

## Female Genital Mutilation Challenges in practice and policy within New Zealand

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### Abstract

Female genital mutilation (FGM) is a harmful cultural practice that has many side effects both physical and psychological. In New Zealand there are no public health policies that are directly address the issues of FGM but programmes related to FGM have been referenced in the New Zealand Health Strategy. This paper examines national and international approaches to FGM and what strategies must address going forward in the education of women subjected to this cultural practice.

### Introduction

Female genital mutilation (FGM) refers to the practice of cutting or altering the female genitalia (Ali, 2012) and is also commonly referred to as female circumcision or female genital cutting. The World Health Organization (WHO) (2008) defines FGM as all procedures involving the removal of the external female genitalia for cultural or non-therapeutic reasons. Literature suggests that FGM is a complex and multifaceted practice which is deeply rooted in cultural, social and religious beliefs (Abdulcadir, Denholm, 2004; Margairaz, Boulvain, & Irion, 2011; WHO, 2008). It is argued that this ancient traditional practice which has existed over for 2000 years may only be understood in the social cultural context in which it is practiced (Abdulcadir, Margairaz, Boulvain, & Irion, 2011; WHO, 2001; WHO, 2008).

FGM is a harmful cultural practice which has many side effects of a both physical and psychological nature (Morison, Scherf, Ekpo, Paine, West, Coleman, & Walraven, 2001). FGM is often carried out by traditional practitioners without the use of anaesthesia and using unsterile cutting devices such as knives, razors, scissors, cut glass, or sharpened rocks (Denholm, 2004). The health complications that young girls and women endure depend on the different types of FGM to which they have been subjected (Denholm, 2004). There are a range of short term as well as long term consequences associated with FGM though the most commonly reported complication is that of shock from bleeding, haemorrhage, pain and stress resulting from cutting of the very sensitive and delicate areas of genitalia without the use of anaesthetic (Utz-Billing & Kantenich, 2008). Globally, there are an estimated 3 million girls and women who are at risk of undergoing the harmful, traditional practice of FGM and according to the World Health Organisation up to 140 million women and girls alive today have experienced some form of genital mutilation (Jones, Ehiri & Anyanwu, 2004 ; Utz-Billing, & Kantenich, 2008; WHO, 2008;). In the past, FGM was seen as a health concern affecting women and young girls primarily in Africa, the Middle-East, and Asia. However with the arrival of immigrants, refugees, and asylum seekers from countries where FGM is practiced it is becoming a concern for countries such as New Zealand, Australia and in areas such as North America and Europe (WHO, 2008; Boyle, Songora & Foss, 2001).

There are 28 African nations where FGM is practiced, mainly located in sub Saharan Africa; also parts of the Middle East and in some parts of Asia (Denholm, 2004; Wheeler, 2003; World Health Organisation, 2010; World Health Organization, 2008;). Growing globalization has led to an increase in migration around the world with the prevalence of FGM varying between countries and within different ethnic groups (FGM Education Programme, 2011); being utilised amongst different

religions such as Islam, Christianity and Judaism. (Jaeger, Caflisch, & Hohlfeld, 2009; World Health Organization, 2001). The highest prevalence of FGM has been found to be in Somalia, where up to 97.9 % of women have experienced this practice, whilst Uganda reports a prevalence as low as 0.6 % (Denholm, 2004).

In France, it is estimated that there are around 4500 girls who are at risk of undergoing FGM. It is further estimated that there are between 13,000 - 30,000 women and girls who have already been subjected to this practice (Gallard, 1995). France has been one of the first countries to raise concerns with the WHO regarding the practice (as far back as 1977) and it is also one of the only countries where convictions have taken place for carrying out FGM on young girls (Smith, 2013). There have been more than 40 FGM trials in France, with two practitioners and more than 100 parents being handed down convictions. Although female genital cutting is banned across the European Union, only a handful of cases have ever gone to trial in other European countries (Rowling, 2012).

In Britain it is estimated that there are over 660,000 women and young girls who have been subjected to FGM. There are 15 specialist clinics within the National Health Service (NHS) UK that offer a range of healthcare options, such as reversal surgery, for women and girls who have been subjected to mutilation (National Health Service, n.d.). Furthermore, the presence of staff perceived to be knowledgeable and having undergone training in working with women who have experienced FGM may also instil confidence for women who attend the clinic (FGM Education Programme, 2011).

Other countries in Africa such as Senegal, Egypt, Kenya and Tanzania where the practice of FGM is prevalent, have developed strategies intending to reduce the practice. In Senegal it is reported that in the decade leading up to 2007 more than 1800 communities have put a stop to FGM. Furthermore, religious leaders in places such as Egypt and Kenya have spoken out against the practice banning FGM in 2006 altogether. In Tanzania there have been many strategies implemented. Some of these strategies include:

- Having public discussions about the issues of FGM
- Government and non-government agencies working alongside religious leaders, societal leaders and health professionals to deliver education on FGM to the community
- Using culturally and linguistically appropriate methods of communication with the community, including theatre and role-play, to heighten awareness of the issues and initiate self-starting cultural change
- Involving men and community leaders in these educational and awareness-raising efforts (including facilitating conversations between men and the women who have suffered FGM)
- Education of young girls
- Promote awareness of key human rights (Mathews, 2011).

### **New Zealand Policies and Programmes to eliminate FGM**

Every year New Zealand grants refugee status to 750 refugees (Mortensen, 2011). In New Zealand there are no public health policies that directly address the issues of FGM; although there are programmes related to FGM referenced in the New Zealand Health Strategy (2000). This strategy addresses the need to work with ethnic minorities and those who are marginalised, including refugee communities which practice FGM. In New Zealand, as a matter of social justice, the practice

of FGM is seen to be harmful and a violation of human rights and as such has been made illegal. New Zealand is a signatory to a number of international conventions such as the Universal Declaration of Human Rights and the Convention on the Rights of the Child (CRC) (FGM Education Programme, 2011); these agreements call for an end to FGM. Other western countries which have put into place laws that stop the practices of FGM include UK, France, Canada, Australia and the United States.

Responding to the rising number of women and girls settling in New Zealand from countries which practice FGM, a community based FGM Education Programme was set up in 1997 (FGM Education Programme, 2011). So far this is the only programme available to improve reproductive health care services for affected women and girls. The programme offers training and support, seeking to prevent the incidence of FGM through community education and health promotion. It also develops educational resources for communities and health and child protection workers providing information, training and support for health professionals. The FGM programme is funded by the New Zealand Ministry of Health and is so far only available within the Auckland region (FGM Education Programme, 2011).

The practice of FGM is totally alien to New Zealand culture with studies limited perhaps due to the fact that many affected women have only been in New Zealand since the early 90's. Two studies however, have been carried out by the New Zealand FGM education programme which involved Somali women living in Auckland (Denholm & Jama, 1997; Denholm, & Powell, 2009). The first was conducted in 1997, involving interviews with 88 Somali women with a follow-up undertaken in 2008 which consisted of 70 Somali women. Findings from the initial study indicated that nearly all of the women respondents' health professionals did not know much about this practice in addition to a lack of communication between Lead Maternity Carers (LMC) and women with FGM. The 2008 study did, however, report that there had been an overall increase in FGM awareness among health professionals with an increase in women undergoing antenatal genital assessment from 20% in 1997 to 80% in 2008. The 2008 survey further showed that compared to peers with no history of mutilation, women having undergone FGM were less likely to have a labour or birth plan with 68% of women reluctant to discuss this with their health providers. FGM Somali women in Auckland also reported a higher rate of caesarean sections than that of any other ethnic group (Denholm & Jama, 1997; Denholm, & Powell, 2009). Limitations of these studies were the use of self-report surveys which may have included biases relating to the level of knowledge on FGM (Babbie, 2008). Within the Somali community, the topic of FGM remains a sensitive issue; hence a lack of confidence during interviews may have altered the manner in which the questions had been answered (Denholm & Jama, 1997; Denholm, & Powell, 2009).

As a result of the 2008 study, the New Zealand FGM programme developed guidelines for both health care and child protection professionals. These guidelines are now used by many agencies. Over the past three decades there has not been a significant change in the prevalence of FGM worldwide (World Health Organization, 2008). Some of the challenges in addressing FGM in New Zealand are the lack of specific public health policy which outlines strategies to eliminate FGM and addresses the associated medical and mental health issues. Guidelines published by the New Zealand FGM programme for health care professionals dealing with antenatal, labour, birth and postnatal care for women with FGM are however not yet mandatory for all health services in New Zealand (FGM Education Programme, 2011). Thus, not all health professionals in New Zealand are sufficiently trained in the care of women with FGM, particularly during antenatal and postnatal periods with the standard of care and awareness varying between clinics. A further challenge relates to the manner in which different ethnic communities practice FGM (World Health Organization, 2008). Discussions around gender inequalities, health inequalities, and the underlining context for or against FGM practice must therefore be taken into consideration (Ali, 2010).

## Where to now?

Australia, UK and France are three of thirteen industrialised countries who have put in place laws against all forms of FGM, and in addition to legislation there are other effective tools that may also be used to assist in the elimination of this practice (UNICEF, 2010; Moeed & Grover, 2012). In Australia since the mid 1990's there have been specialised health workers in hospitals, women's services and community organisations to provide community education, strengthen knowledge about FGM and support a change in attitudes (Royal Australian College of Obstetricians and Gynaecologists [RANZCOG], 1997). This has formed part of a National Education Programme on FGM which is tasked with preventing the occurrence of the practice in Australia, providing a focus on community education, information and support by assisting women and young girls at risk. The National Education Programme on FGM is funded by the Commonwealth Department of Health and Family Services (RANZCOG, 1997), with the Australian Department of Health funding family planning in Victoria by producing a range of materials designed to improve health literacy, service access and planning around FGM (Family Planning Victoria, n.d.).

In New Zealand the FGM education programme utilised community training by implementing a training of trainers (TOT) model. Five communities affected by FGM practice were involved in training sessions. The education topics focused on the adverse physical and mental health outcomes of FGM. It was hoped that through education, women and girls would become aware of this harmful practice, allowing them to make better informed decisions. Community-based empowerment programmes are seen as an effective tool in addressing FGM. It is important for communities to play a role in identifying these needs and fully participating throughout the intervention process by creating long-lasting partnerships (Ali, 2010). Future programmes should also address gaps in law and regulations addressing FGM in New Zealand. Affected women are mostly from refugee backgrounds; fleeing from their home lands not by choice but forced out by war or political terrorism, thus they arrive in New Zealand with complex needs and histories of trauma or other mental health concerns (FGM Education Programme, 2011). Addressing FGM and its specific gender health needs requires further research. Integrating FGM programmes with other women's services could also be a more cost effective and appropriate solution with policies and programmes addressing FGM being inclusive, creative and relevant to these populations.

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