FOCUS FOR SUBMISSION:
1) Taskforce (multifactorial acknowledgement)
2) Increased safeguards for children from female genital mutilation
3) Support for survivors of female genital mutilation

Introduction

This submission is made on behalf of No FGM Australia and on behalf of the young girls in Victoria who are at risk of family based violence in the form of forceful and coercive mutilation of female sexual organs, most often the clitoris and labia. This is often referred to as 'female genital mutilation" (FGM), female cutting, or female circumcision. This submission is also made on behalf of those that have survived the violent removal of the clitoris and labia, which is usually incurred within the family unit. Due to immigration and other cultural factors, these survivors are resident in metropolitan Melbourne and regional Victoria.

Female genital mutilation is a form of family violence steeped in gender inequity. It 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"[1]

Violence to reduce sexual pleasure:

The practice is an example of family violence as it occurs when the parents of female children make the decision to have their daughters genitals mutilated in the form of forceful cutting off of the clitoris and labia, and sometimes the stitching up of the remaining tissue such that there is a hole the size of a grain of rice left for urination and other functions.

This is done in order to conform to long held cultural beliefs. This includes but is not limited to curbing the sexual feelings of a girl in order to prevent her from experiencing sexual pleasure, and as a form of control. Some cultures, which practice this form of violence, believe it is essential for a girl to be mutilated in order to marry, which is often an economic and social necessity. It is very harmful to girls, can result in a long list of health implications or death.

FGM is intentional, culturally driven family violence:

Although it is not violence driven by anger, the intentional mutilation of a little girl's genitals is driven by a need to control the girl or initiate into a community, and is therefore a culturally driven, premeditated act of violence. This form of violence is also classified by the World Health Organisation as a form of torture.

To illustrate this intentional violence we refer to the words of one Victorian-born survivor of mutilation of her sexual organs. Her mother's words to her to justify the

mutilation of her clitoris and labia using a [redacted] were "you used to touch yourself a lot".

> "That means she (her mother) made a conscious decision to do something to stop that, over time. She made a conscious, calculating decision that she is going to prevent that touching from continuing to happen...." [[redacted] FGM survivor]

Although she was also beaten on several occasions by her father in fits of rage which she described as "red-rage violence", [redacted] stated that the mutilation of her clitoris and labia was "cold-black violence, a calculating, intentional violence."

Family pressure to "choose" to genitally mutilate girls:

There is evidence that there is a pressure placed on mothers and fathers to have their daughters mutilated by family both within Australia and when visiting countries which practice FGM, and that despite the laws, it is considered to be a family's choice whether or not they should mutilate their daughters or "break the cycle".

"It's a fear of just breaking the cycle, I think it only takes one to break the cycle so when one actually – yeah it's 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". [4]

"..before the decision there was from the family members, but now I think me and my husband are the one, we take the responsibility and decision" (Eritrean woman, Vaughn et al, 2014, pg. 20). [4]

"People back home they will still call us and say "no you have to bring the kids back and do this and this"[28]

One woman reported that she had been put under pressure to have her daughters "circumcised" on a visit back to Eritrea. Her grandmother insisted that, although she was aware that was against the law, "the Australian government don't check" (i.e. the government doesn't check if a girl has been mutilated on her return to Australia).

Female genital mutilation needs to be recognized as family violence. Mothers and fathers of little girls are being pressured to have their daughters' genitals violently removed, or they can make the "choice" for themselves.

Who practices violent, forceful intentional removal of female sexual organs?

This particular form of family violence is most common to immigrant and refugee

families from 29 countries in Africa, the Middle East, and Asia including Indonesia and Malaysia. These are known as "FGM affected" communities [22]. The RANZCOG report [2] warned:

> Council further suggests that as the volume of migrants from the relevant countries increases cumulatively it might be expected that the incidence of the practice in Australia will increase. [2]

With an increase of refugees and immigrants from countries where violence in the form of forceful removal of female sexual organs is practiced, the risk of this occurring within Victoria has also increased. Recent Australian Bureau of Statistics data about Victoria indicates that in 2011 there were a total of 417,170 people in Victoria who are potentially affected by the practice of FGM. This figure includes 231,948 people who were born in countries known to practice FGM and where the prevalence of FGM has been officially estimated [6], and 185,222 born in countries where FGM is documented but the prevalence is not known [7].

It is important also to recognise that the practice of FGM is not solely attributed to African, Middle Eastern and Asian countries. Cliterodectomies (the removal of the clitoris) were not uncommon in Australia and other western countries from Victorian times until the 1950s and 1960's [17, 18]. This violence was perpetrated in the name of the sexual mores of that generation - when it was perceived that young girls masturbated too much. There are Australian women living today who have survived FGM who were raised in a white Australian household. However the silence and stigma surrounding FGM means that these women are very unlikely to seek support for their problems. [redacted], one of the survivors interviewed for this submission, is one such survivor, a white, Victorian born, Australian woman.

Prevalence of female genital mutilation in Victoria

Although there is no data which accurately describes FGM prevalence in Victoria, there is evidence that there are women in Victoria who have had FGM, as, shown by the 600-700 patients who attend the De-Infibulation clinic at the Royal Women's Hospital in Melbourne every year [23].

Legislation making FGM illegal in Victoria was enacted in 1996 [8], and subsequently the Family and Reproductive Rights Education Program (FARREP) was set up to help meet the needs of survivors of FGM and provide education for potential perpetrators of FGM. FARREP continues to operate in Victoria across multiple metropolitan locations. Workers for the FARREP program will be referred to as "FGM workers" for the purpose of this submission.

There are FGM workers and doctors in Australia and New Zealand who have come across girls that they know for sure are either in danger, or have already been

mutilated. Moeed & Grover (2012) in their survey of obstetricians and FGM workers found that 5 out of 19 FGM workers had *convincing evidence* that a girl had been taken out of the country for female genital mutilation [5].

Some researchers have disputed the presence of FGM in Victoria based on lack of presentations at the Royal Children's Hospital of girls with genital injuries [5]. However, [redacted], an Australian-born survivor of FGM who was mutilated in Melbourne reported that she was never taken to a doctor, as such the injury was never detected. Therefore lack of attendance at emergency departments for acute genital injuries is not an accurate method for estimating the existence of female genital mutilation in Victoria.

As a source of information for the public seeking help for girls at risk, No FGM Australia also has been informed that a Brisbane girl was taken out of Melbourne for female genital mutilation, and subsequently died in Africa. This case was referred to the Australian Federal Police [19].

Is there support for female genital mutilation in Victoria?

There are some indications from recent qualitative studies of people within FGM affected communities who still express support for the continuation of female genital mutilation. A recent study by University of Melbourne [4] in partnership with the Royal Women's Hospital asked members of North Yarra FGM affected communities about the genital mutilation of girls (called "female genital cutting" for the purposes of the study). The aim of the study was to "improve understanding of the impacts of FGC in inner Melbourne" (pg. 2), not to investigate prevalence of FGM in North Yarra. The study reported a decline in support for female genital mutilation in some people who have been in Australia for a long period of time (e.g. between 10-20 years), young women who were brought up and educated in Australia, and those who had had exposure to information about the harms of FGM through programs such as the FARREP program.

However, the study also reported some participants expressed continued support for FGM, and awareness of girls being taken out of Australia for FGM [4].

> "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 is going on a holiday" (Eritrean woman) [4 pg. 16].

Additional studies have also found that there was awareness of support for FGM in Victoria [28]

> "She said these people they shouldn't ne doing it still because it's abandoned back home they abandoned, why are they still doing it even in Australia?"

(Interpreter for community member, Shepparton, responding to the suggestion of children being taken abroad)

Other strong support for the continuing practice was voiced by men and women:

"There is such lip service [government decrees against FGM]. There is no man, a Somali man, who's gonna marry an uncircumcised woman" [(g 18) [4].

Such support for the practice is closely linked to girls being in high level of danger of being forced to undergo the forceful removal of their clitoris and labia [9].

There are also people who live in Victoria from FGM affected communities who either are resistant to the messages of the FGM prevention, or who continue to support the practice despite their messages, or who have not yet had the chance to hear the new (to them) information that forceful removal of a girls genitalia is harmful and is not required by religion:

"We dealt with this issue as we were arriving here, 20 years ago…that was the time when there was a campaign to make the people aware of the 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" [4, pg. 21]

"If I had a daughter, I still, I prefer to circumcise her" [4, pg. 19].

From a FGM worker with the FARREP program:

[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" [4,pg 17]

In addition, although the practice predates all major Judeo-Christian religious traditions, and is not mentioned in any holy books, many people believe that FGM is a religious obligation.

"Some people believe that not to it is a crime, a religious crime or a sin" [4, pg. 18]

The study expressed particular concern about more recently arrived immigrants from FGM affected communities who were not represented in the study. Previous studies from Europe indicated that they are more likely to support FGM.

There are girls in Australia who fear being "circumcised" but do not feel they have anywhere to go or anyone to tell.

"One woman felt that parents living in her city still consider doing it to their girls,

despite fearing the law. She spoke of a friend who was afraid of being circumcised. The friend…felt unable to seek help because she did not want her parents to get into trouble" [28].

There are people from FGM affected communities living in Victoria who still support the practice of FGM. Therefore daughters of these people are considered to be at high risk of the practice being subjected upon them [9].

Barriers to asking questions about FGM or reporting girls at risk:

Although there has been legislation against FGM since 1996, there have been no prosecutions for FGM in Victoria. The lack of prosecutions raises the question of whether or not professionals are making reports when they suspect a girl is at risk of FGM, or whether there is an issue of how to prove if a girl has either had FGM or is in danger of FGM.

A small percentage of doctors in Australia have even been asked to perform female genital mutilation on a girl [5]. Moeed & Grover (2012) found that one doctor had been asked on 6-10 different occasions to mutilate a girl, another on less than 5 occasions. The research indicates that some professionals know of girls in danger of FGM, but this does not correlate to the few if any referrals to police or child protection.

It appears there are barriers which are preventing professionals making reports either to police or to child protection about girls in danger of FGM.

The scarcity of research, and the difficulty of obtaining data on prevalence and circumstance of FGM, and the lack of formal reports of FGM to police and child protection creates a pressing need for an instititionalised research agenda for this very coercive form of family violence.

Regardless of the prevalence, if only one child is subjected to this familial violence in Victoria, it is one child too many.

This submission addresses questions 1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 13, 14, 16, 17, 18, 19, 20, 21

Question One

Are there other goals the Royal Commission should consider?

1. Inclusion in definitions of "Family Violence" of the forceful and coercive removal of girls' genitals known as female genital mutilation (FGM), carried out in families, by families upon children.

2. Prevention of female genital mutilation and support for survivors of this form of violence

Question Two

The Royal Commission wants to hear about the extent to which recent reforms and developments have improved responses to family violence, and where they need to be expanded or altered.

In Victoria there has been very little government engagement on the issue of female genital mutilation and addressing it as a form of family violence, unlike in other states such as NSW. NSW Minister for Women, Pru Goward, for example, has been actively legislating for increased the penalties for perpetrators of this form of violence from seven years to 21 years imprisonment [26]. There is also a strong cooperative approach between FGM programs, the police and child protection.

Victoria, like most states and territories, has dedicated programs that aim to educate potential perpetrators about female genital mutilation. However, although FGM is internationally recognized as a severe form of violence, it is not always presented as a form of violence that occurs to girls within programs running in Victoria. For example, the recent "Our Watch" campaign, a national anti-violence campaign, consulted workers and members of FGM affected communities from Victoria. The community members and FGM workers consulted did not wish the mutilation of little girls genitals to be classified or included as violence as it was often "done by women".

Language has power. Denying female genital mutilation as a form of violence leaves little girls highly vulnerable to this form of family violence, and enables the problem to remain hidden within a cultural context rather than addressing it more broadly and transparently as a human rights abuse, child abuse, and a criminal act which is violence against girls.

The current programs which aim to educate members of FGM affected communities are not explicitly addressing the protection of little girls and do not encourage or promote how to detect a girl at risk, or report of girls at risk of FGM to relevant authorities. Instead workers are encouraged to first check if they are legally mandated to report their concerns [30].

We acknowledge that government reforms have brought child protection issues to the fore when family violence is addressed. Female genital mutilation is carried out by parents upon their child, and as such is also a child protection issue that must also be included within family violence-child protection frameworks.

Question Three

Which of the reforms to the family violence system introduced in the last ten years do you consider most effective? Why? How could they be improved?

Although forceful, coercive removal of female genitals within a family context (female genital mutilation/ FGM) has been in the media and on the Federal government agenda sporadically over the past 10 years, for example the FGM summit in Canberra in 2013, there has been little in the way of systematic Victorian State government response to introduction of safeguards for girls who are in danger of this form of family violence.

Forceful removal of little girls' genitals is a form of violence that is under-reported and goes undetected. This is not helped by the problem that no data is collected by any of the government agencies that could assist identification of which girls are in danger of genital mutilation by their families.

There are government funded programs in Victoria aimed at assisting survivors of genital mutilation such as FARREP, however this program is not aimed at child protection training of professionals working with families and families themselves who may be have daughters at risk of FGM [4]. These programs are not required to ask women and girls whether they had FGM, which would allow identification of girls at risk. Indeed, the resources which have been developed as part of the implementation of FGM awareness programs in Victoria are not actively encouraging professionals to raise concerns about child protection, rather they highlight the legalities of mandatory reporting and why FGM workers may not need to report if the worker is not compelled to by legislation or mandatory protection laws.
For example
" As a community worker or peer educator, you may not necessarily have a legal mandate to report a situation" (pg. 16) [28]

Although FARREP are providing education about female genital mutilation to communities considered affected by FGM, improvements could be made by more extensive application of training of all frontline professionals who are in contact with families who may come from FGM affected communities, and to include an explicit child protection element into their work.

This training on child protection issues around FGM needs to be extended to all the metropolitan, regional and rural centres in Victoria where communities who are known to practice female genital mutilation live. There is currently no systematic training of professionals as a form of prevention of this form of family violence.

We believe there needs to be a better way to allow people to report girls who are in danger of being mutilated without recriminations for the reporter by way of broken trust or through social ostracisation in the event that their identity is discovered.

This could include the automatic referral to social services when a family expresses support for female genital mutilation, for information about the law and also for support and counseling about female genital mutilation.

As new and recent arrivals are the most likely to support the forceful genital mutilation of their daughters [4, 28, 29], we recommend that all new arrivals are provided with information about the laws and harmful effects of genital mutilation of girls.

Current programs run on the assumption that families are not going to mutilate their daughters. This is misaligned with reports of FGM in Australia and in Victoria which find that people continue to support the practice, and that some people do mutilate their daughters either in Australia or overseas [4,5,28].

There needs to be a child-centred approach to the prevention of FGM which looks at the risks to the child rather than making assumptions that parents "wouldn't do that". Parents may for any number of reasons still mutilate their daughters, so a child-centred approach will focus on keeping the child safe, rather than protecting the parents and possible perpetrators.

Question Four

If you or your organisation have been involved in programs, campaigns or initiatives about family violence for the general community, tell us what these involved and how they have been evaluated.

We are currently engaging in research programs which include liaison with Felicity Gerry QC about FGM and the law, and Professor Freda Briggs about child protection for girls in danger of female genital mutilation.

We are collaborating with Sydney University on a project aimed at data collection about girls from Australia who may have been subjected to FGM.

We are also initiating a program which increases the economic empowerment of young women who may be survivors of female genital mutilation. Economic empowerment is associated with reduced support for the practice [4].

These are still in an early phase and are yet to be evaluated.

Question Five

If you or your organisation have been involved in observing or assessing programs, campaigns or initiatives of this kind, we are interested in your conclusions about

their effectiveness in reducing and preventing family violence.

No FGM is involved in the following activities:

Activity	*Evidence of effectiveness*
1 Raising awareness by social media	*-Increased information for an Australian Context about female genital mutilation and which girls are in danger.* *Facebook reach- over 27,000 individuals who saw a posts from our page in the week beginning 21/5/2015* *Twitter: 1400 followers and in the past 3 weeks 14,000 tweet impressions.*
2 Raising awareness through public speaking and public relations	*Stats on reach via hits, likes, shares, newspaper distributions* *Media articles:* We have an active media presence including being regular providers of information to the media through interviews or assistance to locate suitable interviewees about promoting awareness of child abuse and violence against girls through genital mutilation. This has been across a range of mainstream visual and print media including the ABC, SBS, and other national media such as the Herald Sun. For example: http://blogs.news.com.au/heraldsun/theperch/index.php/heraldsun/comments/three_girls_a_day_risk_genital_mutilation1/ One of our Directors, Khadija Gbla, is herself a survivor of the violent removal by force of her clitoris and labia, and a talented and engaging speaker. She regularly speaks at conferences and events about her experience and how to prevent violence abuse by educating about how to stop the forceful removal of little girls' clitorises and labia. One of her talks at TEDx has had 750,000 views.
3. Direct intervention for girls at risk	*On separate occasions across three states we have been directly involved in incidents where girls were considered in danger of FGM. One occasion was dealt with by the police, in two Child Protection in the relevant state.* *On one occasion a girl was taken from Melbourne for FGM and*

	subsequently died. This was referred to the Australian Federal Police for investigation.
4. Website	*Our website in particular has been structured so to provide easily accessible information for people who need help to prevent the violence of forceful removal of little girls genitals. Stats include hits*
5. Generating data	*We have produced a report that allows an estimate of the risk of FGM occurring to girls in Australia. This is the only report of its kind in Australia.* *http://nofgmoz.com/2014/03/25/new-statistics-of-girls-at-risk-of-fgm-in-australia/*
6. Producing information sheets	*We have produced two information brochures; one for communities who practice FGM and another for Professionals who may come into contact with FGM affected communities.*
7. Child protection training	*We arranged for training in FGM and the law/mandatory reporting and child protection with Felicity Gerry QC and Professor Freda Briggs. This included engaging with police and their Sexual And Family Violence Crime Command, child protection and other frontline professionals to help people better understand FGM law and child protection issues.* *No FGM Australia is developing best practice guidelines for each professional group (medical, social, education, legal) to identify and manage the risks of girls who are identified as 'at risk' of the coercive removal of their sexual organs.*

Question Six

What circumstances, conditions, situations or events, within relationships, families, institutions and whole communities, are associated with the occurrence or persistence of family violence?

FGM is a complex problem as it is rooted in long held cultural beliefs about female sexuality.

The factors we know that are associated with the occurrence or persistent of family violence are

- A belief that daughters will not be able to marry unless they have undergone a FGM ritual
- A reluctance from members within the community to use the terms FGM (cutting and circumcision are often used as more acceptable, but belie the violence of the act)

- Religious beliefs about medical intervention
- Social and cultural beliefs about the right of women to experience sexual pleasure.

We know that girls who are in danger of having their genitals mutilated can come from a range of backgrounds, ethnicities and religions, however there are some features which can provide guide to which girls will be most likely to undergo this particular form of family violence. In Victoria, as stated in the introduction, there are hundreds of thousands of people who have immigrated from FGM affected communities.

A girl is "at risk" (in danger) if:

- Her mother or sibling has had FGM.
- She comes from a community where FGM is practiced
- If the above factors are present, and the girl is being taken to the country of origin for a long "holiday".
- A girl talks about preparing for a special ceremony or party where she will "become a woman".

Additional risk factors to consider:

- Girls between the age of 5-8 are in high risk, as this is thought to be when the majority of cases occur
- FGM is thought to occur in Australia as well as abroad; particularly in the summer holidays to allow her sufficient time to recover before school restarts. If a child talks of a long holiday to her country of origin this may be an indication of imminent FGM
- Any child overheard talking about a special procedure or celebration
- Any child who requests direct help from a professional
- Any awareness of a female elder visiting from the country of origin, if known to have a high prevalence of FGM [9,10]

Question Seven

What circumstances and conditions are associated with the reduced occurrence of family violence?

There is no definitive answer to the problem of how to stop violence against girls in the form of genital mutilation. However the solution must be a multi-sectorial one [9] which includes both education about the harmful effects of genital mutilation of little girls, and also the laws, as well as awareness of how to act in the event that a girl is considered in danger.

One of the countries which have had the greatest decline in the prevalence of mutilation of girls' genitals is Kenya, where numerous government departments work in concert to ensure that girls are safe [11].

France is a western country which has taken a child protection view of genital mutilation and uses education combined with use of the law to prevent FGM [12].

The UK has released a report which supports the view that there must be multiple sectors working together to protect girls from this particular form of violence, including training of frontline staff, campaigns by the police and the health department about the laws and the harmful effects, police presence at airports and the interrogation of families who are taking girls back to countries which practice FGM. The UK also has a hotline, which can be used by girls at risk of violence as well as professionals who are concerned about girls in danger. This can act as a first port of call for those who are concerned about girls in danger but do not wish to call the police.

The factors that increase chance of rejection of FGM are:
-Greater integration within the community (less social isolation)
-Time since immigration (i.e. more time passed, more chance that the family will not practice FGM)
-Younger women who were born in Australia less supportive of the practice
-Many older men, but not all older men.
-People who have been informed that FGM is harmful, illegal and is not a religious requirement
-Knowledge that the crime may be detected. [27]

Engaging communities and religious leaders
Research and availability of good data also assists in community engagement and targeted interventions. Changing cultural beliefs is a multi generational challenge and one that is highly sensitive so as to reduce resistance through the argument of western cultural imperialism.

This is why there needs to be engagement with the families who practice this form of violence in order to increase protection for girls in danger of genital mutilation.
One key factor is that religious leaders must also be able to speak out to their communities to inform them that forceful removal of the genitals is not required by any religion. Often it is the religious leaders who can have the most influence.

Violence is not an option:
However like all forms of family violence, we must remember that we cannot simply "ask" perpetrators not to mutilate their daughters. FGM is violence, it is illegal, it is child abuse and it is not an option that families have in Victoria. In the event that people disagree with the laws and still wish to mutilate their daughters, there must

be safeguards in place to ensure that girls can still be safe. There must be some sort system of detection so that perpetrators have reasonable fear of being caught.

Question Eight

Tell us about any gaps or deficiencies in current responses to family violence, including legal responses. Tell us about what improvements you would make to overcome these gaps and deficiencies, or otherwise improve current responses.

Data collection:

In order to prevent and control the violence against girls which is perpetuated in families there must be a clear understanding that **there are girls who are at risk in Australia of having their sexual organs coercively removed by force**.

We know from international studies from the UK and the World Health Organisation that the girls who are most at risk are the girls who are **daughters of women who are themselves survivors** of violence in the form of coercive forceful removal of the clitoris and labia. This is particularly true of a diaspora where a significant proportion of the risk comes from the immediate family.

At this point in Australia, from our investigations, we know that there is no data kept or collected in Victoria or in any other state in Australia as to which women have had their genitals forcefully removed for the purpose of destroying their sexual function. Currently there is no funding for collection of data on FGM in Victoria.

Therefore in order to take the first step to prevent violence in the form of genital mutilation, the first step involves introduction of mandated data collection through the health and social services.

There needs to be systematic collection of data which will allow Victorian government to better understand the extent of the problem rather than relying on population estimates.

This has been introduced in the UK [13] by way of a mandatory FGM dataset.

In Australia, doctors and nurses especially appear reluctant to ask families their intentions about FGM. The introduction of mandatory data collection means that doctors and nurses are mandated to have conversations about FGM with their patients, and therefore they can better understand both the health needs of their patient and also be alert to any potential risk to daughters. Some hospitals have routine questions about FGM as part of maternal health assessment, and opportunities exist within the Refugee Health Assessment, which are not taken up routinely [28].

Training of professionals:
Very few frontline professionals are aware of this form of violence against girls and how to act to protect girls from genital mutilation

Police are often not aware of the laws in regards to "intention to commit" FGM [8]
There is a reluctance to report a girl in danger of being forcefully mutilated as either the practitioner fears being called a racist, or the community member is scared of social ostracism.

Processes for making a report to police or child protection unclear:
The level of evidence required for investigation of a girl at risk of mutilation is difficult to obtain as it is frequently planned in secret, and it is hard to prove an intention to commit a crime.

Mutilation of genitals is also very hard to detect if it has happened, often girls are not taken to hospital but recuperate either overseas or at home over the long holiday period.

Starting conversations about FGM and clear processes for referral:
There is a need for training in how to have conversations about mutilation of genitals, and to have processes whereby there are automatic referrals to support services in the event that a girl is deemed to be in the risk category.

FGM needs to be treated as seriously as any other form of family violence, and child protection processes need to be acted upon accordingly.

The problem is not enough people know how to detect if a girl is in danger of violence of this form, or otherwise there is a fear of offending the parents if a report is made and therefore families feel as if they are being "accused" of a crime they may not have committed. There must be some way to break down this barrier so that there is dialogue around FGM with professionals and how to make it possible to protect girls without causing uproar and insult.

Question Nine

Does insufficient integration and co-ordination between the various bodies that come into contact with people affected by family violence hinder the assessment of risk, or the effectiveness of (early intervention, crisis and ongoing) support provided, to people affected by family violence? If so, please provide examples.

The lack of co-ordination between relevant departments is very big problem for preventing this specific form of violence. There is a complex stakeholder network that needs to align and co-ordinate to protect girls. These stakeholders include GPs, obstetricians, plastic surgeons, midwives, community health workers, teachers,

caseworkers, travel agents, and police. Also important is liaison between Victorian Government Department of Health, Department of Immigration, Department of Education, Department of Families and Children, Department of Women, Department of Prevention of Family Violence, Department of Multi-cultural Affairs, Police Department.

Currently, these groups do not co-ordinate to identify young girls at risk and monitor to ensure their safety. Often the first time risk can be identified is when a pregnant woman presents to a hospital for antenatal care. As the forceful mutilation of a girls' genitals is an [inherited] family violence, **it is more likely that the female child born to a mother who has had her own genitals mutilated will be at risk of FGM.** Midwives, and obstetricians are often ignorant of the implications of FGM or reluctant to initiate conversations about it and the legislative implications within Australia. There is no consistent approach to ensure that girls who are at risk of violence in the form or forcible removal of the genitals are kept safe.

Additionally, once women are identified as having survived FGM there are limited resources available to offer support, such as counseling [4]. Although it is possible to receive some surgical repair, there is often a big waiting list for surgery, and there is no option of clitoral restoration in Victoria, or in Australia. At best women have GPs to support them in the post FGM medical implications of various FGM practices (eg infibulation), if they have a GP who is confident in addressing the health issues around FGM, however many are not aware that a women's problems may be associated with her genital mutilation [28]. There is a huge need for survivors of the practice to have access to support for problems particularly psychological counseling for younger women who have had the practice and now experience psychological trauma from memory of the practice and their own sexual dysfunction [4].

Question Ten

What practical changes might improve integration and co-ordination? What barriers to integration and co-ordination exist?

Practical changes

The establishment of an FGM taskforce:

We need to have a coordinated approach to FGM, which includes all the relevant portfolios as listed in question 9 – Departments of Health, Immigration, Department of Education, Families and Children Women, Prevention of Family Violence, Multicultural Affairs, and the Police.

There needs to be a regular communication between representatives from each of

these areas so that each stakeholder is alert to the issues facing the others.
At the very least there needs to be

-Joint operations and communication between child protection and the police
-Inclusion of female genital mutilation – how to detect and act if concerned- as part of all mandatory reporting training
-Inclusion of female genital mutilation in the school curriculum in a forum such that girls at risk have access to educators who can listen to their concerns if they have already had FGM or if they fear they are in danger of FGM.
-Incorporation of female genital mutilation as part of all discussions about family violence and child abuse/child protection frameworks in Victoria.
-New arrivals need to be made aware of the FGM laws in Victoria
-As part of immigration requirements medical information includes a question about FGM
-Inclusion of voices from FGM affected communities at every opportunity to promote respectful dialogue and cultural awareness. Community voices such as Dr. Berhan Ahmed [14] from the Eritrean community can be amplified.
-increasing healthcare supports for survivors of FGM including physical, social, psychological and economic support.

Barriers to integration and co-ordination

We believe the primary barriers to integration and co-ordination of services for the safeguarding of girls are ignorance and reluctance from white Australia to champion the cause on account of being seen as racist, bigoted or culturally imperialist. The reluctance is well intentioned, but contributes to the perpetuation of violence.

Those that are unaware of the practice and the risks to young girls cannot be part of a co-ordination effort and those who are aware are often reluctant to do anything about it, as it is “not our problem”.

The opportunity to elevate the collective understanding of FGM as an issue of family violence permits the overcoming of those barriers.

Question Eleven

What are some of the most promising and successful ways of supporting the ongoing safety and wellbeing of people affected by violence? Are there gaps or deficiencies in our approach to supporting ongoing safety and wellbeing? How could measures to reduce the impact of family violence be improved?

Female genital mutilation, as it involves the mutilation of sexual organs of little girls, is a difficult form of violence to detect. The first step is to **start keeping data on who has had female genital mutilation so that the girls who are most at risk can be**

safeguarded. This can be done initially through the health system, as part of routine question when a person appears for treatment, whether it is related to FGM or not.

Also there can be information collected at the time of birth of a child into a family that may practice FGM. This can be transferred into babies' "blue book" and can be part of the discharge report that is sent to Maternal and Child Health nurses.

Information can be transferred between health professionals and parents can be regularly asked about female genital mutilation and their daughter's health monitored. Travel plans can also be monitored particularly if the family is planning to go back to their home country for a "holiday"- often used as a guise to commit FGM. We already recommend other health checks for people for example if they are travelling to or returning from an area which is affected by infectious disease such as Ebola, and we already question intention when people travel to war affected areas such as Iraq and Syria. Travel to areas which practice female genital mutilation with a young girl at risk can also raise an alert and initiate a process of action to safeguard a young girl.

Question Fourteen

To what extent do current processes encourage and support people to be accountable and change their behaviour? To what extent do they fail to do so? How do we ensure that behaviour change is lasting and sustainable?

Current processes fail to protect young girls at risk of FGM. There is no need to present your child to a doctor for examination and nor is there an examination of children deemed to be at risk coming back into the country to enable legal proceedings and protection of other daughters in the family.

It could be argued that FGM needs to be managed the same as for other crimes where there is a risk of a serious crime being committed, such as for terrorism [24]. For example, when families affected by FGM travel with a little girl to a country, which practices FGM, as part of the process to leave the country, all families could be asked if they intend to travel to perform female genital mutilation.

Often there are economic rewards for families for subjecting a girl to female genital mutilation, for example that she is "marriageable" once she is mutilated, and therefore the family may either benefit from a higher "bride price" or because she is no longer a dependent. This financial incentive could be reversed if families from FGM affected communities are financially rewarded for not subjecting their daughter to FGM. An example of this that exists currently is in the linking of welfare to immunization. Children in Australia must be immunized in order to access certain welfare payments [25]. This sort of financial reward could also be utilised to protect

girls in danger of female genital mutilation. For example, if a girl is in a high-risk category, parents can volunteer to provide evidence that she is intact regularly in return for getting Family Tax Benefits. This system has been hugely successful in Somalia and Sierra Leone through sponsorship programs [15](see question 16 for an elaboration upon financial incentives being used to protect girls from FGM).

Explicit acknowledgement of female genital mutilation can also contribute to protection of girls. As happens in Sierra Leone and Somalia [15], parents of girls could be asked their views on female genital mutilation and they could be asked to sign a contract stating that they are aware of the laws and they understand the harms associated with FGM, and that they are not going to subject their daughter to this form of violence.

Question Sixteen

If you or your organisation have been involved in observing or assessing approaches to behaviour change, tell us about any Australian or international research which may assist the Royal Commission. In particular, what does research indicate about the relative effectiveness of early intervention in producing positive outcomes?

The evidence from overseas and other states tell us we need

- A multi-sectorial approach which engages Health, Education, Police, Child protection and Immigration and we need increased collection of data about who has FGM [9]
- A systematic approach to safeguards including training frontline professionals about who is in danger of FGM [9].
- Increased training for nurses and doctors to ensure that women who have FGM are given sensitive and dignified support for they health needs especially during pregnancy [9].

International examples:

France incorporates mandatory health checks into their Maternal and Child Health visits, and this has allowed girls to be safe at least until they are able to speak, and to attend school. France is also the only country which has regularly enforced the anti-FGM laws which has acted as a deterrent to parents who wish to subject their daughters to FGM [12]

Somalia & Sierra Leone

Save a Desert Flower program:

A hugely successful program is run in 2 countries (Somalia and Sierra Leone) where there is almost universal FGM.

This is run by the organisation started by Waris Dirie, a survivor of FGM.

This program includes
-Parents signing a contract agreeing not to subject their daughter to FGM
-A yearly health check to ensure the girl remains intact
-Financial incentives linked to the preservation of the girl intact.
The program has had an enormous success rate. 100% of girls remained safe from mutilation using this approach [15].

UK
Tackling FGM via data increased training for frontline professionals, FGM hotline, and police campaigns both locally and at the airports to detect FGM, National media campaigns [9,13].

Queensland:
Maternal intake forms at the Mater in Brisbane include the question "Have you had FGM/circumcision?"

NSW:
High level of engagement between NSW Education Program on FGM, the police and child protection (Case Study Example 1). Government support is high for anti-FGM programs.

NSW Education Program on FGM:
One of the most successful programs at leading the child protection approach to female genital mutilation as a form of violence and child abuse is the NSW education program on FGM while Vivienne Strong headed it up.

This program has been instrumental in the recent prosecutions, which are happening in NSW at present, where two girls were mutilated in Sydney and Wollongong lounge rooms, and an infant was taken to Indonesia for FGM. In both cases the initial reports were made to Ms. Strong at the NSW Education Program on FGM.

The program has a big focus on child protection with close relationship to the NSW police who are responsible for child protection and child sexual assault.

Case study example 1: Child protection for girl at imminent risk of FGM in NSW
In August 2014 a woman concerned contacted No FGM Australia that a girl was at risk of FGM. Her colleague, an Indonesian man whose wife was pregnant with the baby girl, had expressed his intention to "circumcise" the girl after it was born the following month. Based on this expression of intent, and the fact that the mother and father were from a community that practices FGM, The information was passed onto the NSW Education Program on FGM, who then passed it onto the most relevant person in the NSW Police. The girl was considered at imminent risk because she was born into a family, which considered FGM acceptable, and in addition there was an expression of support for and intent to commit FGM.
The family were then visited by the police and informed that the Police were aware of the intention to commit FGM. The NSW Education program on FGM also attended the hospital where the baby was going to be born to inform the medical staff that the child was at risk. They provided education about how to inform the family that FGM is illegal in Australia. The family is now under the watch of the NSW child protection and their travel movements are being monitored in the event that they take the child overseas.
For more information on how the police dealt with this child who was at risk of FGM, please contact [redacted] Parramatta Police station.

The expression of support for genital mutilation is an indicator that any girl child in the family is in danger. The NSW Education program on FGM made sure that any persons within their programs who expressed support for FGM were made note of and referred to social services for follow up.

This approach can be replicated such that legislation could be tightened to ensure that any expression of support for FGM must be considered seriously and that daughters of any people who express support for FGM must be referred to child protection services for support and counseling, if not legal protections imposed on their child by way of child protection order or monitoring of travel movements.

Question Seventeen

Are there specific cultural, social, economic, geographical or other factors in particular groups and communities in Victoria which tend to make family violence more likely to occur, or to exacerbate its effects? If so, what are they?

There are a range of residents in Victoria who come from communities known to practice FGM. There are approximately 417,170 people in Victoria who were born in countries which practice FGM including:
This includes:

Country	**Prevalence of FGM in home country (%)**
Benin	13
Burkina Faso	76
Cameroon	1
Cent Africa Rep	24

Chad	44
Cote d'Ivoire	38
Djibouti	93
Egypt	91
Eritrea	89
Ethiopia	74
Gambia	76
Ghana	4
Guinea	98
Guinea-Bissau	50
Indonesia	97.5
Iraq	8
Kenya	27
Liberia	66
Mali	89
Mauritania	69
Niger	2
Nigeria	27
Senegal	26
Sierra Leone	88
Somalia	98
Sudan	88
Tanzania	15
Togo	4
Uganda	1
Yemen	23
Total	

In addition, Girls are in danger where they live in religious communities which deny medical intervention and are conservative in beliefs about sexuality, such as Christian Scientists and other "faith healing" religions. Although not specifically a religious practice, there are some people who believe that FGM is a requirement in Islam.
"Some people believe that not to do it is a crime, a religious crime or a sin" [4, pg. 18]

Also, there are religious leaders in Australia who promote the idea that "female circumcision" is a separate and acceptable practice and is not a form female genital mutilation [20], effectively condoning the practice. As such it is important that people who come from communities which justify this form of violence on religious grounds are given information about why it is not acceptable, nor is it a requirement

in their faith [21].

There are a range of reasons given for mutilating girls' genitals, some are cultural and some are religious. None are acceptable. Mutilation of little girls' genitals is violence, and a crime.

Question Eighteen

What barriers prevent people in particular groups and communities in Victoria from engaging with or benefiting from family violence services? How can the family violence system be improved to reflect the diversity of people's experiences?

There is cultural stigma and "blaming" of the family unit for perpetrating violence. Female genital mutilation is a special form of family violence. The mothers, fathers and grandparents who inflict violence in the form of genital mutilation are generally not doing so maliciously. However it is a form of control, and is often done out of fear that the girl will not be "pure" or will be promiscuous and "shame" the family in cultures where the female honour is felt to reflect upon the entire family and extended family. The social stigma attached to having a daughter who has not been mutilated can often drive families to carry out the act, regardless of their knowledge of the harmful effects. There can be a belief that there is actually a social benefit, even though there is no benefit to the girl.

"My daughter is growing, would I let her grow in this culture and then be open and …lose control of my daughter?" (Eritrean man) [4]

Raising the voices of all Victorians to speak out against this form of violence:
It is difficult for Australians to shake their fear of appearing to be racist, in their attempt to make up for the racist policies of past governments such as the White Australia Policy. However the fear of calling out practices such as female genital mutilation for what they are has led to a new form of racism. That is where little girls are being left unprotected by Australian laws because those around them are scared to offend their parents.

The best way to overcome this issue is to change the way that we address genital mutilation. **It should be treated as any other form of violence within a family context and should be taken out from behind closed doors within communities, and spoken about as violence against girls.** Just as members of various ethnic communities have started speaking out against other forms of family violence, the violence of genital mutilation should not be hidden as a cultural practice but as a human rights abuse, child abuse and violence and as such is not acceptable in Australia.

The voices of all Victorians from many different communities can be raised to encourage people that they are not alone in speaking out against female genital

mutilation.

This is why female genital mutilation must be clearly articulated as a form of violence, not an honourable act of purity or status. There must be a clear message that as violence it is not acceptable, is against the law and is an act of child abuse regardless of the intention.

Question Nineteen

How can responses to family violence in these groups and communities be improved? What approaches have been shown to be most effective?

In response to this question we need to consider two aspects of female genital mutilation – the prevention and then the support of the survivor. With regard to prevention, we know that as per questions 7, 8, 9 and 19.

- We need a multi-sectorial approach that engages Health, Education, Police, Child Protection and Immigration.
- We need increased collection of data about who has FGM
- We need systematic approach to safeguards including training frontline professionals (teachers, social workers, police) about who is in danger of FGM.
- There needs to be increased training for nurses and doctors to ensure that women who have FGM are given sensitive and dignified support for they health needs especially during pregnancy.
- We need increased awareness of female genital mutilation as a health and social issue facing girls in schools.
- There needs to be clear and blameless processes for initiating safeguards for girls who are in danger of genital mutilation, and these must be child focused, not adult focused.

With regards to supporting the survivors we know that several have indicated that the opportunity for restorative surgery is integral to repairing the devastating impacts to self-identity, self-esteem and sexual pleasure.

> "I hate her (mother) for what I still suffer. You know it's not fair that my whole sexual life has been you know completely destroyed because of what she's done and I still you know, I can't even go on a date without feeling like that sooner or later I'm going to have to explain to this person that I'm completely disfigured. It's not fucking fair. Like to me the idea of sex, I can't think of anything worse and people go oh its fun and I just, to me it's so foreign, it's like I just don't see anything fun in it. You know to me sex is nothing but a fucking struggle and it's not fair I shouldn't have to live like that." ([redacted], FGM survivor)

This was reinforced by recent research done in Victoria highlighting the concerns of women around the sexual problems they experience because of FGM [28].

Currently there are no surgeons able to conduct clitoral restoration in Australia, a reconstructive surgery that allows for women to regain something of what they have had taken from them. This is available in Europe, however we have had confirmation the surgeon who pioneered clitoral restoration, Pierre Foldes MD is willing to come to Australia to train Australian surgeons in the technique. We believe that a significant number of the community of 83,000 women who have survived FGM in Australia would benefit from this surgery [28]. He has already trained many surgeons and performed the surgery thousands of times successfully. Research following up women who have had the surgery has shown that almost universally women have a positive outcome to restoration, even if it is that they have had restored power and identity through the construction of a new clitoris [16].

General questions

Question Twenty

Are there any other suggestions you would like to make to improve policies, programs and services which currently seek to carry out the goals set out above?

What can we do to end family violence in the form of FGM, keep girls safe and support survivors?

There is no ONE way to address the complex issue of FGM.

We need education, both about the law, and about the harmful effects of FGM.

We need safeguards in place to better protect girls IN CASE their families believe some of the beliefs expressed in the recent studies such as that they think it is part of their identity, that they think it is a religious requirement, or that they think it will mean they will be better able to control their daughters.

As FGM is often part of a patriarchal culture that perpetuates gender inequality, it is vital that men are part of the solution to stop FGM. Older men from FGM affected communities *mainly* oppose to FGM, and respect the law, but not all men [4].

There is no "all" within FGM affected communities. We cannot generalise that because some people speak out against the practice, that all people will be against it. This goes back to the very secretive nature of the practice.

Problems to address:

- What are the barriers to reporting girls in danger of FGM by doctors and FGM workers?

- How can we make it easier to report girls who are at risk of this form of family violence?
- How can we better support families so that there is not a sense that they are under attack?
- How can we ensure that new arrivals are informed clearly about the law and that their daughters are safeguarded?
- How can we ensure that survivors of FGM are able to access the support, including the counseling and surgery that they need to recover from FGM?
- Are FGM workers and other professionals able to access all the people who need to hear their messages that FGM is harmful, child abuse and illegal?

- We need to discover what are the barriers to reporting girls who are in danger to the authorities. How cans this happen more easily?

Ultimately, we would advocate for three distinct objectives –
1) The establishment of a multi sector taskforce,
2) Increased safeguards for children, and
3) Support for survivors.

1) Initiate an interdepartmental taskforce to address FGM as violence against children.

Female genital mutilation does not affect just one area of society. Yes, FGM is hugely detrimental to women's health, and this is where the issue has been predominantly addressed in Victoria for the past 30 years. **However, there is a large gap in the current approach to safeguarding girls from family violence in the form of FGM**. This can be better addressed by including all portfolios which may come into contact with girls in danger of FGM. This includes Education, Human Services, Police, Immigration, as well as Health.

This task force could address the critical issue of data collection on how many women and girls have FGM, and how many have been taken out of Australia. They could also address increased safeguards for girls in danger of FGM.

2) Increased safeguards for children

This could include education of frontline professionals especially teachers, nurses, doctors, social workers and child protection. There could be a neutral number/ hotline which people can call so that they can report anonymously without exposing themselves to social ostracisation, or risking the destruction of often hard won relationships with members of FGM affected communities.

These safeguards could also include a middle step of mediation before the police and child protection are involved, initially to create dialogue with families who are thinking about subjecting their daughters to FGM.

This of course would mean more funding for FGM programs to be run in schools, hospitals and other clinics, and for inservicing and systems in place so doctors, nurses and teachers can recognized a girl in danger.

Additionally, when new refugees and immigrants arrive in Victoria, although they absolutely need support for housing, education, and other basic needs for survival, and it is essential that they be informed about the laws about female genital mutilation.

3) Support for survivors

- FGM survivors should be provided respectful treatment and have access to life changing reconstructive surgery. Also there is a high need for young women particularly to have access to counseling in order to deal with the trauma of FGM and the subsequent consequences, particularly the sexual dysfunction which often accompanies genital mutilation.
- All health care providers need to be aware of the issues, which may be facing women who present ante-natally, or for any other gynaecological or sexual health concerns. This includes sensitive, culturally aware and respectful support and referral if necessary.

Question Twenty-one

The Royal Commission will be considering both short term and longer term responses to family violence. Tell us about the changes which you think could produce the greatest impact in the short and longer term.

Our short-term objectives go towards safeguarding and preventing female children from undergoing this act of violence. This can happen through:
Short term:

1. Introduction of an inter-departmental task force on FGM as a form of family violence requiring a clear child protection response.
2. Data collection about the prevalence of FGM in Victoria
3. Resource development, publication and distribution including use of:
    a. Risk assessment checklists:
    b. Culturally sensitive “scripting” for difficult conversations with parents of girls considered at risk;
    c. Simple process flow diagrams to support reporting procedures;
    d. Summaries of the legal position of the professional when dealing with this type of sexual abuse, or girls at risk of this type of sexual abuse;
    e. A directory of resources (e.g. hotline, legal advice, professional advisory bodies etc.)

4. Engagement of religious leaders in speaking out against female genital mutilation.
5. Improvement of reporting processes to reduce barriers to reporting girls in danger of FGM.

6. Providing greater supports for survivors of female genital mutilation including the training of Australian surgeons in clitoral restoration.
7. Holding a National conference for frontline professionals with a focus on child protection and prevention of female genital mutilation as a form of family violence
8. Better utilisation of pre-existing health protocols such as the Refugee Health Assessment form.

Longer term:

1. Distribution and dissemination of information about female genital mutilation as a form of violence to: government; professionals; and the community at large.
2. Professional education about female genital mutilation for nurses, doctors, teachers, social workers and other frontline staff about female genital mutilation
3. Direct intervention through an FGM hotline.
4. Mediation processes if possible rather than police intervention to increase reporting of FGM.
5. Preventing inherited family violence of female genital mutilation through inclusion of FGM in school and university curricula.
6. Generate a risk framework that calculates the probability of further family violence by way of FGM and aligns with appropriate interventions
7. Doctors required to follow a clearly outlined safeguarding process pre and post travel when a girl is being taken out of the country by a family to a country which is affected by FGM.
8. Immigrants from countries which are affected by FGM asked whether they have had female genital mutilation. Such women can be subsequently referred for education and support through FGM prevention programs.
9. Educating and empowering survivors through access to appropriate restorative surgery, and avenues which allow for empowerment.
10. Preventing female genital mutilation by educating and empowering survivors of female genital mutilation including mothers and grandmothers who have already had female genital mutilation Engaging survivors of FGM helps:
    a. 1 Raise awareness of the support we can offer the especially if feeling pressured to have their daughters, nieces, sisters, cousins etc. subjected to FGM;

b. Allows building trusting relationships with those impacted by or survivors of FGM builds and improves their understanding of warning signs / indicators that FGM may be about to occur in order to act to prevent female genital mutilation;
c. Deepening understanding of the warning signs / indicators will enable prevention of female genital mutilation protection of more young girls.

Conclusion:

This submission was made on behalf of the little girls of Victoria who are in danger of a particularly brutal form of family violence, forceful removal of the clitoris and labia, and for those women who are living everyday with the consequences of FGM.
Female genital mutilation is a form of family violence which is perpetuated by families in the name of tradition, culture or religion. There are increasing numbers of people in Victoria who come from countries which are affected by female genital mutilation. Girls in Victoria are in danger of being mutilated despite the laws against the practice. As a secretive practice which involves the destruction of sexual organs resulting in life-long trauma, there must be better safeguarding of girls who are in danger of this form of family violence. Women who have survived the practice have specialised health needs, particularly sexual dysfunction, which is highlighted in a Western context where female sexuality is encouraged and not reviled.

No FGM Australia make this submission and ask the Royal Commission into Family Violence to consider how to better address the problem of female genital mutilation as a form of family violence requiring child protection measures. This submission is the voice of the vulnerable girls who require protection from a form of physical and sexual violence perpetrated in families.

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