experienced by **140 million women and girls around the world**, including 101 million in Africa (WHO, 2008)

Human impact of FGC

In the case of some women, the procedure of FGC compromises their physical health and devastates their sense of wellbeing. The procedure leaves them subject to a lifetime of emotional pain and on-going and severe health problems. Other women experience no health effects and go on to enjoy good sexual and reproductive health. The degree of severity and trauma is highly varied, and some women do not seem to exhibit any post-procedure difficulties – physical or psychological.

Hence, drawing a comprehensive and consistent picture of the effects of FGC has been extremely difficult. It has been difficult to establish whether, to what extent and how women and girls who have undergone FGC are affected – from both a physical and psychological perspective. Some consider the current research findings unreliable because of inconsistencies in the findings, the very limited number of studies conducted to date, the small sample sizes in research projects and the varying quality of research design and methodology.

Some of this difficultly arises not only in the type of cutting performed but in the varied circumstances in which cutting itself takes place. This includes the skill of the person performing it, the hygiene involved in the procedure, the physical health of the girl/woman on whom it is performed and the immediate healthcare provided afterwards (The Hastings Centre 2012).

Nonetheless, research has identified a number of physical health impacts associated with FGC (Multicultural Centre for Women's Health 2013; WHO 2014).

In the short term, these potentially include:

- severe pain
- shock
- severe bleeding and haemorrhage
- wound infections, including tetanus and blood-borne viruses (Hepatitis B and C; there is conflicting evidence regarding HIV, although WHO suggests it may increase risk of HIV transmission)
- urinary retention
- injury to adjacent tissues
- fracture or dislocation as a result of restraint used
- damage to other organs, and
- death.

In the long-term, they may include:

- complications in pregnancy and childbirth
- chronic vaginal and pelvic infections
- difficulties with menstruation
- difficulties in passing urine and chronic urinary tract infections
- renal impairment and possible renal failure
- damage to the reproductive system, including infertility
- infibulation cysts
- increased risk of HIV(there is conflicting evidence regarding HIV, although WHO suggests it may increase risk of HIV transmission) and other sexually transmitted infections

- pain during sexual intercourse, and
- death during childbirth.

In terms of emotional and psychological health, research has identified that women who have undergone FGC may be more likely to develop varying levels and types of psychological difficulties, compared with women who have not undergone any form of the procedure (Osinow & Taiwo 2003; Behrendt & Moritz 2005; Applebaum et al 2008; Lightfoot– Klein, 1989).

The psychological and mental health impacts may include:

- chronic anxiety
- depression
- low self-esteem
- feelings of incompleteness
- somatisation
- phobias
- memory problems
- Post-Traumatic Stress Disorder (PTSD), and
- other psychiatric diagnoses.

There are also women who report having strong, vivid and painful memories of the procedure, which some experience as traumatic feelings of intense fear, horror, helplessness, pain, or continued suffering from intrusive memories of the experience (Behrendt & Moritz 2005). For those traumatised by the actual operation, their culture may not give them any means of being able to express their feelings or resolve their trauma (e.g. through therapeutic treatment), leading to further distress.

In contrast to the findings above however, the Norwegian Knowledge Centre for Health Services, *Kunnskapssenteret*, conducted a systematic review and meta-analysis of research assessing the psychological, social and sexual impact of FGC. The Centre concluded that the existing literature did not provide sufficient evidence significantly linking FGC to specific psychological problems (Berg et al 2010).

Researchers also indicate that in much of the developing world, women lack access to healthcare and have inadequate health awareness. Hence, not all the health issues identified in those regions are necessarily linked to the practice of FGC (The Hastings Centre, 2012).

The above research emphasises the complexity involved in conducting reliable research and arriving at any firm conclusions about the impact of FGC. More research, with larger samples using culturally appropriate methods and understandings that assess different types of FGC is likely to deliver better and more meaningful results so that we are able to fully understand the impacts of FGC on women's lives.

Why is FGC practised?

Female Genital Cutting is a complex cultural and socio-political phenomenon, with historical references to the practice that predate Judaism, Christianity and Islam (Huebner 2009). Neither today, nor in the past, does there appear to be an overarching meaning, reason or articulated purpose for the practice. Nor are there geographical, cultural or religious indicators that explain its origin or development. It is practised in radically different societies and cultures for what appear to be widely varied purposes.

To demonstrate the complexity, persistence and the very long shadow that FGC has cast over women's lives for centuries, we have included a brief history of the practice. This history demonstrates that until recently, FGC was a far more common phenomenon, even penetrating some Western societies and was by no means exclusively the domain of non-western communities.

The exact origins and historical reasons for FGC are unclear. It was first documented in Ancient Egypt as a practice performed at birth, and in later writings as a practice performed at the time of marriage, suggesting a ritualistic element to it at the time (Lii 2009). Other researchers have suggested that the practice possibly began even earlier, most likely as a medical procedure aimed at fixing an irregularly long and therefore perceived as a 'deformed' clitoris (Knight 2001; Lii 2009).

Later, ancient rituals and medical opinions combined to give it a social and moral meaning, leading to "the continuation of a practice that initially may have been narrowly performed and whose original motivation most likely had long been forgotten." (Knight 2001; p. 332).

Centuries on, it was practised in Europe and America, and according to researcher Elizabeth Estabrooks' (n.d) documentation for the United Nations, FGC also took place in Australia as a method of 'curing' masturbation. Further, it was seen by some as a cure for women's mental disorders and general health complaints, as well as a way of reducing their libido (Bell 2008; Royal College of Nursing 2006; History of circumcision 2013; Estabrooks, n.d).

There is evidence that clitoridectomy was practised in the United States until at least 1904 and perhaps into the 1920s (Barker-Benfield, 1996). A 1985 paper in the *Obstetrical & Gynecological Survey* claims it was performed into the 1960s to treat hysteria, erotomania and lesbianism (Cutner, 1985).

Today, the practice of FGC needs to be seen in the context of the individual's understanding and that of her family's, as well as the complex web of influences that sustain this understanding. The reasons, meanings and motivations offered to explain the practice vary between countries, communities and ethnic groups. Typically in practising communities, it is now seen a rite of passage, bringing a sense of pride, respect, honour and status to the girl undergoing the procedure, as well as to her family. Participating in the age-old custom is perpetuated as a way of maintaining a sense of community, belonging, cultural identity and social acceptance, especially at the time of marriage (WHO 2008; 2013).

Practising communities commonly cite the following reasons for carrying out FGC

Sense of Belonging and Identity

Many people, including the women and girls themselves, consider FGC to be a natural, useful and important ritual that is carried out in their best interests. Rewards, public recognition and celebration may follow the procedure, further reinforcing the tradition by contributing to a girl's sense of pride and self-esteem that are associated with notions of coming of age and cultural belonging.

Communities are often unaware of the potential health risks posed by the procedure. However, even when this awareness exists, even among the women and girls themselves, the social pressure to conform appears to outweigh the fear of harm. Families and girls who resist may face the threat of disapproval, rejection, being ostracised and ultimately of isolation.

A Matter of Honour

By rendering sexual intercourse painful, physically complicated (especially in Type III) and by reducing a girl's libido, FGC is seen as a way of preserving her virginity or chastity before marriage and ensuring fidelity after marriage, which are both important requirements in some groups.

Virginity is the basis for marriageability while also enforcing the prohibition of sexual relationships outside of marriage. Virginity is considered fundamental to a family's honour and many girls will not be considered marriageable unless they have had the procedure. After marriage, FGC is seen to ensure that her husband will be the father of her children.

Marriage and Economics

In communities where the practice of FGC is deeply rooted, an 'uncircumcised' girl is not eligible for marriage and will be perceived as a potential economic burden on her parents. This encourages parents to have their daughters undergo the FGC procedure.

Where women are largely dependent on men, economic necessity can be a major determinant to undergo the procedure. Socially, an uncircumcised woman cannot be accepted as a serious and responsible adult unless she has had the operation. FGC is also sometimes a prerequisite for the right to inherit. Marriage and reproduction are the only guarantees for a woman to gain economic security and social status. Marriage is seen as a way to ensure a woman will have access to the old age pension, as well as respect in society.

Religion

Although FGC is often associated with religion – by both communities who practise it and those who do not – none of the holy books of the three Abrahamic faiths mention FGC. Nor is FGC encouraged or sanctioned by religion according to any reliable source. Further evidence that FGC's connection to religion is weak is that the practice predates both Islam and Christianity, dating as far back as the fifth century B.C. (Cassman, 2008).

In Islam, Sunnah[1] attributed to Prophet Mohammad (PBUH)[2], in which he attempted to restrict the severity of the cutting, is sometimes cited in defence of FGC. The authenticity of this reference has been heavily disputed, but if true, tends to suggest that the practice was indeed prevalent before the advent of Islam and that the Prophet (PBUH) sought, at the very least, to curtail the practice. This view is supported by the work of some religious leaders who have participated in efforts to eradicate FGC in the name of Islam (*Stop FGM in the Middle East*, 2014). In 2013, Sheikh Isse Musse, a prominent Muslim Imam in Victoria, stated on SBS television's *Insight Program* that Shari'ah[3] deems the practice prohibited because of the potential harm inflicted on women (Insight SBS 2013).

Beauty and Hygiene

FGC is also perceived as a means of beautification and cleansing. Female genitalia are considered by some to be ugly and impure. It is believed that excision is essential to prevent infection and maintain cleanliness, as well as to enhance the physical beauty of women. There is also a belief that if a woman has not undergone infibulation, air will enter through the vagina and cause infection (*RACOG 1997*). In South East Asia – predominantly in Malaysia and Indonesia – the practice is referred to as *sunat perempuan*, and among the various reasons given the most common are cleanliness, 'purifying the genitals' and 'bestowing gender identity'.

Gender Identity

Gender identity is also given as a reason for the practice of FGC. This explanation is not that common and cited by only some communities[4]. It is practised to clearly distinguish the sex of an individual based on the belief that the foreskin of a boy makes him female and the clitoris of the female makes her a male. So in some FGC practising countries, the removal of the clitoris which is believed to be a male part of the anatomy, makes a woman feminine. In addition, the clitoris is considered to be ugly on a girl and must be removed to eliminate any indications of maleness.

1 Normative behaviour of the Prophet Muhammad (PBUH) that Muslims use to varying degrees to guide their own behaviour and beliefs.

2 Peace be upon him- a traditional blessing by Muslims when citing the Prophet Mohammad.

3 For many Muslims meaning Islamic law. It is not strictly a code, but a combination of a number of Islamic theological sources, including the Quran and the documentation of Sunna; hadith.

4 These beliefs primarily held by the animist Dogon people of Mali. Dogon are an ethnic group living in the central plateau region of the country of Mali, in Western Africa, south of the Niger bend, near the city of Bandiagara, in the Mopti region.

Section 2

Tackling the Practice of Female Genital Cutting: Affected Communities Taking Control

"Whether deliberate or unconscious, those working in the media have the power to marginalise and construct the racial or ethnic minority communities as 'other'. This power comes from the capacity to make connections, to represent events or issues in the context of pre-existing fears or prejudices."

(Anti-Discrimination Board NSW; 2003, 10)

Addressing FGC: Grassroots Movements and International Influence

Today, Female Genital Cutting is globally recognised as an issue of human rights, health and gender, affecting millions of girls and women around the world (WHO, 2013). In fact, affected communities were the first to place FGC on the human rights agenda and were the first to commence work towards its eradication as a human rights violation. It was an understanding that evolved over time after years of grassroots campaigning within affected communities aimed to raise awareness about the harmful impacts of the practice and its scope. Today FGC is seen as a human rights violation because:

- FGC has no health benefits for the girls or women who it is performed on, only health risks which can potentially be severe and even fatal. As such it violates a person's right to the highest attainable standard of health (including reproductive and sexual health after maturity), security and physical integrity, the right to be free from physical and mental violence, injury and abuse, torture, cruel, inhumane or degrading treatment, and, in some cases, the right to life;
- FGC aims at controlling women's bodies and sexuality;
- FGC is nearly always carried out on minors, and because of the potential for harm, it is seen by many as a form of violence against children.

History shows that education initiatives led by communities themselves have been the most effective means of influencing and affecting change in practising cultures. When the empowerment efforts were initiated from within, trust and credibility with communities has been established, and the message respected. The conclusion is that locally -led initiatives tend to have a much more effective and sustainable impact, with significantly less resistance.

In African countries, research demonstrates that resistance to FGC by indigenous and affected communities has been on-going since the 1920s. The table below is a timeline of the grassroots' campaigns and activism aimed at mobilising globally against FGC. From our own research, it appears as if African nations and Egypt spearheaded the global campaign for the eradication of the practice, at least at the beginning.

Timeline of International Grassroots Activism and Campaigns

Early 1900s	Colonial administration and missionaries in the African countries of Burkina Faso, Kenya and Sudan enact laws and church rules against FGC but this only provokes anger against foreign interventions.
	In the late 1920s, The Egyptian Doctors' Society calls for FGC to be banned, and opposition to the practice continues throughout the 1930s – 50s.
1940–1950s	Governments of Sudan and Egypt attempt to pass laws but are ineffective largely because of a lack of prior community awareness campaigns.
	The first international initiative addressing FGC is taken by the UN Commission on Human Rights in the form of a resolution. In 1958, the UN Economic and Social Council invites the World Health Organization to undertake a study on the persistence of customs subjecting girls to ritual operations (*OHCHR, 2013*).
	In 1957-58, an Egyptian women's magazine, Hawwaa, publishes a series of articles criticising FGC. As a result, it becomes illegal to perform it in any of Egypt's state-run health facilities (*El Salam, 1999*).
1960–1970s	Indigenous African activism against FGC takes place. Women's groups lead intermittent campaigns to educate communities. Doctors in Sudan, Somalia and Nigeria begin to document the procedure and write about clinical complications in medical journals.
	The Egyptian physician and writer, Nawal El Sadaawi, publishes her controversial book Women and Sex (1972), describing FGC as a form of violence against girls.
	The WHO sponsors the first seminar on harmful traditional practices affecting the health of women and children in Khartoum, Sudan. Activists from several African countries lead a vote to end all forms of this practice, but their efforts are repeatedly undermined by the medical community of Africa, as well as by western attempts to 'medicalise' the practice.

1980s	African women continue to organise. Four African women activists attend the UN Mid-Decade Conference on Women, as well as the NGO Forum in Copenhagen. Conflict arises between approaches of indigenous African women and those of outsiders towards tackling FGC. A few western women who speak out are perceived by African women as condescending and confrontational. An informal African Network is established.
	In 1984, a group of African women organise a meeting of local NGOs in Dakar, Senegal, resulting in the formation of the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC).
	In the next 15 years following the Dakar Seminar, IAC affiliates are founded in over 26 African countries. This regional network has worked to educate national governments, as well as the general public about the harmful effects of FGC.
	FGC is highlighted as a human rights violation practised against the vulnerable in the 'private domain' of the family, as opposed to the public sphere in which most traditional laws and human rights analysis is focused.
1990s	Strong African leadership on FGC results in female genital cutting being recognised as a fundamental violation of human rights. In 1990, CEDAW releases a recommendation and increasing pressure from the women's movement result in the appointment of Rhadika Coomaraswamy as Special Rapporteur on Violence Against Women.
	The practice is officially recognised as a violation of human rights at the Vienna World Conference on Human Rights in 1993, triggering the start of the practice being outlawed by some African countries.
	In 1998, a group of African women physicians begin a grassroots' campaign in Nigeria called Campaign Against Female Genital Mutilation, to bring together all the local campaigns against FGC in Nigeria.
Today	An extensive network of African organisations including women's NGOs, health, human rights and legal organisations work to eradicate FGC. UN Agencies like WHO, UNICEF and UNFPA provide technical and administrative support. Now, the focus is on basic information, education and communication (IEC) strategies.
	Increased use of innovative methods to reach the population, such as music, theatre and films are employed. Focus is also on engaging members of the community, such as opinion leaders, religious authorities and village elders in local campaigns.

The Global Anti-FGC Campaign Continues

Despite international initiatives to ban and eradicate FGC, the practice is on the rise in South East Asia. Experts say this correlates directly with increasing conservative attitudes throughout the region. In an attempt to reduce public health risks, the governments of Malaysia and Indonesia have authorised Female Genital Cutting to be conducted by medical professionals. In 2010, the Indonesian Ministry of Health standardised the procedure across all public healthcare facilities, and the Malaysian Ministry of Health is in the process of doing the same. The Malaysian Islamic Council has gone so far as to make it a religious obligation. Civil society organisations, however, are playing a pivotal role in fighting against this mindset by focusing on separating this cultural practice from religion and raising awareness about its detrimental impact on girls and women. The Muslim feminist organisation in Malaysia, *Sisters in Islam*, and Indonesian women's organisation, *Kalyanamitra*, are leading activism in this region.

At the global level, the first initiative addressing FGC was taken in the 1950s when the issue was addressed within the UN Commission on Human Rights. In 1952, the UN Human Rights Commission adopted a resolution on the issue (*UNICEF, 2005*) and in 1958, the UN Economic and Social Council invited the World Health Organization to undertake a study on the persistence of customs that subject girls to ritual operations (*OHCHR, 1995*).

With 1975–1985 declared the UN Decade for Women, significant opposition to FGC began to grow during this time. This included a series of actions such as research, writings and seminars. Driven by consistent local struggles against the practice, FGC continues to be raised at various international forums today. It was addressed at both the Five-year Review of the Implementation of the Beijing Declaration and Platform for Action Event (Beijing +5) in 2000, and Ten-year Review (Beijing +10) in 2004. Furthermore, *A World Fit for Children*, a document that emerged from the 2002 UN General Assembly Special Session for Children, calls for an end to "harmful traditional or customary practices, such as FGM/C." In 2008, the World Health Assembly passed a resolution (WHA61.16) on the elimination of FGC, emphasising the need for concerted action in all sectors – health, education, finance, justice and women's affairs. In 2010, WHO published a "*Global Strategy to Stop Health Care Providers from Performing Female Genital Mutilation*" in collaboration with other key UN agencies and international organisations, and in December 2012, the UN General Assembly accepted a resolution on the elimination of female genital mutilation/cutting.

There are some solid government and civil society programs that are working on awareness- raising and eradication of the practice in Australia. These are listed in Appendix 1.

Section 3

Guidelines for Good Practice in Media Reporting on Female Genital Cutting

When having contact with women for the purposes of reporting, don't assume women feel mutilated. Don't assume they feel harmed. Don't assume they want to speak about it, have an opinion on it, or know why FGC is practised. Most especially, don't assume you are talking to a woman who feels she is a victim.

In this section we have compiled some practical guidelines which we hope will help you when you approach communities, spokespeople and report about FGC.

Recommendations for Journalists

1. **Remember that FGC is not totally or solely African**

   You should be aware that for many readers, listeners and viewers, media coverage on FGC will be the only information they receive about the practice and the communities it affects.

   Looking at stories generated in the Australian media, the vast majority of reports on FGC have focused on African communities. This may lead some people to believe that *only* African women have FGC performed on them. People may also mistakenly conclude that *all* communities living in countries in Africa practise FGC. Neither is true.

2. **Avoid sensationalist terms and stigmatising affected women**

   Choose your language carefully and sensitively when reporting on FGC and avoid language that implies judgement from a cultural perspective. Terms like 'horror', 'brutal', 'barbaric' and 'torture' are prejudicial, racially loaded, inflammatory and derogatory terms that should be avoided. Such descriptions do not further the public's understanding of the issue and only risk alienating affected communities.

3. **Be careful about the way you describe the procedure**

   Exercise discretion in your description of FGC procedures. Describing the procedure should neither be avoided nor should it be gratuitous or lurid in detail.

   Using the non-judgemental term, Female Genital Cutting (FGC) - as opposed to Female Genital Mutilation (FGM) - is preferable as it objectively describes the practice. Using the term mutilation can be viewed as removing dignity and enforcing a "victim" status on affected girls and women. However, the term FGM is sometimes used to express the severity of the impact of the practice on women. Responsible reporting should bear these issues in mind.

4. **Remain consistent with use of terminology**

   When conducting interviews and speaking to women, community representatives and professionals, we recommend that you respectfully use the language of the interviewees. Likewise, remain consistent in your use of terminology. For instance, if you use the term FGC in your interviews with professionals, affected communities and women, then use FGC in your report. Alternatively, the same would apply for FGM. If you decide to change your use of terminology, explain the change to those you have interviewed or those who have contributed to your story.

5. **Avoid sensationalist headlines and captions**

   Careful consideration needs to be made when writing headings and captions. There is a risk of distorting, trivialising and sensationalising the story through attention-grabbing headings.

6. **Take care in your choice of images and photos**

   Exercise a high level of discretion in your use of images and photos when reporting on female genital cutting. When using photographs ensure the following:

   - that the image does not distort the reality of FGC
   - that the image does not racialise the issue, and
   - that the image does not contribute to existing issues of racism and marginalisation that some communities feel.

   Again, in our experience, the vast majority of images used for articles on FGC are of African women or women of African descent. This creates an inaccurate profile of practising and affected communities which are highly diverse communities.

7. **Avoid racist claims in your report**

   Racism is strong and present among all societies and cultures. At the heart of racism is the belief that one's own race is superior to others. FGC in particular leaves reporters and the general public susceptible to this, in the sense that cultures which do not practise FGC are considered more advanced than cultures that do.

   Female genital cutting has the potential to seriously impact on women so it is important to treat the reporting of the procedure seriously at all times. Comparing women who have experienced FGC with women from other ethnicities should be avoided. There is not a competition between women of different ethnicities in relation to their development and freedom. Comparisons will make affected women feel inferior and further stigmatise an already disenfranchised community. Racial/cultural comparisons also trivialise what is a harmful procedure by framing the practice as simply a comparison between two cultures.

8. **Contextualise your report**

   You should attempt to put reported incidents of FGC in the international and social context where possible – to help the reader, listener and viewer make sense of the story.

   Refer to reputable studies and analysis to back up your story. Where possible you should use existing data, research and evidence about the current practices of female genital cutting and avoid the mythology and sensationalism surrounding FGC as a topic. For example, although FGC Types III and IV may be better stories – because they attract greater 'readership' - FGC Types I and II are far more pervasive as a practice and therefore better reflect the experiences of affected women. Be balanced in telling your story, avoid stereotypes, distortions and over-simplifications.

9. **Acknowledge those communities challenging the practice of FGC**

   It is important to remember that affected communities have themselves been the primary instigators of change, and that in every community which practises FGC there is also work being undertaken to eradicate it. Progress has been made in many communities around the world in tackling the tradition and eliminating the practice. Conveying this part of the story to your audience will allow the readers, viewers and listeners to fully understand the complexity of the issue and bring them closer to the reality on the ground and innoculate them from sweeping generalisations, such as the belief that all people from Iran or Indonesia condone FGC.

10. **Be aware that the history of practice is not 100% clear**

    Exercise discretion when providing explanations of FGC to your audience. Be aware that there is no irrefutable evidence as to why female genital cutting is practised. There are also divergent theories in different parts of the world to explain the practice of FGC. To date there is no compelling and evidence-based explanation as to why FGC is practised or how it evolved.

11. **Avoid explaining FGC as solely a cultural practice**

    FGC is not unique or isolated to any particular cultural, religious or ethnic grouping or specific part of the world. Radically different cultures practice FGC. Explaining FGC solely as a cultural practice is insufficient to explain the complexity of the practice, for example communities in Iran and Kenya practice FGC but they are distinctly different cultures.

12. **Recognise that FGC is foremost a reproductive health issue**

    FGC should be understood and represented as a reproductive health issue. This is consistent with community understanding, international campaigns and current Australian Government-funded initiatives and services which are aimed at its eradication.

13. **Avoid presenting FGC as a multicultural issue**

    Avoid reference to multiculturalism either in the Australian context or otherwise. It is important to keep in mind that multiculturalism is ostensibly a set of policies that seek to improve the life chances for immigrant communities, not a set of policies designed to explain or justify cultural rituals.

14. **Be self-aware about possible impact of reporting about FGC on your story**

    You should be aware of a possible personal impact on you when reporting about FGC. Discovering the severity and impact of FGC can be a shocking experience for some journalists. Where possible we advise the journalist to seek support and a debriefing. A failure to adequately appreciate the effects that learning about FGC may have on yourself may lead to you adopting a tone or language that expresses how you feel about the practice but does not further the general community's understanding about the issue.

15. **Consider the potential influence you wield as a reporter**

    As a responsible journalist, be aware of the impact and influence of your own cultural biases on how you report a story.

16. **Don't jump to conclusions about the impact of FGC**

    You need to exercise judgement and discretion when making claims about the impacts of FGC on women and girls. There has been limited and inconclusive research on the physical, emotional and psychological effects of female genital cutting.

17. **Respect affected women/girls' privacy**

    You should respect the privacy and dignity of girls and women affected by FGC by keeping the following in mind:

    - Be aware that you are talking about female genitalia,
    - Be aware that women must continue to live in their community and their social circle with all the usual social rules and norms,
    - Be aware that it is difficult for women to speak about their sexual and reproductive health and well-being, and
    - Be aware that many cultures place significant restrictions on discussion about sexuality and reproductive health. These restrictions are applied more stringently on women.

    Respecting privacy is crucial. Remember that you are interviewing women not only about the potentially traumatic procedure they experienced as a child. You are also expecting women to speak about their genitalia and a part of their life that would be difficult for most women to speak about, much less for women who come from cultures in which such discussions are not held in the public space.

18. Be sensitive in your approach to community members for interview

You should be aware that members of communities often directly link media coverage with their prospects for resettlement and integration. Hence, community leaders and members will avoid cooperation with any story that may bring negative attention to their community. Many communities may refuse or avoid contact with media specialists because of a belief that the media will always sensationalise or racialise the issue of FGC, or represent them as inferior. Therefore journalists may encounter greater suspicion and distrust than they might ordinarily face.

19. Getting the full story – use an interpreter

You should never use a community member who has limited proficiency in English without an interpreter. In organising an interpreter it is essential that they are of the same sex as your interviewee, that you share the name of the interpreter with the interviewee and that you secure their consent prior to the interview taking place. This helps to maintain the confidentiality of your interview.

In the interview process, all questions and answers should be directed to the interviewee, not to the interpreter. Maintain eye-contact with the interviewee at all times. Direct the interpreter to interpret word for word rather than summarising the interviewee's responses. This is because summarising an interviewee's responses for the sake of proficiency or speed can radically change the interviewee's meaning. Finally, it can be useful to have the interpreter interpret back to the interviewee your understanding of their statement.

20. Consult reputable health organisations for background information and avoid racial profiling

When developing and researching a story on FGC, it is best to contact government-funded health services. These services are a good first point of contact because they are easily accessible, they are a reliable source of information on both the state and national picture, and they also assist women to deal with the health impact of FGC and undertake preventative work towards its eradication.

Consulting health services will assist in dealing with differences of opinion, contradictory information and help deal with inaccuracies that might be provided by different community sources.

These services are recommended because they are closely connected to practising communities. Hence their community linkages are strong. Additionally, they are strongly linked to hospitals and other women's services that work directly with affected communities. They will recommend other professionals to assist you in the development of your story.

Importantly, consulting government-funded health services also assists you to not fall into the common mistake of contacting African community leaders or African community organisations directly. Many African communities do not practise FGC and have no awareness of the practice.

Therefore contacting African community members and organisations leaves you susceptible to accusations of racial profiling. Journalists should also avoid contacting high profile community leaders, who do not have experience of the issue or the work being undertaken to eradicate FGC. This is a source of much frustration for communities.

21. Clearly explain who has the final say over the story you produce

It is crucial as a journalist that you tell those you are interviewing for your story that you may not have the final say on the editing of your written piece, the picture attached or the headline used. Many communities are simply not aware that a journalist may not have the final say on the completed 'product'. Misunderstandings over this negatively affect relationships and trust between community members and journalists making future work difficult.

22. Maintain fair and balanced reporting in the face of your deadlines

When building ongoing relationships with communities, you need to be aware that community members do not care about deadlines or other pressures that may impact how you write the story. If you report in a fair and balanced manner, community members will continue to support you in future stories you may write.

Case Studies

Media example 1

Egypt launches first prosecution for female genital mutilation after girl dies

Dr Raslan Fadl and father of the 13-year-old girl who died during cutting are the first to be prosecuted in Egypt for practice of FGM.

(Written by Patrick Kingsley in Cairo for the Guardian)

theguardian

Sohair al-Bata'a, a 13-year-old Egyptian girl who died after being subjected to female genital mutilation. Human rights groups forced the government to reopen the case

A doctor will stand trial for the first time in Egypt on charges of female genital mutilation, after a 13-year-old girl died following an alleged operation in his clinic last year. In a landmark case, Dr Raslan Fadl is the first doctor to be prosecuted for FGM in Egypt, where the practice was banned in 2008, but is still widely accepted and carried out by many doctors in private.

Sohair al-Bata'a died in Fadl's care in June 2013, and her family admitted that she had been victim to an FGM operation carried out at their request. The case was initially dropped after an official medical report claimed that Sohair had been treated for genital warts, and that she died from an allergic reaction to penicillin. But after a campaign by local rights groups and the international organisation Equality Now, as well as an investigation by Egypt's state-run National Population Council (NPC), the country's chief prosecutor agreed to reopen the case – leading to this week's seminal prosecution of both Fadl and Sohair's father.

"It is a very important case," said Hala Youssef, head of the NPC, which had pushed for the case to be reopened. "It's the first time that somebody in Egypt will be prosecuted for this crime, and it should be a lesson for every clinician. The law is there, and it will be implemented." According to Unicef, 91% of married Egyptian women aged between 15 and 49 have been subjected to FGM, 72% of them by doctors. Unicef research suggests that support for the practice is gradually falling: 63% of women in the same age bracket supported it in 2008, compared with 82% in 1995. But according to research, FGM still has high support in areas with a lower standard of education, where proponents claim mutilation makes women less likely to commit adultery. Families living near where Sohair died have not been put off the practice, says Reda Maarouf, a local lawyer involved in the case; they simply go to other doctors. Sohair's family are reported to oppose her father's prosecution. "It's a cultural problem, not religious," said Vivian Foad, an official who led the NPC's investigation. "Both Muslims and Christians do it. They believe it protects a woman's chastity."Some Islamic fundamentalists claim FGM is a religious duty, but it is not nearly as widespread in most other majority-Muslim countries in the Middle East. Suad Abu-Dayyeh, Equality Now's regional representative, said: "It's very much rooted in Egypt, but in other Arab

countries – in Jordan, in Palestine, in Syria – we don't have it."

There are four main methods of committing FGM, according to the World Health Organization, and Abu-Dayyeh said the practice of removing a girl's clitoris and labia was probably the most common in Egypt. "It's a very painful procedure and I don't know why they do it. It's the worst one," said Abu-Dayyeh, who visited Sohair's grave in Mansoura, northern Egypt, as part of Equality Now's campaign. "Women will really not feel any pleasure when having sex with their husband. It's criminal." Foad hopes Egypt's interim government will be more proactive about FGM than the administration it replaced after Mohamed Morsi's overthrow last year. Officially, Morsi's Muslim Brotherhood claimed they opposed FGM, but prominent members and allies of the group expressed support for it. "People are entitled to do what suits them," said Azza al-Garf, a female MP from the Brotherhood's political arm, in 2012. Another ultra-conservative MP, Nasser al-Shaker – a member of a Salafi party that was then an ally of the Brotherhood – called for legalisation of FGM, and said it had a religious mandate.

Two years on, Egypt's leadership has been criticised internationally for other human rights abuses, but Foad hopes it will be more progressive than its predecessors on FGM. "Under Morsi, they didn't create a conducive atmosphere through the media, and through education – not only for FGM but all women's issues. Now the government is responding positively, and the media is responding positively."Abu-Dayyeh said Fadl's prosecution was just the start. The case would count for little unless the doctor was jailed and an anti-FGM awareness campaign reached the country's poorest districts, she said. "Now you need much more work. And it has to be done far away from Cairo – in the [rural areas] where the practice is very widespread."

Our analysis

This article demonstrates accuracy, fairness and balance in reporting. All the information included is directly relevant to the story. The article does not dwell on the procedure or the different types of cutting, nor does it dwell on the 'horror' of the story. By simply using an image of the young girl, it reveals the terrible harm and devastation that FGC can inflict.

Furthermore, the article shows a diversity of views; it engages and exposes the enormous social, cultural, religious and even political complexity inherent in eradicating FGC. It also gives a social analysis of the practice in the region. Rather than treating practising communities as unthinking actors, it focuses on the positive action being taken by civil society and the government to mitigate the issue.

Finally, the article ends on a positive note with one of the key anti-FGC campaigners in the story foreshadowing future work which might be done and citing the crucial connection between the media and the new government which advocates hope will promote more education and progressive messaging on FGC.

Media example 2

Breaking the silence over genital mutilation horror

7.30 By Caro Meldrum-Hanna Updated Tue 30 Oct 2012, 1:14pm AEDT

Across the nation, young girls are being mutilated in a brutal and barbaric practice that most Australians struggle to comprehend.

More than 120,000 migrant women in Australia have suffered genital mutilation – a brutal religious practice common in Islamic populations in Africa, South America, parts of Asia and the Middle East.

There is no data held on how widespread female genital mutilation is in Australia, but 7.30 has spoken to women who are voicing their concerns despite the fear of rejection from their communities. The genital mutilation is carried out by women on girls between the age of four and 10.

It is a crime in Australia and is not sanctioned by the Koran; nonetheless, it is happening behind closed doors.

7:30 understands the women chosen to do the cutting often do not have any medical qualifications, with the procedures being carried out in people's homes using crude surgical implements. The procedure can range from a small cut to a girl's clitoris to the entire removal of the genitals.

In extreme cases the wound is sewn up to leave only one opening – the size of a matchstick – for urination and menstruation.

'Clandestine practice'

Imam Afroz Ali, one religious leader prepared to break the silence, says female genital mutilation is a "clandestine practice".

"I have had people mention it has happened to themselves, it's happened to members of their family or they are aware this is happening in Australia," he said.

It is also common for the women doing the cutting to charge a fee for their services.

"The figure could be around $2,000 to $3,000 … the reality is that they are not qualified at all," Mr Ali said.

"These are women from a village who have migrated to Australia and have access to a razor blade and are considered to be an elder or wise person in their community."

Zarine, who moved to Australia six years ago, comes from a Muslim sect known as the Dawoodi Bohras, who originate in India.

In India, female genital mutilation is called traditional cutting.

Zarine was five when her grandmother told her they were going to the market.

Instead, she was taken to a house where she was pinned down and mutilated.

"There were about three other women there – they were sitting and chatting.

They were from the same community because they were speaking the same language," she said.

"They asked me to take my underwear off … I just wanted to run out of there. I knew there was something going to happen to me.

"I don't know if it was two of the women or just one. She pinned me down with her legs pretty much and I had my legs wide open and one of them was holding my hands behind me.

"I don't remember seeing anything but after that I felt a very sharp pain. I still remember that. I still remember that pain."

Mutilation charges

Five weeks ago, New South Wales police arrested and charged eight people with the alleged genital mutilation of two girls in Sydney and Wollongong in the past 18 months.

The arrests followed an anonymous tip to the office of the NSW Child Protection

Minister, Pru Goward. "The secrecy which with this is carried out makes it very difficult for police to collect evidence," Ms Goward said.

"It is unlikely that this is an isolated incident."

The eight people arrested all belong to the Dawoodi Bohra community in New South Wales.

The identities of all those arrested have been suppressed except for one – Kubra Magennis, a 68-year-old retired nurse.

There are fears the practice of female genital mutilation spreads much wider than this one case suggests.

In September, West Australian police arrested and charged a couple with female genital mutilation after they allegedly took their daughter to Bali for a traditional cutting ceremony.

7:30 has also been told that girls are being mutilated in the town of Katanning, 200 kilometres south of Perth, home to a large Malaysian Muslim population.

Transforming lives

At the Royal Women's Hospital in Melbourne, a discreet clinic is transforming lives by reversing extreme forms of female genital mutilation.

The clinic sees around 25 women every month.

Through family planning officers like Zeinab Muhamed, the broader aim in

Victoria is to break the cycle of mothers subjecting their daughters to the procedure.

People tell Ms Muhamed that female genital mutilation is a cultural practice that is hard to move away from.

They say it is women who are pushing it. "When they tell their story, it's heartbreaking. These women have been through an experience that we can't even imagine," Ms Muhamed said.

"They spend days after the procedure when they can hardly urinate. Their legs may have been tied together so the labia actually fuses together."

'Torture'

One woman who spoke to 7.30, Samira, has been surgically reopened.

She says women in Victoria are being stitched closed again after they have given birth even though it is a criminal offence.

Samira says female genital mutilation is "torture".

"I was told whether I wanted to be stitched back up or not and I refused, and [my midwife] said some women insist on being stitched back, so I was quite surprised," she said.

Samira is strongly against the cutting of young girls but says not everyone in her community agrees.

"I think that a lot of people would still like to do it … they've been brainwashed by their families [who say] 'it's good for you, it's important, it's part of our culture'," she said.

"It all depends on the culture, the family, the religion background.

"It's very sensitive and it's hard, but you can't convince everybody to [think like you do]."

Topics: crime, islam, religion-and-beliefs, child-abuse, womens-health, women, Australia

First posted Mon 29 Oct 2012, 8:26pm AEDT

Our analysis

The use of language in this article is its most concerning feature. Terms like 'mutilation horror', 'brutal', 'barbaric' and 'torture' are prejudicial and racially loaded terminology in the context of FGC. The use of such language deeply stigmatises communities; it alienates and marginalises them and leaves them vulnerable to racism.

A statement such as 'Across the nation, young girls are being mutilated in a brutal and barbaric practice that most Australians struggle to comprehend' is alarmist, because it suggests there is a national emergency, when evidence is to the contrary. This statement also draws a racialised line between them and us– them as practitioners of a horrendous secretive crime and us as unknowing Australians. Most importantly however, such a statement suggests a conspiratorial agreement among communities. Yet, as previously mentioned in the guide, affected communities are the primary instigators of the push to eliminate FGC, with many community programs and services across Australia led by women from affected communities.

The article is also inaccurate on several points. FGC is presented as a 'brutal religious practice' common among Islamic populations. This is incorrect in two ways: firstly, while some communities employ religious justifications for the practice, FGC is not a religious practice, and, secondly, there is no evidence to suggest that it is more or less common among Muslims than among non-Muslim communities.

Furthermore, insufficient detail is provided on the type of FGC practised by the Muslim sect, Dawoodi Bohras. It is important to consider that the Bohras traditionally practise ceremonial nicking of the clitoral hood (Type IV of FGC), yet the article refers heavily to more severe forms of FGC, suggesting by omission that the case referred to involves the more severe forms of cutting. This results in an inaccurate and misleading representation of this particular Muslim sect.

One positive aspect of this story is that community members are given an opportunity to voice both their experiences and opinions.

Media example 3

Clear Cut Tuesday, 19 Feb 13

Overview

This week, *Insight* breaks some deeply held taboos to look at a practice which is as personal as it is controversial.

There has been much talk about female genital cutting, also known as female circumcision or female genital mutilation, after several high profile arrests across Australia in recent months. In December last year, Prime Minister Julia Gillard announced a *review* of the current legal framework and said a national summit would be held sometime this year. Gillard said, "It is a violation of the human rights of women and girls and there is no place for it here in Australia. Its occurrence in this country cannot be excused by culture." But some women say cultural reasons are valid, and some say that they're still able to lead healthy sex lives and achieve orgasms – even when they've undergone the most severe forms of the procedure. Presenter: Jenny Brockie

Producer: Fanou Filali , **Associate Producer:** Saber Baluch , **Associate Producer**: Joel Tozer

Finalist for the 2013 UN Media Awards: 'Increasing Awareness and Understanding of Women's Rights and Issues'

Our analysis

This media report is a strong example of respectful coverage on FGC for a number of diverse and compelling reasons.

The program's most evident strength is that it allowed women to speak for themselves on the topic. This allowed for a diverse range of views and experiences. The complexity and diversity of views, reasons and context for the practice were amply demonstrated and all the pertinent and emerging issues were covered. An additional concern relates to affected women were afforded significant exposure and the program resisted presenting these women as 'victims'. Even those who had severe and lasting effects from FGC were still very much experts about their experiences.

On the other hand, the gulf between affected and non-affected women was very much on display and, at times, this led to moments of moralism. Additionally, one of the main guests on the show defended the right of women to undergo initiation rituals such as FGC and travelled to Sierra Leone at the age of 21 to have the FGC procedure. While her experience and views were interesting and valuable, they are also highly unusual. FGC is ordinarily practiced on children and so her experience did not really represent the experience of affected women.

Nonetheless, it was a very powerful piece overall.

Media example 4

Undoing the damage

smh.com.au
The Sydney Morning Herald

Jane Wheatley Published: May 6, 2014–12:19PM

Each year more than 2 million girls worldwide are subjected to genital mutilation, but a pioneering technique is restoring hope to those affected.

It's a crisp and sunny winter's day in Barcelona and I have come to meet Fatou, an 18-year-old architecture student with a sweet smile who arrived in Spain from her native Senegal seven years ago. Like many African girls, Fatou was circumcised as a child, a procedure now known as female genital mutilation, and last year she underwent surgery to remove scar tissue and restore sensation. "Now when I have sex with my boyfriend, I feel something where I felt nothing before," she tells me. "But also I am no longer different from the Spanish girls here. At school when they talked about sexual feelings, I didn't understand. Now I am the same as them, and that is just as important."

Fatou was cut at the age of five against the wishes of her mother, who had already emigrated to Spain. "I was living with my grandmother," Fatou says. "She told me a lady would come to the house and I should be calm. There were four of us; we had to shower first, then our eyes were covered and women held our arms and legs. I was able to see the razor blade: there were four cuts. I bled a lot and cried and my grandmother was frightened, but she couldn't take me to hospital because cutting was against the law."

The practice of female genital mutilation, or cutting (FGM/C), is concentrated in most African countries and the Middle East, as well as – covertly and illegally – among immigrant communities in Australia, Europe and the US. It can take several forms but usually involves excision of the clitoris and partial sealing of the vagina. It is done ostensibly to preserve a girl's chastity and render her immune to sexual desire. When Fatou was 12 and reunited with her parents in Spain, her mother told her about the reconstructive surgery being offered free at Dexeus, a private women's hospital in Barcelona.

"My sister and I said, 'No, we didn't want it', " she says. "But then some years later at school, I did an essay about FGM and I rang my grandmother in Senegal for help with the research. She told me she was no longer arranging cutting for her grandchildren, which made me happy. Then I decided to have the surgery."

What was it like afterwards when she explored her newly exposed clitoris? Fatou laughs: "I thought it would be bigger. But now I know it is normal."

Was she able to feel pleasure? "At first it was painful, but then after a few months it began to be exciting."

Emboldened by her sister's experience, 20-year-old Kadi, a trainee nurse, also had surgery in October last year, but there were complications. "I had inflammation and a urine infection," she tells me. "I couldn't walk for a month." Now she has recovered, is sex with her boyfriend better? "It is certainly different," she says. "The intensity of the pleasure has grown. But it is only four months since the surgery, so there is room for improvement."

Two weeks after I meet the girls, Fatou and Kadi's mother is due to have the surgery: she is apprehensive, they say. What does their father think? "He doesn't understand it," says Fatou. "But he says it is her decision."

The genital reconstruction program at Dexeus is headed by 37-year-old gynaecologist Pere Barri Soldevila, who worked for several years on humanitarian programs in Africa where almost all the women he saw had undergone FGM. "But I did not know reconstructive surgery existed until I did a residency in Paris and saw the technique there," he tells me. "Then I thought, 'Why don't we do something for ladies in Spain?' Everyone at Dexeus was very motivated; we knew from the beginning that we should not charge for treatment and our foundation agreed to fund it."

He was confident there would be demand for reconstruction from migrant women. "But how to access them? It was very hard," he says. "We held a press conference to launch the program in 2007 but it was a year before we had our first patient. It takes a lot of courage to go against the culture."

Pierre Foldés is a urologist and a crusader for the rights of women to a pain-free, pleasurable sex life and safe childbirth. His technique of reconstructive surgery was pioneering work, initially developed when he worked as a volunteer with Médecins du Monde in African conflict zones. But others are picking up the baton: as well as Pere Barri Soldevila in Barcelona, reconstruction is now offered in San Francisco and, most recently, in Berlin at a clinic opened in September 2013 by Waris Dirie, the Somalian model whose Desert Flower Foundation campaigns to eradicate all forms of FGM.

Foldés operates two days a week at the Clinique St Germain, a modern building tucked discreetly away in an outer suburb of Paris. It is a place full of secrets: the women who assemble in the waiting room mostly come alone, saying nothing to husbands or family. They are silenced by shame and the distant memory of pain and fear in their childhood past. One woman sits quietly, her hands folded in her lap. Her daughter sits beside her. Soon two more women arrive: they are around 30-ish and solidly built, with a defiant, slightly aggressive air, and I think they are probably very nervous. The patients are all here in the hope that Foldés can restore their womanhood.

As I wait, leafing through copies of Paris Match, Foldés strides out of his office, a tall man running his hand through rumpled white hair, evidently harassed. He has been in theatre all morning and now faces a clinic rapidly filling up with prospective patients. Seconds later he is back: "Come, we can have a few minutes," he says. On his laptop he plays me a slide show: gruesome examples of the damage inflicted by FGM. "The women who come here are victims of this grotesque practice." He insists he does not push them towards surgery. "They may have a period of reflection, some come back again and again. They are afraid of disapproval, even threats, from their community or family members. They are walled up in their own silence and our aim is to give them back their voice."

I discover the two younger women in the waiting room are sisters, born in Paris to parents from Mali, west Africa, and they were cut when they were six and seven years old. Later they tell me about the woman who did it, a kind of procuress. "She did all the Mali girls," they say. "She would call on the mothers in our community offering to cut their daughters. We had to go to her flat to have it done. She is in prison now."

When Foldés first thought of restoring the clitoris 15 years ago, he was shocked by the dearth of information. "There was nothing, absolutely nothing on this organ, although there are hundreds of books on the penis and several surgical techniques to lengthen it, enlarge it or repair it," he says. "Nobody was studying the clitoris: it was as if it didn't exist."

Foldés explains that though the tip of the clitoris has been excised in the original cutting, several centimetres of the stump remain, complete with nerve endings. He holds up a small ultrasound device: "A very expensive bit of kit," he says, "but useful. I can show the woman the body of her clitoris on the screen.

"Scar tissue surrounds the clitoris as if it is en croute; we remove the scarring, snip the ligaments to pull up and expose a new tip and then, fibre by fibre, stitch the three layers around it to prevent it retracting."

A report by Foldés published in The Lancet journal last year was challenged by three British gynaecology consultants. His claims that neurovascular sensitivity could be preserved in a newly excavated clitoris were not anatomically possible, they said: creation of a cosmetic clitoris could not revive lost or damaged nerves.

"They are totally wrong," insists Foldés, bringing up a colourful diagram of female genitalia on his screen. "Here is the nerve running all along the trunk and these little red dots are pleasure zones – see, there are more of them in the main body than on the tip."

But he admits it is not clear how successfully sexual pleasure can be achieved with reconstruction: "Women tell me they have sexual feelings they didn't have before, but if you've never had an orgasm how do you know what it feels like?"

The elegant woman from the waiting room, who we'll call Aminata, is looking forward to finding out. When I catch up with her after her consultation, she tells me she was cut at the age of nine in her home city of Dakar in Senegal. She is now in her mid-40s but remembers the episode with terrifying clarity: "It was very early in the morning, there was no anaesthetic and the pain was unbelievable. It stays with me today – I can still conjure it up."

Aminata is a financial administrator and lives in Washington with her husband. "He was from a neighbouring country in west Africa, so he was not surprised that I had been cut. Even so, you can't understand what it does to your psyche: you don't feel like a real woman. It has an impact on your sexual relationship but you are ashamed to discuss it." She had not told her 21-year-old daughter, Kenza, that she had been cut until today: she never found the right moment. Kenza admits she was surprised: "I knew of the practice but I'd placed it in a different context – rural villages and ignorance. It was shocking to discover it had been done to my mother in the capital city."

Foldés has told Aminata that he can restore her clitoris. Has she ever achieved orgasm? "I believe I have," she says cautiously. But she is hoping for something better? "Yes! I'm feeling optimistic."

In France, reconstructive surgery for victims of FGM is funded by the government and Foldés has carried out the procedure on thousands of women. In Barcelona, since Pere Barri Soldevila launched his charitable program seven years ago, word has spread: women tell mothers who tell their daughters and numbers are slowly increasing. There have been 52 reconstructions since the first patient in 2008, 13 of those in 2013 and four already this year. Each patient has medical and psychological follow-ups after six months. "Most are happy," says Barri. "Some are extremely happy and for some it did not work – there was no difference in sensation. This could be because nerves were damaged during the procedure or because of previous damage, or for psychological reasons."

How many report achieving orgasm? "Some 75 per cent say there's been an increase in sensitivity," he says. "Between 30 and 35 per cent can have an orgasm whenever they want. But I think the reconstruction is

important to them for other reasons: they can feel like European women."

There have been a few women who have come to him for a reconstruction but when he examines them he finds they are not mutilated. "This is starting to happen," he says. "In her native country the girl has experienced the ritual that attends FGM – the party, so to speak – but she has not been cut. She was told it was done and grows up thinking she is different from European girls. Then I tell her, 'You are lucky, you don't have FGM.' In such cases, the women are referred to a psychologist."

Marci Bowers works as a gender reassignment specialist and began offering genital reconstruction at her clinic in San Mateo, California four years ago. Her patients came via Clitoraid, a charity funded by the Raelian sect, which promotes sexual pleasure as a human right. But the majority of women who seek Bowers' help are, she says, principally interested in the restoration of their feminine identity. At first Bowers was "wildly excited" at the prospect of transforming the lives of circumcised women. "But the results are not what I expected. The procedure is much more subtle than I realised and the clitoris has a tendency to retreat back under the skin of the perineum."

Like Barri, Marci Bowers studied with Foldés in Paris but admits that the disappointment may be due to her own technical limitations. "The other things we battle with," she says, "are that patients are psychologically traumatised, lack sexual confidence and may not easily access orgasm. I try not to set the bar too high and am now more guarded in what I promise."

When Khadija Gbla came to Australia from Sierra Leone, she soon realised that she was different from other girls. "The idea of reversing the procedure was the first thing I went looking for," she tells me, "but that was 12 years ago and there was nothing anywhere that I could find." Recently Gbla, now 25, read about the work of Foldés in Paris. "My first reaction was one of hope," she says, "but I am an intelligent woman – I said to myself, 'Let's think about biology.' Apparently some nerve endings remain after clitoridectomy and some women retain sensation. If you have surgery you might end up losing what little you had in the first place. Then there is the emotional and psychological toll. We are already traumatised by the original procedure – do we want to be traumatised all over again for not necessarily any gain? I don't think this is exciting news, just potential for more damage. I'm waiting for something better to come along."

Meanwhile, more than 2 million girls worldwide are subjected to FGM/C every year. Although the practice has dropped by half in a handful of countries where education has penetrated, it is still prevalent in others – up to 98 per cent of girls are cut in Somalia, according to UNICEF.

In Australia, as in the rest of the developed world, the emphasis is on prevention. At Monash Health, health worker Faduma Musse has spent 10 years working with African migrant communities to stop FGM/C happening. "It is against the law here," she says. "But girls are taken out of the country to have it done. People say, 'She is my child', then I tell them they could lose the child if they break the law. They are not happy with us but slowly people are learning. It takes a long time."

The pain of circumcision

The crude and cruel tradition of circumcising young girls takes different forms depending on local practice. In some cases, only the clitoris is excised (clitoridectomy); in others the inner lips or labia minora are also removed. Infibulation is the sealing of the vaginal opening by cutting and repositioning the inner or outer labia, leaving only a small opening for urination and menstruation. Often all three forms are practised: clitoridectomy, total excision and infibulation.

Opening up the entrance to the vagina for intercourse and delivery is known as de-infibulation and is offered by specialist clinics in the developed world, including, since 2010, the Royal Women's Hospital in Melbourne. This is a relatively simple procedure compared to the reconstructive work offered by Pierre Foldés and his acolytes elsewhere. "Routine de-infibulation leaves the vulva with two scars," Pierre Foldés tells me at his Paris clinic. "Whereas reconstruction of the lips is precise surgery."

Female genital mutilation, or cutting (FGM/C) often causes problems in childbirth. "The vulva has sometimes become attached to the pubic bone, so is not mobile and independent as it should be," Foldés explains. "This may cause both pain and a pseudo infibulation: that is to say scar tissue has partially sealed the vaginal opening, blocking the exit of the baby. In addition, intercourse and delivery can cause lacerations of the perineum with subsequent bleeding."

In some cases the vagina is left so obstructed that urine and menstrual blood cannot pass easily, cysts build up with fluid, and urinary tract and kidney infections are common. One of the more degrading consequences of FGM is a fistula, where a hole is created between the vagina and the bladder or the anus, often after prolonged labour due to the obstructed birth passage.

Our analysis

Reconstructive surgery for women who have undergone FGC is an important new development in treatments offered to affected women. This is therefore an important story. It is well told in that it provides a comprehensive review of the corrective procedure and the different outcomes doctors have achieved, or failed to achieve, for women.

The focus on young women makes this a very strong and interesting piece. The impact of FGC on the sexual awakening of young women and their sexual identity is not something we read about very often. Reporting on the experiences of both mothers and daughters, and acknowledging the changes that have occurred across generations was also very interesting and helps to further understanding of readers.

However, there are subtle and value-laden references throughout the article that detract from its strengths. The most obvious of these are a number of uncomfortable references made about young women seeking reconstructive surgery in order to be like European women. This tends to label affected women as inferior to European women, and, as stated previously, this trivialises the effects of FGC and diminishes affected women themselves. This guide suggests that a better approach might be to measure up effects of reconstructive surgery against what women might have wanted for themselves as sexual beings, or to explore the realisation of their sexual potential and fulfilment against their experience before the operation. This would have focused the story on what was most important: women's own experience. It would have also offered an evaluation of reconstructive surgery that avoided making unnecessary racial comparisons.

Finally, the article referred to young women who have sought out reconstructive surgery, but have not actually undergone FGC. This is explained by young women having attended the ceremony which ordinarily accompanies the procedure and being told that they have had the procedure. We found this unconvincing and felt that an exploration of this issue would have added value to the article. Throughout the article we are told that young women seek reconstructive surgery because of the harm and limitations that FGC has placed on their sexuality. However, these young women have clearly not experienced the harm associated with FGC. This was an important development in the story that should have been pursed further.

Recommended readings and other links

1. **All-Media Guide to Fair and Cross-Cultural Reporting** by Stephen Stockwell and Paul Scott (2000) www.griffith.edu.au/__data/assets/pdf_file/0015/32037/all-media-guide.pdf
2. **Improving the Health Care of Women and Girls Affected by Female Genital Mutilation/Cutting; A Service Coordination Guide (2012)**. Family Planning Victoria www.fpv.org.au/assets/GUIDEBOOK-FARREP-Service-Coordination-GuideFINALJuly292013.pdf
3. **What Works and What Does Not: A discussion of Interventions for the Abandonment of Female Genital Mutilation.** Obstetrics and Gynaecology International, Volume 2013 (2013), Article ID 348248 www.hindawi.com/journals/ogi/2013/348248
4. **Fighting to Make the Cut: Female Genital Cutting Studied within the Context of Cultural Relativism**, Rachelle Cassman (2008) http://scholarlycommons.law.northwestern.edu/njihr/vol6/iss1/5
5. **Listening across difference: Media and multiculturalism beyond the politics of voice**, Tanja Dreher (2009) www.tandfonline.com/doi/full/10.1080/10304310903015712
6. **Race for the Headlines: Racism and Media Discourse**. Anti-Discrimination Board of New South Wales http://pandora.nla.gov.au/tep/39681
7. **Racism and the Media** By Yasmin Jiwani www.stopracism.ca/content/racism-and-media
8. **MEAA Journalists Code of Ethics** www.alliance.org.au/code-of-ethics.html
9. **IWWCV Media Guide** www.australianmuslimwomen.org.au/uploads/3/9/5/0/3950888/mediaguide.pdf
10. **Reporting Diversity project** www.reportingdiversity.org.au/index.html
11. **UNESCO Reporting Diversity**, by Roumen Yanovski www.unesco.org/new/fileadmin/MULTIMEDIA/HQ/CI/CI/pdf/reporting%20diversity.pdf
12. **Reporting on Indigenous Issues: Practical Guidelines for Journalists** by Lynette Sheridan Burns & Alan McKee. http://eprints.qut.edu.au/14959/1/14959.pdf
13. **Immigration and Gender: Analysis of Media Coverage and Public Opinion, The Opportunity Agenda (2012)** http://opportunityagenda.org/files/field_file/immgenderFINALJuly2013UPDATE.pdf
14. **Women Health Victoria's Women Health issues paper no 9, "Women and Genital Cosmetic Surgery".** http://whv.org.au/static/files/assets/ca7e9b2f/Women-and-genital-cosmetic-surgery-issues-paper.pdf
15. Youtube clip on gender relations in a patriarchal society www.youtube.com/watch?v=hg3umXU_qWc
16. NETFA: An excellent source of information on FGC. www.netfa.com.au

Resources, Organisations and People to Contact for Further Information and Guidance on FGC

Kind thanks to Multicultural Centre for Women's Helath for their assitance in the compiling of this list.

FGM/C Related health promotion programs in Australia

Most FGM/C related programs in Australia were established under the National Program for the Prevention of FGM through the Australian Health Minister's Council Sub-Committee on Women and Health. Unfortunately, they are no longer supported directly through Commonwealth funding. Nonetheless, these programs continue to be an important service base for women and affected communities.

Australian Capital Territory

ACT Health, Women's Health Service

Originally founded in 1996 under the National Program for Prevention of FGM, the ACT FGM/C program now runs under the ACT Women's Health Service.

Deborah Colliver
Manager

All media enquiries are to be directed to :

ACT Health Communications and Marketing Unit

Telephone: 02 6205 2105
Facsimile: 02 6207 5775

healthact@act.gov.au

New South Wales

New South Wales Education Program on FGM (NSWFGM)

The NSW Education Program on FGM (NSWFGM) provides training to bilingual community workers and professional development workshops to professional sectors working with FGM/C affected communities. In 1999, the program began an education program for women called Women's Health and Traditions in a New Society (WHATINS), the success of which led to a complementary men's program. NSWFGM also undertake a yearly rural outreach program and have developed several comprehensive resources which can be accessed online, www.dhi.health.nsw.gov.au/NSW-Education-Program-on-Female-Genital-Mutilation/NSW-Education-Program-on-Female-Genital-Mutilation/default.aspx.

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Program Manager

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Linda George
Community Education and Development Officer

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Facsimile: 02 9840 3004

linda.george@swah.health.nsw.gov.au

Northern Territory

Everybody's Business Subcommittee (EBS)

In the absence of any funded programs or services relating to FGM/C in the Northern Territory, Everybody's Business Subcommittee (EBS) was founded in 2011. EBS is part of the Refugee Health/Sexual and Reproductive Health Service initiative called 'Everybody's Business'. The EBS has carried out FGM workshops for the Somali community in Darwin and mapped all local NT services and resources regarding sexual and reproductive health for migrant and refugee communities as a resource for health and community services and relevant community members.

Family Planning Welfare Association NT

Kirsten Thompson
Clinical Coordinator

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Facsimile: 08 8948 0626

nurse@fpwnt.com.au

Royal Darwin Hospital

Dr Nader Gad
Obstetrician and Gynaecologist

Telephone: 08 8922 8888
Facsimile: 08 8945 6922

Nader.gad@nt.gov.au

South Australia

Women's Health Statewide

In 1995, the FGM/C program in South Australia was orginally funded federally until it was moved to Women's Health Statewide. In 2012 it was renamed the Refugee Women's Health and Safety Program and now offers community engagement in collaboration with relevant services including refugee and immigrant services, counselling, support, advocacy and hospital referral services for women affected by FGM/C. Other work includes workforce development for relevant professionals and peer educator training for women in relevant communties.

Gillian Kariuki
Project Coordinator

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Gillian.kariuki@health.sa.gov.au

All media enquiries are to be directed to the SA Health Media Unit

Telephone: 08 8226 6488

healthmedia@health.sa.gov.au

Tasmania

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

The Tasmanian FGM/C program was initiated in 2005 by the Tasmanian Department of Health and Human Services. Since 2008, it is now part of the Red Cross Bicultural Community Health Program and offers training for bilingual community workers, training for health professionals and community education.

Ashley Mattson
Team Leader
The Bi-Cultural Community Health Program

Telephone: 1800 246 850

tasbiculturalhealth@redcross.org.au

Queensland

Family Planning Queensland: Multicultural Women's Health (FGM)

Multicultural Women's Health was founded in 1998 and provides bilingual peer education for women and men in communities and cultural awareness training in collaboration with other departments. The program also carries out advocacy, public awareness raising and has developed a range of online resources.

Multicultural Women's Health (FGM)

Odette Tewfik
Project Coordinator

Telephone: 07 3250 0250
Facsimile: 07 3257 3023

otewfik@fpq.com.au

Victoria

Family and Reproductive Rights Program (FARREP)

The FARREP Program was founded in 1995. The program is channeled through numerous organisations across Victoria in order to cover several regions and therefore each FARREP program is independently run. The programs offer education and awareness raising about FGM/C for a range of communities, ages and situations by using bilingual health workers and community workers. Other services include consultation, education and training for services providers, referrals and support for affected women and girls. FARREP also work in partnership with organisations such as schools and research organisations. Also, clinical services are now explicitly available to affected women through the Well Women's De-Infibulation Clinic located at The Royal Women's Hospital and the Mercy Hospital.

Prevention and Population Health Department of Health

All media enquiries should be directed to the Media Unit

Telephone: 03 9096 8892

Mercy Hospital

Wemi Oyekamni
Community Development Worker

All media enquiries should be directed to Adrian Bernecich

Telephone: 03 8416 7521

abernecich@mercy.com.au

Royal Women's Hospital FARREP Program
The FARREP Team

Telephone: 03 8345 3058 or 03 8345 3050
Facsimile: 03 8345 3053

Farrep.program@thewomens.org.au

Western Australia

FGM Program

The WA FGM Program delivers training to health providers and other relevant agencies. Other services provided include advocacy for communities to access services and the development of education and information resources which can be accessed online.

Carol Kaplanian
FGM and FDV Research Project Officer, Education and Training

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Other national services

There are many other services and professionals working across Australia on Female Genital Cutting. The vast majority of these organisations work with affected communities to raise awareness about the effects of FGC and support a change in attitude to prevent its occurrence. Some of these services also assist affected women to access timely and appropriate sexual and reproductive health services. We have listed a small number of organisations to assist you in developing contacts for your story.

1. MCWH is a national, community-based organisation committed to the achievement of health and wellbeing for and by immigrant and refugee women. It has developed a range of policy and position papers on Female Genital Cutting.

Multicultural Centre for Women's Health

Dr Adele Murdolo
Executive Director

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www.mcwh.com.au

2. African Women Australia (AWA) undertakes advocacy, representation, training and programs to empower African communities. Juliana Nkrumah, its founder has undertaken extensive community education and development work on FGC.

African Women Australia

Juliana Nkrumah AM
Founder/Advisor

17 Macquarie Road
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Sydney
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info@africanwomenaustralia.org

www.africanwomenaustralia.org/home.html

3. The African Women's Council of Australia (AWCoA) was formed as a result of the identified need for African women's voice. It is an advocacy organisation established to mobilise support and develop strategies to ensure inclusion, visibility and reflection of the voices, concerns and demands of African women at the local, national and international agenda. Dr Tungaraza has been undertaken extensive work on FGC with affected African communities.

African Women's Council of Australia

Dr Casta Tungaraza
President

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WA 6953

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africanwomencouncil@iinet.net.au

Appendix

Showcasing some of the work currently being undertaken across Australia on Female Genital Cutting.

Organisation Name	FGC Related Work	Contact Information
The Multicultural Centre for Women's Health	Developed a national website for FGM/C awareness and a centralised mechanism for networking; a national standard framework for FGM/C resources and sharing of resources; a best practice guide for community development program; and convened a national forum of FGM/C service providers.	Dr Regina Quiazon regina@mcwh.com.au
NSW Education Program on FGM	The Program had a professional health practitioner education component and a community education and development component. The Program worked to ensure that doctors and midwives are skilled to provide optimal care for circumcised pregnant and birthing women and their families. Bi-lingual female and male health educators worked with their communities providing health and reproductive health information to women and men, including the NSW Legislation on FGM/C	Vivienne Strong vivienne_strong@health.nsw.gov.au
Family Planning Victoria	Developed national versions of two resources: the FGM Service Coordination Guide for GPs and other primary health care providers and "A Tradition in Transition: Female genital mutilation/cutting" (including a literature review, overview of prevention programs and demographic data by LGA).	resources@fpv.org.au

Organisation Name	FGC Related Work	Contact Information
University of Sydney	Developed an on-line CPD module to assist clinicians to diagnose and discuss FGM/C, and provide accurate information and management. The project was focused on obstetricians and midwives.	Dr Nesrin Varol nesrin.varol@sydney.edu.au
The Australian Colleges of Nursing and Midwives	Developed an online national knowledge exchange on FGM/C for nurses, midwives and other professionals, which included information on CPD and other resources.	Susan Hextell susanhextell@bigpond.com
The University of Melbourne	Completed research with affected communities and service providers in regional Victoria to build evidence on knowledge and attitudes on FGM/C, service needs, and CPD needs.	Narelle White narelle.white@unimelb.edu.au
Royal Australian and New Zealand College for Obstetrics and Gynaecology (RANCOG)	The National Education Program on Female Genital Mutilation promoted the development of a consistent, holistic health approach in working with communities and facilitating supports and access to health services for women and girls affected by or at risk of the practice. It worked on promoting good practices involving sensitive care for women and girls to facilitate better health care and support services.	Nesrin Varol Nesrin.varol@sydney.edu.au

Organisation Name	FGC Related Work	Contact Information
African Women Australia	The Our Voices: Filling in the Gaps – FGM Spokesperson learning program brought together 12 women from 8 affected communities across three states to develop leadership and advocacy for social change around FGM/C. The two central goals of the program were to build the capacities of community-based women to dialogue and educate from within as human rights advocates and educators, and to amplify the voices of community women to lead on this issue in the public sphere.	Juliana Nkrumah AM info@africanwomenaustralia.org
African Women's Council of Australia	Rite of Passage was part of the African Women's Council of Australia leadership program. The 'Mama na Wmana' project provided a space for African mothers to share their hard earned wisdom with their daughters in order to promote positive development as women. The program emphasised cultural awareness and self-development while focusing on issues relevant to girls' behavioural and physical development (sexual and reproductive health).	Dr Casta Tungaraza **African Women's Council** africanwomencouncil@iinet.net.au

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