

ahafoundation

A D D R E S S I N G

Female Genital Mutilation/Cutting (FGM/C)

*A Training
Curriculum for
Law Enforcement,
Educators, and
Service Providers*

Created in collaboration with Culture Works!



What is Female Genital Mutilation/Cutting (FGM/C)?

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

FGM/C has **no health benefits** and can lead to lifelong physical and psychological consequences. In some cases, it is lethal.

**Source: World Health Organization*



What is Female Genital Mutilation/Cutting (FGM/C)?

- CONTINUED -

On average, girls undergo FGM/C between birth and age 15 to initiate them into adulthood and to **ensure their marriageability.**

■
FGM/C **violates** women's and children's human rights.

Does FGM/C affect women and girls in the U.S.?

More than **half a million** women and girls in the U.S. are at risk of FGM/C, including more than **166,000 girls under the age of 18.**

▪

*The number of women and girls at risk for female genital mutilation/cutting (FGM/C) in the United States **more than doubled** from 2000 to 2013.

▪

Immigration to the U.S. from African, Middle Eastern, and South Asian countries has contributed to the **rise in numbers.**

*Source: Centers for Disease Control and Prevention

What can I expect to learn from this training?

The AHA Foundation FGM/C training curriculum provides guidance to professionals for engaging with a client/victim/survivor or person at risk of FGM/C, in a culturally sensitive manner.

Elements of the training include:

Introduction to FGM/C

Working with Clients

- PREPARE
- IDENTIFY BARRIERS
- ACTIVE LISTENING
- INTERPRET
- SAFETY PLAN
- EDUCATE

Case Studies

Specifics I can expect to learn from this training

Introduction to FGM/C

- Legal landscape of FGM/C in the U.S.

Working with Clients

- **PREPARE:** These are the conditions that should be created for a substantive and successful engagement with the victim and/or affected communities and families.
- **IDENTIFY BARRIERS:** You will identify and address the barriers that might limit the client/victim/survivor's participation in your efforts.
- **ACTIVE LISTENING:** You will identify the conditions that need to be created and sustained to enable the client/survivor/victim to gain trust and feel comfortable to engage.

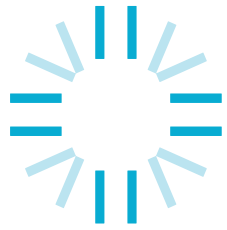
Specifics I can expect to learn from this training

Working with Clients (CONTINUED)

- **INTERPRET:** You will learn the possible range of responses or reactions to the deeper probing of a practice that is taken for granted in their families and communities.
- **SAFETY PLAN:** There are a variety of risks involved for immigrant women and girls seeking support to either prevent FGM/C or to deal with its consequences in their lives that you should be aware of.
- **EDUCATE:** It may be surprising to the clients/victims/survivors that there are other girls outside of their communities that have undergone the practice, that there are girls within or outside of their communities that have not undergone the practice, and that the practice violates international norms.

Case Studies

- FGM/C Hypothetical Scenarios.



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Female Genital Mutilation/Cutting in the United States

Female Genital Mutilation/ Cutting (FGM/C)

The World Health Organization
defines FGM/C as

“all procedures that involve partial or total removal of external female genitalia, or other injury to female genital organs for non-medical reasons.”

WHO classifies FGM/C into four major types:

TYPE I - Clitoridectomy: Partial or total removal of the clitoris, and in very rare cases, only the prepuce.

TYPE II - Excision: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora.

TYPE III - Infibulation: Narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.

TYPE IV - Other: All other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping, and cauterizing the genital area.

Why is FGM/C Practiced?

Causes of FGM/C include a mix of cultural, social, and religious factors within families and communities.

Reasons may include:

- It is considered a cultural tradition, encouraging conformity to social convention.
- Promotion from local structures of power including religious or community leaders, circumcisers, or medical personnel.
- It's considered the proper way to raise a girl and prepare her for marriage and adulthood.
- To reduce a woman's libido and stop her from engaging in "illicit" sexual acts.
- To strengthen cultural ideals of femininity through removal of body parts considered "unclean" or "male."
- To prove virginity at the time of marriage.

Source: World Health Organization

A Note on Reasons FGM/C May Be Practiced

It may be difficult to understand how a mother, grandmother, or father could possibly force their daughter or granddaughter to undergo FGM/C. Parents around the world generally want what is best for their children. A family may believe that the way to ensure the best future for their daughter is to find a good husband for her. In some communities, a girl or a woman is only considered a “desirable” potential spouse if she has been cut.

This explanation is not to justify FGM/C but to explain the possible mindset of families who force their daughter to be cut. It also serves to show the underlying social norms and attitudes that must be addressed to eradicate the practice.

FGM/C Has No Health Benefits

According to the WHO, FGM/C has “no health benefits for girls and women.” The procedure involves the removal and/or damage of normal and healthy female genital tissue. Not only does it have no health benefits either physically or psychologically, it in fact negatively interferes with the natural functions of girls’ and women’s bodies.

FGM is recognized globally as a human rights violation that according to the WHO “reflects deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination against women.”

Because FGM is typically carried out on minors, it is also a violation of the rights of children.

Health Consequences

Immediate Complications:

Severe pain, shock hemorrhage (bleeding), tetanus or sepsis (bacterial infection), urine retention, open sores in the genital region, and injury to nearby genital tissue.

Long Term Consequences:

Recurrent bladder and urinary tract infections, cysts, infertility, complications during sexual intercourse and childbirth, and an increase in newborn deaths.

Consequences to Babies of Mothers Who Have Undergone FGM/C:

Higher rates of neonatal death, increased risk of stillbirth, infants requiring resuscitation, and low birth weights.

Source: World Health Organization



Psychological Consequences

It is important to note that because FGM is often performed on minors, girls may not know what has happened to them until much later in life.

Psychological Consequences:

Women and girls who have undergone FGM/C

- loss of trust, betrayal, post-traumatic shock, depression, anxiety, guilt, suicidal ideation.

Women who have resisted FGM/C

- become a social outcast and are shamed for their 'uncleanliness'
- may be at risk for honor violence or abuse because the family's honor lies with girls undergoing FGM procedures

U.S. FEDERAL STATUTES

Female Genital Mutilation (18 USCS § 116)

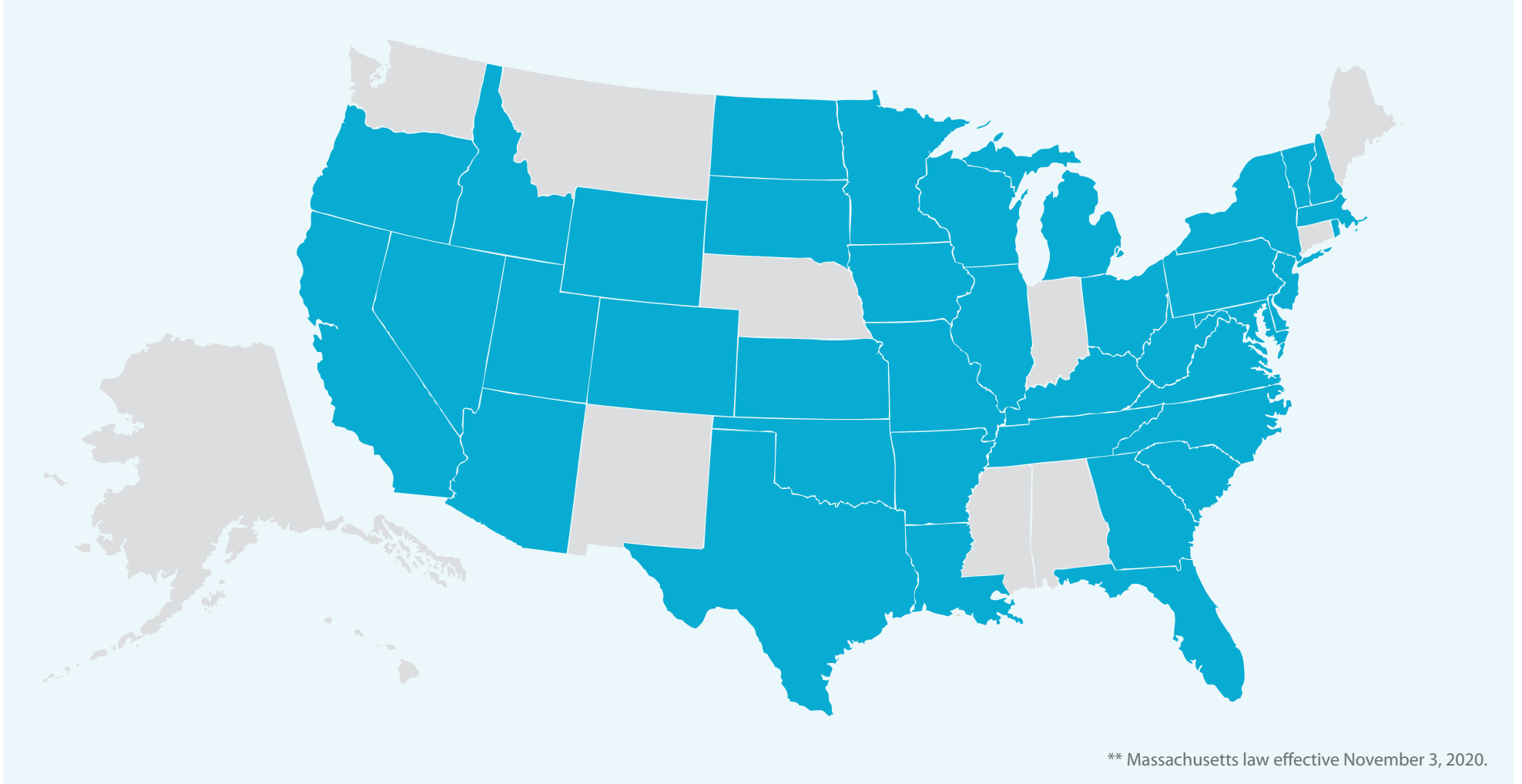
- It is a crime to knowingly perform female genital mutilation (FGM) on girls under 18 years old, including consenting to FGM as a parent or guardian, when interstate commerce is used to facilitate it
- It is a crime to take a girl overseas for a FGM procedure
- Bars religion, custom, tradition, ritual, or standard practice as a defense to prosecution
- Calls on federal agencies to submit a report detailing the prevalence of FGM in the U.S., the protections and actions taken to protect women and girls, and the actions taken by Federal agencies to educate important stakeholders about FGM
- The penalty is a maximum of 10 years imprisonment and/or a fine

Information regarding Female Genital Mutilation (8 USCS § 1374)

- Requires U.S. immigration officials to provide all immigrants with information about the severe physical and mental harm caused by FGM and the legal consequences of performing FGM in the U.S.

U.S. STATE FGM/C CRIMINAL LAWS

39 states have laws against FGM/C



** Massachusetts law effective November 3, 2020.

U.S. STATE FGM/C CRIMINAL LAWS

STATE	SENTENCING GUIDELINES	EDUCATION/ OUTREACH	CIVIL CAUSE OF ACTION	SPECIFIES ABILITY TO PROSECUTE PARENTS/GUARDIANS	TRANSPORTING FOR FGM PROHIBITED	CULTURE, RITUAL RELIGION NOT A DEFENSE
ARIZONA‡	Imprisonment of 5.25 years to 35 years		•	•	•	
ARKANSAS‡Ⓞ	Imprisonment from 3 to 10 years	•	•	•	•	•
CALIFORNIA	Imprisonment from 1 to 7 years	•		•		
COLORADO‡	Imprisonment from 4 to 12 years			•		•
DELAWARE‡	Imprisonment for up to 5 years			•		•
FLORIDA‡	Imprisonment for up to 30 years and fine of up to \$10,000			•	•	
GEORGIA	Imprisonment for 5 to 20 years			•	•	•
IDAHO	Imprisonment for a term not more than life					•
ILLINOIS*‡	Imprisonment for 6 to 30 years			•		
IOWA	Imprisonment up to 5 years and a fine between \$750 and \$7,500	•			•	•
KANSAS	Imprisonment of 55 to 247 months and maximum fine of up to \$300,000			•	•	•
KENTUCKY‡∞	Imprisonment for up to 10 years	•	•	•	•	•
LOUISIANA‡	Imprisonment for up to 15 years			•	•	•
MARYLAND	Imprisonment for up to 5 years and/or a fine of up to \$5,000			•		•
MASSACHUSETTS‡	Imprisonment in the state prison for not more than 5 yrs, or by a fine of up to \$10,000 and by imprisonment in the house of correction for up to 2 1/2 yrs	•	•	• §	•	•
MICHIGAN∞	Imprisonment for up to 15 years	•	•	•	•	•
MINNESOTA*	Imprisonment for up to life and/or a fine	•				
MISSOURI	Imprisonment of 5 to 15 years			•		•
NEVADA‡	Imprisonment of 2 to 10 years and a fine of up to \$10,000			•	•	•
NEW HAMPSHIRE	Imprisonment up to 15 years and fine of up to \$4,000			•	•	•
NEW JERSEY	Imprisonment of 3 to 5 years and/or a fine of up to \$15,000			•	•	•
NEW YORK	Imprisonment for up to 4 years	•		•		•
NORTH CAROLINA	Imprisonment for 44 months to 182 months			•	•	•

(continued)

NOTES: ‡ = indicates Arkansas, Arizona, Colorado, Delaware, Florida, Illinois, Kentucky, Louisiana, Massachusetts (Massachusetts Dept. of Children and Families indicates they view FGM as child abuse making it a mandatory reporting issue), Nevada, South Carolina, Tennessee, Wyoming, and Utah which have mandatory reporting requirements

* = indicates Illinois, Minnesota, Oklahoma, and Rhode Island, which apply not only to minors, but also adults

∞ = indicates Kentucky, Michigan, Utah, and Wyoming which include revoking a practitioner's medical license for performing FGM

Ⓞ = indicates Arkansas and Tennessee, which require annual statistical reporting of FGM to designated governmental bodies

Currently, only Arkansas, Kentucky, and Utah have mandated specific FGM training for law enforcement.

§ = Existing MA aiding and abetting law covers parents/guardians

**Other states may use general child abuse or assault statutes to prosecute. These statutes may have higher sentencing guidelines than specific FGM statutes, so even in states that have FGM/C statutes prosecutors may charge assault in order to impose a higher sentence.

U.S. STATE FGM/C CRIMINAL LAWS

(continued)

STATE	SENTENCING GUIDELINES	EDUCATION/ OUTREACH	CIVIL CAUSE OF ACTION	SPECIFIES ABILITY TO PROSECUTE PARENTS/GUARDIANS	TRANSPORTING FOR FGM PROHIBITED	CULTURE, RITUAL RELIGION NOT A DEFENSE
NORTH DAKOTA	Imprisonment for up to 5 years and/or a fine of \$5,000			.		.
OHIO	Imprisonment for 2 to 8 years and a fine up to \$40,000				.	.
OKLAHOMA*	Imprisonment from 3 years to life and a fine of up to \$20,000					
OREGON	Imprisonment for up to 10 years and/or a fine of up to \$250,000	.		.		.
PENNSYLVANIA	Imprisonment the maximum of which is more than 10 years			.	.	.
RHODE ISLAND*	Imprisonment for not more than 20 years					
SOUTH CAROLINA‡	Imprisonment for up to 20 years or a fine of up to \$20,000, or both			.	.	.
SOUTH DAKOTA	Up to 10 years imprisonment and \$20,000 in fines			.	.	.
TENNESSEE‡Ⓞ	Imprisonment for 2 to 12 years and a fine of up to \$5,000		.	.	.	.
TEXAS	Imprisonment for 180 days to two years and a fine of up to \$10,000			.	.	.
UTAH‡∞	Imprisonment from 1 to 15 years and a fine of up to \$10,000	.	.	.	.	.
VERMONT	FGM Types 1-3; imprisonment of up to 10 years and/or a fine of up to \$20,000, FGM Type 4; up to 5 years and/or \$500			.	.	
VIRGINIA	Class 2 Felony; Imprisonment for 20 years to life and fine of up to \$100,000		.	.	.	
WEST VIRGINIA	Imprisonment for 2 to 10 years and a fine of between \$1,000 and \$5,000			.		.
WISCONSIN	Imprisonment for up to 6 years and/or a fine of up to \$10,000					.
WYOMING‡∞	Imprisonment for 5 to 25 years	.	.	.	.	.

NOTES: ‡ = indicates Arkansas, Arizona, Colorado, Delaware, Florida, Illinois, Kentucky, Louisiana, Massachusetts (Massachusetts Dept. of Children and Families indicates they view FGM as child abuse making it a mandatory reporting issue), Nevada, South Carolina, Tennessee, Wyoming, and Utah which have mandatory reporting requirements
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 Currently, only Arkansas, Kentucky, and Utah have mandated specific FGM training for law enforcement.
 § = Existing MA aiding and abetting law covers parents/guardians
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PROSECUTIONS FOR FGM/C IN THE U.S.

- In 2006, a father in Georgia was convicted of battery and cruelty for removing his daughter's clitoris and was sentenced to 10 years in prison
- In 2010, a mother in Georgia was charged with FGM after her 10-year old daughter was found to have suffered the procedure
- In 2013, a woman in Illinois was found guilty by a jury of aggravated battery and was sentenced to 10 years in prison for cutting her 13-month old daughter
- In 2004, a couple was charged with conspiring to violate the federal FGM law for agreeing to perform female genital mutilation at the bequest of an undercover FBI agent
- In 2017, a physician in Michigan was charged under a federal anti-FGM law for conducting the procedure on nine victims, some of which were transported from Minnesota and Illinois which had existing anti-FGM legislation with strong associated penalties. The district court judge presiding over the case ruled the federal anti-FGM statute to be unconstitutional in 2018.

* On January 5, 2021, the STOP FGM Act of 2020 was signed into law, successfully reaffirming the federal FGM ban.

U.S. STATES WITH THE HIGHEST NUMBER OF WOMEN AT RISK FOR FGM/C

Total number of women in the U.S. who have undergone or are at risk of FGM/C is estimated at up to 513,000. Approximately 60% of all women and girls at risk live in eight states.*

1. California (56,872)
2. New York (48,418)
3. Minnesota (44,293)
4. Texas (33,087)
5. Maryland (31,820)
6. New Jersey (31,023)
7. Virginia (30,830)
8. Washington (25,000) **no FGM statute*

Note: Total number estimated by the Centers for Disease Control and Prevention as of 2012. State-by-state breakdown is as of 2013 provided by the Population Reference Bureau

WHAT CAN WE DO?

Federal Law

- Include efforts to end FGM/C as part of the reauthorization of the Violence Against Women Act
- Advocate for resources to study prevalence of FGM/C in the U.S. and provide services and support to victims
- Advocate for increased investigation and prosecution of FGM/C at the federal level

State Law

- Advocate for the criminalization of FGM/C in states that do not currently have FGM laws
- Advocate for civil protections for girls who may be at risk of FGM/C
- Encourage lawmakers to strengthen existing FGM/C laws to criminalize taking a girl out of the state for the purpose of FGM/C and include community outreach and education provisions
- Advocate for increased investigation and prosecution of FGM/C at the state level

Awareness Raising

- Raise awareness in your community about the risk of FGM/C to girls in the U.S.

*“It is a matter
of principle that
women are free
and equal.”*

—Ayaan Hirsi Ali



WORKING WITH CLIENTS

Framework Element: **PREPARE**

Short Definition: During this foundational element, the conditions will be created for a substantive and successful engagement with the victim and/or affected communities and families. Whether in a moment of crisis or for a sustained relationship, the tools employed in preparation will inform subsequent framework elements and can set the tone for any continued work.

Longer Explanation: Allot the time for extended and multiple interactions.

Create a safe space for the victim. A safe space can be a formal or informal place where women and girls feel physically and emotionally safe and their wishes, choices, rights, and dignity are respected without fear of judgment or harm.

WORKING WITH CLIENTS

PREPARE

1. There are various factors that can extend the normal time to engage or interview a woman or girl at risk or affected by FGM.

1.1. Logistical

- Allow 50%- 75% additional time for language interpretation.
- Due to trauma, victims may tire and will need to take breaks. Allow for breaks every 60-90 minutes or when requested. It will be important to let the victim know that they can request breaks or regularly check to see if the victim needs a break.
- Allow time for the victim to get to know their surroundings. Give them a tour of the facility or the room; show them where the bathrooms are, etc.

1.2. Storytelling

- Allow for multiple visits (at least 2, ideally 3): Survivors may reveal their stories in increasing detail as they become more comfortable, similar to concentric circles. Because of the secrecy associated with the practice, survivors may wait to reveal specific details as they are assured a safe space and they gain trust in the professional.

WORKING WITH CLIENTS

PREPARE

2. Partner with culturally- and linguistically- specific organizations

2.1. Identify allies, ambivalents, and enablers

2.2. It will be important to learn the landscape of the community. Where are the elements of the community that are uncritical or unsympathetic to the practice? Where are those who might protect a child or potential victim? It is important to recognize while there are those who are sympathetic to the practice they may have other reasons for not believing that children should go through the practice.

2.2.1. Allies: Allies are those members of the community who are informed about FGM and its impact and have chosen to actively resist (whether publicly or privately) the practice, often at great risk to themselves.

- They may be survivors or not. They can be women, men, or children.
- Allies have taken a stand against the practice in places where it may be unpopular and are risking the negative consequences or response from members of the community.
- They are vocal about their position and often reach out to organizations and media to help them spread their message.

(CONTINUED)

WORKING WITH CLIENTS

PREPARE

2.2.2. Ambivalents: Ambivalents are those members of the community who have taken no public stand on the practice but may be in the process of changing their minds from the views of the practice that are most common in their community. They may not take a public stand, and will not actively advocate for the practice.

- Most often these are the majority of the members of an immigrant community.
- They are questioning the practice. They may wonder whether American-born children need to go through the practice or whether it is worth the financial cost to a family.
- Ambivalents will rarely take a public stand against the practice and may remain silent when witnessing preparations for the practice because they'd rather "mind their own business."

2.2.3. Enablers: Enablers are invested in FGM, believe the practice to be necessary and advocate for it to continue. They will work to facilitate FGM in their families and in their community.

- They can be savvy about how the practice is viewed in the United States and the laws and may not express their beliefs to outsiders.
- They may be unaware that the practice is illegal or may feel that their domain of their children is unquestionable.

(CONTINUED)

WORKING WITH CLIENTS

PREPARE

2.3. Identify translators and interpreters

2.3.1. When identifying possible translators, consider looking into universities that have advanced language programs, particularly for those languages that are 'rare.' This allows for a bit more objectivity and reduces the possibility of enmeshment in the community of note. Ideally, the translator should not come from the same community as the survivor. Make sure that if the translator comes from a community that does practice FGM, you check on her views on the practice to prevent exposing the survivor/victim to further risk which may happen if the translator supports the practice of FGM. Consider having translators sign confidentiality agreements.

2.3.2. Ideally in advance of the encounter with the survivors, it is vital to identify translators and interpreters who are allies. It can take time to determine whether the interpreter is an ally. Questions that help to identify allies include:

- What do you believe about FGM?
 - Does your family and/or community know how you feel about FGM?
 - Do you intend or have you or your children undergo the practice?
 - How have your beliefs about FGM evolved over time? What has informed that evolution?
- (CONTINUED)

WORKING WITH CLIENTS

PREPARE

- Whose responsibility is it to protect girls from FGM?
- What should happen to those who facilitate FGM in the United States?
- What would you do if your family wanted to have your daughter undergo the practice?
- If a friend told you that she wanted to defy her family and not have her daughter undergo the practice, what would you do?

This can be complicated for smaller and lower-incidence languages where there are few options for interpreters. However, where it is difficult you may be able to consult with the victim to identify someone they personally trust. It will be important to utilize the aforementioned questions with any person acting as a translator to assess their relationship to the issue.

2.4. Understand and mitigate the risk of the community-based organization partner: It may often appear that culturally and linguistically-specific organizations are ambivalent to the practice when they in fact may be weighing risks that their position against the practice would pose on other work that they may be doing in the community. Here are some factors they are considering:

- The ability of women and girls to utilize their services. If the organization is perceived as a threat to those most powerful in the community who defend FGM, women and girls may not be permitted or may be scared to access the organization for services beyond FGM.
- The reputation of the organization as a liaison between the community and the mainstream. If the organization is seen as taking a side, they may not be of service in other realms.

WORKING WITH CLIENTS

PREPARE

3. Do your research

3.1. Prior to engaging with a survivor, learn about where they are from, the role of women and children in their culture, the prevalence of FGM, religious frameworks, etc.

3.2. Important questions to answer and where you can find the answers:

3.2.1. Where is the individual, family, or community from?

- From the survivor: Ask not only which country, but also which region, community, ethnic, and religious group.
- Do they belong to an ethnic group that engages in the practice? To what degree? Have there been any changes in attitudes toward FGM in this community/ethnic group/region in the past decade? What strategies have been successful in fighting against FGM in this community/group/region?
 - This information can be found on the website of the World Health Organization (WHO): <http://www.who.int/mediacentre/factsheets/fs241/en/>

WORKING WITH CLIENTS

PREPARE

4. Contextualize: Despite doing research it will be important to check what you have learned against the migration experience of the communities you are engaging. Cultural practices are rarely translated directly to a new environment. Factors such as the size of the community, financial cost of having FGM performed, environment and space can impact how cultural practices are translated or continued. Here are some questions you can ask an ally that might help you understand how the practice is translated:

- How has your culture changed since coming to the United States?
- What is the purpose of FGM in your culture? This question will get at what the practice is rooted in (cleanliness, womanhood, solidarity, etc.)?
- What does it mean to the girl to not be cut?
- How might they be treated if they are not cut? Do some girls appear to choose to undergo the procedure in response to family or peer network pressure and in order to be considered a “woman?”
- What do you call a person who has not or has refused to undergo the practice?
- How is that person viewed in the community?
- How will that person be treated in the community?
- How will her family be treated in the community?
- Who makes the decision about when and who goes through FGM in the family?
- What if that person is not in the United States?
- What happens if a family cannot afford FGM?

WORKING WITH CLIENTS

Framework Element: **IDENTIFY BARRIERS**

Short Definition: In this most important element, you will identify and address the barriers that might limit the client/victim/survivor's participation in your efforts. This will be an ongoing part of your work and will require that you privilege and take seriously the concerns that the survivor may have as well as work to anticipate those they might not foresee. Survivor's perspectives should be respected and acknowledged as legitimate responses to the circumstances of the FGM/C experience.

Try to understand the prevalence of violence against women and girls in a particular community. So, for example, is violence or harm against women and girls an accepted fact in the given culture?

WORKING WITH CLIENTS

IDENTIFY BARRIERS

Longer Explanation: In this element, safety and belonging are central themes. Often, for the service provider, safety is prioritized over the survivor's need for belonging and doing what is seen as a mandatory and critical event within a person's culture. However, belonging and maintaining their cultural integrity is often the client/victim/survivor's priority as they may be in a new country and may have very little in the way of support. Thus, they face double alienation. Often service providers are more concerned for physical safety and are frustrated by the client/victim/survivor's seeming lack of attention to physical safety. It will be important to strike a balance between physical safety, and the client/victim/survivor's desire to not face alienation from their community. In this phase, your purpose is to determine and to address the stakes at hand for the client/victim/survivor.

What are the stakes?

1. For physical safety...

1.1. **Objective:** Learn who is a physical threat to the victim/ survivor. Use the following questions:

- What is the victim/survivor's relationship to this person?
- How much access does this person have to the victim/survivor?
- Is there a threat from someone else if that person does not get the victim/survivor to comply?

(CONTINUED)

WORKING WITH CLIENTS

IDENTIFY BARRIERS

- Assess the risk of that threat with the following questions:
- When were they last physically violent with her?
 - What type of physical violence was last enacted and is there legal documentation about any previous acts of violence?
 - What was the outcome of the last violent episode?
 - Have there been verbal threats?
 - How has the violence escalated over time?
 - Does the girl appear to “want” the procedure due to family or peer network pressure?
 - Has there been someone else in the family who has resisted FGM or any other harmful cultural practice? What happened to them?
 - Will she be at further risk if discovered she is discussing the FGM/C situation with a service provider or other source of support?

Plan.

- Is the threat of violence avoidable?
 - If so, how?
 - If not, where can she go? Is she willing to go?
- What authorities can be engaged in her protection?
- At what point should they be alerted?
- What tools are needed? (e.g. secret cell phones, an emergency overnight bag, migration documents)

WORKING WITH CLIENTS

IDENTIFY BARRIERS

2. For housing...

2.1. Objective: Learn about the threat to housing for the victim/ survivor. Use the following questions:

- Where is she staying?
- Under what conditions is she living?
- Who is living there?
- How much of the cost of living expenses is she responsible for?
- How does she pay these living expenses?
 - Assess the risk of that threat.
- What relationship do those she is living with have to FGM?
- Has she ever been homeless?
- When was her last housing crisis?
- How was the housing crisis resolved?
- Is she responsible for a child or another family member?
- Is her means for paying her living expenses contingent or dependent upon FGM enablers or threats to her safety?
- What other housing options does she have?
- What public housing options is she eligible for?
- Can these options be contacted and alerted in advance without alerting someone who may commit violence against her?
- In case of an emergency how would she escape?

WORKING WITH CLIENTS

IDENTIFY BARRIERS

3. For financial security...

3.1. Objective: Learn about her financial situation.

- How are her day-to-day needs met?
- What are her major expenses on a weekly, monthly or annual basis?
- If she doesn't have money to take care of herself, whom does she go to for support?
- Who is she responsible for caring for financially?
- Where are they?
- What is her relationship to them?
- What is the nature of that support?
- If she was suddenly unable to provide for them what would happen?
 - Assess the risk to her financial situation.
- Who is responsible for meeting her day-to-day needs?
- How is her employer connected to her community?
- Who does she have to consult if she wants to spend money?
 - What relationship does that person have to FGM?
- If she needed to leave suddenly, could she continue her work?

Plan.

- What savings can the victim/survivor generate in case she has to leave suddenly?
- Are there public programs that can meet some of her financial obligations?

WORKING WITH CLIENTS

IDENTIFY BARRIERS

4. For belonging...

4.1. Objective: Learn about her family and community life.

What is the composition of her family?

- Have her draw a family tree.
- Where do these family members live?
- Who are the most powerful members of her family?
- How does she define her community?
- If applicable, have her draw the geographic dimensions of that community.
- Who makes up this community?
- What institutions are most important in that community?
- Who are the most powerful members of that community?
- Who are the most important members of her family in her life?
- Who are the most important members of her community in her life?

Assess the risk to her family and community life:

- What happens to people who do not undergo FGM in her community?
- Can she give an example?

(CONTINUED)

WORKING WITH CLIENTS

IDENTIFY BARRIERS

- What happens to those who are seen as traitors or disloyal to the community?
- Can she give an example?
- Who does she believe will stand with her even if they disagree?

Plan.

- How much distance (physical or emotional) is she comfortable having from her family/community?
- In cases where she may have to leave, how can she let her family know that she is okay?
- Is there someone in the family or the community who would act as a mediator or liaison?

5. For residency...

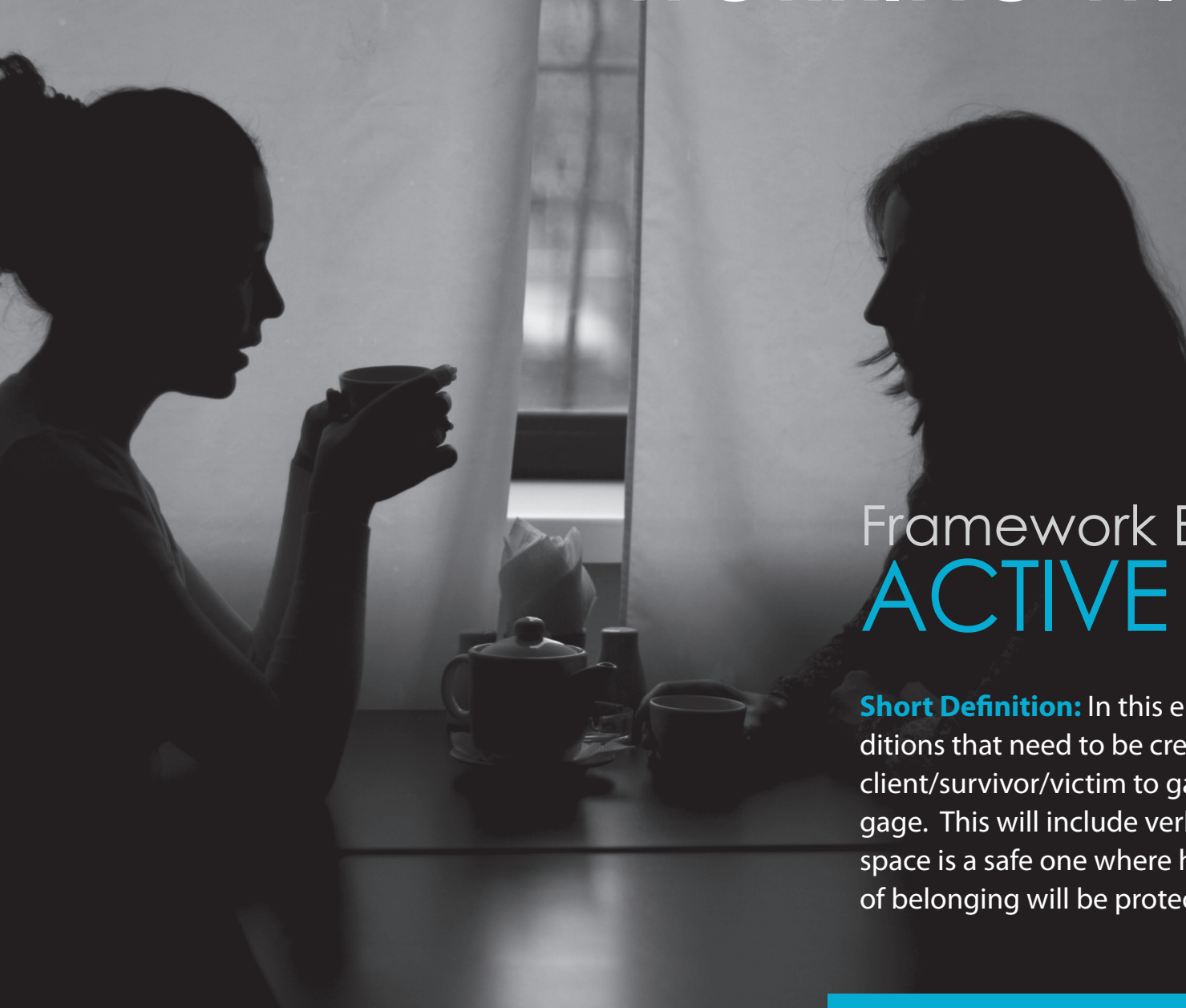
5.1. Objective: Learn about her residency status.

- Obtain copies of her residency documents to ensure that she actually knows her status.
- If the documents are unavailable, find out why.
- Who has the documents?
- Verify her identity and age on the documents.
 - Assess the immigration residency risk.
- If she is not a citizen or a green card holder, what immigration relief programs is she eligible for?

Plan.

- Seek out an affordable immigration attorney or program that can be available to her.

WORKING WITH CLIENTS



Framework Element: **ACTIVE LISTENING**

Short Definition: In this element, you will identify the conditions that need to be created and sustained to enable the client/survivor/victim to gain trust and feel comfortable to engage. This will include verbal and non-verbal signals that the space is a safe one where her vulnerability, safety, and sense of belonging will be protected.

WORKING WITH CLIENTS

ACTIVE LISTENING

Longer Explanation:

1. Strategically select the interviewer: There is no one perfect interviewer for all cases of FGM. However, each decision made about who interviews a client/victim/survivor may impact the pacing and the outcome of the interactions. It should not be assumed that attempting to match the exact identity characteristics would yield the best results. Sharing identities may also serve to trigger fear that their interviewer is not an ally.

1.1. Here are factors to consider when deciding who will interview a client/victim/survivor:

- **Gender:** In most cases a female interviewer is preferred. Because the interview may include discussion of intimate parts of the body, it is inappropriate in most cultures where FGM is practiced to discuss these issues with a man.
- **Age:** The importance of age will depend largely on the age of the client/victim/survivor. For younger clients/victims/survivors, it may be important to have an interviewer a bit younger than their parents to mitigate relationships of authority they may be accustomed to. However, this can be made less important if the person does not belong to their community or once a sense of trust has been established.
- **Race/ Ethnicity:** Choosing someone from the same race or ethnic group as the client/victim/survivor may serve to make her more comfortable or may serve to make her feel less willing to share based on a fear that her confidentiality will be breached. In smaller towns, it is important that the interviewer/translator is not from the exact same community or social circle as the victim.
- **Role:** Those in formal roles of authority (e.g. judges, police, attorneys, etc.) may present an additional power dynamic that will have to be overcome. Also, those who are older, male and of other races or ethnicities may appear more powerful through the eyes of the client/victim/survivor. Do not assume that the power dynamic is a negative one. For some survivors, power may communicate safety. Consider how
(CONTINUED)

WORKING WITH CLIENTS

ACTIVE LISTENING

positions of power may have been viewed or even feared in the home community. For example, survivors may have never considered law enforcement as a means of safety and support, so attention should be paid to building understanding of the law enforcement context in the given situation as well as ensuring that a service provider can be present or directly involved with the interview process that happens in a law enforcement context.

- **Class:** Although you may choose an interviewer from the same race, cultural, and/or ethnic group, class differences may also create a barrier to engagement.

2. Strategically select the location:

Locations can also communicate power and form a barrier to engagement. Where possible, identify a meeting place that meets the following characteristics:

- Quiet and without interruption
- Confidential
- Ability to move around
- Outside of a more formal setting and not in police stations, legal offices, or a place where the atmosphere may appear official or threatening

3. Open-ended and closed-ended questions:

While balance between open- and closed- ended questions will depend on the purposes of your interaction with the victim/survivor/person at risk, open-ended questions are preferred when gathering background and contextual information. In situations of cultural difference, it is preferable that she voices a description of her life, her community and her relationships to (CONTINUED)

WORKING WITH CLIENTS

ACTIVE LISTENING

FGM directly. Utilizing closed-ended questions too early on in the process may draw parameters around the conversation that may miss important details to the situation at hand. On the other hand, closed-ended questions are useful for clarification and to collect specific information needed to support the client.

3.1. Below are examples, of when closed- and open-ended questions are most appropriate:

3.1.3. Closed-ended questions

- Demographic information
- Clarifying questions
- Offering limited options
- Determining relationships and alliances
- Questions around safety

3.1.4. Open-ended questions

- Background information (e.g. where they are from, descriptions of family and other relationships, descriptions of living situations, etc.)
- Descriptions
- Contextual information
- Meaning
- Importance
- Impact
- Belief and opinion

3.2. You may also want to use a timeline, which could include when the girl or woman first learned about the ritual, when it took place, or symptoms of complications. Anything that builds a more cohesive narrative for investigating or understanding the details around an FGM case is worth noting in your timeline.

WORKING WITH CLIENTS

Framework Element: **INTERPRET**

Short Definition: In this element, you will learn the possible range of responses or reactions to the deeper probing of a practice that is taken for granted in their families and communities. This deeper probing can often lead to survivor/ person at risk feeling more vulnerable and isolated than before, thus creating dynamics and responses that may seem strange, resistant, or threatening.

Longer Explanation: Here, you will learn about the range of common manifestations of the following dynamics that often arise in addressing FGM with:



WORKING WITH CLIENTS

INTERPRET

1. Trauma

- Depending on the age of the client/victim/survivor and their distance from the time they underwent the practice, trauma may look different. Also, it is important to note that the trauma may not only stem from the actual procedure (which may have happened before she remembers) but may also stem from life milestones that the practice may impact such as marriage, the first menstrual cycle, the onset of any medical consequences, childbirth, the first sexual experience, the first gynecological exam, the first time the survivor realizes that the practice is a violation of human rights.
- Also, it is important to note that the process of migration adds an additional dimension to FGM. If they underwent the procedure abroad, women and girls are leaving a place in their home countries where their experience of FGM may be the norm to a place where the practice is abnormal. The response or the perceived response to the practice and their bodies by medical professionals, law enforcement, etc. can also retraumatize them and can create a barrier to engagement with services and support.

2. Ambivalence

- At the other end of the spectrum is ambivalence. While women and girls may have experienced negative consequences due to FGM, they may still find value in the practice and/or the meaning that the practice has for their families and community. This creates a tension that can appear as ambivalence.
- Or, while the women and girls may object to FGM and have experienced negative consequences, they may respond negatively to Western characterizations of their communities. It may be true that FGM may be the only time they have experienced any violence or abuse at the hand of their families or community members (CONTINUED)

WORKING WITH CLIENTS

INTERPRET

and are dealing with the dissonance at the descriptions of their communities as violent and abusive. Additionally, the harm and impact of FGM may not be recognized and identifying the specifics of that harm may be unwelcome or not immediately recognized.

3. Betrayal

- The realization that a cultural practice that she has undergone through the complicity and actions of her family and community can lead to feelings of betrayal and isolation. This may lead her to question if she is able to count on the most important relationships in her life. This is isolating and disorientating. Supporting the client/victim/survivor may mean brainstorming ways to sustain those otherwise important relationships and how they can come to heal those relationships while honoring the trauma that she has experienced.

4. Coercion

- Seeking support for her experience with FGM may be difficult due to the negative response from family and community members. These family and community members can explicitly threaten or passively try to deter her from seeking support and resources. During the interview process, it will be most important to uncover those relationships that may be coercive to the client/victim/survivor.
- It is also crucial that you ensure that your relationship is not coercive. While it may be frustrating to deal with the ambivalence and the decisions that she may make, it will be important that she knows that she has your support that goes beyond whether you agree or disagree with her decisions.

WORKING WITH CLIENTS

INTERPRET

5. Anger/Hostility

- It may seem obvious that she may experience anger at her family, community, and culture for subjecting her to FGM. This anger can be unsettling and while understandable it leaves the client/victim/survivor isolated and without other support systems in her life. Working to reestablish a system of support within their communities will have the best long-term impact.
- She may also experience anger/hostility at the service provider that may represent for her a constant reminder of what she has experienced especially when the practice is normalized in her community.
- If the women and girls come from cultures where expressing anger/hostility is not culturally acceptable, she may turn those feelings on herself. This may be manifested in self-harm, depression, and other mental health challenges.

6. Shame

- Seeking support or addressing the impact of FGM on their life forces questions of a very intimate nature. Having these questions asked in public multiple times can lead to feelings of shame. It can be difficult to normalize the discussion of such intimate issues in the public sphere.

A silhouette of a person, likely a woman, looking out a window. The person's hand is near their face, possibly resting their chin on it. The background is a bright, overcast sky seen through the window frame.

WORKING WITH CLIENTS

Framework Element: SAFETY PLAN

Short Definition: There are a variety of risks involved for immigrant women and girls seeking support to either prevent FGM or to deal with its consequences in their lives. While it is beyond the scope of this framework to offer safety planning training, we suggest that you engage law enforcement and social workers in the development of more localized safety resources.

Longer Explanation: What we include here are specific factors to take into account when developing a safety plan with regard to FGM. Again, as much as possible, we advise that these resources be identified, be trained and vetted in advance, to ensure they are readily available in high-risk situations.

WORKING WITH CLIENTS

SAFETY PLAN

1. To Stay or to Go?: It may be assumed that the safest place for client/victim/survivor is outside of the home. However, given cultural traditions that make it difficult for single women to leave the home, her departure might alert and trigger a response that may further limit her options or mobility. If there is a way to protect her and maintain her privacy while remaining at home, it should be seriously considered.

2. Tracking & Surveillance: Every attempt should be made to minimize the degree to which any hostile family or community members are able to track the movements and communications of the client/victim/survivor as she seeks support. Similar to domestic violence or anti-human trafficking interventions, a violent family or community member will utilize any tools at their disposal to track and control the movements of the client/victim/survivor.

3. Residency Status: From the very first encounter with the client/victim/survivor it will be important to gather documentation that may either support a prospective residency or asylum petition. Pay attention to situations where family or community members use the exposure of FGM/C in the community to confiscate documents or create obstacles to obtaining residency.

WORKING WITH CLIENTS

Framework Element: EDUCATE

Short Definition: It can seem that because a woman or girl has undergone FGM that they understand what has happened to them, what the practice means for their families and communities, what the practice means globally and what its impact is or will be on their lives moving forward. But that is often not the case. It may be surprising to the clients/victims/survivors that there are other girls outside of their communities that have undergone the practice, that there are girls within or outside of their communities that have not undergone the practice, and that the practice violates international norms. It will be important to utilize the encounters to educate the girls about the global practice of FGM and the dangers it presents, regardless of whether she has experienced any negative consequences.



WORKING WITH CLIENTS

EDUCATE

Longer Explanation: Below are important pieces of information to share with the client/victim/survivor. These forms of education are often best conducted in a group setting that enables open and honest discussion within the allotted time to ask and answer questions. However, these conversations can also occur over time and on an individual basis.

1. What is the practice?

This will include helping the client learn about the practice, its various forms, rationales, and locations in the world. This is important because it can help the survivor determine what has happened to her and help her feel part of a community of survivors.

2. What does it mean globally?:

This will include helping the client understand the leadership of women from countries where FGM is practiced and their role in bringing world attention to the practice and creating change. This will include also helping her understand existing international norms and how the practice violates those norms. It will also include a discussion on why the world deems this to be a harmful practice.

WORKING WITH CLIENTS

EDUCATE

3. What are the health risks?: While FGM is a dangerous and potentially fatal practice, many women and girls may never have any direct consequences that they can directly attribute to the practice. Notwithstanding, it is important for women and girls to understand the potential for harm and to alert them to risks they are still susceptible to that they may have never attributed to FGM. It might be useful to identify other types of health risks as an analogy that affect some but not all, such as smoking, drinking, or taking controlled substances.

4. What is trauma? How might it impact me?:

It will be important for them to know that the consequences of FGM are not only physical but may also be emotional and psychological. Helping her define trauma and to recognize its signs in her life or those of her loved ones is the first step helping her find the appropriate supports as she builds a life beyond FGM.

WORKING WITH CLIENTS

EDUCATE

5. Where can help be found?: As part of the preparation for this engagement, you should have identified resources such as counseling, medical care, and legal support that are sensitized to FGM and are aware how to best support survivors/victims. It will be important to walk her through accessing these services including the appropriate vocabulary, the limitations and possibilities of the support, and challenges she may face in accessing the resources. If she is worried about backlash from her family and community, it is important to identify services that can be used discreetly.

6. How can she get involved?: As survivors learn more about FGM they may be interested in opportunities to get involved in the fight against FGM. Their experiences are of central importance as it should also be what most informs any efforts to end FGM. Thus, it is important to identify opportunities for survivors/victims to organize and to take leadership in building awareness in their communities and preventing the continuation of the practice. Consider organizing a mentor program where women and girls affected by FGM/C can be linked to other women who have gone through the practice and can serve as confidantes and safe people for women and girls just acknowledging the harm done to them.



HYPOTHETICAL CASE STUDY 1

Safety Planning for Going Abroad

SETTING

Safirah is 12 years old and the eldest daughter of the [name] family from [country]. Every summer, Safirah and her 3 siblings travel to [country] to spend the summer with her family. Although Safirah, a U.S. citizen, is sometimes disappointed that she will miss summer at home, she enjoys the time with family and the space to play and hang out with her many cousins. In previous years, Safirah and her siblings traveled without their parents, but instead with an uncle who makes sure that they arrive safely to [country]. However, Safirah was excited to learn that her parents will travel with her this summer. Safirah also learned from her older 15-year-old cousin that she will undergo the same ceremony that her cousin experienced the previous summer. Safirah's cousin does not give her much in the way of details, but the little bit of information she provides is enough to scare Safirah and prompt her to share her concerns with a teacher, Mrs. Maldonado. Mrs. Maldonado wonders aloud if the practice that Safirah will undergo is female genital mutilation (FGM). Upon hearing this, Safirah conducts an Internet search and is terrified to learn what may be awaiting her during summer vacation, which is only two months away.

GOAL:

To prevent Safirah from being taken to [country] to undergo FGM



INTERVENTION QUESTIONS:

- What information needs to be gathered? Who should gather this information?
 - What professionals, institutions and systems need to be engaged?
How fast should they be engaged?
 - How might Safirah be engaged?
- How might Safirah's family be engaged to ascertain whether their plan is to have Safirah undergo FGM?
 - What role should the teacher play in supporting Safirah?
 - Who is leading the charge to have Safirah undergo FGM (e.g. mother, father, extended family, etc.)?



RESOLUTION:

- Immediately connect with child welfare in your jurisdiction. It may be fair to assume that child welfare may not have any familiarity with such cases, so it would also be important to encourage them to reach out to the U.S. State Department for guidance, as well as organizations like the AHA Foundation. Do not alert Safirah's family until these supports are in place.
- It will be important for child welfare to determine whether Safirah is considered a citizen in the family's country of origin.
- Law enforcement/child welfare should meet with Safirah's family (without Safirah) and begin an investigation once a plan for Safirah's safety has been put in place. This may mean the possibility of removal from the home for Safirah and her siblings, if the situation arises.
- Consider the possibility that any of Safirah's sisters are also potentially at risk of being forced to undergo the procedure.



RESOLUTION:

- CONTINUED -

- Law enforcement/child welfare should provide the family with an opportunity to respond positively by informing them of the laws and prohibitions against the practice in the U.S. and for their U.S. citizen daughter. This conversation should also be conducted with concrete “asks” from the family, such as confiscating Safirah’s travel documents, alerting the U.S. consulate in [country], and an explanation of the consequences for the family should it be discovered that Safirah has undergone FGM.
- Child welfare and law enforcement should ascertain who might be allies in the family or community. Safirah may not be reliable in gathering information given her age and lack of familiarity with the practice.
- Child welfare should engage the family for the long term. This may include family counseling, monitoring of travel, support with finding childcare for the summers (as this may be why the children are sent abroad), regularly checking in with the family to ensure they are not considering carrying out the procedure in the U.S. instead, and supporting the family in dealing with any community fallout from Safirah not undergoing the practice.



VARIATIONS:

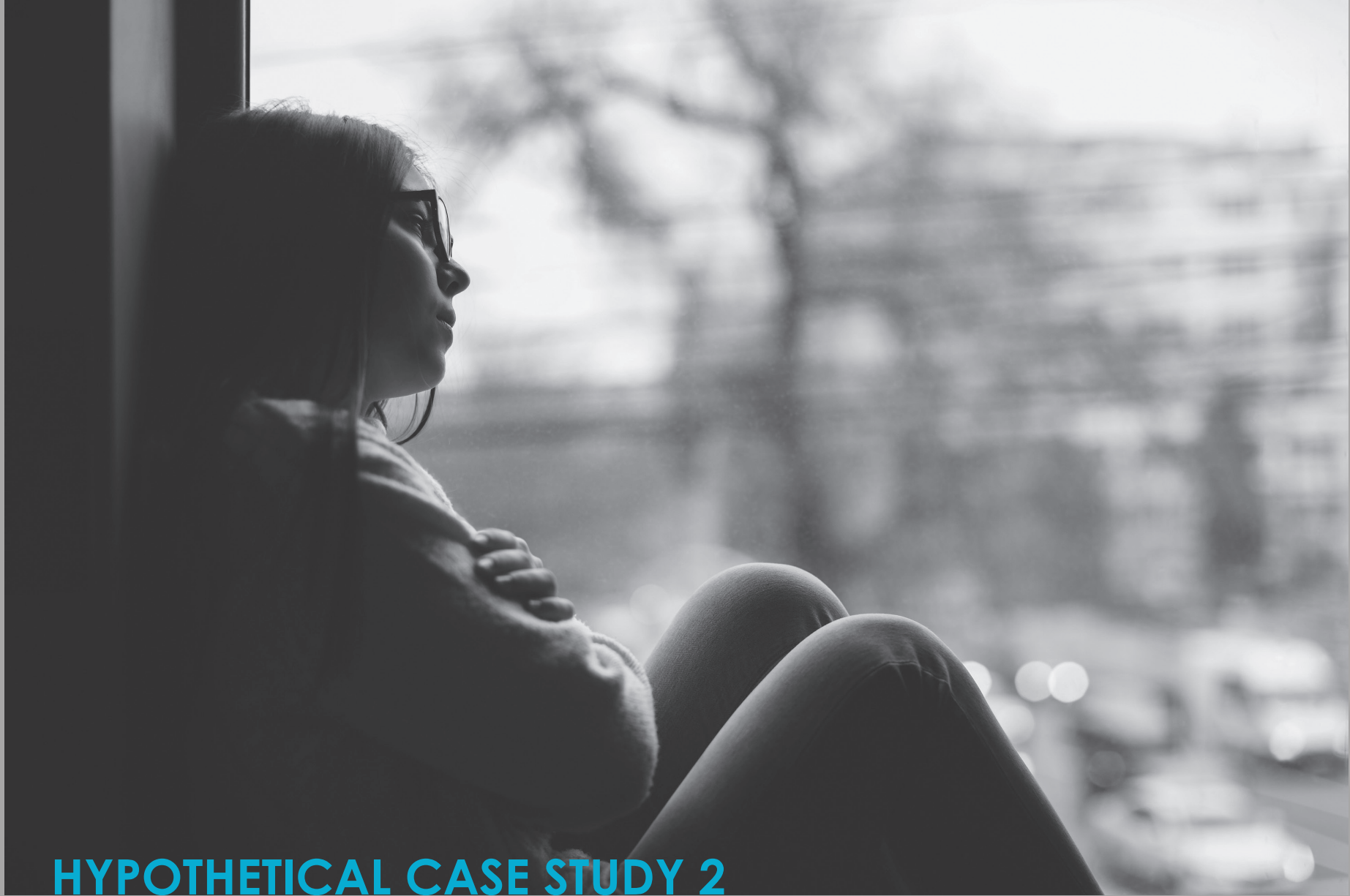
What if Safirah is expected to leave in one week?

This variation heightens the danger for Safirah. It will be particularly important to disrupt the family's travel plans. This will mean alerting authorities in child welfare, law enforcement, and at the consulate of the destination country, if possible. Measures should be taken to try to ensure that Safirah does not leave the country, since it will be much harder for authorities to act abroad. Advise Safirah that should her family take her to the airport and she is unable to notify authorities in advance, she should place a spoon or some metal object in her clothing that will trigger a private screening at the airport so she can inform authorities that she is traveling against her will.

What if Safirah is not a U.S. citizen?

This variation should not limit what can be done for Safirah while she is in the U.S., however it may limit the ability to keep her in the U.S. and to protect her if she leaves the country.





HYPOTHETICAL CASE STUDY 2

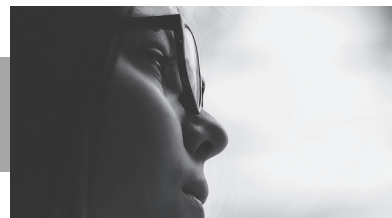
Teenager Dealing with Health Care

SETTING

Nafiza is 19 years old and underwent FGM in her birth country of [country] when she was a young child. She came to the U.S. when she was 13 years old. For as long as Nafiza can remember, she has experienced blood and pain when she urinates. Often the pain and the bleeding are so bad that she cannot attend school. Before she traveled to the U.S. her family paid for a “corrective” procedure at the hands of the same woman who conducted the initial FGM. The procedure did not help and in fact made the pain worse. She was afraid to tell her parents because they had spent so much money to correct what was done wrong the first time. She could not bear to see them sacrifice again simply because she was in pain. One day at school the pain was so severe that she could not walk or stand up straight. She heard about a teen health clinic that she could go to without her parents finding out. Nafiza went to the clinic for help.

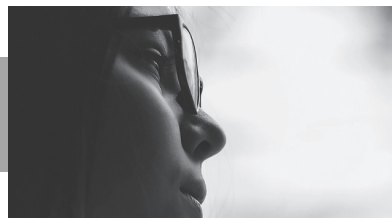
GOAL:

To ensure the best medical care for Nafiza



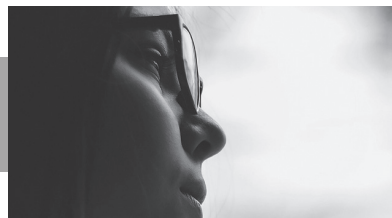
QUESTIONS:

- What information needs to be collected before an examination of Nafiza?
- What cultural sensitivities should the health care provider be aware of before the examination?
- What support systems might be available to help Nafiza understand what has happened to her?
 - How can the relationship between Nafiza and her family be supported?
 - What exactly are the medical conditions that Nafiza is experiencing and what might be the long-term consequences?
 - What options are available to relieve Nafiza's pain?
 - What trauma has Nafiza undergone related to FGM?
- How might Nafiza's family feel about her disclosure to medical providers?
 - How can Nafiza maintain privacy from those who might not be allies or might negatively judge medical intervention?



RESOLUTION:

- Gather as much information as possible from Nafiza about her symptoms and then compare that to the likely ways that FGM is practiced in her home country.
- If the health care provider is not familiar with FGM, consider having them contact organizations like the AHA Foundation for more information, including finding a doctor to consult who has experience in working with FGM survivors.
- Assure Nafiza that her family will not face legal consequences for their participation in FGM. If Nafiza plans to tell her family she is seeking help, it may also be necessary to explain this to her family. Optimally, Nafiza could count on parental support. Work with her to assess the possibility of talking with her parents.
- There may be some education that Nafiza will need about her reproductive system as well as the way FGM is practiced in her community. Ensuring that Nafiza has access to counseling and support services will be vital.
- Ensure that the medical provider and health insurance company are in early and regular communication regarding any medical procedures that Nafiza needs to undergo. This can often be a long process and doing so can make sure that she is not given unrealistic expectations.





HYPOTHETICAL CASE STUDY 3

Mother Resisting the Practice

SETTING

Talanza is 23-year-old woman from [country]. Talanza came to the U.S. with her parents and four siblings during civil conflict in her country when she was 14 years old. Her family are refugees. As her family fled their country, Talanza became pregnant as a result of a rape in the refugee camp. To cover the shame of the rape, her parents have been raising her U.S.-born daughter as their own. Talanza signed over parental rights to her parents and, for the intents and purposes of the community, her daughter is her sister. Talanza's parents are planning to send the now 8-year-old child "home" with a family member, and Talanza is sure they plan to subject the girl to FGM. Talanza's family attributes her rape to the fact that she was not cut. Talanza has attempted to report her suspicions to the agency that resettled her family, although they are no longer working with the family.

GOAL:

To prevent Talanza's daughter from undergoing FGM



QUESTIONS:

- In actuality, what rights does Talanza have to her child?
 - Does Talanza feel equipped to parent her child?
What services might she need if she chooses to do so?
- How is Talanza dealing with trauma from her sexual assault?
- Who is leading the effort to have Talanza's daughter undergo FGM?
 - How far has the family gone in their planning?

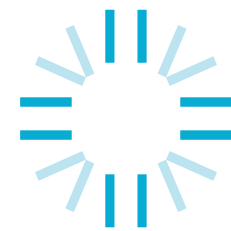


RESOLUTION:

- **Immediately** engage child welfare. It may be fair to assume that child welfare may not have any familiarity with such cases so it would also be important to reach out to the U.S. State Department for guidance, as well as organizations like the AHA Foundation. It will be important that Talanza's parents **are not alerted** until these supports are in place.
- Ensure comprehensive support services for Talanza and the child.
- Learn what Talanza's rights are with regard to her child.
- Ascertain what Talanza wants.
- Plan for the safety of Talanza and her child given her history of violence and trauma. This may mean the possibility of removal from the home for Talanza and her daughter.



T H A N K Y O U



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