Improving the health care of women and girls affected by female genital mutilation/cutting

A service coordination guide
A service coordination guide: Improving the health care of women and girls affected by female genital mutilation/cutting

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Published September 2012

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ISBN 978-0-9871928-1-3

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Acknowledgements

Family Planning Victoria would like to thank the local and rural health and community service providers who contributed to the development of this service coordination guide. Their contributions are greatly appreciated.

We would also like to acknowledge the contributions of the following staff from the Victorian Government Department of Health: Trudy McInnes, Manager, Integrated Health Promotion, Linda Williamson, Senior Project Officer, Integrated Health Promotion and Shelly Lavery, Project Manager, Primary Health Programs.
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Using the guide

This guide aims to support health and community service providers who work with women and girls affected by female genital mutilation/ cutting (FGM/C). It provides them with the information they need to talk with women and girls about FGM/C and its potential impact on their health and wellbeing.

For ease of referencing, the guide has been divided into key areas of information, which are introduction and policy context, understanding FGM/C, working with women and girls, partnerships and training.

<table>
<thead>
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<th>Introduction and policy context</th>
<th>Introductory information, including the purpose of this guide, an explanation of service coordination, guiding principles and relevant policy regarding FGM/C</th>
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Language used in this guide

FGM/C is similarly known as ‘female circumcision’ or ‘female genital cutting’. The word ‘mutilation’ is used to emphasise both the severity and harmful effect of the practice and the violation of the rights of women and girls. In 1990, this term was formally accepted by the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children.

When working with community members, it is recommended that service providers use more culturally sensitive language such as ‘traditional cutting’ or ‘circumcision’. Appendix A provides a list of culturally specific terms used in reference to FGM/C.

Adding the word ‘cutting’ is intended to reflect the importance of using non-judgemental language with communities known to practise FGM/C. The term FGM/C is generally used throughout this document, except when referencing or quoting other sources.

...in 2006, there were 29,229 people living in Victoria who were born in countries that practise FGM/C.
Introduction and policy context

This service coordination guide seeks to provide the information health care professionals may need to support the development of partnerships between services to respond to the health care needs of women and girls affected by female genital mutilation/ cutting (FGM/C).

Consultations conducted to inform the development of this guide indicate that although many professionals would ask the question about FGM/C, this does not constitute part of standard practice. These consultations also indicate that many professionals feel unsure or unprepared for asking the question and discussing FGM/C with women and girls from communities that practise FGM/C.

Aims of the guide

› To improve care and referral pathways for women and girls who come from communities known to practise FGM/C

› To improve the capacity of service providers to identify women and girls who are affected or are at risk of being affected by FGM/C

What is service coordination?

Service coordination places the clients at the centre of service delivery, to ensure that they have access to the services they need, opportunities for early intervention, health promotion and improved health and care outcomes.²

Service coordination emphasises collaborative partnerships between services and organisations in the community. A service coordination model sets out a multi-service response to assist organisations in working together to better meet the needs of clients, reducing service duplication and ensuring better coordination of referral and response.³ The focus is on the client, with the model being driven by the needs of the client and community rather than the needs of the system.

The key components of service coordination are initial contact, initial needs identification, assessment and care planning. Other elements include information provision, consent, referral, feedback, service delivery and exiting, all of which can occur at any stage.⁴ ⁵

Initial contact: first contact the client has with the relevant service

Initial needs identification: broad screening and analysing process to determine the best possible services, urgency and type of assessment required by the client

Assessment: the decision-making process that collects, weights and interprets relevant client information, using professional and interpersonal skills to uncover relevant issues for informing the development of a care plan specific to the client⁵

Care planning: process of deliberation that incorporates care coordination, case management, referral, feedback, review, re-assessment, monitoring and the development of exiting plans


⁴ ⁵ Victoria, Department of Health 2009, op.cit.
What is female genital mutilation/cutting?

The World Health Organization (WHO) states that the term FGM/C refers to all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. FGM/C is a harmful practice and a violation of the human rights of affected girls and women. In 1997, the WHO issued a joint statement with the United Nations Children’s Fund (UNICEF) and the United Nations Population Fund (UNFPA) against the practice of female genital mutilation (FGM). It is difficult to know the precise number of women and girls in Victoria who are affected by FGM/C. However, RMIT was commissioned by Family Planning Victoria in 2010 to conduct a demographic study of communities that have arrived in Victoria from countries known to practise FGM/C. Census data from the Australian Bureau of Statistics indicates that in 2006, there were 29,229 people living in Victoria who were born in countries that practise FGM/C.

Policy context

Victorian context
The Crimes (Female Genital Mutilation) Act 1996 states that it is illegal to perform FGM/C and/or take a child from Victoria to have such procedures performed. Under the Children, Youth and Families Act 2005, professional groups are mandated to report concerns if they form a belief on reasonable grounds that a child is at risk of undergoing FGM/C.

Australian context
New South Wales, South Australia, Australian Capital Territory, Northern Territory, Victoria and Queensland have legislated against the practice of FGM/C and it exists in the Criminal Codes of Western Australia and Tasmania. There is currently no federal legislation in Australia regarding FGM/C.

International context
In international and human rights treaties, there is strong support for protecting the rights of women and girls by abolishing FGM/C. In some African countries, despite legislative measures outlawing the practice, more than half of all women and girls have undergone FGM/C.

Universal Declaration of Human Rights, 1948
Everyone has the right to life, liberty and security of person. No one shall be subjected to torture or to cruel, inhumane or degrading treatment or punishment. All are equal before the law and are entitled without any discrimination to effective remedy by the competent national tribunals for acts violating the fundamental rights granted him by the constitution or by law.

Convention on the Elimination of All Forms of Discrimination Against Women, 1979
This convention aims to outline the appropriate responses for government to eliminate the practice of FGM/C and other forms of discrimination against women.

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

Convention On the Rights of the Child, 1989
One of the guiding principles of this convention is the consideration of the best interests of the child. Parents who submit their daughters to FGM/C believe that the benefits outweigh the risks. However, the convention states that FGM/C is a permanent and potentially life changing practice that violates the fundamental human rights of girls.

Maputo Protocol, 2003
The Maputo Protocol, also known as The Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, guarantees comprehensive rights to women including the right to take part in the political process, social and political equality with men, control of their reproductive health and an end to FGM. In 2003, the protocol was adopted by the 53 member countries of the African Union.

In the development of this service coordination guide, Family Planning Victoria has drawn on the above policies and statements which reflect national and international positions on the practice of FGM/C. We also value and support:

- the upholding of zero tolerance of FGM/C
- the paramount importance of the safety of women and girls affected or at risk of being affected by FGM/C
- meeting the sexual and reproductive health care needs of affected women and girls
- the use of culturally sensitive and non-judgemental language
- an awareness that families that practise FGM/C do not see it as an act of abuse, but an act of love and cultural identity
- an understanding that the practice of FGM/C is embedded in cultural tradition
- an awareness that FGM/C is illegal in Victoria.

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7 Costello, S., Quinn, M & Tatchell, A  2012, Female genital mutilation/cutting (FGM/C): A tradition in transition: report to Family Planning Victoria on Victorian demographics and international program response to FGM/C, unpublished research paper, RMIT, Melbourne.

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It is estimated that over 140 million women and girls worldwide have undergone some form of FGM/C, with at least three million girls at risk of undergoing the practice each year.
Understanding female genital mutilation/cutting

There are no known health benefits to be gained from undergoing female genital mutilation/cutting (FGM/C). The practice is known to be extremely painful and has serious health consequences, both at the time of the procedure and in later life. FGM/C, however, is a complex and sensitive issue embedded in age old cultural traditions. Communities that practise FGM/C believe doing so to be part of their cultural identity and important to preserving their cultural traditions. Despite the harmful impacts on health and wellbeing, many women who have undergone the procedure believe that they appear more attractive and desirable for marriage than those who have not undergone the procedure. Women who attempt to resist undergoing FGM/C are at risk of being excluded and ostracised from their community, with their families being made to believe that no one will want to marry their daughters.

FGM/C is known to be practised in 29 countries, 28 in Africa as well as Yemen. FGM/C is also reported to be practised among certain ethnic groups from parts of Asia and the Arabian Peninsula.

It is estimated that over 140 million women and girls worldwide have undergone some form of FGM/C, with at least three million girls at risk of undergoing the practice each year. FGM/C is not confined to a specific population group and it is not sanctioned by any religious values.

Types of FGM/C

There are four types of female genital mutilation (FGM) identified by the World Health Organization:

- **Type I:** Partial or total removal of the clitoris and/or prepuce (clitoridectomy)
- **Type II:** Partial or total removal of the clitoris and labia minora, with or without removal of the labia majora (excision)
- **Type III:** Narrowing of the vaginal opening through the creation of a covering seal formed by cutting and re-positioning the labia minora and/or labia majora, with or without removal of the clitoris (infibulation, the most common form of FGM)
- **Type IV:** All other harmful procedures to the female genitalia for non-medical purposes, including pricking, piercing, scraping, incising and cauterising

The age at which the procedure is carried out varies depending on the community the girls live in. It can be performed when the girl is newborn or during childhood or adolescence, though the most common ages are between five and eight years.

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Harmful consequences of FGM/C

There are many documented health consequences for women and girls who undergo FGM/C. The procedure removes healthy female genital tissue, which can interfere with the natural function of the bodies of women and girls and lead to ongoing health complications.

It is reported that almost all girls who undergo FGM/C experience pain and bleeding as a consequence. The process itself can be traumatic, with girls often having to be held down. If they have been infibulated, their legs are bound together for several days or weeks. Physical and psychological health problems can occur with varying frequency, though the true extent of these complications is unknown. The documented knowledge of immediate health consequences is based on those who seek hospital treatment after having the procedure.

Some of the documented immediate health complications are:

- excessive bleeding/haemorrhage
- difficulty passing urine
- severe pain
- infection
- pelvic and urinary tract infection
- obstructed menstrual and urinary flow
- painful sexual intercourse (particularly with type III)
- childbirth complications
- dangerous to newborns (higher death rates and reduced Apgar scores)
- psychological stress (flashbacks, post traumatic stress disorder, trauma)
- fistulae
- infertility
- HIV.

Long term health complications

The long term health complications which can eventuate following FGM/C include:

- vulval scaring and pain
- pelvic and urinary tract infection
- obstructed menstrual and urinary flow
- painful sexual intercourse (particularly with type III)
- childbirth complications
- danger to newborns (higher death rates and reduced Apgar scores)
- psychological stress (flashbacks, post traumatic stress disorder, trauma)
- fistulae
- infertility
- HIV.

Child birth complications

The WHO conducted a multi-country study of 28,000 women who had undergone FGM/C and found they had significantly increased risks of adverse events during childbirth. Women who had undergone FGM/C types I, II and III had a higher incidence of caesarean section and post partum haemorrhage in comparison to those who had not undergone the procedure. The study similarly found death rates during or immediately after birth to be higher for women who had undergone FGM/C than those who had not.

The consequences for women affected by FGM/C who deliver their baby outside a hospital setting are even more severe, including a higher incidence of post partum haemorrhage, which can be a life threatening condition without medical assistance.
FGM/C is a complex and sensitive subject requiring service providers to engage in culturally appropriate conversations with women and girls affected by FGM/C for the purpose of providing quality health care.
Working with women and girls

Health and welfare service providers are best placed to assist in meeting the health needs of women and girls affected by female genital mutilation/cutting (FGM/C) and preventing its occurrence. Raising awareness among service providers of the issues confronting communities known to practise FGM/C will help ensure relevant services are better able to support women and girls affected by FGM/C, build the capacity of workers to engage in difficult conversations about FGM/C and establish collaborative partnerships to improve health outcomes.

FGM/C is a complex and sensitive subject requiring service providers to engage in culturally appropriate conversations with women and girls affected by FGM/C. There are a number of measures an organisation can implement to improve access to relevant services and meet the health care and other needs of women and girls affected by FGM/C. Adopting a service coordination approach can facilitate information provision and referral processes and using this guide can assist service providers in streamlining assessment and referral pathways for women and girls.

Another important consideration when working with communities known to practise FGM/C is the journey of the families to Australia. Many families who have come to live in Victoria as refugees may have experienced considerable suffering and trauma before their arrival. They may have experienced war, famine, violence, lost contact with or witnessed the murder of family and friends or spent time in refugee camps. Experiences such as these can have profound effects on health and wellbeing. As such, a health care system that adopts an holistic approach to the health of the individual is best placed to assist with assessment and care planning.

Why it is important to ask whether the woman or girl has been circumcised or cut

Asking women and girls whether they have been circumcised or cut will help ensure they receive the health care they need and assist in the prevention of FGM/C.

In some circumstances, pregnancy is the first time a woman comes into contact with the health care system. This can be the best time to discuss any health issues she has experienced as a result of FGM/C, as well as support she may require, the associated legalities and whether de-infibulation will be required.

Women and girls affected by FGM/C may experience ongoing health complications such as chronic pelvic infections, sexual problems, vulval abscesses, infertility, cysts or menstrual problems. A well informed assessment of the health status of women and girls affected by FGM/C will help ensure they are referred to and cared for by appropriate services, which can significantly improve their health and wellbeing.

Language may be a barrier to asking questions about FGM/C. In such cases it is important to ensure there is an interpreter, preferably a female, present at the consultation. It is not recommended that a family member (e.g. husband or child) interprets for the woman or girl, as she may not feel comfortable discussing personal issues in their presence. Allowing family members to interpret also assumes they will be able to interpret the complex issues associated with FGM/C. If a child of the woman interprets, pressure can be placed on them to talk about the health issues experienced by their mother or listen to adult health issues, about which it may not be appropriate for them to hear. Misleading information can be deliberately delivered by family members who may want their relative to submit to community or family wishes, rather than representing her true wishes if they go against cultural tradition. For information on accessing language services, see page 16.
When to ask the question

Knowing not only how but when to ask the question is essential. When taking client history during the initial needs identification process, consider asking about FGM/C. There will always be exceptions, however, depending on the reason why the woman or girl has made contact with the relevant service. Country of birth is usually a good indicator that the woman or girl may have undergone FGM/C and as a result, may have ongoing health complications that need to be addressed. When starting a conversation about FGM/C, it is important to remember that it is a sensitive and private issue. As such, it is important to explain the reasons for asking and how the information will be used. Some possible reasons include:

› as part of conducting a thorough health assessment
› to identify health complications that may need to be addressed by medical staff
› to develop a labour plan, particularly for women who have been infibulated, as they may require de-infibulation before labour and information regarding the legality of re-infibulation and the changes experienced as a consequence
› to assist with referral.

Talking about FGM/C with women and girls

Talking about FGM/C with women and girls can be uncomfortable for both the individual and the professional. It is important to include a question about the FGM/C status of the woman or girl in your assessment or first contact meeting.

When discussing FGM/C with the woman or girl, it is important to:

› avoid making assumptions and judgements
› be sensitive to the intimate nature of FGM/C
› use simple language and ask straightforward questions
› use value neutral non-judgemental language such as, ‘have you been cut down there?’, ‘have you been circumcised?’ or, ‘do you have traditional cutting?’
› be direct when assessing its impact by asking questions such as, ‘do you experience any pain or difficulties during intercourse?’; ‘do you have any problems urinating?’ or, ‘have you had any difficulties in childbirth?’
› make the woman or girl feel comfortable and ensure she knows she can come back if she wishes
› inform the woman or girl that FGM/C is illegal in Australia and that the law is there to help women and girls
› use a female interpreter where possible and avoid using family members to interpret
› be aware of your own responses and reactions the first time you examine a woman or girl who has undergone FGM/C to ensure she does not feel uncomfortable or different
› be aware of the potential risks to young women and girls
› understand that not all families want their daughters to undergo FGM/C
› record FGM/C status on the birth notification to ensure the maternal and child health nurse is mindful of any ongoing health concerns.

Assessment

Assessment is not an end in itself, but rather an ongoing investigative process between the individual and the professional. This process draws on the expertise and interpersonal skills of the professional to uncover relevant health and wellbeing issues for informing the development of a care plan.27 The assessment builds on information obtained during previous contact with the woman or girl to develop an holistic understanding of their situation.

Obtaining information about whether the woman or girl is affected by FGM/C is important for informing care plans and referrals. Signs of FGM/C can be missed if the practitioner is not specifically looking for evidence of the procedure during examinations.

Ensuring the woman or girl is asked whether she has been circumcised or cut is of paramount importance, particularly when a woman is accessing services such as antenatal care or a Pap test. If a woman has been infibulated and is accessing antenatal services, de-infibulation and re-infibulation will need to be discussed. Women who have been infibulated may request to be re-infibulated post partum. In Victoria, it is against the law to re-infibulate a woman or girl. This will need to be discussed in full with the woman, preferably on her own and with a female interpreter, where necessary.

Many hospitals have long waiting lists for obstetricians and making women who have been infibulated a priority is an important policy and procedural change. For more information regarding policy and procedural change, go to <http://www.ranzcog.edu.au/publications/womens-health-publications/female-genital-mutilation-fgm-booklet.html>.

Similarly for Pap test providers, conducting a Pap test for a woman who has been infibulated may be difficult and/or uncomfortable for the woman. Knowing this information before the appointment will help with conducting the test.

Asking the question is essential, but represents only one part of the whole service. Organisations need policies and procedures in place for FGM/C and to have staff trained and well informed about the procedure. The Royal Women’s Hospital (the Women’s) in Melbourne has useful examples of policies and procedures for working with women affected by FGM/C, to which service providers can refer when developing their own policies and procedures. To access these documents, go to <http://www.thewomens.org.au>.

Important points to remember

› Be aware of your own judgements and reactions.
› Families have their girls undergo the procedure out of love, not to harm them.
› Not all women or girls who are affected by FGM/C are aware that they are ‘different’ to other women and girls.
› Some women and girls do not realise that they have had the procedure.
› Not all families from communities known to practise FGM/C want to have their girls undergo the procedure.
› Be alert when families are planning a holiday with their girls for an extended period of time.
› Engage the person, not the issue, ensuring that the woman or girl feels important and heard.
› All women and girls coming into the relevant service at point of intake or initial assessment from countries known to practise FGM/C should be asked whether they have been circumcised or cut.
› Referral may be necessary for women and girls who experience flashbacks during examinations.

Care planning

Partnerships are the key to care planning working effectively. Local networks, for example, can be used to discuss issues relating to FGM/C. Within your organisation, one or more staff members can be chosen to be responsible for providing support to other staff in relation to FGM/C, where necessary. In addition, hospitals can explore the option of making women who are affected by FGM/C, in particular type III (infibulation), a priority for obstetrician and/or gynaecological services.

Assisted referral is an integral part of care planning, as it can help families navigate the system and ensure they are referred to, and seen by, the appropriate service provider.

Providing the woman or girl with information about the relevant service will ensure she is fully informed and aware of the reasons for referral. Before referral, her consent is needed and must be documented using the Service Coordination Tool Template (SCTT), Consent to Share Information. For more information or to access this template, go to <http://www.health.vic.gov.au/pcps/sctt.htm>. The Human Services Directory (HDS) can also be used for further referral options. To access the directory, go to <http://www.humanservicesdirectory.vic.gov.au>.

Care plan flow chart

The following information outlines the steps in identifying and assessing the needs of women and girls who may be affected by female genital mutilation/cutting (FGM/C). It is designed to assist health and community service providers in developing their understanding of the health impacts associated with FGM/C and suggest ways for talking to women and girls from communities known to practise FGM/C about whether they have undergone the procedure. It also provides the information to support referral pathways.

FGM/C is defined as all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.

It is important to ask whether the woman or girl has been circumcised or cut to:

› raise a topic the woman or girl might be reluctant to discuss
› ensure she receives the best possible care
› prevent FGM/C occurring in the future to her daughters
› discuss de-infibulation and re-infibulation with her before labour
› ensure she has access to appropriate services
› enable families to receive information about the legalities and health consequences of FGM/C
› determine and document FGM/C status for assisting with care and follow up
› enable her to receive information about changes she may experience after de-infibulation.
Flow chart

Considerations

Is the woman or girl from a country known to practise FGM/C?  
N.B. Arrange for interpreting services if necessary

YES

NO

Discuss whether she has been circumcised or cut

YES

NO

Discuss the impact of FGM/C on her health and wellbeing

Does she require further referral or assessment?

YES

NO

Supporting information

Countries known to practise FGM/C

Interpreting services

The journey to Victoria

Talking about FGM/C with women and girls

Health impacts of FGM/C

Information and referral services

Discuss the type of FGM/C that she may have undergone

Discuss infibulation, de-infibulation and re-infibulation  
(where relevant)

Address health and wellbeing issues associated with FGM/C

Types of FGM/C

Assessment considerations

Develop a care plan that includes possible health impacts and prevention work

Care planning considerations

Information and referral services
Initial contact
The first contact the woman or girl has with the service

In this step, the woman or girl is given information about the service, eligibility and the intake process, as well as other relevant information. The collection and recording of client information using the Service Coordination Tool Templates (SCTT) begins, with client registration and consent obtained.

To access these forms, go to <http://health.vic.gov.au/pcps/sctt.htm>.

The woman or girl will progress to initial needs identification if she needs further advice or support. In preparation for her next appointment, you can start to consider whether she has undergone FGM/C.

Key questions to ask yourself

› Is the woman or girl likely to have come from a country known to practise FGM/C?
› Does she need an interpreter?

A Countries known to practise FGM/C

The table below lists countries known to practise FGM/C and the estimated prevalence among women and girls aged 15-49.

<table>
<thead>
<tr>
<th>Country</th>
<th>Estimated prevalence (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benin</td>
<td>16.8</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>72.5</td>
</tr>
<tr>
<td>Cameroon</td>
<td>1.4</td>
</tr>
<tr>
<td>Central African Republic</td>
<td>25.7</td>
</tr>
<tr>
<td>Chad</td>
<td>44.9</td>
</tr>
<tr>
<td>Côte d’Ivoire</td>
<td>41.7</td>
</tr>
<tr>
<td>Djibouti</td>
<td>93.1</td>
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<tr>
<td>Egypt</td>
<td>95.8</td>
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<tr>
<td>Eritrea</td>
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<td>Ethiopia</td>
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<td>Gambia</td>
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<td>Ghana</td>
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<tr>
<td>Guinea</td>
<td>95.6</td>
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<td>Guinea-Bissau</td>
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<td>Kenya</td>
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<tr>
<td>Liberia</td>
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<tr>
<td>Mali</td>
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<td>Niger</td>
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<td>United Republic of Tanzania</td>
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<td>Yemen</td>
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</tbody>
</table>

N.B: There is anecdotal evidence that FGM/C type IV occurs in parts of the Middle East and Asia, including Indonesia, India, Malaysia, Israel and Iraq.

B Interpreting services

Listed below are interpreting services that may be helpful. Ensure you have an interpreter, preferably female, if required and avoid using family members to interpret.

Translating and Interpreting Service (TIS)
› Free interpreter (doctor priority line) T/ 131 450
› Onsite interpreter (booking faxed two weeks in advance) T/ 1300 654 151
› For service users other than doctors T/ 131 450

VITS LanguageLink (fee for service interpreter)
› Bookings T/ 03 9280 1955
› Translations T/ 03 9280 1990
Oncall T/ 03 9867 3788
All graduates T/ 03 9605 3000
This step allows for the woman or girl’s health, social, emotional and wellbeing needs associated with FGM/C to be identified.

**Key questions to ask yourself**

› What are the health impacts associated with FGM/C?
› When should the woman or girl be asked the question?
› How should she be asked?

**The journey to Victoria**

Factors to consider when talking to women and girls who may be affected by FGM/C include the following:

› Refugee experience
› Grief and loss
› Trauma and torture
› Witnessing and/ or experiencing violence
› Refugee camps
› Social isolation or lack of family support
› Settlement issues or cultural shock
› Language barrier
› War
› Famine

When working with individuals who have experienced any of the above, referral to counselling and appropriate support services may be helpful. For more information, see page 19.

**Talking about FGM/C with women and girls**

The woman or girl will need to be told why the question is being asked and how the information will be used. For example:

› to conduct a thorough health assessment
› for referral purposes
› to develop a labour plan.

When asking the woman or girl about FGM/C, it is important to use value neutral, non-judgemental language, such as:

› ‘Have you been cut down there?’
› ‘Have you had traditional cutting?’
› ‘Have you been circumcised?’

Be direct by asking questions such as:

› ‘Do you experience any pain or difficulties during sexual intercourse?’

When having the conversation:

› ‘Do you have any pain when urinating?’
› ‘Have you had any difficulties giving birth?’

When working with individuals who have experienced any of the above, referral to counselling and appropriate support services may be helpful. For more information, see page 19.

**Health impacts of FGM/C**

The health impacts associated with FGM/C include the following:

› Vulval scarring and pain
› Pelvic and urinary tract infection
› Obstructed menstrual and urinary flow (e.g. can take up to 20 minutes to urinate)
› Painful sexual intercourse
› Childbirth complications
› Fistulae
› Infertility
› Post traumatic stress disorder
› Flashbacks
› Trauma
› Psychological or emotional distress

N.B: Assessing whether a pregnant woman is affected by FGM/C before birth is vital in her care preparations before and during labour. If she has been infibulated, de-infibulation will need to be discussed, options provided and consent obtained.
Assessment
An investigative and decision-making process to address issues relating to FGM/C, with the aim of developing a care plan

Assessment is an ongoing process where your professional skills are used to gather as much information as possible, with the aim of developing a care plan specific to the woman or girl.

**Key questions to ask yourself**

› What type FGM/C has the woman or girl undergone?
› Have I discussed infibulation, de-infibulation and re-infibulation with her (where relevant)?
› Have health and wellbeing issues associated with FGM/C been addressed?

**F Types of FGM/C**

The four types of FGM identified by the World Health Organization are as follows:

**Type I**: Partial or total removal of the clitoris and/or prepuce (clitoridectomy)

**Type II**: Partial or total removal of the clitoris and labia minora, with or without removal of the labia majora (excision)

**Type III**: Narrowing of vaginal opening through the creation of a covering seal by cutting and re-positioning the labia minora and/or labia majora, with or without removal of the clitoris (infibulation)

**Type IV**: All other harmful procedures to female genitalia for non-medical purposes including pricking, piercing, scraping, incising and cauterising

(WHO 2008)

*N.B: See page 8 for illustrations.*

**G Assessment considerations**

The assessment process enables:

› a more thorough investigation of the presenting issue/s of the woman or girl
› the identification of relevant services to ensure the most appropriate referral for the development of a comprehensive care plan
› a more in-depth exploration of the impact of FGM/C on the health of the woman or girl
› any risk to her daughters and granddaughters to be discussed.


Obtain consent from the woman or girl where possible to ensure she is part of the decision-making process.

If the woman has been infibulated, a childbirth plan will need to be developed and antenatal and postnatal care discussed. It is important to determine:

› what the woman expects to happen after childbirth
› if she wants to be de-infibulated before childbirth
› if she is expecting to be re-infibulated (due to the legalities of re-infibulation, this needs to be discussed before labour).

*N.B: To access a childbirth plan template, see the Women’s hospital flow chart at <http://www.thewomens.org.au/FemaleGenitalMutilationMaternity>.*
Care planning involves health practitioners and the individual working together to ensure the planning and delivery of services meets the needs and circumstances of the individual. For more information about care planning, go to <http://www.health.vic.gov.au/pcps/downloads/sc_pracmanual2.pdf>.

### Care planning considerations
- A care plan should include the possible health impacts and associated prevention work.
- Women and girls who have been infibulated should be fast tracked to medical services, gynaecologists and obstetricians, where appropriate.
- Partnerships and trained resource people should be used to assist in referral and care planning and for support.

### Information and referral services
Listed below are relevant information and referral services to assist in referral and care planning. When working with women or girls who have experienced grief or trauma, referral to counselling and appropriate support services may be helpful. These service providers are highlighted orange.

#### Clinical care pathways
- Family Planning Victoria
- Maternal and child health services
- Metropolitan/ regional community health services
- Metropolitan/ regional GP services
- Metropolitan/ regional hospitals
- Refugee health nurse
- The Women’s de-infibulation clinic

#### Counselling and support services
- AMES Settlement Services
- Centre Against Sexual Assault
- Centre for Multicultural Youth
- Child and mental health services
- Foundation House
- Gatehouse Centre, Royal Children’s Hospital
- Headspace
- Metropolitan/ regional family services
- Migrant resource centres

#### Advisory service pathways
- Office of the Child Safety Commissioner
- General Practice Victoria
- Medicare Locals
- Multicultural Centre for Women’s Health
- Primary Care Partnerships
- Royal Australian and New Zealand College of Obstetrics and Gynaecology (RANZCOG)
- Women’s Health West

#### Child protection pathways
- Child First (metropolitan/ regional)
- Department of Human Services Child Protection Service (statewide, including emergency contact)
- Student Critical Incident Advisory Unit
- Victoria Police
Duty of care

A 2011 report from Great Britain titled, Multi-agency practice guidelines: FGM stated that there are four issues to consider in regards to duty of care when working with women and girls affected or at risk of being affected by FGM/C. These issues are as follows:

1. FGM/C is an illegal act on a female, regardless of age.
2. Girls and young women at risk of FGM/C need to be safeguarded.
3. Female relatives of a girl or woman who has undergone FGM/C maybe at risk.
4. A girl may be removed from the country to undergo FGM/C.

Although this report was in relation to health care workers in England, it can be argued that the duty of care is similar for service providers in Victoria who work with women and girls affected by FGM/C.

Duty of care in Victoria is addressed in the Wrongs Act 1958 (Vic) as follows:

Under common law principles of negligence and the Wrongs Act 1958 (Vic), as amended by the Wrongs and Other Acts (Law of Negligence) Act 2003 (Vic), care providers must exercise reasonable care to prevent service users and others from foreseeable injury.

Confidentiality and disclosure: Important considerations

› Service providers are encouraged to use the Service Coordination Tool Templates (SCTT).
  » The Consent to Share Information template makes obtaining consent universal and transparent and is used by many agencies.
  › If the client does not have the capacity to consent, consent must be sought from a representative authorised by the client.
  › If the client refuses consent to share information, a referral can still proceed, however the service to which the client is being referred will need to obtain the relevant information from the client.
  › The SCTTs and supplementary information are available in 57 languages and can be downloaded at <http://www.health.vic.gov.au/pcps/sctt.htm>.

Mandatory reporting

Doctors, nurses, teachers and police are required by law to report to Child Protection if, in the course of their professional practice, they form a belief, based on reasonable grounds, that a baby, child or young person is at risk of significant harm and is in need of protection from physical injury or sexual abuse. This covers children up to the age of 17 years (unless in relation to a protective order, which may continue up to the age of 18 years).

Professionals are required to contact Department of Human Services Child Protection if they have reasonable concern that a child is at risk of significant harm. It is then up to the department to determine whether there is reasonable grounds for investigation and further intervention. For a step-by-step guide to making a report to Department of Human Services Child Protection or Child FIRST, see Appendix B.

Confidentiality and disclosure

The aim of service coordination is to improve communication between the client and the service provider and streamline referral and the sharing of client information. This requires the client to be informed that her personal information may be shared with other service providers. Obtaining client consent before sharing client information is of paramount importance. The client also needs to be aware that she has the right to withhold consent to the sharing of her personal information.

Case studies

Mrs A
22 year old woman, country of birth: Saudi Arabia
Mrs A arrived at the birthing unit with her husband in labour. It was not until she was in the second stage of labour that the Associate Midwife Unit Manager (AMUM) became aware that Mrs A had signs of FGM/C. The AMUM requested that the registrar on call attend, as she ‘did not know what to do’. If Mrs A had been assessed in relation to FGM/C at the antenatal clinic, the staff involved would have been better prepared for de-infibulation either before or at delivery and there may have been the opportunity to arrange a female registrar or female obstetrician in advance.

When the clinical midwife followed up with Mrs A the next day, she explained her role and the role of the program. Mrs A was open to discussing female circumcision, which was important in helping to ensure her needs were met. Her husband, however, did leave the room before the discussion took place, highlighting the sensitive nature of the topic.

Mrs B
28 year old woman, country of birth: Sudan
Mrs B and her husband attended the hospital for a termination of pregnancy at 18 weeks gestation due to a severe congenital abnormality. Both Mrs B and her husband were most distressed about the loss of their baby. It was identified that Mrs B had undergone some form of FGM/C as a child and as a result, a referral was made to a clinical midwife and female obstetrician. Mrs B gave consent to assess her circumcision, with type III being noted. The clinical midwife and obstetrician discussed at length with the couple that due to female circumcision, de-infibulation would be necessary for the birth of the baby.

Assessing the circumcision of Mrs B ensured a detailed care and management plan for delivery could be discussed with Mrs B and her husband, then documented and conveyed to key clinicians involved in her care. Mrs B gave consent for de-infibulation at the time of delivery. Labour was induced and the baby was born without de-infibulation, but needing some assistance.

Mrs C
31 year old woman, country of birth: Sudan
A pregnant Mrs C arrived at the emergency department of the hospital after significant blood loss at home, which caused her to collapse. The decision was made to perform an emergency caesarean section. When the clinical midwife went to catheterise Mrs C, she found that Mrs C had undergone FGM/C type III (infibulation) and was unable to catheterise her.

The registrar who was to perform the caesarean had previous experience with women who had undergone FGM/C and was able to catheterise Mrs C. This caused a delay in performing the emergency caesarean, though the baby was born in good health.

The clinical midwife followed up with Mrs C the next day and arranged an Arabic interpreter. Through the interpreter, with a registrar present, the clinical midwife explained the reasons for the medical condition and caesarean section. A sensitive and detailed discussion then took place regarding FGM/C. Mrs C was aware that she had been circumcised as a young child, though could not remember the age at which it occurred or the reason. A note was made under ‘Obstetric Alerts’ in her clinical notes that for a subsequent pregnancy, Mrs C should be referred to the program which works specifically with women affected by FGM/C.

Mrs C asked, ‘what if I had gone into labour…how would the baby have come?’ She said the work that the clinical midwife was doing was, ‘wonderful for the women like me,’ and that, ‘you will be helping many women.’ Mrs C also said she would consider de-infibulation in the future.

These case studies sourced from a hospital in Victoria, provide examples of how health professionals can work in partnership to meet the health needs of women affected by FGM/C, ensuring they receive the best possible care.

After examining their statistical data, the hospital saw a rise in the number of women affected by FGM/C who were attending their antenatal and birthing clinics. As a result, the hospital established a clinic to work specifically with affected women. The program involves a number of health professionals, including a clinical midwife, a social worker, two educators, two female obstetricians, an antenatal clinical manager and a representative from an external health organisation. These professionals work as a team to meet the needs of women affected by FGM/C, ensuring they are assessed in relation to FGM/C at triage or at the antenatal clinic. They then ensure the woman is referred to a specialist service within the hospital which is able to work with her to ensure her health needs are met.
It is important for all potential partners to have a shared understanding of the issues relating to FGM/C and a commitment to supporting the issues faced by communities known to practise FGM/C. Identifying resources needed and the services each partner can provide is essential for ensuring the partnership is sustained and successful.
Service coordination partnerships and training

Mainstream services working with communities known to practise female genital mutilation/cutting (FGM/C) need to be trained and well informed about FGM/C and FGM/C practising cultures. Forming collaborative partnerships in the relevant regional or local government areas can be the most efficient way to pool resources and support women and girls affected by FGM/C.

For the success and continuation of collaborative partnerships, there needs to be support from senior management. Policies and procedures need to be developed and there must be consistent and thorough communication between partners and clients. In addition, change management approaches need to be considered, resources need to be allocated to workers taking on extra responsibilities and all staff need to be provided with the necessary training and support.

The three stages involved in developing successful collaborative partnerships are outlined below:

Problem setting
It is important for all potential partners to have a shared understanding of the issues relating to FGM/C and a commitment to supporting the issues faced by communities known to practise FGM/C. Identifying resources needed and the services each partner can provide is essential for ensuring the partnership is sustained and successful.

Reaching agreement
Partners will need to develop a working agenda, outlining roles and responsibilities, how frequently they will meet and an agreement on addressing the issues faced by communities known to practise FGM/C.

Implementation
At the implementation stage, partners need to reach an agreement on how to work together. Organisations can support the establishment of a pool of resource people to provide additional support to the work already being carried out in organisations such as hospitals, community health centres or local government offices. The role of these professionals would be incorporated into their existing responsibilities. As such, it is important that they receive the support and are allocated the time they need for the work to be carried out. It is recommended that there be more than one resource person in larger organisations, such as hospitals, for staff to call on when they need support.

The resource people need to be appropriately trained to ensure they have the necessary knowledge about FGM/C and communities known to practise FGM/C. This will help ensure they are well equipped to support staff and community members in their work. For service providers to be able to work effectively and collaboratively with these communities, whole agency training in FGM/C is essential.

The role of the resource person
- To provide support and information to colleagues about FGM/C and communities known to practise FGM/C as requested
- To provide assistance and knowledge in relation to referral pathways
- To provide training and information to all staff, including new staff members
- To support the work of the partnership and attend partnership meetings
- To be available to external organisations and community members for secondary consultation

Change management needs to be embedded as part of a whole staff training program. HealthWest Partnership has made available a number of change management techniques that can help ensure organisations are prepared and responsive to staff needs.

Training
For training to be worthwhile, health professionals must first develop a thorough understanding of FGM/C as a cultural practice and learn ways to work with and engage communities known to practise FGM/C. They then need to be trained in the clinical practice and health consequences of FGM/C.

If organisations are to meet the needs of both communities known to practise FGM/C and workers, they need to provide training to all staff, both clinical and non-clinical, ensuring that they have a thorough understanding of the complexities, sensitivities and health consequences of FGM/C. FGM/C is a sensitive topic for both the professional and the client and with appropriate training, health professionals can become well equipped to raise the issue and ask the question.

Clinical training in FGM/C and how to assist women and girls who have undergone the procedure is vital. Currently, there is no specific clinical training provided to health professionals in Victoria. The Women’s hospital, however, provides clinical training on request and has been working with affected women for many years. Regarded as a leader in the field, the Women’s has established policies and procedures and has recently set up a de-infibulation clinic that operates one morning per fortnight.

More recently, Western Hospital is offering clinical training to medical staff via their clinical midwifery service. They are also establishing a wellness service for African women with processes and protocols for working with affected communities.


References


## Appendix A

### Terms used in reference to female genital mutilation/ cutting

<table>
<thead>
<tr>
<th>Country</th>
<th>Terms used in reference to FGM/C</th>
<th>Language</th>
</tr>
</thead>
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<tr>
<td>CHAD – the Ngama Sara subgroup</td>
<td>Bagne</td>
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<td>Yoruba</td>
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See over
<table>
<thead>
<tr>
<th>Country</th>
<th>Terms used in reference to FGM/C</th>
<th>Language</th>
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<tbody>
<tr>
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<td>Mendee</td>
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Source: UK report - languages from FORWARD (www.forwarduk.org.uk) and IKWRO (www.ikwro.org.uk)
# A step-by-step guide to making a report to Child Protection or Child FIRST

## Protective concerns
You are concerned about a child because you have:
- received a disclosure from a child about abuse or neglect
- observed indicators of abuse or neglect
- been made aware of possible harm via your involvement in the community external to your professional role.

## At all times remember to:
- record your observations
- follow appropriate protocols
- consult notes and records
- consult with appropriate colleagues if necessary
- consult with other support agencies if necessary

<table>
<thead>
<tr>
<th>STEP 1</th>
<th>RESPONSE TO CONCERNS</th>
<th>STEP 2</th>
<th>FORMING A BELIEF ON REASONABLE GROUNDS</th>
<th>STEP 3</th>
<th>MAKING A REFERRAL TO Child FIRST</th>
<th>STEP 4</th>
<th>MAKE A REPORT TO CHILD PROTECTION</th>
</tr>
</thead>
</table>
| 1.     | If your concerns relate to a child in need of immediate protection; or you have formed a belief that a child is at significant risk of harm*.
Go to Step 4  
2.     | If you have significant concerns that a child and their family need a referral to Child FIRST for family services.
Go to Step 3  
3.     | In all other situations
Go to Step 2  

* Refer to Appendix 2: Definitions of child abuse and indicators of harm in the Protocol – Protecting the safety and wellbeing of children and young people

| 1.     | Consider the level of immediate danger to the child.
Ask yourself:
- Have I formed a belief that the child has suffered or is at risk of suffering significant harm?
  YES / NO
- Am I in doubt about the child’s safety and the parent’s ability to protect the child?
  YES / NO
  
2.     | If you answered yes to a) or b)
Go to Step 4
3.     | If you have significant concerns that a child and their family need a referral to Child FIRST for family services.
Go to Step 3

| Child Wellbeing Referral | 1. Contact your local Child FIRST provider.
- See over for contact list for local Child FIRST phone numbers.
  
2. Have notes ready with your observations and child and family details.

| Mandatory/Protective Report* | 1. Contact your local Child Protection Intake provider immediately.
- See over for contact list for local Child Protection phone numbers.
- For After Hours Child Protection Emergency Services, call 131 278.
  
2. Have notes ready with your observations and child and family details.

* Non-mandated staff members who believe on reasonable grounds that a child is in need of protection are able to report their concerns to Child Protection

For further information refer to Protecting the safety and wellbeing of children and young people – A joint protocol of the Department of Human Services Child Protection, Department of Education and Early Childhood Development, Licensed Children’s Services and Victorian Schools
### Contact Numbers

**Department of Education and Early Childhood Development**

**METROPOLITAN REGIONS**
- Eastern: (03) 9265 2400
- Northern: (02) 9488 9488
- Western: (03) 9291 6500
- Southern: (03) 9794 3555

**RURAL REGIONS**
- Barwon South Western: $225 1000
- Gippsland: $127 0400
- Grampians: $337 8444
- Hume: $761 2100
- Loddon Mallee: $440 3111

**Office for Children and Licensed Children’s Services:**

**METROPOLITAN REGIONS**
- Eastern: (03) 9265 2400
- Northern: (03) 9412 3333
- Western: (03) 9275 7000
- Southern: (03) 9096 9555

**RURAL REGIONS**
- Barwon South Western: $225 1000
- Gippsland: $127 0400
- Grampians: $337 8444
- Hume: $761 2100
- Loddon Mallee: $440 3111

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### METROPOLITAN REGIONS Child Protection

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<th>Intake Unit</th>
<th>Regional Office</th>
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<tbody>
<tr>
<td>Eastern</td>
<td>1300 360 391</td>
<td>Box Hill</td>
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<td>North and West</td>
<td>1300 664 977</td>
<td>Prestan</td>
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<td>Southern</td>
<td>1300 655 795</td>
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**RURAL REGIONS Child Protection**

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<th>Rural Region</th>
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<tr>
<td>Barwon South Western</td>
<td>1800 075 599</td>
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<td>Gippsland</td>
<td>1800 020 202</td>
<td>Traralgon</td>
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<td>Grampians</td>
<td>1800 000 551</td>
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<td>Hume</td>
<td>1800 650 227</td>
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**Alternative after hours Child Protection Emergency Services (AHCPES)**

Statewide numbers for all emergency child protection matters outside of normal business hours (24 hours, 7 days a week):

- **Victoria Police**
  - 1300 278

### Victorian Catholic Education Offices

<table>
<thead>
<tr>
<th>Office</th>
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<tbody>
<tr>
<td>Catholic Education Office, Melbourne</td>
<td>(03) 9267 0228</td>
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<tr>
<td>Catholic Education Office, Ballarat Diocese</td>
<td>5337 7135</td>
</tr>
<tr>
<td>Catholic Education Office, Sale Diocese</td>
<td>5622 6600</td>
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<tr>
<td>Catholic Education Office, Sandhurst Diocese</td>
<td>5443 2377</td>
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</tbody>
</table>

**Independent Schools Victoria**

- (03) 9825 7200

**Other**

- Victorian Aboriginal Education Association, Inc. (03) 9481 0800
- Victoria Police Sexual Offences and Child Abuse Unit (03) 9247 6666
- Centre Against Sexual Assault (03) 806 8066
- Gatehouse Centre, Royal Children’s Hospital (03) 9345 6591
- Child Safety Commissioner (03) 8601 5884
- Victorian Aboriginal Child Care Agency (03) 8388 1855

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**CHILD FIRST**

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<td>La Trobe, Rawson</td>
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<td></td>
<td>Ararat, Pyrenees, Hepburn, Ballarat, Golden Plains, Mooroobool</td>
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<td>Hume</td>
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<td>Wodonga, Towang, Indigo</td>
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<td>Alpine, Banna, Mansfield, Wangaratta</td>
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<td>Greater Shepparton, Strathbogie, Moira</td>
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<td>Mitchell, Murrindindi</td>
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<td>Greater Bendigo, Campaspe, Central Goldfields, Loddon, Macedon Ranges, Mount Alexander</td>
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<td>Buloke, Goonawarra, Swan Hill, Mildura</td>
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<td>Yarra Ranges, Knox, Moorooduc</td>
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<td>Monash, Whitehorse, Manningham, Boronia</td>
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<td>Hume, Moreland</td>
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<td>Hobson’s Bay, Maribyrnong, Melbourne, Moonee Valley and Wyndham</td>
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<td>Casey, Cardinia, Greater Dandenong</td>
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<td>Aboriginal children and families</td>
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<td>Frankston, Mornington Peninsula</td>
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<td>Kingston, Bayside, Glen Eira, Stonnington, Port Phillip</td>
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**Important Information for Government schools**

Principals of Victorian Government schools must report all incidents to the Emergency and Security Management Unit on 03 9589 6266.

Victorian Government schools should contact the Student Critical Incident Advisory Unit (SCIAU), Student Wellbeing Division, for advice and support when responding to allegations of student sexual assault or inappropriate sexual behaviours.

The SCIAU can be contacted on 03 9637 2394 or 03 9637 2487.

Appendix C

Useful websites

<www.ames.net.au>
<www.casa.org.au>
<www.cmy.net.au>
<www.dh.vic.gov.au>
<www.dhs.vic.gov.au>
<www.foundationhouse.org.au>
<www.fpv.org.au>
<www.gpv.org.au>
<www.headspace.org.au>
<www.humanservicesdirectory.vic.gov.au>
<www.kids.vic.gov.au>
<www.mcwh.org.au>
<www.oncallinterpreters.com>
<www.police.vic.gov.au>
<www.RANZCOG.edu.au>
<www.rch.org.au/gatehouse>
<www.refugeehealthnetwork.org.au/referral/Refugee-Health-Nurse-Program>
<www.thewomens.org.au>
<www.vits.com.au>
<www.wh.org.au>
<www.WHO.int>
<www.whw.org.au>