

Listening to North Yarra Communities

about female genital cutting

A community-based research project to generate evidence to inform health promotion & clinical practice.

Conducted in partnership between the University of Melbourne, the Royal Women's Hospital and North Yarra Community Health.



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This report summarises findings from a community-based research project conducted by a team comprising academics at the Centre for Health Equity (Melbourne School of Population and Global Health) and Melbourne Law School at the University of Melbourne, staff at the Royal Women's Hospital, and at North Yarra Community Health (now known as cohealth*), in conjunction with members of the Eritrean, Hararian, Oromo, Somali and Sudanese communities of Carlton, Collingwood, Fitzroy, Flemington, North Melbourne and beyond.

The project came about following an approach to the University of Melbourne Engagement and Partnerships Office by Munira Mahmoud and Louise Sadler from North Yarra Community Health (NYCH), who had identified the need for current information on the impact of female genital mutilation/cutting in the communities where NYCH work. The research team would like to thank NYCH, and Munira in particular, for playing such a pivotal role in the community consultations that led to the establishment of this research project.

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- Munira Adam (Women's Health in the North)
- Sandra Morris (Women's Health in the North)
- Jacinta Waters (the Royal Women's Hospital)
- Zeinab Mohamud (the Royal Women's Hospital)
- Shadia Mohamed-Aly (Eritrean Young Mother's Association)

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*North Yarra Community Health (NYCH) merged with Dousta Galla Community Health and Western Region Health Centre on 1st May 2014, after this project had been completed. This new entity is known as cohealth, and is one of the largest community health organisations in Australia. NYCH research team members can be contacted via cohealth.



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Executive Summary

Female genital cutting (FGC) is a practice that involves the partial or total removal of the external female genitalia for non-medical reasons. There are no health benefits associated with FGC, but there may be significant short and long-term consequences for the physical and mental health of women and girls. There are approximately 35,000 people living in Victoria who were born in one of the 29 countries where female genital cutting (FGC) is traditionally practiced (Costello et al 2013). In the North Yarra area (Carlton, Collingwood and Fitzroy) in inner Melbourne there are sizeable communities from countries where FGC is prevalent, including Eritrea, Ethiopia, Somalia and Sudan.

FGC is illegal in Victoria, and various services are provided to women and girls who are, or may be, affected by the practice. These include prevention and care services provided through the Family and Reproductive Rights Education Program (FARREP) in settings across metropolitan Melbourne, and specialised clinical services provided by the Well Women's De-infibulation Clinic at the Royal Women's Hospital. North Yarra Community Health (NYCH, now known as cohealth) has engaged with communities affected by FGC for over twenty years, including through the FARREP and the provision of other primary health care services.

In 2012 NYCH initiated formation of a partnership between the University of Melbourne, the Women's, and NYCH to conduct research to investigate the impact of FGC in the diverse inner Melbourne communities where they work. The aim of the partnership was to investigate the local impact of FGC in order to better design, deliver and evaluate appropriate responses. This report shares findings from the resultant community-based research project "Listening to North Yarra Communities about female genital cutting".

Research design

Prior to the research commencing, consultations were held with the Eritrean, Hararian, Oromo, Somali and Sudanese communities in the North Yarra catchment area. These consultations were to ascertain community interest in the project, confirm whether the project should proceed, and provided an opportunity for community input into the research objectives and methods. Six consultations were held with relevant community groups and one with sexual and reproductive health service providers. A total of 91 individuals participated in these consultations between late 2012 and early 2013.

The aims and objectives of the project were informed by these community consultations, and review of the literature. The project aimed to *improve understanding of the impacts of FGC in inner Melbourne*, by engaging with local women and communities to explore their:

- Knowledge of FGC;
- Understanding of the legal status of FGC in Victoria;
- Views on the role and meaning of FGC for families now living in Melbourne;
- Health-service experiences;
- Experience of health promotion activities; and
- Suggestions and recommendations to NYCH and the Women's about how to better engage with communities in relation to FGC.

A total of 123 individuals participated in the research – 112 community members (across 8 focus group discussions, 4 small group discussions and 10 individual interviews) and 11 service providers (who participated in in-depth interviews).

Thematic analysis of transcripts and field notes enabled researchers to identify key themes in the data. Early results of the thematic analysis were presented back to research participants at community feedback meetings, enabling community members and service providers to discuss and give feedback on the research team's interpretation of the data. Participant feedback on early analysis was then incorporated into this final report.

Findings

Generational change

FGC has decreasing relevance to communities now living in North Yarra, and community members who participated in this project felt that FGC was also happening less frequently in their countries of origin. While FGC was associated with tradition, community cohesion and cultural identity, the importance of the practice was seen to reduce over time following resettlement in Australia. The stigma experienced by uncircumcised women in countries of origin was not something that participants reported in Australia. Community members emphasised the enormous generational change that has taken place, with younger women usually being strongly opposed to FGC for their daughters.

This project was not designed to assess frequency of FGC in North Yarra communities, and therefore it is not possible to be definitive about incidence of the practice. However no evidence was found of FGC occurring within Victoria, among the community groups who participated in this research. Given the very high prevalence of FGC in countries of origin for most of the participants in the study, this suggests an immense change has taken place within, and been led by, these communities. Factors supporting this change include

education about the physical and mental health consequences of FGC, increased awareness in communities that there is no religious obligation for FGC, awareness that FGC is illegal in Australia, and changing gender relations within communities.

High levels of knowledge about FGC among community members

Women who participated in this study had high levels of awareness of the physical and mental health consequences of FGC. Some of the negative health consequences of FGC identified by service providers, were not seen as problematic by women who had undergone the practice. Community members described their greater access to education and health promotion initiatives in Australia as increasing their knowledge about FGC, and highlighted the role of FARREP workers as trusted sources of information about the practice. Male participants in the study had general knowledge of the health consequences of FGC and expressed a desire for more information. Female participants agreed that raising the awareness of men was a priority.

Participating community members were, in the main, aware and accepting of Australian law in relation to FGC. Some participants expressed confusion about the legal status of re-infibulation after childbirth.

Impact of changing knowledge and norms within communities

Community members described FGC as being less important than in the past, but some participants had mixed feelings about abandonment of the practice. While older women were aware of the health consequences of FGC, they were more likely to express resistance to, or sadness about, the abandonment of the practice. A number of middle-aged and older participants expressed concern about erosion of

the important cultural and community values that they associated with FGC, with some perceiving the abandonment of FGC to be directly linked to the challenges they faced raising children in a cultural context so different to that which they had grown up in.

Community members described how relations between men and women were changing in communities, and felt this contributed to the decline in FGC. Many of the male participants reported that they did not want their daughters to undergo the practice and that they would be prepared, or would prefer, to marry an uncircumcised woman. This represents an important and substantial change in social norms. Men highlighted that FGC had declined as communities (and men in particular) became aware that there was no obligation in Islamic teaching for women to undergo the practice.

Continuing impacts of FGC in relation to sex, pregnancy and childbirth

A number of participants who had experienced FGC reported no general health consequences as a result. However many participants did report difficulties during pregnancy and childbirth, with women perceiving there to be significant physical consequences of FGC including increased likelihood of caesarean section and episiotomies (sometimes described as poorly performed) or severe perineal tears. Procedures such as internal examinations during pregnancy and pap smears were particularly uncomfortable for women, with some participants reporting this discomfort as a barrier to women accessing screening and other services.

Male and female participants described the negative impacts of FGC on women's sexual experiences. Sex was often described as difficult and painful with some women needing to be de-infibulated by a health professional in order to consummate their marriage.

Particular impacts on young women

The consequences of FGC described by younger women were heavily influenced by whether or not they were sexually active and whether or not they had children. Young women who had experienced FGC often described few physical consequences (particularly if they were not sexually active), but did report a range of psychological impacts. Some young women described difficult memories of FGC itself, as well as difficulties in coming to terms with something that had happened to them as a child. Other young women described unanswered questions in relation to their bodies, what was 'normal', and worries about possible future impacts on sex, relationships and childbirth.

For some young women who had experienced FGC, this was associated with a sense of grief and was a source of difference from their peers in Australia. For other participants who had *not* experienced FGC, this was then a source of difference from their family and friends in their countries of origin and contributed to family pressure when they visited 'back home'.

Improved but inconsistent experiences of care

North Yarra community members felt that generally health services have improved over the last 10 to 20 years and that doctors and midwives have more awareness of, and increased medical competency in relation to, FGC. However experiences of care during childbirth remained inconsistent and dependent upon the individual staff members a woman happened to be attended by – community members and health service providers felt there needed to be ongoing training to remove this element of 'luck' in care.

Several of the participants described childbirth experiences where they perceived that they were not listened to by health professionals, with

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both physical and psychological consequences. Women described a lack of communication from health professionals of the reasons why certain clinical interventions were required during childbirth, or what had led to different sequelae (such as tears). Cross-cultural misunderstandings during childbirth were also reported.

Participants (female and male) discussed experiences and perceptions of racism within the health sector. Women who had undergone FGC described how health professionals viewed them as different and foreign because they were circumcised. Women also detailed the distress caused when health workers saw their bodies as 'shocking' and something that should be put 'on show' to colleagues.

Challenges to service delivery

Health professionals at the Women's expressed concern about whether their services were being accessed by all those who could benefit, and identified community outreach as a priority to facilitate awareness of the service by community members. However all the health workers who participated in the study also described the difficulties associated with community outreach. Women and communities affected by FGC face a range of challenges associated with resettlement in Australia. FGC is not community members' first priority, and health professionals engaging with communities can find it difficult to respond to communities' needs and expectations, while also maintaining professional boundaries. Some community members in this study expressed frustration that FGC remains a focus of community engagement when other priorities remain unaddressed.

Service providers and community members identified limitations in the clinical and cultural competencies of some health workers in relation to FGC, with many junior staff having had

limited training and experience in this area. Health professionals emphasised a need to improve communication between health professionals within and external to hospital settings such as the Women's. It was also perceived that there was a need to increase awareness among doctors, community midwives and other health professionals of the services provided by the Women's.

Community members and health professionals identified language and communication barriers as challenges to effective delivery of FGC related services, emphasising the limited pool of interpreters available. Health professionals recognised the fragmented response to FGC across Melbourne, and noted the need for improvement in coordination and communication. Participants expressed concerns about the limited availability of services in the outer suburbs of Melbourne, where large and newly arrived communities had resettled from countries that traditionally practice FGC.

Implications for policy and practice

The findings of this study have a number of implications for policy and practice, including considerations relevant to engaging communities, and to the delivery of health services:

- **Need to recognise, and build upon, community-led change:** It is clear that the social norms in participating communities, in relation to FGC, have undergone enormous change over the last ten to twenty years. It is vital that organisations engaging with North Yarra communities recognise that the communities themselves have led this change. North Yarra community leaders could potentially have a role to play in supporting other more recently arrived communities in their response to FGC

- **Public discussion of FGC should reflect the complexity and diversity of issues involved:** Public discussion and debate about FGC in Australia is often framed by the use of stigmatising language, ignores the complexity of issues that inform people's decision making in relation to FGC, and rarely acknowledges the diversity of women's and girls' experiences. Health workers and policy makers can play an important role in contributing to more informed public discussion of FGC that recognises its history as a valued practice integral to community membership, and a social norm that requires collective change for abandonment to occur.
- **Importance of community workers to community engagement:** Community members employed in responses to FGC are seen as trusted sources of information and have a particularly valuable role to play in contributing to collective behaviour change.
- **FGC as one of many changes associated with resettlement:** Community members recognise the consequences of FGC, but FGC-related services are not their highest priority following resettlement. Organisations working with North Yarra communities could consider whether and how to integrate responses to FGC with interventions in response to other health issues raised by community members in this study.
- **Need for improved communication between women affected by FGC and health professionals:** There is a clear need to improve communication between women who have undergone FGC and health professionals, both in the hospital and community setting. Health professionals need to be supported to spend time with women post-delivery, in particular, to provide information and respond to questions and concerns.

- **Increasing awareness of existing services:** There is scope to increase community awareness of existing services available in relation to FGC, particularly the de-infibulation clinic at the Women's. This includes increasing awareness of women from non-African backgrounds who may have experienced FGC.
- **Improving skills and training for health professionals:** While it is clear that FGC-related health services have improved, the quality of care experienced by women is inconsistent. There is a need for greater, and ongoing, professional education in relation to FGC. Participants emphasised that health professionals need technical *and* cross-cultural communication skills to be able to provide appropriate care. A more formal liaison or referral system could be considered across relevant services in Melbourne.
- **Not forgetting the role of men:** Women across participating communities emphasised that it was important to promote the supportive involvement of men so that women's health was a priority for couples and families. Men themselves noted the positive impact of increasing men's knowledge about the health consequences of FGC.
- **Addressing the specific needs of young women:** Younger participants in this study identified a number of issues under-addressed in responses to FGC in Victoria, including the need for support dealing with psychological consequences of the practice. Younger women identified the potential to increase FGC-related health promotion through schools.

Limitations of the study

While this is the largest study focused specifically on FGC that has been conducted in Australia, not all cultural communities and individuals in North Yarra who may be affected by FGC participated in the project. There were limitations to the research team's networks, and the voluntary nature of participation means that findings may not represent the entirety of views held by individuals from diverse communities. Most participants in this study had lived in Australia for a considerable length of time, and findings cannot be directly generalised to more recently arrived families and communities, including those who have settled in parts of the city less well served by organisations providing health services and information related to FGC.

The study did not include girls aged less than eighteen years. Several of the younger participants, aged in their late teens and early twenties, provided rich information about the impact of FGC on their lives and their perspectives on what could be done to better support girls from affected communities. However the lack of direct engagement with girls is a significant limitation of this study. Further research to examine girls' experiences, FGC-related needs, and priorities is warranted.

Conclusion

This report summarises findings of the only study of FGC in Australia that has taken an explicitly community-based approach, emerging from the needs of a community health organisation, and basing research questions and methods upon community perspectives and preferences. This community-based approach has supported the participation of a large number of individuals from inner Melbourne communities.

Findings highlight the substantial changes that have occurred in FGC-related social norms, with the practice being of declining importance to communities now living in the North Yarra area. The changes that have occurred within communities have been led by community members themselves, and supported by health promotion interventions and the legislative context in Victoria. The study also highlights that, while the health-service experiences of women who have undergone FGC have improved, quality of care remains inconsistent. A number of implications for policy and practice, relevant to engaging with communities and the provision of health services, are identified in order to strengthen efforts to prevent FGC and provide high quality information and services to women who have experienced the practice.

1. Introduction

The project described in this report is based on a novel collaboration between researchers, health promotion practitioners, clinicians and service providers working in inner Melbourne. The initial idea for the project came about when staff members from North Yarra Community Health (NYCH) in Carlton approached the University of Melbourne for research expertise to help them examine and understand community needs and perceptions around FGC in diverse inner Melbourne communities. NYCH wanted to better understand current community attitudes and the impact of the practice in order to strengthen their provision of services to affected women and families, and to ensure that their health professionals were responsive to the needs and priorities expressed by community members. A new research partnership was formed between University of Melbourne researchers from the Centre for Women's Health, Gender and Society (Melbourne School of Population and Global Health) and the Melbourne Law School; a senior women's health researcher and clinician at the Royal Women's Hospital; and NYCH health promotion workers. The research partners jointly designed a process of community consultation that ultimately informed the design and implementation of the research project.

1.1 A note on terminology

Female genital mutilation (FGM) is the term most commonly used by the United Nations and other international agencies to describe all practices that “involve partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons” (WHO, UNICEF, UNFPA, 1997). For over 20 years the World Health Organization (WHO) and the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children have recommended using the term ‘female genital mutilation’ to emphasise that the practice is harmful and a violation of the rights of women and girls. ‘Female genital mutilation’ and ‘FGM’ is used in Australian legislation. However the term FGM can be offensive to women who have experienced the practice but do not consider themselves to be mutilated, and it can also be a barrier to engaging communities where female circumcision is traditionally practiced.

During the community consultations that informed design of this project, it was clear that some members of the community used, and were comfortable with, the term ‘FGM’. However it was also very clear that this term was uncomfortable and offensive to many other members of the community. As one community member said, “the name mutilation is a bit too harsh and it is too stigmatising for a woman who has been circumcised”. It was perceived that ‘FGM’ was a polarising term, and that requests made previously to researchers and service providers to use alternative language had been ignored. Women and men who participated in this study used a variety of terms to describe the practice – FGM, FGC (female genital cutting), female circumcision, and words in their mother tongue that most directly translated to ‘cut’ or ‘circumcision’. For the purposes of this report, the acronym FGC is used – other than when directly quoting respondents or source documents. The research team acknowledges the diversity of ways that girls and women who have undergone this practice identify and interpret their experience, and recognises the limitations of any one term adequately capturing these diverse perspectives and experiences (for extended discussion of the history and challenges associated with terminology, please see UNICEF, 2013, p.6-7).

1.2 What is FGC?

The World Health Organisation (WHO) classify female genital cutting into four major types, as described in the table below (WHO 2014, UNICEF 2013):

World Health Organisation Classifications	
Type I	Clitoridectomy: partial or total removal of the clitoris and/or the prepuce (the fold of skin surrounding the clitoris). Some practising communities refer to this type as <i>sunna</i> (Arabic for 'tradition' or 'duty')
Type II	Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora. There is considerable variability in the form and degree of cutting within this type
Type III	Infibulation: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris. Usually the cut edges of the labia are stitched together (infibulation), resulting in near complete covering of the urethra and vaginal orifice. This must be reopened for sexual intercourse and childbirth (de-infibulation)
Type IV	Other: all other harmful practices to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area. Nicking the genitalia to draw blood, without removal of tissue or permanent alteration of genitals, is sometimes called 'symbolic circumcision'

Female genital cutting does not have any health benefits. All of the practices described above involve removing or injuring normal, healthy female genital tissue. This interferes with the natural functions of girls' and women's bodies (WHO 2014). FGC can have significant short- and long-term consequences for the physical and mental health of girls and women.

Health consequences of FGC

Short-term consequences of the practice include pain, shock, bleeding and infections. Some of these consequences can result in death.

Longer-term health consequences can include dermoid cysts and abscesses, chronic pelvic infections, recurrent urinary tract infections, increased risk of complications during childbirth (including association with higher caesarean section rates, increased risk of haemorrhage and tears), negative psychological consequences, and sexual problems (WHO 2011). Risk of longer-term complications increases with the severity of the cutting and subsequent scarring. It should be noted that some women report no adverse consequences.

Where and why is FGC practiced?

FGC is most commonly practiced in 29 countries in Africa (in a belt of countries from the Atlantic coast to the Horn of Africa/East Africa) and the Middle East (Yemen and Iraq). Cutting practices across and within these countries are highly diverse, as is prevalence – with estimates of the percentage of women and girls who have experienced the practice ranging from 1% in Uganda up to 98% in Somalia (UNICEF 2013).

FGC is also known to occur in some countries in Asia (including countries with large populations now living in Australia, for example India, Indonesia and Malaysia) but it is unknown how common this is, or how many women and girls are affected (WHO 2011).

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In most practicing communities, FGC is regarded as a cultural tradition, something that is expected for girls and women, and as a social obligation to the community (usually other members of the same ethnic group). It is perceived that the majority of girls in the group are circumcised and that families, and the girls themselves, may be subject to community sanction if daughters are not cut. That is, in many communities, FGC can be defined as a *social norm* meaning “it is difficult for individual families to stop the practice on their own” (UNICEF 2013, p.15). A social norms perspective highlights the role of the collective in making change, rather than seeing responsibility for elimination of FGC lying solely with individuals or individual families.

In some communities prevalence of FGC is associated with place of residence (with FGC being more common in rural areas) though this is not consistent across countries and cannot be seen as a causal association. FGC is usually less common in households that are relatively wealthier and where mothers have had more education, though again there is some variability across countries and data need to be interpreted with caution (UNICEF 2013).

1.3 What is the current context?

A long-standing challenge facing policy makers and health service providers in countries where FGC is traditionally practiced, and in countries where migrants from practicing communities now reside, has been the absence of reliable data on the prevalence of the practice. However in the last twenty years, data on FGC has been collected through national Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) in countries where the practice is most common. These data were recently drawn together in a comprehensive compilation of the current statistics across affected countries, *Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change* (UNICEF 2013). UNICEF estimate that more than 125 million women and girls alive today have undergone female genital cutting in the 29 countries where the practice is concentrated. It is unclear how many women and girls have been cut elsewhere.

Of particular relevance to this report, which examines the attitudes and experiences of women and families now living in inner Melbourne, are the data in this UNICEF (2013) report specific to Eritrea, Ethiopia, Somalia and Sudan - countries of origin for sizeable communities now based in the North Yarra catchment area of Melbourne's inner north. The current estimated prevalence of FGC for women aged 15-49 years in Eritrea is 89%, in Ethiopia is 74%, in Somalia is 98% and in Sudan is 88% (UNICEF 2013, p. 26). It should be noted that the majority of migrants from 'Sudan' now resident in inner Melbourne suburbs (as opposed to other parts of the city) are actually from South Sudan. As a new country there is no reliable FGC data for South Sudan, but the prevalence of FGC in the country is thought to be considerably lower than in its northern neighbour.

These national level data mask the substantial variability that exists in cutting practices within countries (between different ethnic groups and between rural/urban areas). It should also be noted that using national level prevalence measures to estimate the number of girls at risk in destination countries for migration “overestimates the true risk to girls from countries where there has been a decline in FGM/C prevalence” (UNICEF 2013, p.23), and that researchers have found that parents' intentions to circumcise their daughters decline after migration (see, for example, Morison et al 2004, Johnsdotter et al 2009, Gele et al 2012).

Attitudes towards FGC appear to be changing in the countries of origin most relevant to this report, with levels of support for FGC lower than the national prevalence of the practice, and lower among younger women than older women in Eritrea, Ethiopia, Somalia and Sudan. Reported prevalence for 15-19 year olds is lower than that of 45-49 year olds in all four countries as well, though the difference in Somalia is only 2% (UNICEF 2013).

Current legislative context

In the last ten years legislation to prohibit FGC has been enacted in countries relevant to this report (UNICEF 2013), including in Eritrea (in 2007), Ethiopia (2004), Somalia (2012), and in some states of Sudan (2008-2009). Legislative reform alone is insufficient to change practices in relation to FGC, but when accompanied by measures to influence community attitudes and expectations, law reform can contribute to a social environment where new behaviours have legitimacy and where new social norms can emerge.

FGC is illegal in every state and territory in Australia. In Victoria the Crimes (Female Genital Mutilation) Act was passed in 1996, which made it illegal to perform female genital mutilation or to take a person from Victoria, or arrange for someone else to take a person from Victoria, with the intention

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of having female genital mutilation performed. At the time of the change to the legislation, there was considerable debate and discussion among Victorian health and legal practitioners as to how to best prevent FGC within the state and increase communities' awareness of the new law. Subsequently, in 1998 the Victorian Department of Health established the Family and Reproductive Rights Education Program (FARREP) as the primary response point for women and communities affected by FGC. FARREP aims to work with communities that practice FGC in order to strengthen their knowledge about the practice and support changes to attitudes, with the aim of preventing the occurrence of FGC; increase access to sexual and reproductive health services by women and girls from affected communities; and to build capacity of health services to respond to the health needs of women affected by or at risk of FGC (Department of Human Services 2009).

Impact of FGC on inner Melbourne communities

Families from countries that traditionally practice FGC began settling in Australia in notable numbers in the late 1980s. Today there are approximately 110,000 people living in Australia, including 34,821 in Victoria, who were born in one of the 29 countries where FGC is concentrated (Costello et al 2013). The vast majority of people from countries where FGC is traditionally practiced, who now live in Victoria, live in metropolitan Melbourne.

North Yarra Community Health (NYCH) provides support to communities that are, or could be, affected by FGC in Carlton, Collingwood and Fitzroy through FARREP. In 2010 the Royal Women's Hospital established the Well Women's De-infibulation Clinic to provide clinical services, including but not limited to de-infibulation, to women who have experienced FGC. It is the first clinic of its kind in Australia (Waters 2011).

Review of the literature highlights a number of documents published around the time that FARREP was established in Victoria. These include publications relevant to clinical practice (Bayly, Dowd et al 1997), the clinical experiences of women affected by FGC (Knight, Hotchin et al. 1999), and African women's reproductive health more broadly, including discussion of FGC (for example Allotey, Manderson & Grover 2001; Allotey, Manderson et al. 2004). In 2012 Moeed & Grover surveyed health workers to investigate whether FGC was being performed in Australia, and found there was no evidence of health professionals performing FGC, but that people other than registered health practitioners may be doing so. In 2013 Family Planning Victoria published a *Service Coordination Guide and Care Plan Flowchart* (Jordan & Neophytou 2013) in relation to FGC and, with RMIT University, an overview of relevant Victorian demographic data (Costello et al 2013). However very little has been published about the FGC-related knowledge, attitudes and health-service experiences of affected Victorian communities based on data collected since 2001.

A need for locally grounded research

North Yarra Community Health (NYCH) has provided services to women and girls affected by FGC for many years, and has long-standing relationships with relevant communities in Melbourne's inner North. In 2012 NYCH approached the University of Melbourne requesting assistance with research to better understand the current impact of FGC on local communities. Staff reported that gaps in contemporary knowledge about FGC made it difficult to design, deliver and evaluate appropriate services for affected women and families living in inner Melbourne. Subsequent discussions with staff at the Royal Women's Hospital confirmed that they also saw a need for locally

grounded research that could improve the quality and reach of the health care and information available through their services, for women and girls who have experienced FGC.

A new research partnership was formed between the University, NYCH and the Royal Women's Hospital. The partnership was successful in attracting funding from the University of Melbourne Partnership and Engagement Office (MEPO) to conduct consultations with relevant communities in late 2012 and early 2013. These consultations were to establish whether the communities thought that a research project focused on FGC was warranted and appropriate, and if so, what research questions were the highest priority for communities. The consultations also served to gather community members' views on the most appropriate methodology for such a research project. In the past, policy and legislative development with respect to FGC has often been informed by policy-makers' assumptions and perceptions about the practice, failing to take into account the experiences and views of the communities in which the practice occurs. Therefore it was an explicit aim of the partnership that community members' views be foregrounded and a collaboration approach to the research developed. The research project that was subsequently developed was funded through an Interdisciplinary Seed Grant from the Melbourne Social Equity Institute at the University of Melbourne.

2. Research design



Consultation with women from the Hararian community, March 2013

An effective community-based approach to research on FGC is complex, time-consuming and sensitive. This was particularly true for this project – planned community consultations to establish whether the relevant communities thought that the project was warranted happened to coincide with substantial media coverage of FGC in Australia.

Late in 2012 a number of arrests were made of parents (and others) who had arranged for young girls to be circumcised either within Australia, or had made arrangements to take daughters overseas for the purpose of FGC. These arrests, in Sydney and Perth, were associated with considerable, negative media coverage in which the voices of women and girls from communities that traditionally practice FGC were completely absent. There was particular media attention on the African diaspora, despite the fact that none of the families involved in the cases before the courts were African.

It was in this environment that the research team commenced community consultations. Our approach to these consultations, and the subsequent research project, sought not simply to listen to women and girls from affected communities, but to elevate their voices and views to a position where they could be heard and shape policy.

2.1 Community consultations

Prior to data collection, or indeed deciding whether the research project should proceed, the research team held consultations with relevant community groups in the North Yarra catchment area. These consultations sought to confirm community interest in the project and willingness to discuss FGC.

If community members were receptive to a project focused on FGC, it was also intended that these consultations provide an opportunity for community input into the research approach and objectives.

Six consultations were held with community groups, and one with sexual and reproductive health service providers (see table below). In total, 91 people participated in these consultations:

Participants	Number of Participants
1 Eritrean Men's Group (Carlton)	18
1 Eritrean Women's Group (Carlton)	16
3 Somali Women's Group (Carlton) <i>including an Oromo & Eritrean participant</i>	6
4 Young Women's Group, mixed	21
5 Women, mixed (Fitzroy)	12
6 Hararian Women (Carlton)	14
7 Royal Women's Hospital	4
Total participants:	91

2. Research design

Consultation meetings were held in local community facilities and were facilitated by a member of the research team, with or without an interpreter and/or childcare (as requested by the community group). Community members were asked whether or not they thought research around FGC would be useful (and why or why not). If the group suggested that they did think such a research project had value, community members were asked what questions they thought the researchers should focus on, and what they perceived to be the most appropriate methods for answering these questions.

While some community members questioned the importance of a research project looking at FGC (“why are we still discussing this? Nobody does it any more”), all consultations – including with health professionals – suggested that there was value in better understanding the health service experiences of women who had undergone FGC, and whether their needs were being met. Community members also wanted to better understand differences within and between groups, in terms of their attitudes towards FGC. There was some concern as to whether knowledge of the Australian law was as high among newly arrived migrants and refugees as it was among the more established members of the communities.

Feedback from these consultations showed that if FGC is discussed respectfully and in a non-judgmental manner, community members were appreciative of the opportunity to present their views. It was clear, even during this early consultation phase, that there was a diversity of attitudes towards FGC held by community members. It was also clear that many people the research team met with wanted an opportunity to ‘speak back’ and counter the negative representations of their communities, with regard to FGC, that were circulating in the media at that time.

Following the community consultations, the research team agreed that there was sufficient community interest in and support for the research, and that we should proceed to seek funding to go ahead with the project.

2.2 Research aims and objectives

The aims and objectives of the project were informed by the literature, the initial research request from NYCH, and the community consultations. Broadly the project aimed to improve understanding about the impacts of FGC in inner Melbourne. Specifically the project sought to engage with women and communities in North Yarra to explore their:

- knowledge of FGC (including the short and long-term consequences of cutting for women’s health)
- understanding of the legal status of FGC in Victoria
- views on the role and meaning of FGC for families now living in Melbourne (including investigation of whether/how views have changed with length of time in Australia; how views are different between and within different communities; and intergenerational and gender differences)
- health-service experiences (including, but not limited to, experience of services provided by NYCH and the Women’s)
- experience of health promotion activities (including access to, and perspectives on, sexual and reproductive health information and education)
- suggestions and recommendations to NYCH and the Women’s about how to better engage with communities in relation to FGC.

2.3 Methods

Recruitment

A number of strategies were used for recruitment. The project was advertised through posters (in English, Arabic and Somali) that were placed in communal spaces in the Carlton, Collingwood and Fitzroy housing estates served by NYCH; at the three NYCH sites; at the Women’s (including at the de-infibulation clinic); and at meeting spaces used by the African Women’s Network.

Participants were also recruited through community members who had volunteered to be ‘project contact persons’ during the original community consultations, and through the networks of the FARREP workers from NYCH and the Women’s. Contact persons and FARREP workers were provided with a project induction (covering the project’s ethics and other protocols), and were asked to inform members of their cultural communities about what participation in the project might involve. If community members expressed interest, contact persons/FARREP workers outlined the options for participation, disseminated written (translated) information about the project and invited community members to provide consent to pass on their contact details to the research team. A member of the research team then contacted potential participants, at which time they were provided plain language statements and consent forms (in English, Arabic or Somali as appropriate).

Once ethics approval was obtained, the research team met with more community groups to speak about the project and invite their participation, including the African Women’s Group in Collingwood, the Living in Harmony team in Collingwood, the Collingwood Neighbourhood Learning Centre Mothers’ Group, and the Richmond Oromo Women’s Group. Participants

2. Research design



Focus group discussion with men from the Eritrean community, October 2013

were also recruited through community associations, including the Eritrean Community Association and the Somali Women's Association in North Melbourne.

Key informants (health service providers) were identified by the research team in conjunction with NYCH and the Women's, contacted by email, and invited to respond if they were interested in participating in the project. Interested informants were followed up by telephone to arrange a convenient interview time, at which time written consent was obtained.

Data collection

Community consultations emphasised the need to offer potential participants *options* for how they could engage with the project. Therefore participants were offered the choice of participating in a focus group discussion (FGD) or in an interview (and whether they would prefer to be interviewed on their own, or with a friend and/or relative).

Community consultations also suggested that *who* was asking questions in an interview or FGD would influence the participation of some people. Therefore, in consultation with the Multicultural Centre for Women's Health (MCWH), trained Bilingual Health Educators (BHEs) who spoke the relevant languages, and who were available to be engaged to undertake data collection, were identified. Participants in interviews were offered the option of being interviewed by a BHE or by a member of the research team (with an appropriately qualified interpreter as required). Participants in FGDs were also offered options as to whom the discussion would be facilitated by, and in what language. As often as possible, FGDs in a language other than English were facilitated by a BHE to minimise the need for interpreters during a FGD. However, on occasion and as requested by the community group, a member of the research team facilitated an FGD in conjunction with a registered interpreter.

FGDs averaged approximately 1.5 hours in length, and interviews approximately 1 hour. Participants were asked permission for the discussion to be audio recorded (which was granted on most occasions). Where a digital audio recording was not made of the discussion, a member of the research team took written notes. Group discussions and interviews took place in a range of locations, including in community meeting rooms available at the public housing estates in Carlton, Collingwood and Fitzroy (where the majority of participants lived, and where participants regularly met for a range of other activities). Health service providers were interviewed by a member of the research team, for approximately one hour, at a time and location of their convenience.

Participants

Over 100 community members participated in 8 focus group discussions, 4 small group discussions/group interviews, and 10 individual interviews. In addition 11 health service providers were interviewed at NYCH and the Women's. In total 123 individuals participated in the research. All participants were aged 18 years and above.

2. Research design

Community groups	No. of participants
<i>Focus group discussions</i>	
Young Eritrean Mother's Group (Flemington)	8
Eritrean Women's Group (Flemington)	12
Eritrean Women's Group (Carlton)	8
Eritrean Men's Group (Carlton)	12
Somali Women's Group (North Melbourne)	12
Somali Women's Group (Carlton)	10
Somali Men's Group (Carlton)	11
Oromo Women's Group (Flemington)	16
<i>Small group discussions</i>	
Young Women (mixed)	3
Somali Women (Carlton)	4
Hararian Women (Keysborough)	3
Hararian Women (Carlton)	2
Total number group discussion participants	101

Interviews	No. of participants
<i>Community member interviews</i>	
Eritrean women (Collingwood, Carlton)	3
Sudanese women (Collingwood)	4
Oromo women (Collingwood, Richmond)	2
Somali man (Carlton)	1
Islamic Sheikh (Outer Melb)	1
<i>Service provider interviews</i>	
Senior women's health clinician (The Women's)	1
Senior Clinical Midwife (The Women's)	1
Obstetrician/Gynaecologist (The Women's)	2
Co-ordinator, De-infibulation clinic (The Women's)	1
General Practitioner (NYCH)	1
Community Midwife (NYCH)	1
FARREP Workers (various*)	4
Total number interview participants	22

*FARREP workers were recruited from NYCH, MCWH, the Women's, and Women's Health in the North

2. Research design

Data analysis

Where interviews and group discussions were digitally recorded, these recordings were transcribed verbatim and translated (where necessary) into English. For the two FGDs, two small group discussions and one interview that were not audio recorded, the interviewer or note taker typed up a record of the discussion based on their notes as soon as possible after the event.

These transcripts were subjected to thematic analysis. Through reading and re-reading the transcripts the research team developed a list of codes and clustered these into key themes. All data were coded, with NVivo software used to facilitate this process. Research team members reviewed the coded data and revised the list of identified themes, prior to drafting an early summary of our analysis for feedback to participants.

All participants, BHEs and members of the research team were invited to community feedback meetings (separate meetings were held for male and female participants). Early findings were presented back to affected communities, and to the project's advisory group, to give them the opportunity to reflect upon and interrogate the research team's interpretation and analysis of the data. These meetings enabled community input into the final thematic analysis, the results of which are contained in this report.

2.4 Ethical issues

A number of ethical issues were considered in the design and implementation of this project. FGC is a personal and private issue, and community members highlighted the need for privacy and confidentiality during data collection. Community consultations suggested that some members of the community would prefer to be interviewed in private (on their own, or with a friend or relative) and by someone who was *not* a member of their community/ethnic group. Often this was the preferred option for younger women who were concerned about confidentiality within their communities. Other consultations suggested some participants would find the idea of a one to one interview too intimidating and that people would prefer to engage with the project in a group with other members of their community, often in their mother tongue facilitated by a person from their community (ie. a bilingual health educator). This advice was integrated into the research design, with community members offered choices about how they could participate in the project to minimise discomfort associated with the approach to data collection.

Participation was voluntary, with all participants having the opportunity to read and discuss the project's plain language statement and consent form (translated as appropriate) – with and without a researcher being present – prior to providing written consent to their participation in the project.

Research questions were designed so as to avoid being personally intrusive. Community members were asked about their awareness of FGC, their views on the role and meaning of FGC in their

cultural community, and about their health-service experiences related to FGC. They were *not* specifically asked about their own experience of FGC, or their intention with regard to circumcision of their daughters or granddaughters. Some participants chose to share their personal story (of circumcision prior to coming to Australia, for example), and were not prevented from doing so. However the plain language statement emphasised that this was not the purpose of the research, and the question guides used in FGDs and interviews were carefully designed to minimise the potential for unintended disclosure. Participants were given written information about services, including counselling and other services offered by the de-infibulation clinic at the Women's, that were available in their local area. Participants were also offered the opportunity to debrief with a member of the research team as requested.

At the beginning of each FGD or interview participants were reminded that should researchers form a reasonable belief that a child or children were at risk of FGC that researchers would then have a mandatory duty to report this to the Department of Human Services. This information was also included in the plain language statement. Participants were also reminded that disclosure of any information to suggest a health practitioner had performed FGC might oblige researchers to notify the Australian Health Practitioner Regulation Agency of the conduct. There was no occasion that required mandatory reporting during the project.

This project was approved by the Human Research Ethics Committee at the University of Melbourne.

2. Research design

3. Findings

Findings will be discussed in relation to the role and meaning of FGC for participating communities; participants' knowledge of FGC; the impacts of FGC that were described by participants; community members' experiences of health services; and challenges that were identified for the delivery of effective health services.

3.1 Role and meaning of FGC

Declining importance of FGC

Throughout the project participants expressed their belief that FGC is 'finished' or 'on the way out' in their countries of origin, with many giving examples of changes that they had observed on visits back to see family and friends.

"Not only here in Melbourne, even back home you know, attitude towards circumcision has change a lot" (Somali woman)

"Going back there recently, it is something that's still practiced, but it's not as extreme as it was back with my mother's age" (Somali woman)

"It's not responsibility [now] for a mother, and it is something that is old-fashioned, not practiced anymore... it's an old thing that you just leave behind" (Hararian woman)

Participants were aware of the changes in legislation related to FGC in their countries of origin over the last ten years, and felt that this both reflected changing community attitudes towards the practice and was one of the reasons why FGC was declining 'back home'.

"In Eritrea, ah legally, it's stopped. Anyone who do this will have, will be fined" (Eritrean woman)

"These days I don't think nobody does it. It's illegal now with Ethiopian policies" (Hararian woman)

Female and male participants also expressed that the practice was of decreasing relevance to women and families now living in Australia.

Interviewer: *If a girl or a woman is not circumcised in Australia, what will that mean for the girl?*

Participant (Eritrean woman): *Nothing.*

"The community themselves are recognising it as something they need to correct here [in Australia], that they don't like, that they want to change" (Somali man)

"I'm not throwing out the possibility that somebody may be doing secretly or maybe going overseas to do it, but it's not any more a habit or culture that the people advocate or stick to" (Somali man)

The women who participated in this study showed great resilience and adaptability, not just in coming to terms with substantial change in a practice that was the norm for the vast majority of women in their cultural communities, but in leading this change. Women's leadership of this change is often unacknowledged in media and other discussion of FGC in Australia.

"We would like to be recognised for our effort in leaving the practice behind. So, we want to be recognised as Harari women [who made this change]" (Hararian woman)

While not specifically designed to identify incidences of FGC, this project found no evidence that FGC was being practiced within Australia, within the participating communities. There were, however, descriptions of instances where parents had sought to circumcise their daughters abroad:

"[There are] cases where girls are born here and stuff, but their parents will take them back and bring them back just to circumcise them... it happens... the worse thing is the girl will think

she's going on holiday" (Eritrean woman)

Similar accounts were given in focus group discussions from more than one cultural community, but there was no evidence to suggest that this was a common occurrence – it is indeed possible that different respondents were referring to the same few families (identifying information was not shared by participants).

Meanings of FGC

Participants described FGC as being a cultural tradition that had been valued within communities for centuries. It was seen as something that was passed on from generation to generation, something that in times past had not been discussed as optional or a choice – it was just something that one did (and did for one's daughters).

"It is consid- it used to be considered to be a privilege to be circumcised in Harari culture. Uh my, my mum talks that this is one of the gifts that she would give to me and this is a good thing, she thought this is a good thing you know" (Hararian woman)

"You can't blame your mum, you know, because this is like a culture. People you know, they do it you know, [so] you have to do it. Even maybe if you don't do it you feel you are, uh, different from other people you know when you grow up" (Eritrean woman)

"You have to cut. It is culture" (Oromo woman)

"It is culture and it's embedded psychologically. It's the norm. It's not that man force it or the woman force it. It's normal, it's the system. Like having lunch. You don't ask whether there's lunch or not, you get hungry, it's midday, you go for lunch... We never thought of it other way" (Eritrean man)

3. Findings

The type of FGC that was practiced in a community was also described in terms of tradition and maintenance of culture. Though it was noted that the type of circumcision practiced in different cultural groups had often evolved over the generations.

"Some families are more traditional you know, like you know they wanted to keep that original [Pharaonic, or Type III] circumcision as a way of [maintaining] culture, yeah ... but in the time I grow up in the city of Harar, um being stitched is not that highly valued, because I haven't been discriminated because mine was not stitched. Nobody cares if I was stitched or not! [laughing]" (Hararian woman)

Some participants described the rationale for FGC as being hygiene or cleanliness, or more often the curtailment of female sexual desire and sexual activity. Others felt that the practice was perpetuated through the generations by its association with community celebration and reward (in the form of social inclusion) for families.

"Have to let the girl have the circumcision because if the girl... once she become like a woman, she have to have that part of it out, because when she is not having it out, she will look out for men, like sexual or something like that, she will have that kind of desire" (Sudanese woman)

"I forced them to do it. Can you believe it? I cried, because in Eritrea it was something that was celebrated, you know the young kids, they all did henna. I was like 'why am I different?'.... Me crying and 'I want to, why am I different, you know all the girls they have party'. You know and I want it too, you know. So she [her sister] took me and they did the circumcision, so now I'm circumcised" (Eritrean woman)

FARREP workers interviewed during this study described how some of their clients saw FGC as instrumental in creating group identity, and as part of cultural identity.

"[Clients tell her] 'I come here as a refugee, I don't want to be Westernised. I don't want them to take away my identity'" (FARREP worker)

However the role of FGC as a marker of identity was seen to weaken when families moved to countries where FGC was not common. FARREP workers reported that children growing up in a society that does not accept FGC cease to see the practice as a desirable marker of cultural identity.

"We now have a lot of young women who are not circumcised and some of them are, 'we grow up in Australia and we want to have this [Australian] culture'" (FARREP worker)

In contrast, many participants described how not being circumcised was an undesirable and shameful source of difference in the communities that they had grown up in. For some participants, not being circumcised relegated a woman to a state of persistent childhood – an adult female wasn't recognised as a woman unless FGC had occurred.

"Was almost no, no choice, because if you don't put your daughter through this system she will not be seen by community, she cannot be trusted... So it become the culture she has to go through this in order to be proper woman" (Somali man)

"It was more everybody had to do it, and especially in the neighbourhood, everyone's really tight, so they talk within each other, 'but your daughter hasn't, why?', you know ... when it doesn't happen it's more of 'why not?' you know, 'she should'" (Eritrean woman)

"It's a form of growing up, it's like getting your period, this is another thing. You have to do this or you don't become a big girl kind of thing" (Eritrean woman)

"When I went back my grandma was like 'oh you can't tell people that you weren't circumcised, it's embarrassing'" (Somali woman)

Many of the women who participated in this project, across cultural groups, felt that in the past FGC was required to ensure that girls were marriageable. Given the difficulties that were associated with being an unmarried woman, mothers and grandmothers had perceived FGC as being in the best interests of their daughters.

"Back home, girls who are not circumcised were looked down upon... Uncircumcised girls are not married you know, are not courted for that matter. And if she give birth to say her children, and not be re-sewed, re-circumcised, the husband walks out on her" (Somali woman)

"Back home they used to say that how would a guy know that you're a virgin if you're not circumcised? It was sort of what determines whether or not you were pure. So that's the, I think that's why they preferred someone that was" (Eritrean woman)

Male participants described the attributes that they valued in a future wife as including acquiescence to elders and coming from a 'respectable' family – "they look for the one already sitting all the time with mum" (Eritrean man). In the past these attributes had been associated with FGC.

"In our generation... you wanted to marry from some family who does their responsibilities, who's respectful, who is like you know, you want to marry from them, you don't wanna marry some irresponsible family who breaks the cultural boundaries and norms" (Hararian woman)

3. Findings

Participants held varying views as to whether FGC still influenced a girl's prospects in relation to marriage now that they were living in Australia.

"That is such the lip service [government decrees against FGC]. There is no man, a Somali man, who's gonna marry an uncircumcised" (Somali woman)

"The younger ones [men] say 'no I don't want a girl that's circumcised... I think it's different, what they hear about circumcision, um, some of it would be like, like the, what is it, the pleasure or the desire is, her desire is very low, so you know she's really, she's just going to be boring if you know what I mean" (Eritrean woman)

"In the past it was [important]. But now, all they [young men] care about is whether the girl is religiously good, you know, she can handle the marriage" (Somali man)

Role of men

Some participants, male and female, felt that traditionally men had had little influence on whether or not a girl was circumcised. FGC was seen as 'women's business' that was performed by women on other women and girls, sometimes without the knowledge of men. Other participants felt that male members of a community did have a significant influence on the practice, in part by their decisions in relation to whether it was or was not acceptable to marry an uncircumcised woman.

Evidence of men's influence on FGC-related decision-making was also apparent in women's discussions about sexual relationships. The support of a fiancé or husband around issues of pre-marital (de-infibulation) or post-natal surgeries (including re-suturing) was highly valued, and men's expectations figured significantly in women's weighing up the cultural, aesthetic and health implications of these surgeries.

"I had an Eritrean friend, she was about to get married and about to have a baby, and I'm like what are you doing here [in Melbourne], and she said I came here to open the circumcision and I said 'wow', and she's like, 'yeah, I talked to my fiancé and he said do it' – I was very happy to see that... But I've got another friend, she said she wanted to do it [de-infibulation] but the fiancé said no 'that's my job'" (Eritrean woman)

Female participants urged researchers to 'speak to men' and 'involve men'. It was felt that if men were educated and aware of the health impacts of FGC, they would be supportive of women making decisions that prioritised their health.

Participants from all cultural groups in this study reported significantly changed attitudes towards FGC, with the practice having less relevance and significance, and not being something that was seen as desirable by men.

"Young men in the first place, especially those who are in Australia, uh are not favourable to the practice because they believe that the cutting will take something that they would rather prefer to be there for their own way of life, lifestyle. Or at least it's something that helps the relationship between men and woman" (Somali man)

However some young men were described as taking a view of 'culture' that was inconsistent with how cultures do and have changed.

"It's funny, some of the boys who are grown here, they actually, they go back to Sudan and get married because they want a girl who is circumcised" (Eritrean woman)

In contrast, older men were predominantly opposed to FGC, accepting of Australian law, and saw that men could contribute to prevention of the practice by speaking up against it within families and communities.

"I disagree with that one [another participant], that it's only for the woman that's responsible. No I don't think so. Men is responsible for the family... so man is part, important part [of FGC prevention]" (Eritrean man)

Women also felt it was important that men were included in responses to FGC, both with regards to prevention of the practice, but also to ensure that young men were aware of the impact of FGC on their wives. A number of participants noted that younger men who had grown up in Australia were often unaware of how FGC could influence a couple's sex life.

"They've got no idea to be honest" (Eritrean woman).

Role of religion

FGC is not a religious obligation (for any religion), however there was a false perception among some participants that the practice was endorsed or required by Islam.

"In our country only Muslims are use the circumcisions. Because if you are Muslim you must do it" (Sudanese woman)

"We call it Islamic or sunna, yeah. Sunna. Even our religion doesn't have any problem with that" (Somali woman)*

*In Arabic, sunna means 'tradition', or normative or usual practice, but it can also mean 'duty'.

"Some people believe that not to do it is a crime, a religious crime or a sin, people are starting now to understand. [But] The longer they live here, the more they understand" (Somali man)

FARREP workers described the opposition that some community members had expressed towards their work, on the grounds that FGC was a religious obligation. However FARREP workers were well aware that this was not the case.

3. Findings

"It's more about men's control over women over centuries... People come under this hierarchical system, so they always reinforce it with weak ideas by saying it's an Islamic practice, or it's been recommended by the Prophet. Whereas, if you research, it is not that" (FARREP worker)

Similarly, most participating community members were aware that there was no obligation in Islam for FGC to occur. A number of male participants identified that there had been a change in attitudes towards FGC among community members when it was made clear that FGC was not religiously endorsed.

"In the Holy Koran, both types (sunna and Pharaonic) are refused. It's not there" (Eritrean woman)

"[Knowledge] become very widespread that it is not religiously sanctioned, that it is not a very nice thing, so people got actually a lot of excuse to not do it, rather than do it" (Somali man)

"I think twenty five years ago, people started to say, ah become [aware] that it wasn't religion based and then it become eh- started you through questioning and say 'it's not religion based, and it's a harm, so why are we doing it?'" (Somali man)

A number of participants emphasised the impact of religious leaders clarifying Islamic teachings in relation to FGC, and felt that this was a key contributor to changing attitudes and the decline in the practice among migrant communities in Australia.

Mixed feelings about abandonment of FGC

While respondents described FGC as being less important than it had been in the past, individuals expressed a range of perspectives in relation to the abandonment of the practice. As anticipated, women from different

communities held varied views on the role and meaning of FGC, and there was also a diversity of opinion within cultural communities. Indeed, individual women expressed mixed feelings about FGC and its abandonment, with some participants describing the internal conflict they felt about the practice.

"All people are convinced of its risk and it doesn't have any health benefit, and not even think of it. My thinking is if I could have the ability to [circumcise] my grand daughter, I might prefer to have a sunna type [Type I]" (Eritrean woman)

"You know, in the back of my head, I see some benefits like he said before [but] it is not that we are approving it" (Eritrean man)

One young woman who had refused FGC described her mother's struggle in trying to come to terms with her daughter's decision. Her mother had prioritised her daughter's education and encouraged her to think independently from a young age. The daughter felt her mother supported her decision not to undergo FGC, but:

"I think she had a tiny hope that eventually I'd do it, yeah so, I don't know. But yeah, it was, it was really sad for her" (Somali woman)

In trying to articulate their views on the role and meaning of FGC, women often sought to reconcile their personal experiences of the practice – which were often painful, but also often associated with celebration, a sense of belonging, and pride – with the wider social environment in Australia where FGC is viewed in primarily negative terms.

"I was told, that you know, you're going to be circumcised now. I was excited because it is part of the things that you do... then all my friends come, they brought me special like gifts like you know gifts and all that. It's like a festive thing. They put henna on my hand" (Hararian woman)

"If you come back from Africa you, you can say it with pride, you know 'hey I'm like this' you know, but when you come here... if you say it, it's a shame" (young Eritrean woman)

Older women were more likely to express resistance to, or sadness about, the abandonment of FGC. Older women questioned how the important cultural values that they associated with FGC – female virginity at marriage, modesty, restraint, respect for elders, responsibility to community – could be passed on to younger generations if FGC was no longer practiced.

"If I had a daughter I still, I prefer, to circumcise her" (Eritrean woman)

"Thanks God I have all my daughters grown up and married with respect. They had their FGM when they were young and their kids are not my responsibility" (Somali woman)

"The reason why girls back home are circumcised is to reduce their sexual desires. And here, woman, girls are not circumcised and they still have the high sexual desire. So who's gonna you know, restrain them?" (Somali woman)

Some of the participants directly associated the difficulties they were experiencing in parenting teenage daughters in a cultural context very different to that of their own youth, with the abandonment of FGC.

Participant (Somali woman): *Yes, there's changing because back home if we tell, you know, our girls to do something or, uh, they used to heed our you know, us, yeah, our advice if we say 'stay here', they used stay there for the whole day. Here they say, here, 'no way'. Yeah, not fair. This the kind of behaviour we have here.*

(several women speak in Somali)

3. Findings

Interpreter: *Yeah this concern is not only for myself, it's for the whole community. Of course we have uh, safety, here in Melbourne, we have peace here but we don't have another thing.*

Interviewer: *Do you think the different behaviour in Australia is because the girls aren't circumcised or is it because it's just such a different culture?*

(interpreter translates, response in Somali)

Interpreter: *Yeah, it's something to do with lack of circumcision yeah. Yeah it's very difficult to restrain girls.*

It was clear from the focus group discussions that, to varying degrees, parents from all the cultural communities who participated in the project found it challenging raising their girls in a cultural society that was so different to the home country, particularly in relation to the role and position of women.

"My daughter is growing, would I let her grow in this culture and then be open and ... lose control of my daughter?" (Eritrean man)

"Of course, yeah I'm worrying because I need my daughter to stay home" (Eritrean man)

"Yes I can talk about my own experience you know. My own daughter dropped out of school and she doesn't listen to me, and she's talking about opening a business you know. What kind of business can she open you know when she is too young? She's twenty!" (Somali woman)

Male participants, in particular, felt that women had more equality with men in Australia than in countries of origin. This was described in positive terms, but was noted as being a substantial change requiring re-negotiation of family relationships and roles.

"There [Eritrea and Sudan] there wasn't equality between woman and man. Here there is equality. The female, the woman has a right. This is her right [not be circumcised] so I can't deprive her of her right" (Eritrean man)

Participants' mixed feelings about the abandonment of FGC were evident in (older) women's regret that sunna (clitoridectomy or Type I circumcision) cannot be performed. Sunna was perceived as consistent with tradition, but without harm.

"Even now I condone that type of circumcision" (Somali woman)

"The importance of FGC will change with time and we already see a change... sometimes we feel and discuss among our self, maybe Type 1 will be good, and sometimes we say 'no forget all its forms'" (Somali woman)

Younger women were more likely to be opposed to FGC, perceiving all variations of the practice as something that should be stopped.

Generational change

While some of the older women who participated in this study were regretful that FGC was no longer practiced, it was clear that there had been a change of perspective among their daughters.

"Our daughters are more aware of the health risk of FGC. And they do not want to circumcise their daughters" (Eritrean woman)

"If we ask our married daughters who have girl child to circumcise, they totally refuse" (Hararian woman)

Some participants suggested that, in contrast to countries of origin, in Australia couples were able to make decisions about the circumcision of their daughters independently, without the decision being taken by extended family (in particular grandmothers).

"I don't think the other family members or elderly will, uh – before there was a decision from the family members, but now I think me and my husband are the one, we take the responsibility and decision" (Eritrean woman)

There tended to be more agreement among young women that the abandonment of FGC was a good thing. However young women who were the first not to be circumcised in their families described the pressures associated with this (for themselves and their wider family).

"It's a fear of just breaking the cycle, I think it only takes one to break the cycle so when one actually - yeah its that fear of, you know that, that change is coming... so if I don't do it, my kids would end up not having it, their kids won't have it, so the cycle will be broken. So to be the one person that started it... and to be that family that broke it, then it's like yeah, it's the whole family that's looked upon" (Somali woman)

"Speaking to other Eritrean girls, it's very similar, that is whether it's Sudanese, whether it's Eritrean, I think all that section, East Africa, they've all got the same, same pressure, cultures, yeah so they're very stuck to that" (Eritrean woman)

Young women felt that these pressures were sometimes unrecognised by health professionals and the media in Australia, as is discussed further in section 3.3 in relation to the impact of FGC on young women.

3.2 Knowledge of FGC

Knowledge of the law on FGC

Consistent with research conducted soon after the change to Victorian law in 1996 (see for example, Allotey et al. 2004), this project found a high level of awareness and acceptance of Australian FGC legislation among the participating communities.

"We know it is illegal to circumcise girls or to take them out of Australia in order to do it and it's really good because a lot of people will think twice as it involves prison term and fine and it's a deterrent" (Somali woman)

"We know it's illegal, and Eritrean community are very worried abiding the law. That's why we see less of it" (Eritrean man)

Some community members expressed concern that 'new arrivals' may have less access to information about the legal context in Australia.

"We dealt with this issue as we were arriving here, twenty years ago... that was the time when there was a campaign to make the people [aware] of this issue. And we held a lot of workshops, meetings, discussions in the community, so the people who came around that time, they are fully aware of where the community and where the religious leaders stand. Maybe people who recently arrived, maybe a year ago, two years, three years ago, maybe those people need awareness" (Somali man)

Most participants in this project felt that they personally had good awareness of the law overall, but it was apparent that the most recent arrivals had lower levels of understanding of the law. For example a participant who had only been in Australia seven months knew that FGC was illegal here, but not that it was illegal to take someone out of the country for the purpose of FGC.

The one area of the law where some participants expressed confusion was in relation to re-infibulation after childbirth. During focus group discussions, participants would sometimes exchange contradictory experiences in relation to (re)suturing after birth. A number of women stated that they had been 're-infibulated' after delivery, while other women said that their requests for such a procedure had been refused. Women often noted that 'back home' they would be 'sewed back up' after childbirth.

"It was also a beauty not to see all those hanging pieces, [and] it increases male sexual pleasure. If a woman has children she will be repaired in order to have a tight vagina" (Somali woman)

While many participants indicated that they did not want to be re-infibulated after childbirth, in order to prevent further scarring and health complications, some women felt that re-infibulation was desirable and that they wanted their genitalia to look and feel the same as it had been before the birth of their child.

"If it is not stitch after birth, she feels like missing something. [She] will have infection, so it is better to stitch her. It will affect her mental health so just ask her and respond to her will, I mean the law have to be flexible" (Eritrean woman)

Suturing after childbirth would be expected if a woman had had an episiotomy or a tear – some participants' responses suggested the reasons for 'stitching' after birth were not always clear to them, and that they were unsure whether surgical repair might be considered re-infibulation. The contradictory stories women shared in relation to their requests for re-infibulation added to this confusion.

"All my daughters have their babies at the Women's and asked to be restitched back and they have done it [suturing that was perceived to be re-infibulation] for them" (Eritrean woman)

"Sometimes women who had babies at the hospital, after they have a repair for their tear. They [are] mistaken and think they were re-infibulated, and tell the others of something that is not true" (FARREP worker)

Women's confusion in relation to re-infibulation reinforced the perception among some of the participants that the law in relation to cutting of the female genitalia was applied in an inconsistent, and discriminatory, way.

"[Clients say] 'Of course I can be re-stitched because this is my body and I'm free, consenting adult woman'" (FARREP worker)

"Sometimes I see people discriminate, discriminating us we did circumcision, we did bad stuff. But it happens as well in free countries. There's the plastic surgeon who is doing that" (Somali woman)

"[Describing questions she is asked by clients] 'If an 18 or 19 year old woman wants to do it, why the law will stop her and not stop the other women? This is a racial issue'" (FARREP worker)

The legal status of FGC, as practiced by African women, was contrasted unfavourably with the status of labiaplasty (a procedure involving cutting of the female genitalia that may be covered by Medicare). Participants described their perceptions of unequal treatment of women in Australia on the basis of whether or not the individual had an African background, and felt this was an illustration of racism.

"There is this huge stigma that you know that uh, circumcised women want their thingy narrower, tighter, you know?" (Hararian woman, contrasting the lack of apparent stigma around labiaplasty)

3. Findings

Knowledge of the health consequences of FGC

"People have history you know. Before they doing it. Why now they didn't do it? Because they know the health effects, they know it's a problem" (Oromo woman)

Women who participated in this study were aware of both physical and mental health consequences of FGC. This included participants who had and who had not undergone the procedure. Participants perceived that the high levels of awareness of the impacts of FGC were due to more open communication about the practice; higher levels of education generally in the community; and the awareness raising efforts of FARREP workers.

"The younger generation also have been kind of integrated to the mainstream. They studied here, they grew up here, and also they read a lot... so they will not repeat the practice to their children" (FARREP worker)

"I think this is the level of education which they have. This lady is educated. She knows more about it. She came from Sudan and she said, "I came from Sudan and my daughter was not circumcised". But again the elder group which doesn't have, you know, the level of education is a bit low, they said, they have to have the sunna type of circumcision" (FARREP worker)

"If you learn it, you don't do it. If you don't learn, or you don't get any information, how are you going to know?" (Oromo woman)

However several of the health workers emphasised that consequences of FGC that might be viewed as a 'problem' by health professionals, were not seen that way by women who had undergone the practice.

"The last couple of women have said they don't have any problems with their periods, they don't have any problems passing urine. And after they've had their de-infibulation they realise how different it is, actually being able to sit on a toilet and wee normally, as we would think is normal, um, and have a normal period. It is actually quite different, which they're surprised by" (Midwife)

"I don't know if they would think about the whole range of problems, but obviously, painful intercourse and urinary infection, they're all pretty consistently aware of those. And then problems with delivery, and you know things being a bit more complicated around delivery of the baby" (General practitioner)

It should be noted that resolution of some of these 'problems' after de-infibulation was not universally celebrated by women. One focus group discussion dissolved into laughter when a participant described her horror at the speed of her urinary stream after de-infibulation – "so noisy, like a cow!".

Participants emphasised that community members' awareness of FGC was heavily influenced by the approach taken in health promotion interventions. FARREP workers, who shared language with some of the communities that they worked with; shared some of the challenges associated with migration and resettlement; shared understanding of the cultural importance of FGC; and could empathise with community members' mixed feelings at its abandonment, were highly valued by participants as a trusted source of information about FGC.

While a number of the male participants demonstrated general knowledge of the health consequences of FGC (referring to difficult sex, risks during childbirth, and to a lesser extent mental health

consequences), men also saw that there was a need for more information on the specific consequences of the practice to be made available to men. Men saw education about, and knowledge of, the health consequences as being key to community change.

"We don't know its health implications, yes consequences. And that's – many people who I think... they don't really understand what does it mean in future for the girl when she grows and gives birth. So more information on that" (Eritrean man)

"I still remember vividly how my sisters were suffering when they were circumcised, and I think it shouldn't happen, uh, I don't think it should happen to my daughters" (Somali man)

Female community members agreed that raising the awareness of men in the community was a priority. They observed that in Australia men were more likely to attend the birth of their child, and that this was increasing men's awareness of the health consequences of FGC and opposition to the practice. It was felt that when men have accurate knowledge about FGC, they are able to use their status as leaders of communities and heads of families to advocate against the practice.

"Men [that] have the full awareness will intervene. They will say I don't want this to happen to my children. But otherwise [if they are not aware] they would say, it's all women's business and we don't have anything to do with that" (Eritrean woman)

"They didn't know how painful, what you are suffering... but in this country they see everything, they changing their mind" (Hararian woman)

3.3 Impacts of FGC

Participants' descriptions of the health and other impacts of FGC were enormously varied, and were strongly influenced by the type of circumcision that they had undergone, whether or not they had children, and age at migration. The consequences of FGC described by the younger women in the study were different than for the older participants.

Impact on young women

The consequences of FGC described by younger participants were heavily influenced by whether or not they were sexually active and whether or not they had children. Many young circumcised women felt they experienced no physical impacts, particularly if they were not yet sexually active. The young women associated uncomfortable periods and recurrent urinary tract infections with FGC, but described these as minor and/or normal, and in terms that expressed resignation.

"It won't change, like we've been through it and there's nothing we can do about it" (Eritrean woman)

For many young women the impacts of FGC were described more in terms of the psychological consequences. For some this was related to their memories of the FGC experience itself.

"Can I also say like, like state the obvious, for people who have experienced that, they tend not to talk about it because there's no local anaesthetic. They actually remember, like, details, so they try to erase it from their memory" (Somali woman)

"Sometimes we don't want to remember things" (Eritrean woman)

Other participants described the psychological consequences of FGC more in relation to their coming to terms with something that had been done to them as a child, by their loved and trusted family.

"You're thinking, 'no I'm sure it's not something bad if my parents?', my parents would know best you know?" (Oromo woman)

"A lot of the young women we've seen are upset that they've had this procedure done, that they understand why, but they're you know, you know, they're really torn. Like they're, you know, they're angry that they're different, and that they've had you know a circumcision that really they don't, wouldn't, want and certainly don't want on any of their sisters or daughters. But they also understand that you know their mothers and grandmothers thought they were doing the right thing" (Midwife)

The young women were understanding towards their mothers and other family members, and did not use language of blame, but none the less some of the participants described difficult psychological processes that they had had to work through.

"When they grow up, and they know that this is, it's different, it's something else, they feel like oh my god why did, like, they've been lied to and stuff" (Eritrean woman)

Several participants described how, after migration, they were shocked to learn that most young Australian women had not experienced FGC. The young women then began to question what they had thought was 'normal', with participants describing unanswered questions in relation to their bodies, worries about the possible future impact on their sex lives and ability to deliver babies, and for some a sense of grief.

"Okay, now I'm missing something that other women has. Well the first shock was to find out that people here are not circumcised. I was like what?!... You have to deal with that... I'm not the same as women here and slowly you have to deal with it and then I started to kind of - you grieve a bit, that 'what is this thing that has been taken away from me?'" (Hararian woman)

For young circumcised women, FGC was a source of difference from their peers in Australia. Some of the participants described this in terms of the negative impact it had on their sense of well being.

"Yeah, it [FGC in Australia] is a shame, it's just a disgrace, you feel, you feel less, you feel little yeah? And then you can't really speak up. Back home if you said it, well hey man like nobody can say anything against it, but here ... you feel you're not like everybody else" (Eritrean woman).

FARREP workers noted that the young women they worked with did not like to have their communities associated with FGC, seeing the practice as unnecessary and shameful in the Australian context in which they were trying to make their way.

However, when young women were not circumcised this was then a source of difference from their family and friends in their countries of origin. Participants also described this in terms of the negative impact it had on their sense of wellbeing, and the pressure that some of them experienced to undergo the practice when they visited relatives 'back home'.

"You go back and [they're] like 'oh now she's so Westernised ... she doesn't belong, she doesn't follow us any more, she feels like she's her own individual'. You know, so they kind of take that as offence" (Somali woman)

Whether or not a girl had experienced FGC, the practice could mean she felt different to her peers in Australia; felt different to her peers in her country of origin; felt responsible for her family being seen as having 'broken a cycle' of tradition; or felt resigned to dealing with the consequences of something over which she had had no control. It was clear that the young women in this study had had little opportunity to discuss the psychological consequences of FGC, and the relationship between the practice and their mental health and wellbeing.

3. Findings

Older women rarely raised psychological consequences as a harmful outcome of FGC, but the negative physical impacts of the practice were frequently and openly discussed.

"I have one patient who um, she's getting recurring urinary tract infections related to hers [FGC], but she is very reluctant to go to the Women's hospital clinic and have it assessed, because she was pre-she wasn't married. And she hadn't had intercourse yet, and it was all a bit overwhelming I think. Um, but the older women who've had kids are much more likely to be quite blasé about it, for themselves, and agree that it's not a good thing to do to, to younger women" (General practitioner)

Impact in relation to pregnancy and childbirth

Participants emphasised that not everyone who has undergone FGC has subsequent difficulties during pregnancy and childbirth. However, for those women who did suffer physical health consequences (most commonly, but not exclusively, women who had undergone Type III procedures), these usually related to difficulties with childbirth and were considerable.

"I was infibulated and still now had no any problems either at the time of circumcision, marriage and birth" (Eritrean woman)

"Yeah, it's not good. Even for delivery, for baby delivery, it is hard" (Oromo woman, who perceives she ended up having a Caesarean because of her FGC)

"Having a birth it was so, quite difficult to give birth, yeah you know, um the doctor sometimes is very confused you know. It's uh, actually, there's nothing that they can see... for myself I have C-section after" (Somali woman)

A number of women described severe perineal tears that they had experienced during childbirth, and attributed these to their FGC (or, as often, the inadequate care that they received at the time of childbirth in relation to their FGC).

"During birth the midwife didn't cut FGC and this poor woman had a tear towards the anus and was not repaired" (Eritrean woman)

Some women reported that procedures during pregnancy such as pap smears and internal examinations were particularly uncomfortable.

"Cos they have this test that they do when you are pregnant [internal examination]. Yeah, it's very hard when you like you're circumcise, and the doctor, I was struggling with them like 'no don't do it to me' and you still have to do it and it's very painful"... they do it every time you go for an appointment and it's very very painful" (Eritrean woman)

Women in one focus group discussion felt that the discomfort associated with pap smears stopped some of their peers from having screening.

"It does. Some people stop because they just thought [inaudible]... Yeah it depends on the doctor that's doing the test. Some of them make it so easy and they talk to you, but some of them they you know rush, they just do their job" (Eritrean woman)

Impact on sexuality

Many of the participants, both male and female, described the negative impacts of FGC on women's sexual experiences and their sexual relationships with men.

"Some women that underwent FGM/C had no problems at the time of circumcision, but later when they reach puberty they had problem with the period and most of them, especially those who have type three, after they get married [and become sexually active] it's big problem for them" (Somali woman)

"I suffered when I was having the baby. I suffered when I got married and was trying to have sex with my husband. I don't want my daughter to go through that" (FARREP worker)

Sex was often described as difficult and painful. A number of participants had needed to be de-infibulated (by a health professional) in order to consummate their marriage. This was a source of embarrassment, disappointment and frustration within relationships.

"Some men found out the first night that their wife is circumcised and then they took them to the clinic, and they you know, say you have to come back after one month, after twenty days... it was not nice, you know this woman, they want to start their, they want to consummate their marriage" (Somali man)

"Because the effect of it when the new marriage, [it] is very hard for the man to come close or to sleep with the wife... Because it is very hard, some, after that experience, they don't want to see the man" (Eritrean man)

Some participants felt that FGC, and in particular infibulation and the creation of a 'tight' vaginal opening, increased men's sexual pleasure. For these participants, this was one of the underlying reasons that FGC was performed in the first place.

"Sometime people, they just put it like that way, men have to enjoy the sex better than the ladies" (Sudanese woman)

However others, including men themselves, described men as wanting their wives to enjoy sex and in particular their first sexual experiences. Men felt pressured to 'open' their wives on their wedding nights, and that this led to distressing experiences for both men and women.

3. Findings

"He said, 'I hate it as well'. He said, 'When I first married my wife, I don't know what to do', and culturally and other people telling him if you don't do it on your own, you're not man enough. But he said 'when you are dealing with a skin that was stitched together when the person was five years old, it becomes like normal skin. How can I use my skin to cut to that skin?'" (FARREP worker)

"[A recently married young man] said 'I cannot, I cannot have ah relations with this girl, I cannot have my sexual, I cannot penetrate, so they already made the decision to break up, yeah, so we gave, we gave, the woman came forward and asked for a divorce and we gave her a divorce'" (Somali man)

3.4 Health service experiences

Improved but inconsistent experiences of care

A number of participants in this study had had several children since resettling in Australia, and felt that the health services that they received (particularly in relation to childbirth) had improved over the last ten to twenty years.

"Back in to '96, they have no idea you know about the process of circumcision... they was very confused and said 'oh my god, what's? Where? Can I have a look?'" (Somali woman)

"Yeah the medical team or the doctors and, uh, midwives have now got used to attending to circumcised women giving birth, but in the beginning it was very, very difficult yeah. And again, uh, there was also the problem of language barrier you know, yeah communication was very difficult as well" (Somali woman)

Participants felt that there was more awareness among midwives and doctors than in the past, and more

skills in relation to procedures, such as anterior episiotomies, that may be required by a woman who has had FGC when giving birth. Women expressed considerable gratitude to the services in the North Yarra area. However, experiences of care in relation to childbirth remained inconsistent.

"If you're lucky, they know what they're doing ... They try their best you know?" (Eritrean woman)

"It was an inexperienced midwife who cut me and it wasn't correct. I had to get it fixed privately again after" (Hararian woman)

"But I still think it depends on the midwife, yeah. Sometime, not everyone know what they are doing. Some midwives they find it very difficult, a lot of them they struggle" (Eritrean woman)

A recurring theme among women's birth experiences was a feeling of not being listened to. This was true of women who had delivered at a range of public facilities across Melbourne. Women talked about knowing their child's birth was imminent and asking to be cut (episiotomy), but instead being instructed by midwives to wait and that it might not be needed. Participants spoke of painful tearing that they felt could have been avoided if the midwives had respected their knowledge.

"In our culture when you have a baby, normally we don't shout, that's our culture, like that's a big problem for us you know. We keep the pain inside... Yeah they think, 'no no', they think we are not ready to have the baby and try to send me home" (Hararian woman, who experienced a severe perineal tear)

"Listen to woman and understand what she need, [and] cut her FGM during labour, don't leave her until she has a tear like happen to me because they didn't listen. The baby push out quickly and I had a big tear" (Somali woman)

"When I had my fourth one, I had a really terrible midwife. I don't even want to recall that. She was trying to send me home. She said 'you are not ready, you can go home and sleep'. I said no because I know myself. And when I start pushing, I pressed the button. She came with the blood [on her gown and gloves] and with everything, she was delivering with another woman and starts shouting [at me]. Still it's not nice [to remember]. And then when she saw it's the baby's coming. 'Oh' she said" (Hararian woman)

Women also expressed concerns about the manner in which they are cut during childbirth. Some of them attributed the painful outcomes of 'bad cutting' or tearing to a lack of knowledge and skill among service providers. Some of the older participants felt that this issue had been raised previously with health care providers, and yet remained a persistent problem, reinforcing feelings of not being listened to.

"They were like kind of, didn't know what they were doing, and uh, they, you know they had to give me more cuts then in an awkward way... I have suffered because of that" (Hararian woman)

"[I was] telling the doctor to cut the FGM and totally he ignored me. And he was cutting in the sides instead of cutting the practice [the infibulation]" (FARREP worker, describing a birth with particularly poor outcomes for the infant which she attributed to poor management of FGC)

"15 years ago I was in one of the focus group who participated in the consultation of FARREP Program at the Royal Women's Hospital. Then we said the hospital use one of our expert's in FGC to show you how to cut woman at birth centre. Still some women are suffering either they wouldn't been cut good, or left, and the baby push and has a tear toward the anal" (Eritrean woman)

3. Findings

The experience of not being listened to was perceived by participants to cause physical harms, but it also left women feeling disempowered in the health care setting.

"The midwife, they don't listen to the patient. That's the one problem they have. And then when they don't listen to the patient they have, uh, they degrade [her]" (Somali woman)

FGC exacerbates 'othering' by Western health care professionals

Women talked about experiences of, or perceptions of, racism within the health sector. They also discussed the assumptions that were often made about them, based on ill-formed prejudices about African refugees.

"So sometimes the way they address you when you are different background is like they treat you like you're deaf. I'm not deaf. I can hear you. Speak slowly. And sometimes they were getting frustrated and becoming angry" (FARREP worker)

Some of the women who had undergone FGC perceived that their experience of the procedure further increased the degree to which health professionals saw them as 'other' (different, foreign and shocking).

"For me it has caused me lots of problems because when I went to health services, the minute that I say 'I was circumcised' it just create huge barrier between them and me, like you know suddenly I'm from another planet... And I could see that they have no idea what they're doing, in terms of how to deal with circumcised women and that cause a whole lot of kind of misunderstanding and conflict" (Hararian woman)

"My experience, when the midwife was shocked and she called another midwife and I said 'oh my goodness' – like am I on exhibition here like you know. Like it would have made life

much easier if she didn't do that, shocked. Like I just, I don't fight her, she's another female, just like me and suddenly now she find me shocking!" (Hararian woman)

Women who perceived that health professionals found their bodies 'shocking' and worthy of being put 'on show' to other health workers, often linked this to the offence they experienced at being described as 'mutilated' by health professionals.

Doctors also recognised that health professionals' responses to women who had experienced FGC could undermine respectful and effective doctor-patient communication.

"It's just part of their lives and they don't regard it [FGC] as a problem. They sometimes see our response to it as being a bit strange, in that if a doctor says to them 'oh my goodness, you're not going to be able to have a baby unless you get that reversed' or 'you know you're going to have all of these troubles or you're going to need a caesarean', then they regard, I think that they regard that as being, as being an unusual response" (Obstetrician & Gynaecologist)

Cross cultural challenges in relation to childbirth

The arrival of a child, and a woman becoming a mother, is a time of particular significance for individual women and their families and is also associated with culturally determined celebrations and practices. In several of the focus group discussions, women noted that the process of childbirth itself and the support provided to birthing women was also strongly shaped by culture. Some women felt frustrated by what they perceived to be cross-cultural misunderstandings in their experiences of childbirth in Australia.

"The way we are attended to when we are giving birth back home and the way we are attended to here are totally different" (Somali woman)

"I would like the young doctors to understand like sometimes especially when they [women] have FGM and they have a baby and all those stitches and if they're feeling pain, they [the doctors] think they're less interested in the baby. There was a woman who had a baby and she gives birth. They give the baby to her and put on her chest. And she says, 'No'. But then African families, they don't like their babies to be put on their chest. When they [doctors] come in and say, 'This woman, I think the husband forced them to have babies because they don't like the babies'" (FARREP worker)

Improving cross-cultural communication between health services and community members with African backgrounds was identified as a priority area for intervention by a sizeable proportion of (female and male) participants in this study.

3.5 Challenges to health service delivery

Health worker training

Health service providers and community members alike felt that there needed to be further, and ongoing, training of health professionals to ensure that the improvements seen in the quality of care provided in relation to FGC are consistent across the major facilities serving North Yarra communities.

"Our junior doctors feel as though they haven't been exposed to women with these needs. I'm getting that feedback from my junior doctors, which is a concern because they're going to be at the coal face seeing them in emergency department or antenatal clinics, and they're asking oh, you know, I haven't got experience in dealing with this can, you know, even though it might be a simple consultation they feel as though there's something that

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they haven't been made aware of" (Obstetrician & Gynaecologist)

"Yeah I just, I feel, yeah there's a lot of health professionals still, I mean they haven't seen any woman with circumcision, so it's fairly, um, confronting when you do for the first time" (Midwife)

"I think they need more education. I know that they already – they need more – there's not enough, [that] know about it, circumcision what to do, but it's not good enough. I think they need more education" (Eritrean woman)

As a specialised area, clinical and cultural knowledge around FGC is highly concentrated among a small number of staff. For patients of the Women's (and other hospitals), this can translate into a 'hit or miss' experience. When discussing their experiences of childbirth many women expressed that the quality of their care in relation to FGC was still going to depend on who they were lucky enough to get on the day. This was consistent with the perceptions of health workers from the Women's.

"I think there's a certain group of people who are very aware and, um, that's probably of our generation. But the younger doctors ... they're just not getting adequate sort of information to help these, to sort of counsel these women appropriately" (Obstetrician & Gynaecologist)

A senior midwife described how many of her junior colleagues were 'scared' when presented with a patient who had experienced FGC and, in particular, infibulation.

"Ninety-nine percent of women don't have circumcisions, so [for junior midwives] to see that would be totally different. And how's it all going to, is it going to stretch? Is it going to tear more, is it going to you know, be more difficult? And also, you're cutting a very sensitive area, and they normally, they're scared about doing ordinary

posterior episiotomies, let alone anterior ones... It's just that they've never seen it before, it's something new" (Midwife)

Previously an experienced midwife led clinical education in relation to FGC for midwives working in the antenatal and birth suites at the Women's. However, in recent years she had retired, and this was identified as a significant loss to the hospital. A number of clinicians interviewed for the study felt that ongoing professional development and workforce training in relation to FGC had somewhat 'dropped off the radar' since this midwife's departure. This concurs with community members' perception of patchy FGC knowledge and skills across the Women's (which was still recognised as providing high quality care in comparison with other facilities).

Lay and professional participants in the study emphasised that there was a need for health workers to develop both clinical and cultural competencies.

"Just the background to it, the whole background of FGM, ah not to be, not to be frightened of talking to the woman about it but to know how to talk to her about it... I suppose just getting over that shock value of, you know, what they think is something terrible. They don't realise that the women mightn't actually be that traumatised by it, I mean that mightn't be the worst thing in their life" (Midwife)

"I think it's really important that when they access a health service that they don't feel different or ashamed of what has happened. That they're treated with respect and knowledge" (Midwife)

Reach and coverage of services

Health professionals based at the Women's were concerned about whether their specialised skills and services were being accessed by all those that could benefit from them. The profile of women who access the de-

infibulation clinic (predominantly younger women of African background) raised the question of who does not.

"I think there's a big group of women we're not capturing at all" (Midwife)

Staff at the Women's, and the de-infibulation clinic in particular, identify community outreach as an area requiring future development. This was seen as important in ensuring that communities were aware of the range of services available through the hospital, and so that the Women's were able to tailor their FGC-related work to community needs and experiences.

"I don't know that enough people know about us... that's probably one of the biggest challenges" (Midwife)

Health professionals also felt that the Women's had a significant role to play in building capacity and service coverage in relation to FGC in other parts of Melbourne. Several participants noted that the largest populations from countries that traditionally practice circumcision are now in Melbourne's outer suburbs, particularly in the outer west, outer north, and south-east (around Dandenong). It was perceived that these communities are particularly under-resourced and that service providers working in these locations could benefit from training provided by the Women's.

"When we talk about this area service, now a lot of change at Royal [Women's]. But in that area [Melbourne's outer west] and Dandenong area they don't have like these experts" (FARREP worker)

"I think internally we have to get it right and develop it for our setting here, and then maybe think you know, how can we support the education in the sector, you know for various health professionals and their roles" (Midwife)

Community members and health workers also recognised that there

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were communities other than those with African background who practiced FGC, who were not being reached with interventions to prevent the practice or with services for women who had undergone the practice. Several participants noted that none of the recent court cases in Australia involved persons from an African background, and yet very little was known about (or emphasis placed upon) other circumcising communities.

Community engagement

All health professionals who participated in this study emphasised the importance of community engagement, in order to build relationships with community members where FGC could be discussed and awareness of the health consequences of the practice raised. Participants felt that engaging with communities (including community and religious leaders), fostering discussion and debate about FGC, was the most effective prevention strategy.

"Sometimes we have success stories that will tell us like, you know, 'I used to be very strongly attached to my cultural practice, but now thank God, because I have read or because I have attended classes or because of the way how I had my children in the hospital, I don't want this to be repeated to my daughter', things you know, will come or circumstances will change then, you know, it will change their mentality" (FARREP worker)

However there were substantial barriers to engaging with communities. Some participants expressed frustration that FGC was such a focus for health workers and authorities, when the communities' priorities were perceived to remain unaddressed.

"But sometime we ask them to come about the FGC training or anything, so they say: "we had enough – fifteen years already, we hear about this thing too much" (FARREP worker)

"Circumcision is not an issue for us. Our main concern is about sheesha [substance use by young people]" (Somali woman)

Other participants stated that they felt that health services in North Yarra needed to engage more with communities to get a better understanding of local priorities.

"You think that's the standard service everybody needs, but that's from your [service provider] point of view. You really have to go out and find out what services they, they're neglecting" (Eritrean woman)

Community members emphasised, however, that how communities were engaged was important – that health workers needed to ensure they were not judgmental of women and their families, or community engagement efforts could 'backfire'.

"They feel like you're pointing the finger, you know 'maybe you should go see someone', and it's just no, I'm not saying that to you, I'm just saying it's there if you want it, so I think it's, they get defensive about it... and because they know that it's illegal, that they feel like their parents will get in trouble because they're the ones that actually did it" (Somali woman)

"If people got a bit alienated and they think someone is trying to say to you are some sort of a backward community, you are back with something horrible and I'm here to correct you, people will start to not get help from you, and be evasive, and say and be dismissive and go into defence mode" (Somali man)

Professional boundaries

Health professionals described how their clients tend to see FARREP workers as 'government authorities', or at the very least, as links to the authorities or systems of government. Community members usually present to FARREP workers with concerns other than FGC, and have an expectation that the workers will be able to fast-track issues related to their more pressing concerns such as housing or immigration.

"It's not only I am a FARREP worker that works with this issue, but also they will see me as someone who is very close to authorities so therefore I can solve a lot of their problems, for example, housing, immigration, and resettlement issues" (FARREP worker)

"[Describing a recent interaction with a client] 'Look, I have issue of the FGM and that's why the doctor referred me here but I also have another issue. I have only one bedroom and I'm expecting a child'" (FARREP worker)

"I know the community expects a lot more from FARREP workers. It is like a one window that they give them access to [to other government services]... you know they deserve better recognition, better support, better pay definitely, because they're doing a whole lot more than that job description" (Hararian woman)

This places FARREP workers in a challenging position. They recognise that their role is to primarily focus on FGC, however this is not the immediate priority of the communities that they work with. If they do not, in some way, respond to these immediate priorities then they are unable to build the rapport and trust with women that is required to be able to raise the sensitive issue of FGC and effectively address FGC-related concerns.

3. Findings

Communication between health professionals

Several of the health professionals interviewed felt that there was a need to improve communication between health workers both within and external to the hospital setting. Staff at the Women's felt that there was a need to increase awareness of the services available for women who had undergone FGC, among colleagues working in other clinics or areas of specialisation.

"There can always be better communication in a hospital setting. I think that, you know, I think there could be a, a bit more of a flow - not a flow chart, a flow chart's the wrong word, but just um, yeah probably a flow chart to say who in the hospital setting is available to actually either discuss, or these are the options that are at the hospital. Because a lot of people within the hospital system don't know that" (Obstetrician & Gynaecologist)

"That's another thing that we've talked about, a few of us. Is not only to communicate with the wider community but to actually communicate with the staff in the hospital" (Midwife)

In addition, it was recognised that there is fragmentation of responses to FGC across Melbourne, and that this was an area requiring investment to support improvements in coordination and communication.

"It would be great to have some sort of link between all the different services. It's very frustrating... I mean we should all be helping each other and, you know working together. It just doesn't make sense to me, because it's such a very small area of health, that if everyone knew what was going on and helped each other, it would just be so much more helpful to the women" (Midwife)

Communication barriers with community members

Both community members and health professionals identified language and communication barriers as a challenge for effective delivery of FGC-related services. In part this related to a limited pool of interpreters, who may be known to community members.

"Whenever we asked them whether they want to do the interpreter they said 'no, I know the interpreter and she's somebody I don't want to have access to my medical [history]', you know, I'm too embarrassed or I'm - you know, I don't want somebody knowing that I've been here" (Obstetrician & Gynaecologist)

Participants also highlighted that the vocabulary of some languages in relation to FGC was limited, causing difficulties for health communication even when an interpreter was present.

"So her English was very good from a communication point of view, but [not] articulation about words that we would often use [in a clinical setting]. Whether it was because English wasn't her first language or whether it's because they're just not the equivalent discussion, or that would have been a very difficult discussion with her anyway" (Obstetrician & Gynaecologist)

The cross-cultural challenges associated with discussing a sensitive and personal matter such as FGC were also raised as a barrier to effective service delivery by a number of health professionals.

"Muslim women tend to be um quite, quite shy or not really comfortable about having conversations on sexuality. And, I, they're young, well in my experience here anyway, if they haven't been married and not sexually active they find it very awkward to talk

about. Um, so that, yeah definitely the language and then a hospital's a big place, it can be quite intimidating" (General practitioner)

Finally a number of the community members who participated in this project identified health workers' assumptions about 'African women' as a significant barrier to satisfactory interactions in the health care setting.

"They think you don't speak English well, so you don't know nothing... Some people they take advantage of people, they think you don't know your rights" (Sudanese woman)

"How about some respect and trusting her, she's your patient... not making assumptions" (Hararian woman)

4. Implications for policy and practice

The findings of this study have a number of implications for policy and practice, suggesting various factors for consideration by organisations and health professionals working with communities in inner Melbourne in response to FGC. These include considerations relevant to engaging communities, and to the delivery of health services. These two areas of policy and practice are not mutually exclusive, with community engagement strengthening the ability to provide relevant services that are responsive to evolving community needs. Conversely provision of high quality services that meet people's health needs and are therefore valued, strengthens the relationship between communities and healthcare providers, increasing uptake of services.

4.1 Informing the field and the wider community

Policymakers, organisations and health professionals working with communities in inner Melbourne in response to FGC must ourselves understand why FGC has been practised and the factors contributing to its abandonment, and then use this understanding to contribute to informed public debate and building the understanding and awareness of the wider community.

To do this professionals in the field must understand that FGC occurs because these practices have been the social norm within relevant communities, accepted as a fact of life, arranged by caring families for their daughters and integral to identification as adult women members within those communities. Just as the practices and their prevalence differ between communities, a diverse range of beliefs have been invoked to support the practices, relating to

religion, hygiene and sexual behaviour among other things, but the overall effect of FGC has been to bestow a sense of full belonging within the community. If we understand this, we are better equipped to support the cultural change that is required for acceptance of abandonment and that is well established within the communities who participated in this study.

Factors supporting change identified in the study were:

- education about the harms caused by FGC and the fallacies in some of the justifications used to support the practice;
- recognition that other communities do not practice FGC and that it is therefore not a requirement for women's maturity, healthy relationships and motherhood; and
- knowledge that FGC is against the law in Australia and increasingly in countries of origin.

Factors mitigating against change in those, usually older, participants who were ambivalent or resistant to abandonment were:

- the importance of identifying with community in a new country and not abandoning culture of origin; and
- the development of new beliefs supporting FGC, such as that the non-circumcision of girls contributes to rebelliousness and resistance to parental guidance and community mores in the Australian context.

Understanding of these factors assists health professionals and policy-makers to engage and communicate effectively with individuals and communities, to support and reinforce their own progress towards change and to provide responsive services that will in turn augment confidence and trust in the information and education that the health sector is able to offer.

4.2 Considerations when engaging with communities

Need to recognise, and build upon, community-led change

This study found no evidence that members of participating North Yarra communities were practising FGC within Australia, consistent with the findings of others (Moeed & Grover 2012). It is not possible to say that FGC never occurs in Australia among these communities, and is also important not to discount reports that on occasion a girl may be taken overseas to be circumcised. However it is clear that participating communities' social norms in relation to FGC have undergone enormous change over the last ten to twenty years. The health promotion efforts of clinicians, community health personnel, and particularly FARREP workers, have supported this process, but it is vital that health workers and policy makers engaging with North Yarra communities recognise that the communities themselves have led this very major change. Practitioners and policy makers need to give credit to the leadership of Eritrean, Hararian, Oromo, Somali and Sudanese women and men for what has been achieved in prevention efforts.

The international evidence on 'what works' in FGC eradication is incomplete, with many interventions inadequately documented and evaluated. However it is well established that interventions are most effective if driven by, and involving, whole communities (Berg & Denison 2013; Johansen et al 2013). There are strong resources within North Yarra communities that organisations can draw upon in relation to FGC prevention – women and men who are well educated about the practice (including about religious teaching in relation to the practice), who have

4. Implications for policy and practice

used this understanding of FGC to lead change within their own families and to shift attitudes within communities. Health workers and policy makers could consider how to better engage with, and build upon, the experience of these community leaders. This could include linking North Yarra community members with the (female and male) leaders of more recently arrived communities in other parts of Melbourne, to share their experiences.

Public discussion of FGC should reflect the complexity and diversity of issues involved

Public discussion and debate about FGC in Australia is often framed by the use of stigmatising terms such as 'barbaric' and 'horrific' in the media and by politicians. Public representations of communities that traditionally practice FGC are also often inaccurate and sensationalised (MCWH 2013), and ignore the complexity of issues that inform people's decision making in relation to FGC (Brown et al 2013). Review of relevant Australian media coverage in recent months suggests that public debate around FGC rarely acknowledges the diversity of women's and girls' experiences and perspectives. Health workers and policy makers responding to FGC have the opportunity to ensure that their contributions to public discussion of the practice are well informed, and that their engagement with communities is respectful, empathetic and knowledgeable. This includes careful consideration of the language used to describe FGC when working with and in communities.

Health workers and policy makers can also play an important role in increasing public awareness of the traditional role and meaning of the practice, how this is changing, and of the leadership of community members themselves in responses to FGC within Australia.

Importance of community workers to community engagement

Study participants emphasised the particular value of community members who were engaged as health workers in local responses to FGC. FARREP workers, in particular, were seen as being on the same 'level' as community members – that is, they were seen as understanding the cultural imperatives for FGC, as having useful personal and practical experience in managing the consequences of FGC, and as being trusted sources of information.

Evaluation of responses to FGC in migrant communities elsewhere has emphasised the importance of trusting relationships for effective community engagement (Brown et al 2013, Costello et al 2013). Programs that have focused on professionals 'delivering' information are seen as less likely to support behaviour change, than interventions where community engagement is based on listening to local people and responding to the specific beliefs and experiences of the particular groups in that community (Brown et al 2013). Health workers who are members of affected communities themselves may be particularly well placed to identify and respond to local understandings about FGC. Organisations working with communities in inner Melbourne in response to FGC already employ a number of individuals from affected communities. Community members felt that health organisations could expand their connections to community by considering recruiting and training members of migrant and refugee communities in a broader range of roles including, but not limited to, as FARREP workers.

FGC as one of many changes associated with resettlement

Community members who participated in this study repeatedly raised the changes and difficulties associated with

resettlement. Participants emphasised that, while FGC had important health and legal consequences, it was not their highest priority and that there were many other unmet needs and issues in their communities, ranging from housing, education and employment, to addressing intergenerational conflict and mental health issues.

Key informants from health organisations providing services in North Yarra also recognised that FGC is only one issue among many of the challenges facing community members upon resettlement in Australia. Service providers were aware of the pressure that this sometimes put upon community workers who were employed to respond to FGC. Community workers may be identified as one of the community's few connections to 'the system', and so are often presented with a range of problems and requests for assistance. If community workers are not able to respond, in some way, to these problems, it then becomes difficult for them to build the trusting relationships required to effectively engage communities about FGC.

In their review of 'what works' in responses to FGC, Johansen et al (2013) suggest "targeting FGM is most effective and well received when a broader approach is used, assisting the community with other challenges" (2013, p.7). Organisations and health professionals engaging with North Yarra communities could consider whether and how to integrate responses to FGC with responses to the other health issues raised by community members in this study (such as the need for facilitated intergenerational dialogue and communication, including about sexual health and substance use; the poor understanding of mental illness and access to services promoting mental health and wellbeing in North Yarra communities; and the need for increased access to healthy leisure activities for young people).

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4.3 Considerations for health service providers

Need for improved communication between women affected by FGC and health professionals

It is very clear from the data presented in this report that there is a need to improve communication between women who have undergone FGC and health professionals. This is particularly the case around the time of pregnancy and childbirth. Women report not feeling listened to during labour, and it is apparent that there is often limited explanation given to them about events or procedures that they may have experienced during delivery (such as a perineal tear, episiotomy, re-suturing, or Caesarean section).

Findings of this study suggest that organisations providing clinical services to North Yarra communities need to ensure health professionals are supported to spend time with women post-delivery, providing information, responding to questions, and addressing concerns that women may have. This would increase women's understanding of why particular procedures were required (and whether or not this was associated with FGC), and potentially reduce perceptions that procedures were unnecessary or related to professional incompetence in relation to FGC. Increased communication would also reduce the current confusion among communities about the legality of re-infibulation after delivery.

Women continue to report cross-cultural misunderstandings associated with childbirth, and perceive that FGC exacerbates the degree to which they are seen as 'foreign' by health professionals. This resonates with findings from research conducted in Victoria over ten years ago (Allotey et al

2004), suggesting an ongoing need to prioritise building health professionals' cross-cultural communication skills.

The requirements to listen carefully and respectfully to women's concerns, to explain recommended interventions, and to make time to discuss any complications and resolve questions after the event are standard in health care. They are more difficult to deliver when there are language and/or cultural barriers; clinicians need to be trained and supported to listen better and to be alert to misunderstandings and "unasked" questions such as "*Did you do the caesarean because of the circumcision?*" or "*Was this tear because you don't know how to look after women who have been cut?*" Women need to be supported and encouraged to express their concerns and ask questions, as well as be provided with good information and realistic expectations of the local health system, for example the reality of caesarean section rates and the provision of Pap testing programs in Australia, both of which may be unfamiliar. The involvement of bicultural workers and broader community engagement directed to improving health literacy can assist. Both women and health professionals may have misapprehensions about the effects of FGC on the individual and their care, which can only be resolved by effective communication and sharing of accurate information.

Health professionals and community members also identified the need for greater 'outreach' or engagement with communities by hospitals, and the Women's in particular. Increasing communication between health professionals and community groups could increase awareness of services that are available to North Yarra communities, as well as ensure that health professionals are aware of changing beliefs and practices and are able to respond to current community needs.

Increasing awareness of existing services

Both community members and health professionals felt that there was scope to increase community awareness of existing services available in relation to FGC, particularly the de-infibulation clinic at the Women's. While some participating community members were aware of the clinic and the range of services it offered, many were not. Community members felt that the Women's could better promote their services through other community-based organisations (such as NYCH, but also other community health centres, and African community groups and associations), and FARREP workers based at other institutions (such as Women's Health In the North and Women's Health in the West).

Community members and health professionals also raised the challenging issue of how to raise the awareness of existing services for women from non-African backgrounds who may have experienced FGC. One strategy that was identified was to ensure that any media coverage that related to FGC, including media coverage associated with the findings of this study, included contact information for the de-infibulation clinic. It was also suggested that the Women's provide GPs, and other pap smear providers working in areas with large migrant communities, with written information about the clinic so that health professionals would be able to give this to women if they identified FGC at the time of a pap smear or other gynaecological examinations. It was identified that if health professionals themselves were more aware of the range of FGC-related services provided by the Women's, that they could utilise the opportunities afforded by provision of pap smears and pregnancy care to refer women as required.

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Improving skills and training of health professionals

Women from all participating community groups consistently reported that health services in relation to FGC had improved over the last ten to twenty years. However there remained an element of 'luck' with the quality of care that individual women received, particularly at the time of childbirth. This study has identified that there is a need for greater, and ongoing, professional education in relation to FGC, ensuring that all relevant staff participate. Community participants and staff members from the Women's identified that training for doctors and midwives about FGC needed to be increased, to ensure that women giving birth at the hospital were attended by staff knowledgeable and skilled in providing care to women who have had FGC. It was emphasised that health professionals needed technical *and* communication skills to be able to provide appropriate care. It may be helpful to explore means of ensuring less experienced staff have ready access to those with more specialised skills for advice, assistance or supervision when needed.

In addition to increasing the capacities within the hospital, it was also identified that staff from the Women's with specialised skills in relation to FGC had a potential role to play in increasing the awareness of other health professionals. Community members perceived that clinicians outside the hospital setting were not always comfortable talking to women about FGC, perhaps did not recognise the possibility of FGC, and were not aware of how it may affect procedures such as pap smears. Community members felt that staff from the Women's and FARREP workers could educate other professionals in the community.

Organisations working with North Yarra communities, and beyond, could consider the development of a more formal liaison and referral system, so that health professionals (and community members) were aware of clinicians with a particular interest and skill in responding to FGC who are practising in the region: given the mobility and connections between inner city locations and communities in outer Melbourne, such a system could include services across Melbourne.

Not forgetting the role of men

Community members who participated in this study were very clear that men had a role to play in responses to FGC. Women across participating communities emphasised that it was important to promote the supportive involvement of men so that women's health was a priority for couples and families. Men themselves identified their role as community and family leaders, and noted the positive impact of increasing men's knowledge about the health consequences of FGC and, in particular, religious teaching with regard to FGC. Religious leaders were actively engaged in early responses to FGC in Victoria around the time the current legislation was introduced in the mid 1990s. Participants emphasised the value of this and felt that this should be considered as a priority with more recently arrived communities.

Addressing the specific needs of young women

The younger women who participated in this study raised a number of issues that have been under-addressed in responses to FGC in Victoria, including the need for support in dealing with psychological consequences of the practice. Young women also identified

that girls needed more information about where they could access services and get answers to their questions and concerns about how they are different to uncut women, what had been done to them and what consequences this may or may not have. They highlighted the importance of providing young women and girls with informal and supportive settings for talking about FGC, emphasising that this was not something young women necessarily enjoyed discussing. This suggests that health professionals and organisations working with young women need to ensure that they engage with girls who may be affected by FGC on a range of issues, taking a holistic approach to health and wellbeing that enables young women to raise other health priorities in addition to discussing issues related to FGC. A number of younger participants identified the potential to increase FGC-related health promotion through schools, positively referring to the existing work done in this area by Women's Health In the North. Participants felt that schools could provide a valuable link to FGC-related services and information if school nurses were aware of what was available in the local area. Description of the contribution that schools could make to FGC-related care is limited in the published literature, suggesting the need for intervention research in this area.

Research describing how schools can most effectively contribute to FGC prevention in migrant communities is also limited and emergent. Organisations and policy makers could examine the outcomes of current work in the UK (and elsewhere) that aims to prevent children being taken overseas for FGC (RCM et al 2013), to assess the efficacy of different approaches and their relevance for the Australian context.

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4.4 Limitations of the study

This is the largest study focused specifically on FGC that has been conducted in Australia, involving the participation of 123 individuals. However the research team were not able to engage with all cultural communities and individuals who may be affected by FGC. The research team's networks and reach were not as strong with the Oromo community, for example, and the participation of Oromo women and men in the study is not reflective of the size of that community in the North Yarra area. There are a number of non-African communities that are known to traditionally practice FGC (for example, Kurdish and Yemeni communities), as well as other groups and individuals who practice FGC in countries where the majority of the population do not (for example, in India, Indonesia, Malaysia). It is unclear how many women and girls from these groups who are affected by FGC now live in Australia or in the North Yarra region, and women from these communities did not participate in this research.

Participants in this study had usually lived in Australia for a considerable length of time, and were part of cultural communities that were quite established in inner Melbourne. Findings from this research cannot be directly generalised to more recently arrived families and communities (including, for example, the very large Sudanese communities who have settled in outer metropolitan Melbourne), or to parts of the city less well served by organisations providing health services and information related to FGC.

To the research team's knowledge, this is the only study of FGC in Australia that has taken an explicitly community-based approach, basing research questions and methods upon community perspectives and preferences (including who collected data, and in what language). This approach facilitated the involvement of a broad range of community members, however the voluntary nature of participation means that the findings may not represent the entirety of views held by individuals from diverse communities. While our findings do reflect a range of perspectives, for example with regard to the desirability of abandonment of the practice, people who chose to participate in the study may have been those who were more open to discussing FGC and particularly interested in change.

The study did not include girls aged less than eighteen years. Several of the younger participants, aged in their late teens and early twenties, provided rich information about the impact of FGC on their lives and their perspectives on what could be done to better support girls from affected communities. However the lack of direct engagement with girls is a significant limitation of this study. Further research to examine girls' experiences, FGC-related needs, and priorities is warranted.

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5. Conclusion

This report summarises findings of a large, community-based qualitative study that specifically aimed to increase understanding of the impact of FGC on communities living in inner Melbourne and served by North Yarra Community Health and the Royal Women's Hospital. Participating cultural communities – originally from Eritrea, Ethiopia, Somali and Sudan – were well established, with most participants having lived in Australia for many years at the time of data collection (2013).

Analysis of data generated by this project highlights the substantial change that has taken place in communities that traditionally practice FGC, with the practice being of declining importance to families now living in North Yarra. Younger women, in particular, were likely to strongly oppose the practice suggesting generational change. Communities had, overall, high awareness of Victorian law in relation to FGC. While it is not possible to definitively say that FGC never happens in inner Melbourne communities, this study found no evidence of the practice being performed in Australia by members of participating cultural communities. However suggestion that on occasion girls may have been taken from Victoria to be circumcised in other countries deserves consideration.

One of the areas of focus for the study, and a priority for participating communities, was the health-service experiences of women who had undergone FGC. Findings suggest that health services in relation to FGC have improved over the last ten to twenty years, but that the quality of care received by women remains inconsistent. Women still perceive that they are not listened to at the time of childbirth, and that health professionals have variable skills in managing the particular clinical needs that may arise relating to FGC. In many instances, the concerns raised by women and their families could be addressed by improved communication from health care professionals, supported where appropriate by interpreters and bicultural health workers.

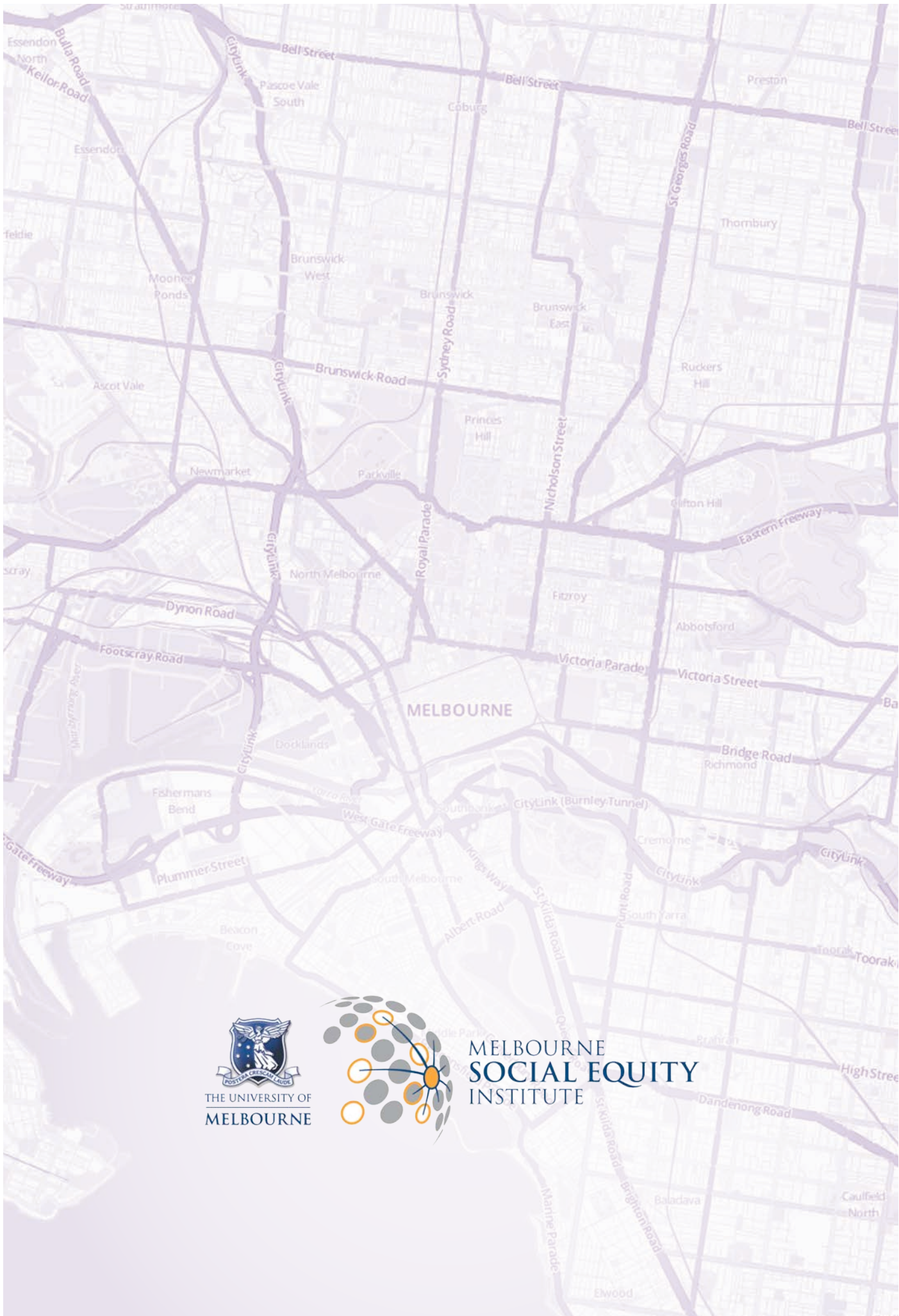
Younger women who participated in this study raised issues in relation to psychosocial support that have been under-addressed in current responses to FGC in Victoria. The need to engage men in responses to FGC was identified by both male and female participants, as was the need to address FGC in a holistic fashion, recognising that it is not the biggest health priority for affected communities following resettlement.

The findings of this study have implications for policy-makers and practitioners working with North Yarra communities, relevant to their efforts to engage communities in FGC responses and to deliver appropriate health services. These are identified in order to strengthen efforts to prevent future incidences of FGC and to provide high quality information and services to the thousands of women and girls now living in Victoria who have already undergone the practice.

5. Conclusion

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