FGM Aware Training Notes - good practice and key points

These additional background notes cover good practice and key points in relation to delivering training on FGM, and are intended to support use of the FGM Aware slide presentation to raise awareness of Female Genital Mutilation. Please note that notes are also provided within the PowerPoint presentation, which is available at www.fgmaware.org

Programme

The slide presentation is suitable for an interactive three-hour workshop but can be adapted to suit a shorter session. Alternatively key points can be embedded within other training presentations such as child or adult protection.

'Sara's Story' DVD

The short animated film, Sara's Story, can be used to support training sessions. In a three-hour session you may choose to show the film at the beginning and then to build on the issues raised. Alternatively it can be shown at the end as a way of summarising key points.

Sara's Story can also be used as the basis for a shorter input on FGM, in which case separate facilitators' notes are available on the DVD.

Advance reading for trainers / facilitators

We strongly recommend that you read the following documents before leading sessions on FGM: *Tackling Female Genital Mutilation in Scotland. A Scottish model of intervention*, Scottish Refugee Council and London School of Hygiene and Tropical Medicine, 2014; *FGM Guidelines*, FCO, 2011; *Tackling FGM in the UK*, Royal College of Midwives, 2013.

FGM is complex and different ethnic groups carry it out for different reasons, in different ways, and at different ages. It is therefore likely that trainers / facilitators will be asked questions that they won't be able to answer in detail – in some instances the information may well not be available.

The US Department of State publishes country reports on FGM and participants can be referred to these as one source for more detailed information. www.state.gov/

Terminology

It is preferable not to use 'female circumcision' as the main term since this minimises what happens in FGM.

Cutting is a common term used for FGM types 1 to 3, but be aware that cutting is not an accurate description for all the harmful practices included within type 4 FGM.

It is recommended to refer to 'potentially affected communities', rather than 'practicing communities'. (See page 10, Tackling Female Genital Mutilation in Scotland.)

Use of real life or graphic images
We recommend not using real life photographs or film of girls or women undergoing FGM. Neither do we recommend use of real life photographs to illustrate the different types of FGM. Depending on the setting trainers could use line drawings to illustrate the different types, or models (available from Maaasi Aid Association). We acknowledge that actual images or film may be of value in terms of specialist training for those with a medical role, see for example the FGM National Clinical Group website.

Services, not pity
Although FGM is child abuse and a serious crime in Scotland, women who have experienced FGM, especially younger women, often express that they want appropriate services, but they do not want to be pitied - they want to be treated like everyone else. Women survivors can lead full and happy lives. Whilst it is important that practitioners pro-actively raise FGM when appropriate, it is also important not to stigmatise survivors, and to consider holistic needs.

Possible parallels between FGM and other social issues
A parallel can be made between the practice of FGM and the treatment of intersex children. To date it has been common practice for parents and medical professionals to 'assign' a sex to intersex babies and this may involve irreversible surgery. Such medical treatment has been carried out in the belief that it is in the best interests of the child, not least because the majority societal expectation is that a persons' sex is clearly defined.

There has been at least one US case reported of an intersex person taking legal action because they later identified with a different sex from that which they were assigned at birth. See for example www.advocate.com/society/youth/2013/05/14/lawsuit-filed-over-unnecessary-surgery-intersex-baby

A parallel can also be drawn between FGM and (mainly) Western women choosing to opt for labiaplasty and other genital cosmetic surgeries. . For information on labiaplasty and the NHS see www.nhs.uk/conditions/labiaplasty/pages/introduction.aspx

People who value and defend the practice of FGM might well ask 'why are you criticising our culture when women here can have cosmetic surgery?' so it is important to consider in what ways it is different. You can invite views from participants.

A common suggested difference is that adults choose to carry out cosmetic surgery and it is an informed choice. Some might dispute this view and point out that women face considerable pressure to conform to what is held as acceptable or ideal body images for women, e.g. removal of body hair, bigger breasts or buttocks.

The law does not specify what is right – it specifies what is against the law. Cosmetic surgery has not been criminalised, but if a person could evidence that they had been forced or coerced into surgery on their genitals for non-medical reasons then a prosecution under FGM legislation could be possible.

Male circumcision
Participants at FGM training often ask about male circumcision. You may choose to raise it when you are discussing the definition of FGM.

There are valid concerns about routine circumcision of boys for non-medical reasons, but there are significant differences between male and female circumcision:

- Firstly the motivation for male circumcision does not include limiting or controlling male sexuality or sexual desire.
- Secondly the procedures and health impacts are not comparable. For example type 1 FGM would be the equivalent of cutting off the entire glans (head) of the penis and type 3 would involve removing all the external male genitalia and closing the wound, leaving only a small hole for urination.

This is why many FGM campaigners prefer not to use the term female circumcision – because it minimises what actually happens.

Information on male circumcision for religious reasons is provided at www.scotland.gov.uk/Publications/2008/02/14143159/3

Historical roots of FGM
There are many theories as to the roots of FGM, but it is not possible to say where it first started, or for what reasons. A common view is that the Pharaohs' first practiced it in Egypt, whilst an alternative suggestion is that female slaves in Rome were forced to undergo a form of infibulation in order to prevent pregnancy.

The following quote is taken from www.unfpa.org/resources/promoting-gender-equality

"In the Horn of Africa it is referred to as Pharonic circumcision. There is mention made of Egyptian mummies that display characteristics of FGM/FGC. Historians such as Herodotus claim that in the fifth century BC the Phoenicians, the Hittites and the Ethiopians practiced circumcision. It is also reported that circumcision rites were practiced in tropical zones of Africa, in the Philippines, by certain tribes in the Upper Amazon, and in Australia by women of the Arunta tribe. It also occurred among the early Romans and Arabs.

As recent as the 1950s, clitoridectomy was practiced in Western Europe and the United States to treat 'ailments' in women as diverse as hysteria, epilepsy, mental disorders, masturbation, nymphomania, melancholia and lesbianism. In other words, the practice of FGM/FGC has been followed by many different peoples and societies across the ages and the continents."

Justifications given for FGM
There are many reasons given for why FGM should be carried out and these vary considerably between different ethnic groups and across different areas. For more information see: www.who.int/mediacentre/factsheets/fs241/en

The main reason now given for carrying out FGM is *social acceptance or, conversely, fear of social exclusion*. Amongst ethnic groups and communities where FGM has become the *social norm,* parents are likely to regard having their daughters cut as part of their duty as parents. Indeed, there may be adverse consequences for girls and their families if FGM is not carried out. It is important to understand the possible negative impact that **not** undergoing FGM can have:

- In some FGM-practicing societies women who have not undergone FGM are regarded as unclean and are not allowed to handle food and water.
- Women may not be regarded as adult if they have not undergone FGM
- When FGM is part of an initiation rite then it is accompanied by explicit teaching about the woman's role in her society. A girl who has not been cut is likely to be shunned by her peers.
- In some communities the clitoris is regarded as dangerous and it is believed that it can kill your husband and baby. Traditional birth attendants might refuse to assist a woman who has not been cut.

Whatever the origins of the practice, or the stated reasons for continuing it, FGM serves to control women's bodies and sexuality.

In working with individuals, families and communities to prevent FGM, it is important to know what beliefs and motivations underpin the practice, and to amend any intervention to suit. *Getting to know your local community* is an essential part of responding to and preventing FGM.

Identifying communities potentially affected by FGM
Nationality is usually seen as a main indicator of potential risk of FGM, however it is more accurate to say that FGM is carried out by ethnic groups rather than by nationalities. Groups that have traditionally practiced FGM may straddle national boundaries, as with the case of the Maasai whose traditional grazing lands can be found across Kenya and northern Tanzania.

It therefore follows that it is important not to overlook countries where *average* prevalence is lower since there may be one area of that country in which prevalence is much higher than the average rate. For example:

"The most recent Demographic and Health Study (DHS) for Nigeria (NPC Nigeria 2009) suggests that the prevalence of FGM differs by region, ranging from 53.4% in the south west, to 2.7% in the north east. UNICEF gives a 27% national rate for Nigeria."
(Page17, 'Tackling Female Genital Mutilation in Scotland. A Scottish Model of Intervention')

The Nigerian case study, which can be found at page 17 of the above report highlights that whilst ethnicity is one indicator of potential risk there are other factors to consider, including educational and socio-economical background, age and in some communities, religion.

In terms of planning services for women affected by FGM and protecting girls potentially at risk, it is important that services / practitioners *get to know* communities in their area.

'Prevalence' in Scotland

There are many limitations to current data, and it is not possible to give an accurate figure for the number of women in Scotland who are living with FGM, nor for the number of girls at risk. For more information on this we strongly recommend that you read pages 9 – 10 of '*Tackling Female Genital Mutilation in Scotland'*.

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