# Interim guidelines for the Family and Reproductive Rights Education Program

November 2009

**Background**

Worldwide, it is estimated that over 130 million girls and women have undergone some form of genital mutilation/cutting, and at least three million girls are at risk of undergoing the practice every year. Cultural practices such as female genital mutilation (FGM) are rooted in a set of beliefs, values, cultural and social behaviour patterns that govern the lives of people in society. The practice of FGM is not confined to a specific population group and it is not sanctioned by either Islam or by Christianity.

The practice of FGM is common in parts of Africa, Asia and in some Middle Eastern Countries. It could be practiced among communities settling in Victoria from Cameroon, Democratic Republic of Congo, Djibouti, Egypt, Ethiopia, Eritrea, Ghana, Kenya, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Somalia, Sudan, Tanzania, Togo and Uganda. FGM could also be practiced among certain ethnic groups from a number of Asian countries such as India, Indonesia, Malaysia and Pakistan, as well as among some groups in the Arabian Peninsula such as in Oman, Saudi Arabia, United Arab Emirates and Yemen.[1]

The Family and Reproductive Rights Education Program (FARREP) was established in 1998 as a primary health response to increasing populations from countries that practice FGM settling in Australia. Annually, Australia accepts around 13,000 refugees under the Australian Government's Humanitarian Program. In 2006-07, more than a quarter of this number settled in Victoria with over a third coming from Africa and over a quarter coming from the Middle East.

The performance of FGM and/or the removal of a child from Victoria to have such procedures performed are specifically prohibited in Victoria under the *Crimes (Female Genital Mutilation) Act 1996*. Moreover, ccertain professional groups are mandated to report concerns under the *Children, Youth and Families Act 2005* if they form a belief on reasonable grounds that a child is in need of protection from physical or sexual abuse, including FGM. More information on mandatory and voluntary child protection reporting can be found at **Appendix A**.

**Policy Context for FARREP**

The Victorian Government's social, health and cultural diversity policy and planning frameworks provide the policy context for these guidelines. These include:

- *DHS Integrated Health Promotion Framework*
- *Refugee Health and Wellbeing Action Plan 2008-10*
- *Growing Victoria Together*
- *A Fairer Victoria*
- *Valuing Cultural Diversity*
- *Victorian Women's Health and Wellbeing Strategy Stage 2: 2006–08*

[1] United Nations Population Fund 2007 Nov FAQ's on Female Circumcision http://www.unfpa.org/gender/practices2.htm#7

**Aims of FARREP**

FARREP aims to work with communities that practice FGM in order to:

- strengthen their knowledge about FGM and support changes to their attitudes about the practice to prevent its occurrence
- increase access to timely and appropriate sexual and reproductive health services by women and girls from communities that could practice FGM
- build the capacity and expertise of mainstream and specialist sexual and reproductive health services to deal with women and girls affected by or at risk of being affected by FGM.

**Target group**

With a focus on those most at risk, FARREP targets all communities that practice FGM regardless of mode of arrival, period of settlement, race, religion, and culture. Currently, some communities that are known to practice FGM, are newly arrived, while others have a long history of settlement in Victoria.

In addition, FARREP targets health and other related professionals who work with the affected communities.

**Philosophy**

FARREP is based on an understanding of health within a social and cultural context and recognises that:

- Community education and health promotion services need to be delivered with regard to the cultural diversity and capacity of affected communities.
- Services need to be flexible and culturally responsive to emerging issues.

In recognition that FGM is a violation of women and children's fundamental human rights, FARREP is underpinned by a human rights approach. The basis for this is the affirmation that human well-being and health is influenced by the way a person is valued, respected and given the choice to decide on the direction of her/his life without discrimination, coercion or neglect of attention[2]. The *Victorian Charter of Human Rights and Responsibilities Act 2006* states that 'every child has the right, without discrimination, to such protection as is in his or her best interests and is needed by him or her by reason of being a child'. Accordingly, FARREP encourages health services to:

- Provide a choice of gender or gender-sensitive health services to women and their families.
- Reflect the various roles of women, their partners, families and communities in their culture and within Australian society.
- Seek to promote wellbeing and prevent illness, injury or disability.
- Adopt a holistic approach and ensure linkages exist between health and other professionals who work with the affected communities.
- Recognise women and their families' rights as health care recipients to be treated with dignity, confidentiality and give informed consent.

**Interim status of guidelines**

There is general consensus between relevant stakeholders that the previous guidelines for FARREP as contained in the *Community and Women's Health Program Guidelines 2003-04 to 2005-06* did not provide clear programmatic direction for workers. These current interim guidelines attempt to provide greater structure and clarity to the program.

It is considered that a more general reconsideration of FARREP is required to ensure that the program is achieving maximum reach, outputs and outcomes within a best practice framework. These interim guidelines are intended to provide FARREP workers and their managers with clearer direction about what is currently required, until the broader reconsideration of the program has been undertaken. It should be noted that the reconsideration may result in no substantive changes to the program.

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[2] UNFPA 2008 http://www.unfpa.org/rights/approaches.htm

**Role of the FARREP Facilitator**

In July 2009, the Department of Health appointed Family Planning Victoria to the role of FARREP Facilitator for two years, from 1 July 2009 to 30 June 2011.

A key role of the FARREP Facilitator is to manage a statewide FARREP health promotion plan. It is expected that quality health promotion practice as outlined in the *Integrated Health Promotion Framework (DHS, 2008)* would be embedded within health promotion planning, implementation and evaluation.

A central purpose of the statewide FARREP health promotion plan is to provide a more strategic approach to the program so that its limited resources are fully utilised, any gaps are identified and reduced, and unnecessary duplication is avoided. The FARREP Facilitator will be responsible for ensuring that the plan achieves this purpose.

The role of the FARREP Facilitator is also to:

- Provide advice to the Department of Health (the department) to assist in FARREP policy and service planning, review and development.
- Initiate and maintain effective relationships with community organisations, members of target communities, sexual and reproductive health professionals, relevant government departments and academic institutions.
- Identify FARREP worker training needs in order to develop training programs in collaboration with the department and FARREP agencies.
- Work with agencies that provide sexual and reproductive health to FGM target communities to support them in the development of culturally sensitive policies procedures and practices.
- Provide current national and international information about FGM and related sexual and reproductive health issues to the department and FARREP agencies.
- Prepare articles/presentations for relevant community newspapers, journals or seminars on FARREP activities to continue to raise the FARREP profile in the community and service system.
- Maintain strong consultation, referral, collaboration and support relationships with regional FARREP colleagues and the state-wide and national FARREP network.
- Convene quarterly meetings with FARREP workers.

The FARREP Facilitator contributes to the monitoring of FARREP through its overarching management of the statewide FARREP health promotion plan. The FARREP Facilitator will provide advice to the department about agencies' progress against the statewide FARREP health promotion plan. This aligns with the new health promotion reporting arrangements between community health services, Primary Care Partnerships and the department.

The FARREP Facilitator is not responsible for managing the accountability of individual FARREP-funded agencies.

**Role of workers funded under Activity 28016 - FARREP – Health Promotion**

Activity 28016 - FARREP – Health Promotion provides funding for workers to undertake a variety of health promotion interventions within the categories of screening, individual risk factor assessment and immunisation, social marketing/health information, community action (for social and environmental change) settings and supportive environments, organisational development, workforce development and resources.

Agencies funded under this activity are required to work with affected communities and other relevant stakeholders to develop, implement and evaluate local health promotion interventions to prevent the occurrence of FGM and to increase quality of care and access to sexual and reproductive health services for communities who practice FGM.

These health promotion interventions will contribute to the statewide FARREP health promotion plan. It is expected that quality health promotion practice as outlined in the *Integrated Health Promotion Framework (DHS, 2008)* will be embedded within health promotion planning, implementation and

evaluation. In line with the principles of integrated health promotion, FARREP initiatives should also be included in local community health service and Primary Care Partnership health promotions plans, where they align with the catchment's health promotion priorities.

Agencies funded under Activity 28016 should not be used in any capacity other than in relation to issues concerning female genital mutilation, including as interpreters or community development workers more broadly.

**Role of workers funded under Activity 28015 – FARREP – Direct Care**
Activity 28015 – FARREP – Direct Care provides funding for suitably qualified persons working directly with individuals, couples, families and groups that comprises assessment, therapeutic interventions, practical assistance, support, referral and advocacy to achieve harm reduction, and/or improved quality of life, social function and/or health.

Agencies funded under Activity 28015 should not be used in any capacity other than in relation to issues concerning female genital mutilation, including as interpreters or community development workers more broadly.

**Role of agencies that employ FARREP workers**
It is expected that agencies that employ FARREP workers will provide day-to-day direction and support to the role. Managers should be involved in regular discussions with their FARREP worker and the FARREP Facilitator about broader strategic objectives for the position.

**General comments about reporting requirements under FARREP**
The below reporting requirements for FARREP are more rigorous than has previously been required. In part, this reporting is aimed at providing an evidence-base to inform a reconsideration of the program.

In the same way that community health services are required to report progress against health promotion initiatives to Primary Care Partnerships who then report to the department, FARREP workers are required to report to the FARREP Facilitator who will then report to the department.

**Reporting requirements for workers funded under Activity 28015 – FARREP – Direct Care**
FARREP agencies funded under activity 28015 – FARREP – Direct Care are required to report direct and indirect hours of service to the department. This must adhere to the reporting requirements specified in the *Community & Women's Health Programs 2008-09 Data Reporting Guidelines.*

The data reporting guidelines can be located at:
*http://www.health.vic.gov.au/communityhealth/downloads/datareport/cwh_reporting0809.pdf*

FARREP workers funded under this activity must also provide 12-monthly narrative reports to the department through the FARREP Facilitator (due to FPV by 30 November) detailing the direct care services provided during the reporting period.

**Reporting requirements for the FARREP Facilitator**
The FARREP Facilitator is required to prepare and submit to the department 6-monthly reports (due 1 January and 1 July) on the activities performed in the role during the reporting period.

The FARREP Facilitator is also required to prepare and submit to the department an annual progress report due on 1 January on:
- the statewide operational FARREP health promotion plan
- the activities undertaken by the direct care FARREP workers.

The FARREP Facilitator may also be required to prepare and submit interim reports to the department as requested.

**Reporting requirements for workers funded under Activity 28016 - FARREP – Health Promotion**

FARREP workers funded under activity 28016 FARREP – Health Promotion are required to provide 12-monthly narrative reports (due to FPV by 30 November) to the department through the FARREP Facilitator relating to the progress of local health promotion initiatives.

In July 2009, the department implemented integrated health promotion reporting measures for Primary Care Partnerships, community health services and women's health services that are funded to undertake health promotion activities. Planning for, and reporting against, the statewide FARREP health promotion plan should reflect these reporting measures as adapted for FARREP below.

The five core FARREP integrated health promotion measures are:

- Reach
- Increased knowledge about health, welfare and human rights issues associated with FGM
- Change in behaviours regarding FGM
- Social action and influence
- Reoriented health services regarding FGM.

The four core FARREP capacity building measures are:

- Increased organisational commitment to make FGM health promotion a priority
- More effective targeting of FGM health promotion investment through evidence-based practice
- Enhanced organisational learning and improved practice through evaluation
- Greater proportion of planned FGM health promotion initiatives delivered in partnership with local communities and other organisations.

**Contact details**

For more information please contact your local regional offices or Catherine James, Manager, Primary Health Programs, Department of Health, on 9096 8762 or via Catherine.James@dhs.vic.gov.au.

Additional information about FARREP and FGM can also be found at the FARREP website: http://www.health.vic.gov.au/vwhp/farrep.htm

## Appendix A

### When to make a report to Child Protection about a child in need of protection

A report to Child Protection should be made in any of the following circumstances:

- Physical abuse of, or non-accidental or unexplained injury to, a child (mandatory reporters must report).
- A disclosure of sexual abuse by a child or witness, or a combination of factors suggesting the likelihood of sexual abuse – the child exhibiting concerning behaviours, for example after the child's mother takes on a new partner or where a known or suspected perpetrator has had unsupervised contact with the child (mandatory reporters must report).
- Emotional abuse and ill treatment of a child impacting on the child's stability and healthy development.
- Persistent neglect, poor care or lack of appropriate supervision, where there is a likelihood of significant harm to the child, or the child's stability and development.
- Persistent family violence or parental substance misuse.
- Parents with a psychiatric illness or intellectual disability which is not effectively managed and/or supported and there is a likelihood of significant harm to the child or the child's stability and development.
- Where a child's actions or behaviour may place them at risk of significant harm and the parents are unwilling or unable to protect the child.
- Where a child appears to have been abandoned, or where the child's parents are dead or incapacitated, and no other person is caring properly for the child.

A report to Child Protection should be considered if the concerns currently have a serious impact on the child's immediate safety, stability or development, or the concerns are persistent and entrenched and likely to have a serious impact on the child's development.

**If you are unsure about whether a Child Protection response is appropriate, you should contact Child Protection for further advice.**

### Mandatory reporting responsibilities

Any person can make a report to Child Protection. However certain professional groups are mandated to report concerns under the *Children, Youth and Families Act 2005* if they form a belief on reasonable grounds that a child is in need of protection from physical or sexual abuse.

**Mandated reporters**
Mandated professionals are:

- Doctors
- Nurses
- Teachers
- School principals
- Police.

Section 184 of the Children, Youth and Families Act spells out this responsibility:

**Section 184 Mandatory reporting**

A mandatory reporter who, in the course of practising his or her profession or carrying out the duties of his or her office, position or employment, forms the belief on reasonable grounds that a child is in need of protection as a result of physical injury or sexual abuse (s. 162(c) or (d)) must report to the Secretary that relief and the reasonable grounds for it as soon as practicable:

a) after forming the belief; and

b) after each occasion on which he or she becomes aware of any further reasonable grounds for the belief

It is an offence for a mandated professional not to make a report if there were reasonable grounds for forming a belief that a child is in need of protection as a result of physical injury or sexual abuse.

### Reasonable grounds

Grounds for a belief are matters of which a person has become aware and any opinions based on those matters. There may be reasonable grounds when:

- a child states that they have been physically or sexually abused
- a child states that they know someone who has been physically or sexually abused (sometimes the child may be talking about themselves)
- a relative, friend, acquaintance or sibling of the child states that the child has been physically or sexually abused
- professional observations of the child's behaviour or development lead the mandated professional to form a belief that the child has been abused
- signs of physical or sexual abuse lead to a belief the child has been abused.

### Other considerations and protection for reporters

This mandated responsibility arises if in the course of practicing their profession, mandatory reporters form a belief on reasonable grounds that a child is in need of protection from physical or sexual abuse. Mandated professionals are not legally obliged to report suspicions of abuse encountered in their private life or when working in a capacity not directly related to their profession. However, in such situations mandated professionals may have a moral or ethical obligation to report concerns if there are reasonable grounds to believe that a child is at risk of harm.

Other considerations include:

- You must make a report without delay.
- You are required to make a report **each time** you become aware of any further grounds for your belief.
- You do not have to prove that the abuse has occurred. You only need reasonable grounds for your belief.
- It is your responsibility to report your belief; it is not the responsibility of your supervisor, principal, senior or manager. If you are one of a group of mandated professionals who share the belief, based on reasonable grounds, then only one mandated professional needs to make the report. However, you must be satisfied that the report was made promptly and that all of the reasonable grounds were included in the report.
- If a mandated professional (supervisor, principal, manager) directs another mandated professional not to make a report, and that professional continues to hold the belief that a child is in need of protection, then that person is legally required to make a report to Child Protection.

- Mandatory reporting requirements take precedence over professional codes of practice where confidentiality or client privilege is claimed. You do not need permission from parents or caregivers to make a report, nor do they need to be informed that a report is being made.
- If you make a report in good faith, you cannot be held legally liable, regardless of the outcome of the report.