SERC
SEXUALITY EDUCATION RESOURCE CENTRE MB

Working with Women and Girls Who Have Experienced Female Genital Cutting (FGC)

A Culturally Sensitive Approach

Introduction

Female Genital Cutting (FGC) is an ancient practice dating back to 500 BC. It is traditionally practised in some parts of Africa as well as in the middle East and Asia. Because of migration, the tradition of FGC is sometimes practised in Europe and North America, as well. While female genital cutting may not necessarily be seen as a problem by those who practise it, it is illegal in most countries of the world, including Canada.

Its significance and the reasons for its continuation are complex and often difficult to understand from our position outside the culture. This presents service providers with significant challenges when working with women who have experienced FGC.

The Sexuality Education Resource Center (SERC) does not support the practice of female genital cutting. However, we believe that cultural change takes time and requires an approach that includes building trust with women from FGC practising communities and focuses on education rather than punitive legal measures. We also believe that women who have experienced FGC have the right to receive respectful care and services. This document has been developed as a way of providing information to service providers and others to assist in dealing with this very complex legal, medical, and social issue in a culturally sensitive manner.

Terminology

Terminology is significant because it either builds trust and connection or acts as a barrier to effective service provision by alienating the patient/client and creating mistrust. One of the difficulties in deciding which terms to use is our tendency to understand the meaning of words from our own cultural perspective and understanding. As well, words from one language do not always translate well into another because the cultural "meaning" behind the word cannot be conveyed accurately. In fact, there may not be a word in one language to describe a concept that exists and is easily understood by the speakers of another language.

Throughout SERC documents we use the term Female Genital Cutting (FGC). Our need for respectful terminology that is also responsible from a medical and legal perspective led the agency to a thorough examination of the current terminology.
Since 1991 when the WHO recommended the use of the term Female Genital Mutilation (FGM) to the United Nations, it has become the dominant term in medical literature, legal language and world-wide policies on the practice. Female genital mutilation is also the term that is widely used by anti-FGC campaigns. However, it should be noted that many anti-FGC activists in Africa claim that adopting the term female genital mutilation resulted from giving in to pressure from colonizers and Western feminists.

While SERC acknowledges that FGC is a traditional practice that violates the human rights of young girls, we also believe that finding a more respectful way to describe the procedure is a necessary part of working *with* communities toward changing beliefs and ending the practice. SERC has made the decision to use the term Female Genital Cutting (FGC) because we want to use language that is not offensive or hurtful to the women who have experienced it. More importantly, the term female genital cutting acknowledges that not all forms of FGC lead to mutilation of the genitals and that mutilation is not the intent of the action.

Ideally, service providers will use the language that is most acceptable to the women with whom they are working. "Circumcision" is the English word that many communities use to describe the practice in their cultures. Note that it is used to describe the practice for both males and females. Many health professionals argue that it is not accurate because the word circumcision implies "circular" removal of tissue making it an inappropriate term to be used with women. What makes it appropriate is that many women, themselves, use and understand the term in a way that is meaningful to them. If the term circumcision is too problematic, we suggest using "cutting" as the alternative.

Within cultures where FGC is practised, it is referred to by terminology that differs from group to group and language to language. There are also a variety of traditional meanings associated with the practice. Some women will refer to *sunna* which incorporates the cultural belief that the genital cutting is something morally good or virtuous. A word commonly used for FGC in Arabic-speaking countries, tahur or tahara, means "purification" - cleanliness achieved through a ritual activity. Other women describe the type of cut i.e. referring to "cutting a little bit"; "cutting more/a large cut" or "being closed". We have found that the categories of FGC as defined by the World Health Organization (see next section) hold little meaning to the women in most communities.

The Canadian Council of Muslim Women uses the term female genital cutting/mutilation (FGC/M) to respect the opinions of women who have experienced the procedure as well as to show strong opposition to this practice. See: Canadian Council of Muslim Women: Position Statement: FGC/ M The Society for Obstetricians and Gynaecologists of Canada have also chosen to use the term Female Genital Cutting because "it is considered medically correct, netural, and culturally sensitive." (*FGC Clinical Practice Guidelines*, 2013) Other terms in use are female genital surgeries, female genital alternation, female genital excision, and female genital modification.

Please note that the World Health Organization publication *Management of Pregnancy, Childbirth and the Postpartum Period In the Presence of Female Genital Mutilation* states that

the terms 'deinfibulation' for the procedure that opens up the infibulated genitals to facilitate childbirth and 'reinfibulation' for the subsequent restitching are "thought to be inappropriate as they may be construed by the general public as endorsing the practice." The Technical Consultation who wrote the report recommends the use of the terms 'opening up' and 'repair or reconstruction' as suitable replacements.

In the contexts of patient/client-centered care and harm reduction, it is important to consider carefully the terminology we use with women who have experienced FGC. This is an important discussion to have within your organization.

World Health Organization Categories

According to the WHO categorization, FGM constitutes all procedures which involve partial or total removal of the external female genitalia, or other injury to the female genital organs whether for cultural or any other non-therapeutic reasons.

In order to facilitate information collection, professional communication, and unified criteria for research the World Health Organization established a standardized definition of female genital mutilation (FGM) and a classification of types. (WHO | Classification of female genital mutilation)

The topic of female circumcision often generates discussion that focuses on Type III - infibulation and its possible health consequences as if it is the only type of female genital cutting that is practised. In reality, around the world only 15 - 20 % of female circumcision can be classified as Type III - infibulation. (World Health Organization) Because of the difficulties around classifying this traditional practice, some researchers place the incidence of infibulation as low as 10%. The percentages are not the important issue. What is important is being careful not to frame our discussions regarding FGC as if it is synonymous with infibulation.

Classification of FGM

Type I Excision of the prepuce with or without excision of part or all of the clitoris (clitoridectomy).

Type II Excision of the prepuce and clitoris together with partial or total excision of the labia minora.

Type III Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation.)

To see diagrams of Types I - III: File:FGC Types.jpg - Wikimedia Commons

Type IV Unclassified

- Pricking, piercing or incision of clitoris and/or labia
- Stretching of clitoris and/or labia
- Cauterization by burning of the clitoris and surrounding tissues
- Scraping (angurya cuts) of the vaginal orifice or cutting (gishiri cuts) of the vagina

- Introduction of corrosive substances into the vagina to cause bleeding, or of herbs into the vagina with the aim of tightening or narrowing the vagina
- Any other procedure which falls under the definition of FGM given above.

Note: WHO recognizes that some practices that are legally accepted in many countries and not considered to be female genital mutilation actually fall under the above definition. However, WHO prefers to keep the definition of FGM broad "in order to avoid the loopholes that might allow the practice to continue." (*WHO Eliminating FGM: an interagency statement*, 2008)

Cultural Sensitivity

We know that effective service delivery incorporates responsible and genuine sensitivity to all clients. Providing respectful care becomes more challenging when our client's cultural background differs from our own and what we are familiar with in our everyday work. However, the responsibility lies with us, as service providers, to look for places where we can connect with a client as opposed to focusing on cultural differences and "othering" her. We must also remember that scientific and medical knowledge is culturally bound and this influences what we know to be true.

There are numerous terms related to the many stages of working with cultural diversity. Addressing a topic like female genital cutting entails more than *cultural awareness*. Working across cultures requires a competence in working with difference. Skills and knowledge are important but lose their effectiveness if service providers are unaware of their own misconceptions and the impact these can have on their clients.

Cultural competence is a process that involves exploring culture – our own personal and professional culture as well as our client's culture. We engage in an examination of our personal biases and how they might influence our interaction with a client. It also involves examining how culture has impacted our personal attitudes and professional beliefs. We need to ask ourselves: *What are my 'gut' reactions? Where do they come from?* We need to acknowledge the many social and emotional issues that may arise for both ourselves and for the women with whom we are working regarding an issue like female genital cutting.

It is important to remember that all cultures, including Canadian culture, have practices and beliefs that are harmful, to a greater or lesser degree. Although it may feel uncomfortable to question our own cultural beliefs, an important part of working toward providing culturally sensitive services is challenging ethnocentrism - i.e. our way is the correct way. We need to consider where our cultural beliefs come from and why we defend them. When and how do they change?

> "[The] acknowledgement that western countries have also developed ways of abusing women, of violating their rights, and of exercising power over them, forced western women to recognize the universality of the oppression of women and allowed for a more culturally-sensitive approach to FGM."
>
> From: *Feminist Leadership and Female Genital Mutilation in Canada: A Community Health Centre's Advocacy and FGM Eradication Efforts* - by Wangari Esther Tharao and Linda Cornwall

What assumptions or stereotypes are we making when we use our own lens on an issue like personal rights to interact with our client/patient and her family? Can we set aside beliefs about, for example, patient autonomy as it relates to making medical decisions if consulting with her husband or other family elders is what makes the patient most comfortable (and no laws are being broken)?

Cultural competence involves applying these insights to our interactions with clients or patients in order to provide the best possible services. When a woman has a negative experience, it is often shared with other women and stories travel quickly through the community. We work against our own goals if we don't take the time to ensure that our interactions make sense to our client. One simple thing we can do is ask ourselves: *"How does this woman see it?"* The client's beliefs guide her needs as well as her actions. At the same time, we need to acknowledge that it can be challenging to respect choices that we don't understand or with which we don't agree.

Cultural safety is only possible when we are making every effort to understand the underlying complexities of the cultural beliefs of our client and the cultural context in which she now lives. We need to think about what we can do to help create connection and build trust. The ultimate goal is to provide a safe place for our client to share her concerns and ask questions - a necessary pre-requisite to having conversations about change with regard to beliefs about repair of an infibulation or circumcising a daughter.

Cultural safety is also an essential consideration for teachers who may need to deal with questions regarding female circumcision in the classroom. We have been told stories of assignments being given as part of studying various cultures and cultural practices. Depending on the age and sophistication of the students' research, these assignments can result in a very stereotyped, ethnocentric and culturally insensitive approach to the topic. The concern is that such an assignment could lead to stigmatizing and/or bullying of students and families who are from an FGC practising country. As a teacher it is imperative that you be able to speak to the complexity of the topic.

Cultural Beliefs About FGC

There is no consensus or clear understanding of where or why the practice of female genital cutting began. It predates Islam, Judaism and Christianity. While male circumcision is a commandment under both Judaism and Islam, female circumcision is not required or supported by any major religion. In fact, today we see many religious leaders at the forefront of anti-FGC campaigns or discussing the issues within their religious communities.

People often ask: "Why is female circumcision against the law in Canada, but male circumcision is allowed?" Culturally, people from FGC practising countries often perceive the intent of these practices as similar. FGC may be closely tied to a woman's cultural identity; not being circumcised puts a girl/woman at risk of being ostracized by her community.

In recent years symbolic cutting has been suggested as a way of eliminating the harm associated with FGC. Medical practitioners from countries around the world have suggested an

anaesthetized pricking of the clitoris with no removal of tissue as a replacement for all forms of female circumcision, including infibulation. While immigrant communities have often been supportive, these efforts have consistently been blocked by anti-FGM activists arguing that consent issues and anti-FGM legislation in most countries would prohibit this. The obvious question then is: Why do we still allow physicians to perform male circumcision, removing healthy genital tissue in a medically unnecessary procedure?

Male circumcision has also been performed as part of maintaining a cultural, religious, or even family identity - circumcising sons so they will 'look like their fathers'. Many North American men have been circumcised as infants and it is a procedure that was very much considered the norm as recently as the 1970's.

The debate continues as there is new research that medically supports male circumcision as a means of preventing or reducing HIV infection. On the other hand, there are individuals and organizations in North America who challenge the beliefs and research that support male circumcision, even for religious and cultural reasons. Many of the arguments surrounding the ending of male circumcision are similar to those put forward in anti-FGC campaigns, including less sexual sensitivity. For further information on this issue see: Ten Reasons Not to Circumcise | Intact America.

So we see that belief systems are complex and not easy to change. The beliefs regarding why female genital cutting is important are as diverse as the communities that practice it. As well, different groups practice different forms of FGC. Women from one community may judge another community's way of circumcising as lesser e.g. the other group doesn't do it "the proper way" and there likely will be long term consequences regarding the girl and her behaviour.

The most frequent reason given for circumcising a daughter is to ensure that her behaviour will be that of an honourable woman, ensuring her virginity and marriageability. Many parents still regard virginity (particularly for the girl) as necessary for marriage. No man will want to marry her otherwise, so the mother is fulfilling her role as a responsible parent.

> *The mothers do circumcision because the girl will be given bad name if she is not circumcised. She will not be married too.*

There is also a belief in many cultures that FGC prevents rape, so FGC is seen as a way to protect the girl. Mothers may wonder why they are being criticized so harshly for loving and trying to protect their daughters and ask what they can do instead.

Men may say that they cannot control what the women do to their daughters or that it is not men's business. They may also feel that their honour or family name is at stake if a daughter is not circumcised.

> *Women want the practice because they know it is acceptable in the community and if it doesn't happen the girl will be given names and considered different from others.*

Some men express concern over losing control of their teenage daughters. FGC is thought to reduce a girl's/woman's interest in sex so she will also make a good wife - one who is not interested in looking for sex outside her marriage.

> *To control women's sexuality so that she will be loyal to her partner or sexually less active than her husband.*

Although FGC is usually considered a women-led practice, these opinions and the expectations on mothers to properly fulfill their role put men at the centre of the debate. Women say that their husbands are the first to berate them if an uncircumcised daughter misbehaves - circumcision is believed to 'calm' a girl so she behaves according to the culture.

Another perceived benefit of female circumcision in some groups is that a "tight vagina" can enhance men's sexual enjoyment. However, some men have said that a negative of FGC is that "*her body is so tight and [this] causes pain. This affects the psychology of the man in return. He will worry and not relax when thinking about sex*." Some men see an advantage for their marriage relationship when the woman is not circumcised.

> *The girl who is uncircumcised is preferred by men because she is sexually active and compatible with the man. She takes initiative to have sex and be responsive during sex.*

As indicated in the following quote, FGC may also be considered one of the many diverse practices in which women all over the world engage to enhance their female beauty - make them sexually attractive to men. We can explore our own feelings about the range of practices and beliefs regarding enhancement of the female body i.e. traditional practices vs 'modern' options like breast implants or female genital cosmetic surgery which have become normalized in many cultures, including our own.

> *The genitalia will become beautiful.*
>
> - quotes from Our Selves, Our Daughters community-based research

Understand that some members of the community will be ready to change their thinking - or may have already done so. While a typical view is that FGC is part of patriarchy that involves violence against women it is important to say that, today, many men are seen at the forefront of the debate to end the practice.

Those people who are firm in their beliefs or reluctant to change may still fear the moral and/or sexual consequences of a girl/woman not being circumcised. These are likely grounded in powerful emotions and ideas about cultural identity or family honour.

Anti-FGC campaigns may also be seen by some as an attempt by Western colonizers to take over the culture. Some people campaign in favour of continuing the practice as an act of resistance against colonizing forces.

Working With Women

Women who have experienced female genital cutting now live all over the world. Experiences will vary from woman to woman depending on their individual background with regard to race, cultural background, religion, gender identity, socio-economic background, education, and sexual orientation. While it is helpful to know the cultural background of the groups that are most likely to practice FGC, it is important to remember that not all women from those countries or cultural groups will have been circumcised. As well, of those who have experienced FGC, not all of them will have suffered negative outcomes. We need to make sure that we don't stereotype or make assumptions about our client/patient based on articles or books written from one person's perspective.

It is important to learn as much as you can about the *context* of your client's life before and after arriving in Canada. For example, the experience of refugees differs from that of immigrants. While an immigrant makes a conscious decision to resettle elsewhere (usually with family), a refugee often leaves her home suddenly under extreme circumstances. She is often separated from at least part of her family and may have experienced significant personal trauma.

A woman's social environment in Canada also needs to be considered as a critical determinant of her overall health. She will likely be missing her cultural and family support systems related to housing and child rearing. While living in Canada, an immigrant/refugee woman may also face obstacles due to racism, language difficulties, gender discrimination, and lack of employment. There are also economic consequences if racism and/or Islamaphobia contribute to difficulties finding a job.

The outward representation of a woman's religious background (e.g. hijab) becomes a symbol that can isolate her because of recent world events. A story that has been shared tells of two Muslim women attending an education session who knew each other from their home country. They did not even realize they lived on the same street because neither left her apartment unaccompanied. If a woman has experienced discrimination because of her religion or cultural beliefs encourage her to find connections within her community. These can help her find support and help her build on the resilience that has gotten her to Canada.

A woman's experience of FGC and how her body works occurs within her own cultural context. This can be a context of cultural celebration or at least an experience of cultural validation. In the Canadian context her culture is being labeled "barbaric" and we must consider the impact this has on her overall well-being.

Following is a checklist of related concepts to consider when working with women from countries where FGC may be practised:

- Although your client may be from a community where FGC is commonly practised she, herself, may not be circumcised.

- A woman's experience of having been "cut" is only one event in her life, which may or

may not be affecting her currently. Newcomers to Canada are sometimes confused by the media and government attention that has been placed on traditional practices like FGC, while so little attention is paid to their other experiences of poverty, war, racism and resettlement in a new country.

- There may be positive emotions associated with a woman's circumcision. For example: cultural pride - identifying with other women in her culture, feeling beautiful and desirable to men, positive memories of a cultural celebration, or a belief in her own virtue as a woman.

- Women who experience the most severe health problems and psychologically damaging effects are usually those that have experienced infibulation. It is important to remember that infibulation constitutes only about 15 - 20% of all circumcised women. Remember not to look at a girl/woman from a community that practices FGC only in the context of female genital cutting. If she is experiencing psychological difficulties or a health issue, don't make assumptions. They may not be related in any way to having been circumcised.

- Remember not to "other" your client - validate her experiences and questions. Remember that she has the right to decide what is important to her.

- Who are the decision-makers in this woman's family? "In some cultures, it is usual for a husband to give consent before his wife undergoes any form of treatment or investigation. In such situations, there may be a need to involve husbands or other relevant family members in pre-examination discussions." (*WHO Technical Consultation*, 1997). We need to guard against stereotyping and be prepared to soften our bias regarding a woman's autonomy as it relates to decision-making

- Service providers often wonder how to begin the conversation about FGC. Rather than asking "Are you circumcised?" you can say "*I know that some of the women in your community are circumcised (some are not). Circumcision can cause health problems for some women. Have you heard about this? If you want information ....*"

Additional practices for providing optimal care to women can be found in the SOGC Clinical Practice Guidelines regarding Female Genital Cutting:
http://sogc.org/wp-content/uploads/2013/10/gui299CPG1311E.pdf

Health Issues

Some women who have experienced FGC will have no or very few long term health consequences. For other women, FGC will result in a range of health consequences or some degree of emotional trauma and it is our responsibility as service providers not to "re-traumatize" these women through our reactions, judgments or comments. We need to remember to think of a woman's health from a holistic perspective; not just focusing on her body but paying attention to her feelings, her mind, and the spiritual aspects of her life.

While the 'gendered' practice of FGC *may* contribute to negative health outcomes for women, the health system with its inequities and gendered biases is also a significant determinant of health for women who have experienced FGC and are now living in Canada. We heard from the women and community leaders that systemic barriers (language barriers, hours of operation, weather, transportation etc.) make it difficult to for women to access services. Some women affected by FGC perceive Canadian doctors as unapproachable. They also worry about the competence of health care professionals to deal with FGC related health issues. This causes many women to keep medical problems hidden rather than access services that may stigmatize them. Unfortunately, it is not uncommon to hear of infibulated women being seen by health care providers who were not at all informed about FGC and appeared shocked. Inappropriate questions or behaviour, such as calling in other nurses or doctors to look at a woman's genitals, can only be considered disrespectful.

> *Once women are aware that they are "different" and that the Canadian system may not know how to deliver appropriate care, they are likely to feel stigmatized and far less likely to access care when needed (e.g. for pregnancy and childbirth care)* (Chalmers & Omer-Hashi, 2002).

Positive stories that we have heard from women confirm the importance of culturally sensitive attitudes on the part of service providers. It is important to remember that every discussion with a healthcare or other service provider impacts whether or not a woman accesses services or keeps future appointments. For example, a pregnant woman will continue to access care during her pregnancy and the postpartum period if she can trust the people providing care. However, if we disregard cultural beliefs and practices, our suggestions will be seen as useless advice.

As with any procedure that alters the physical body, there *may* be long term health consequences that can appear at any age. However, it is important not to assume that a woman's physical or psychological health issues are directly related to her circumcision. Some researchers suggest that the link between negative health outcomes and FGC has been exaggerated or politically biased. As well, the discussion often discounts the impact of other aspects of women's experiences in their home countries such as poverty, lack of clean water, political conflict/war, lack of medical care and barriers to accessing what does exist.

Long term health consequences are most likely to occur in a woman who has been infibulated (WHO-Type III). However, what was intended to be a less invasive or Type II circumcision can end up healing (with scarring and obstruction) similar to infibulation. Possible health consequences include difficulties with menstruation, recurrent urinary tract infections, pelvic inflammatory disease, infertility, scarring/hardening of the perineal tissue, painful intercourse, difficult/complicated childbirth, fistula, epidermal cyst and possible psychological trauma. However, the frequency and severity of these issues have not been studied in any depth. See: WHO | Health complications of female genital mutilation

Many of these health difficulties are not related to female genital cutting only. It would be difficult to assess whether or not a given woman would have experienced some of the same health problems had she not been circumcised. For example, some women have more frequent vaginal yeast infections after coming to Canada likely related to the stresses they live with and

the fact that the food they can typically afford contains more sugar than what they are used to eating.

Through our work with women we have also learned that many of them do not connect their health concerns with circumcision, even when there is a direct correlation. Many assume that pain and/or recurrent health conditions, for example the symptoms of vaginal or urinary tract infections, are just a normal part of being a woman.

Women in Canada take for granted that we can access a walk-in doctor or over-the-counter medication to treat common problems like vaginal infections. Remember that many women in the world have to walk/travel for many hours or even days to access medical care. As well, we need to remind ourselves that how we all experience our health and well-being is largely a result of cultural upbringing and the cultural norms we unconsciously assume to be valid.

It is important to be aware of the long term health issues experienced by women regardless of their background or the cause. Ask questions in a spirit of learning about your client and re-consider how you ask the questions. For example, during a discussion about flow of urine in one of the women's education sessions it became clear that "normal" is determined by what happens among the people we know about i.e. family and friends with whom we might discuss a health issue. Using terms like *abnormal* or *excessive* may not provide you, the service provider, with the information you are seeking. Using this example, talk about anatomy & physiology, then allow discussion about whether the flow of urine is "fast" or "slow/not flowing well" and finally include some information about FGC and how urination may be affected. Discuss these as situations some women notice.

Offer information on how a woman's body works as well as the possible causes for problems that women <u>everywhere</u> commonly experience (e.g. vaginal infections, urinary tract infections). Provide information and explore possible solutions with your client. This requires making the time for non-judgmental discussion and answering questions.

<u>Sexual and Reproductive Health</u>:

Women may not be aware of the availability of preventive health care in the form of regular medical check-ups and Pap testing. We have been told that in the home country many people do not access health care unless there is a serious medical problem. There may be a fear of hospitals and clinics because of a belief that hospitals are "where people go to die". This perception stems from the fact that accessing health care is not a simple matter - the distance to travel and the associated costs are prohibitive so people often don't go until it is too late for treatment.

Women will also need information about their rights as a patient - possibly another unfamiliar concept. In many cultures a doctor is held in high esteem and not questioned. Advise women that they have the right to bring someone into the examining room with them. Health care providers should explain any procedures and advise of practices that can minimize pain and discomfort, especially if the woman has experienced infibulation. <u>Explain to her that if something causes pain, it is culturally acceptable to tell the physician.</u> As well, it may be necessary to use additional lubricant and/or a pediatric speculum.

It is important to explain all options for family planning so that women with FGC can make an informed decision. However, it is unlikely that a woman with infibulation would be able to use a diaphragm, cervical cap, contraceptive sponge or IUD. Women will need information on alternatives such as hormonal methods (pill, patch, Depo Provera) and male/external condoms as well as natural family planning. In our experience, the cost of some of the birth control methods is a real barrier for many couples. Also, women may not comfortable with some of the birth control methods and prefer some form of natural family planning.

Be aware that couples will sometimes use anal sex as a way of avoiding pregnancy or maintaining virginity in spite of religious and cultural beliefs. However, sex is a taboo topic for many women and anal sex is not openly discussed. Incorporating issues around consent and safer sex into discussions about birth control and STI prevention is one way to educate without requiring disclosure. You should know that you may encounter a strong negative reaction to discussing various sexual behaviours. Be clear with a client that you are not suggesting she participates in these activites. Explain that different people enjoy different sexual activities for many reasons; we do not judge people's behaviour and give the same sexual health information to *all* clients. They take the information that fits with their life.

It has been suggested that FGC may play a role in the transmission of HIV. Research shows that it is not possible to conclusively link FGC with HIV infection at a later life stage because there are so many other risk factors that come into play; age, level of education, area of residence, economic status, religion, marital status, condom use, number of partners etc.

Pregnancy and Childbirth:

Most forms of female genital cutting do not directly affect obstetrical care. However, women who have been infibulated may possibly delay seeing a health care provider for fear of judgment or legal repercussions. Lack of familiarity with the health care system along with concerns about the competence of medical staff (to deal with infibulation) are additional issues that concern women.

"Women who have undergone type III FGM require sensitive antenatal care. They may be apprehensive about pelvic examination particularly when the introitus is very tight and digital vaginal examination may be uncomfortable. It is important for healthcare workers to be knowledgeable about FGM and its different types so that they do not ask women embarrassing questions, blame them for FGM, or convey any signs of misapprehension to their clients. Health workers should relate to the women in a sensitive, empathic manner. A rapport should be developed with clients and information provided about the appropriate care during during pregnancy and childbirth. Careful explanations should be given about any intimate examination considered necessary and consent should be obtained." (*WHO Technical Consultation*, 1997)

The high rate of Cesarean sections is the number one childbirth related health concern of women with infibulation. FGC is not an indication for Caesarean delivery and frequency of C-sections can be reduced if "deinfibulation" (opening up the infibulation) is done before birth. This can, however, create a real dilemma for a woman whose request for repair of the incision to open up the infibulation may be refused. While the Canadian Criminal Code does not specifically prohibit "reinfibulation" or repair of an opened infibulation, the SOGC has stated that "requests should be declined on medical grounds because repetitive cutting and suturing of the

vulva is likely to increase scar tissue, thus causing or perpetuating dyspareunia or voiding difficulties." (*SOGC Female Genital Cutting: Clinical Practice Guidelines,* 2013)

Unfortunately, the necessary policies and protocols regarding treatment and procedures for a woman who has experienced circumcision, especially infibulation, opening up, and repair/reconstruction, are lacking in most Canadian hospitals. There is a very real lack of education materials in English and/or first languages to help practitioners with the task of giving women appropriate information. This makes informed consent a real challenge. The Clinical Practice Guidelines recently issued (2013) by the Society of Obstretricians and Gyneacologists of Canada do give recommendations for providing culturally competent and sensitive care to FGC affected women.
See: http://sogc.org/wp-content/uploads/2013/10/gui299CPG1311E.pdf

Women's Sexuality

It is not likely that the women you see in your work will initiate discussion about their genitals or their experiences within their sexual relationships. Most topics related to sexuality are culturally considered taboo and not openly discussed, especially for a 'respectable' woman.

FGC is closely tied to a woman's sexual identity and women from FGC practising communities often express a frustration with how health professionals and others stereotype their sexual lives and dismiss their experiences. They also experience stress/tension regarding their sexuality and body image as a result of stigmatizing messages about their bodies being "different" and somehow unacceptable.

Our society likes to believe we have a culturally enlightened view about women's sexuality. However, female sexuality is a complex topic and it serves us well to think about our sources of information and what political or economic interests might be influencing the information. Many researchers and educators challenge the current pre-occupation with 'where and how women *should* experience their sexual response'. This focus only results in creating yet another set of limitations for women from all cultures - including our own.

We can only speculate about how any woman's sexuality is affected by genital cutting, whether as a traditional practice or as genital cosmetic surgery. The degree to which a woman from any culture has internalized social messages about sexual expression will also play a role in how she perceives sexual pleasure. For those of us who are not from an FGC practising culture, we need to make sure we are not dismissing women's realities because we are only thinking about them from our Western perspective. Feminist writings and most anti-FGC campaigns desexualize circumcised women and claims of sexual satisfaction are often patronizingly dismissed. And yet, it is truly impossible for any woman (or man) to really know what another woman, circumcised or not, feels during sex. It is quite possible that the negative correlation between FGC and sexual pleasure has been exaggerated, as some researchers have stated, or that our interpretations of women's experiences regarding sexual pleasure are prejudiced by a focus on the biology of the clitoris, its role in orgasm, and the necessity of orgasm for sexual pleasure.

We also need to keep in mind the effects of possible sexual trauma that have nothing to do with FGC. Rape is often used as a 'weapon' during war and can result in sexual trauma for a majority of the women from a specific war-torn community or country. As well, many refugee women and their families have spent years in refugee camps. Because of the lack of organized infrastructure (like policing) and corruption etc., they may have lived with the fear of sexual assault, witnessed the sexual assaults of others, or had such experiences themselves. These events can cause trauma that significantly impacts a woman's life and may certainly take precedence over childhood experiences such as female circumcision.

Again, we do not want to make assumptions. However, when we are working with refugee women it is important to be aware of the possibility of trauma and to have the ability to respond appropriately when discussing an issue like sexuality.

Sexual Pleasure:

A woman's sexual function is complex and related to many factors other than anatomy. While the Western feminist opposition to FGC highlights women's rights to an unaltered sexuality and sexual response, this agenda also acts to erase any sexual enjoyment that a circumcised woman may experience. The clitoris and a woman's right to have an orgasm have become symbols of female power and agency. But we have to remind ourselves that female agency is not expressed the same way in all cultures. As well, sexual priorities are not the same for all women, regardless of their cultural background.

The problem with conventional ways of examining sexual pleasure says the Egyptian researcher, Mawaheb El-Mouelhy, is "the emphasis on measuring performance - how often, how many, how strong." In her opinion, this doesn't work for looking at women's sexual pleasure because for many "their enjoyment is bound up in broader questions of family life: how are the kids, are the bills paid, and - critically - are their husbands happy in bed." (*Sex and the Citadel*, pg. 109) Discussions in the women's education sessions under the Our Selves, Our Daughters project support this. Other issues like privacy, sharing of the domestic workload, communication, and positive relationship dynamics - "Does he treat her well?" - all contribute to an enjoyable sexual relationship. An abusive partner, poverty, chronic illness and lack of health care are issues that can negatively affect a woman's sexual pleasure.

> "The ability to achieve sexual arousal and orgasm is a complex process. Psychological aspects of sexual arousal involve emotions, concepts of morality, past experiences, acceptance of eroticism, fear of disease and pregnancy, dreams and fantasies. The combination of physical responses to sensory stimuli and subjective arousal culminate in a psycho-physiological state during which a person is able to experience orgasm." (*The Canadian Journal of Human Sexuality*, Vol. 4[2])

Many women who have experienced FGC will not have sexual problems and many will be able to achieve orgasm. (Many women who have <u>not</u> experienced FGC will have sexual problems and may not be able to have orgasms.) However, FGC, especially if there is resulting trauma and improper healing, *may* affect various aspects of a woman's sexual desire and arousal. This may be caused by either physical discomfort or psychological issues (for a variety of reasons) or

both. This depends on each woman's individual experience and the meaning that experience has for her.

With the less invasive forms of FGC much of the sensitive tissue at the base of the clitoris, along the inner lips, and around the pelvic floor remains intact and capable of arousing sensations when stimulated. Infibulation may leave a woman with what appears to be little sexually sensitive genital tissue. However, there is an extensive nerve network linking the clitoris to the spinal column. We now know that there are two separate clitoral 'roots' with so many nerve endings that stimulating the genital area can produce waves of sensations that result in orgasm.

Pain during initial intercourse is common among infibulated women. There may be difficulty with penetration due to the tiny size of the vaginal opening. That said, many women and many research studies report that, after the pain experienced during the early sexual encounters, women go on to enjoy full sexual satisfaction. One study involving women in North Sudan (where infibulation is common) showed that the percentage of women who report sex pleasurable 'sometimes' is the same percentage as for uncircumcised Western women in the United States. (Mansura Dopico, *Infibulation and the orgasm puzzle* in Transcultural Bodies) Some women said that their state of mind, the quality of the relationship, and the expertise of the partner have a greater impact on their sexual pleasure and satisfaction. Some women believe the culture (not infibulation) is responsible for sexual dissatisfaction.

Sexual Relationship:

It is easy to look at the sexual relationships of others (regardless of cultural background) and apply a label to the dynamics that we observe. Patriarchy, in one form or another, still exists in most cultures and affects the gender roles, communication, decision-making, and other dynamics within sexual relationships. It might be helpful to take some time to think about how patriarchy and sexual relationships play out in Canadian culture and in our own lives. This can help us connect with our clients in a way that contributes to meaningful discussion about women's sexuality.

Sexual relationships are dynamic and complex. Part of that complexity comes from the cultural context in which the relationship dynamics exist. The role of sex in any given relationship is unique to that couple. The gender identity and role expectations that each partner brings to a sexual relationship play out in a cultural context. Cultural competence does not give us permission to ignore a situation that threatens the well-being of a client, but we also need to remember not to judge on the basis of our own beliefs and experiences. We have to remind ourselves that there can be many positive aspects within a relationship that we don't have the privilege of observing.

Migrating to a new country adds to the complexity of a relationship as Canadian culture presents both new information to consider and challenges to familiar traditions. These challenges can cause problems for some couples, especially if they are not adapting in a similar manner or in a similar time frame. Other couples, like couples everywhere in the world, build a stronger relationship by facing their challenges together.

There are many accounts of how FGC negatively affects people's sexual relationships. As with the discussions relating to sexual pleasure, the negative stories are the ones that receive the most attention. That being said, when an infibulated woman first has intercourse, she must undergo gradual dilation by her partner. This can be accomplished through repeated attempts at intercourse or, in some cultures, the vaginal opening is dilated with an instrument (such as an animal's horn) to allow for penetration.

Repeated attempts at intercourse may be painful for the woman and accomplishing penetration may take days or even weeks. Sometimes this can also be painful for the male partner and may cause trauma to the penis. In some cultures successful vaginal penetration is considered a test of manhood. Excessive force during the first experience of intercourse can damage the tissue surrounding the vagina and cause severe bleeding, shock, infection and urine retention. In some women the scar tissue needs to be cut and a husband and wife may travel together to a health facility to have this done. If this is not possible the man or a woman from his side of the family will make the incision with a knife or blade. Because the cutting may be happening in the dark, a combination of lack of light and lack of knowledge about anatomy creates the added risk of damage to nearby organs.

These customs can have a serious impact on the woman's life and the couple's relationship. There is a need for education/information about the harms that can result from such practices. Our community-based research shows that many men are conflicted about the pain that might result from sex with their wives. It has been said that men would like to have an uncircumcised wife but, at the same time, need to ensure their daughters are circumcised. This comment illustrates the difficulty in overcoming long held beliefs and cultural teachings that speak to how the community sees a man with regard to his sexual responsibilities and family honour.

What we learned from our work with the three communities is that change regarding marriage and sexual relationships is happening in the home countries, as well as in Canada. Men and women of all ages are recognizing that FGC has a negative long term impact on some women's lives and their sexual relationships. (See Community Reports www.serc.mb.ca) Many young men are saying they no longer consider circumcision or virginity necessary requirements for a good marriage partner. Men realize that if their wife/partner has health issues related to FGC their sexual relationship and, consequently, their marriage is negatively affected. For this reason some community members feel that FGC also plays a role in the rate of divorce in their community.

In Canada a woman with FGC, especially infibulation, who is sexually active could be advised to use a water-based lubricant during any form of penetration to minimize lacerations around the vagina. Be aware, however, that wetness in the vagina during sex is not desirable for many couples. Messages about the lack of 'cleanliness' of the vagina are deeply embedded in the cultural understanding of women's health in most cultures; we only have to think about North American advertising about douching to realize this is a common theme regarding female sexuality.

Women who have been infibulated can also be counseled to ask their doctor about increasing the size of the vaginal opening if pain during sexual intercourse is an ongoing concern This must be a careful conversation with opportunity for the woman to consider her options.

Although her circumcision may be causing her discomfort, it is an important part of her sexual identity and she will likely want to discuss this with her partner as part of making a decision.

In spite of these complications, there are reports of women with infibulation enjoying sex and having a positive view of their sexual relationship after an initial period of pain. Our own ethnocentric viewpoint might cause us to rationalize away their reports about pleasure, but we need to remember that even though we might not understand everything about their lives, their reality needs to be respected. Cultural values dictate the meaning of sexuality and normal, adequate sexual relationships. To insist on a uniform expression of sexual behaviours or meanings about sexual pleasure is doing a disservice to women everywhere.

Working With Adolescent Girls

Adapting to a new culture is a challenge for every member of an immigrant/refugee family. However, adolescents who were not born in Canada likely have their own set of challenges adapting to an adolescent culture they don't always understand.

Like their mothers, adolescent girls who underwent FGC and now live in Canada may or may not experience problems as a result of the procedure. Girls who underwent FGC at a young age may have only vague or no memories of the procedure. Girls who do not remember may realize that their genitals were modified based on information that they hear in school, from their peers, or from the media and the internet.

There is little research on the experiences of young circumcised women growing up in Canada, but anecdotal information suggests their concerns about FGC are intertwined with normal adolescent concerns related to sexuality, body image, and identity, and also "fitting in" with a new culture. (OSOD Community Friendly Reports and Toubia, *Caring for Women with Circumcision*)

You may become aware that a girl has undergone FGC in the context of facilitating sexuality education or providing services. Don't assume that she is experiencing emotional or psychological problems due to her FGC experience. If the young woman mentions FGC herself, it is appropriate to gently explore the subject and let her know that you are comfortable discussing the issue if she would like to.

This kind of discussion is an ideal opportunity to help the young woman talk about any physical discomfort or medical problems that may or may not be related to the FGC. For example, some young women need extra time for bathroom breaks at school due to difficult or slow urination. (However, some need extra time because of religious beliefs/practices regarding hygiene not necessarily related to FGC e.g. washing the genitals.) Some young women with infibulation or extensive scarring may be absent from school more than other students when menstruating. These are areas to ask about or discuss. If necessary offer to advocate for her regarding the time she needs for self-care.

Some adolescent girls may be sexually active or considering becoming so. There may be some confusion about how they are/are not different from their friends. They will need accurate

information about their bodies, sexuality, and how to protect themselves from pregnancy and sexually transmitted infections. Many schools have cultural liaison staff who could assist with organizing a session and finding an appropriate facilitator for female students who would consider attending an extra-curricular session on female anatomy and reproductive health.

When teaching about anatomy and the physiology of the reproductive organs, it is helpful to show diagrams of female genitalia and include information about the *range and diversity of women's bodies* and experiences. Because of the almost universal taboos related to openly discussing women's sexuality, most women do not realize how much diversity there is among female genitalia. The easy access to airbrushed images of the female body, including the genitals, contributes to a general insecurity about the appearance of the genitals. There are many images on the Internet related to the diversity of female genitals. The Great Wall of Vagina is a website about an art installation that promotes/advocates for acceptance of genital diversity. See: Changing female body perception through art | The Great Wall of Vagina

Note: In a group setting, be especially careful to present the information in a way that does not stigmatize any of the group members. It is also crucial to consider the potential for strong reactions on the part of other participants/students that could embarrass a female who is dealing with some form of genital difference - including being circumcised. Cultural safety in a classroom or other educational setting is critical. A non-discriminatory environment is necessary for the well-being of all students.

Adolescent girls who have been circumcised have many of the same concerns around appearance and fitting in as other Canadian youth. In fact, there may be an increased concern about body image - their body structure not matching the North American cultural ideal of the female body. Some young women who have been infibulated may wish to seek reconstruction. This is a decision that requires careful consideration. You can support your client/student in her decision-making by helping her find the appropriate community support, counselling, and medical services if that is her decision.

The greatest challenge for many immigrant and refugee adolescents is that they are torn between the values of their culture of origin and those of their new country. Adolescence is developmentally the time when sexual identity is forming. Girls are concerned about what will help them be a "good" girlfriend and future wife. There can be inner conflict about what information to believe and which set of values to follow. Information will need to be given to help them understand the difference between the messages of the popular/media culture and "Canadian culture".

Nonetheless, youth have said they feel as if they have one foot in their home culture and the other foot in Canadian culture. As a result, they feel like they don't belong anywhere. Immigrant youth may feel a pressure to reject their family's culture completely as a way of finding belonging with their Canadian peers. A concept that can be helpful is to talk about finding a balance between their home culture and its values and the more individualistic Canadian culture.

Working With Families to Prevent FGC

Working with a family from an FGC practising culture that has recently welcomed a baby daughter into the family poses some very real dilemmas for service providers. Firstly, we can't assume that the parents are planning to circumcise their daughter. Some women/couples eagerly use "Canadian culture" and its laws as the excuse for breaking with tradition. Other parents will have little or no knowledge of Canadian law.

Parents who value FGC as a legitimate cultural practice may be defensive. If you are not from a culture that currently practices FGC, they may question your beliefs and values and may not expect you to understand. Being culturally sensitive means that, as a service provider, you have taken the time to examine how it feels when your own value system is challenged. You are then making every effort to understand the underlying complexities of your client's cultural beliefs. Focus on building trust rather than interrogating mothers/parents.

Do not attack, threaten, or blame parents. Try to develop a relationship so that you can begin to trust each other. Provide the space to talk about migration, the pain of loss, their feelings of displacement and their desire to hold on to cultural traditions. Plan on several visits to have these conversations - it is not likely to happen the first time you meet a family.

Whenever possible, focus on the positive aspects of their parenting and of child rearing in their culture; these may include extended family support, breastfeeding, mothers and babies in close physical contact, and children welcomed as a natural part of almost all activities - often being cared for by the whole community. Make the effort to find commonalities between you and your clients in health or cultural practices and beliefs.

You may find out that parents are struggling to decide about circumcising their daughter. In this case, FGC must be discussed, as it is illegal to practice FGC in Canada or to send a girl out of the country to have the procedure done. Parents have the right to receive this information.

Interacting in a respectful and culturally sensitive manner can have a positive impact on future decision-making regarding female genital cutting. It can also help prevent the practice from being carried out 'underground'. This carries the added risks to the child of not receiving proper medical care should complications arise.

Provide Information:

Give parents information about female genital cutting in a holistic way. It can be discussed in the context of general health and wellness for girls and women.

Discuss the changes that are happening in their home country. (FGC is illegal in most countries of the world.) Talk about cultural change as an ongoing reality. You can ask about the changes they have noticed in their home country or countries in which they have lived. While cultural change can be upsetting, there can also be positives. Discuss these.

Ask questions in a spirit of learning about your client and her family. Provide information about possible long term health consequences. Sometimes this information triggers memories/ stories of their own or other women's experiences. Be respectful of cultural beliefs about health and possible fears or misconceptions about healthcare in Canada. Listen and provide as much time to talk as possible, but occasionally repeat the facts and maintain a firm stance on the issue.

Legal Considerations

Within Canada, FGC is illegal under both criminal and child protection laws. Persons performing FGC and/or the girl's parents can be charged under the laws relating to assault causing bodily harm or criminal negligence causing bodily harm. FGC would also be considered child abuse and dealt with under Manitoba's Child and Family Services Act. It should also be noted that the criminal code can be used to prevent girls from being sent overseas to be circumcised.

As service providers, we walk a fine line between child protection laws and cultural competence because most policies and laws have been written from the perspective of punishment as a way of changing behaviour or culture. Laws are often an attempt to find a simple solution to a very complex situation and, as a result, are not effective at creating change. We need to consider all the ramifications on a child's life of removing her from her family because she has been circumcised.

The World Health Organization suggests: "Laws should be seen to be protective rather than punitive and should be designed to prevent harm to children. The latter aspect should be emphasized at community level so that the law comes to be seen as providing protection and support to the individual." (*WHO Technical Consultation*, 1997)

SERC believes that the best tools for fighting harmful traditional practices are rooted in education and advocacy - not law. However, parents also have the right to understand the legal implications in choosing to circumcise a daughter.

Female genital cutting includes everything from an extensive procedure, like infibulation, to the non-invasive "pricking" of the genitals to draw a drop of blood. Genital cosmetic surgery often involves removal of labia and sometimes removal of clitoral tissue, as in a "clitoris lift". So we see that genital cosmetic surgery and hymen repair, while legally accepted in Canada, constitute female genital mutilation under the World Health Organization definition. At the same time, the summary statement of the SOGC Clinical Practice Guidelines regarding Female Genital Cutting reads: "There is concern that female genital cutting continues to be perpetuated in receiving countries, mainly through the act of re-infibulation." We can see that there are conflicting messages within these policies and laws. The problem rests in the way and to whom the laws are applied. The prohibition against genital modifications in Western countries concerns primarily African groups.

Authors Sara Johnsdotter and Birgitta Essen write:

> *If this is purely a children's rights issue, then ... laws need to include a paragraph stating that a woman above a specific age may choose to have her*

genitals modified, irrespective of ethnic background." That would protect children while giving women of Western and non-Western origin the equal right to make decisions about their bodies, including repair of a surgically opened infibulation. (Genitals and ethnicity: the politics of genital modifications, 2010)

The SOGC Policy Statement regarding Female Genital Cosmetic Surgery (FGCS) recommends that health care practitioners should help women "to understand their anatomy and to respect individual variations." It also states that comprehensive counselling should be a priority for women requesting FGCS including the lack of evidence regarding outcomes and possible later life impacts. This describes an informed consent process that could be available to FGC affected women as suggested by Sara Johnsdotter and Birgitta Essen.

SERC's Approach

Whatever the reasons for female genital cutting, the practice is an experience that involves the community as a whole. Be aware that a family who no longer supports the practice can still experience a great deal of family and community pressure to continue with tradition. Because of technology and the Internet, this pressure can also come from family and community back in their home country, as well.

As such, any prevention work should involve collective approaches. Involving both men and women who are leaders in the community can be an important first step in building the trust required to approach a sensitive topic that is often considered taboo.

There is no "formula" for engaging the community but we can say that addressing the issues involves a dialogue that makes sense to people. This means that we open our minds to new learning rather than approaching the community from the position of expertise. We also need to consider the importance of reducing stigma and how this can support community change.

Connecting with the Community:

Building a relationship with someone in the community who supports ending the tradition of female genital cutting can help bridge the gap between mainstream services and a family who is trying to decide whether or not to circumcise their daughter. This person can also be a resource in working with the community to address some of the challenges that will arise as community members engage in a dialogue on the challenges and benefits of changing long held beliefs.

For example, the cultural and parental emphasis on FGC as a way of ensuring virginity at marriage and a "calm" personality regarding sexual desire and expression may contradict the opinions of a young woman's friends and Canadian society, in general. Our community based research also shows that opinions among the younger generations in FGC practising communities are beginning to challenge the long held beliefs around the practice. (Read more on this in the Community Friendly Reports on SERC's website: Female Genital Cutting | SERC MB)

The resulting communication gaps between these young people and their families can be challenging for everyone involved. However, our community work tells us that under the right circumstances, community members of both genders and all ages may be willing to have these important conversations in small groups or as a community. Service providers working with families need to pay special attention to the possibility of bridging the gap by facilitating dialogue between parents and children. This can help open doors to communicating about issues that have typically been taboo. When working from the perspective of the sexual and reproductive health rights of youth, it is also important to consider the protective factor of connection to family and cultural community.

The community at large and young women, in particular, need an opportunity to work through these issues. What is the impact for a girl who has been circumcised to hear that young men in her community no longer consider virginity in a marriage partner important? Or that many young men think they would rather marry a girl who is not circumcised because she will enjoy their sexual relationship more?

Community Education / Mobilization:

Education about both male and female sexual and reproductive health is an important strategy to challenge myths and increase awareness about the possible harms that can result from female genital cutting. Building community support for cultural change involves the whole community i.e. women of all ages, men of all ages, and community leaders. The participation of young men in these awareness campaigns is especially useful.

We need to create places of connection – safe places where community members can speak openly without being judged. We need to be mindful about naming people and communities when we address this issue. Community dialogue is instrumental in creating change, but some people worry about how they will be viewed by the government (who labels such practices "barbaric") or providers of social services. Islamaphobia - a very real concern for some communities – results in feeling judged and unsafe in the new culture/country. These dynamics increase the risk that the practice will be pushed underground.

Add your skills and resources to *assist* those in the community who are working to change beliefs about female genital cutting. Stand side by side with community members and use the language that they use. Work together to overcome some of the barriers that face women who want to attend education workshops or discussion groups such as: childcare issues, transportation, weather, work or school, and family responsibilities.

Information through education sessions and discussion groups that challenge beliefs about why female circumcision needs to be done can help change thinking. Reasons to support ending the practice include:

- There is no requirement in *any* religion to circumcise females.
- FGC does not guarantee there will be 'trauma' to the hymen *proving* virginity i.e. bleeding at the time of first intercourse. Some hymens are thick and some are very thin and can easily be broken by everyday physical activity.
- There is no proof to support the belief that FGC decreases sexual desire. There are circumcised women who have sex before and outside of marriage and uncircumcised women who do not.

- The brain is an important 'sex organ' that determines the choices women make regarding their sexual lives. It is important for parents to teach/talk about the values that are important in sexual relationships and sexual decision-making.
- Anti-FGC campaigns in some countries simply tell people the practice is "bad". The campaigns do not include education about how women's bodies function and the possible health consequences to FGC. This is critical information for people to have as part of their decision-making.
- Be ready to talk about other harmful practices which have now been abandoned due to education and recognition of the medical risks and/or human rights violations.

Another way to approach the topic in a community outreach setting would be to integrate a discussion of FGC into workshops or groups that are addressing any of the following topics:

- Sexuality
- Women's Reproductive Health
- Men's Reproductive Health
- Culture and Adaptation
- Rights of Children and Young People
- Families Communicating About Sexuality
- Sexual Development (Puberty)
- Birth Control
- Pre-Natal Classes
- STI / HIV prevention
- Relationships

Consider how technology can be used to reach youth and young adult women and men. Worldwide, youth have embraced the new technologies. We need to seize this opportunity to inform youth, and help change attitudes about FGM and women's rights. The youth can then share their knowledge with their parents, grandparents, and others in their communities in the hopes of influencing a shift in beliefs and practices.

Conclusion

Female genital cutting is a complex cultural tradition that we can only begin to understand by uncovering the many layered meanings of the practice for the women and families with whom we work. SERC's work in the community regarding female genital cutting is rooted in providing information that allows women, and the community at large, to act on new information and a new understanding that will help with changing beliefs and attitudes regarding the practice.

Change regarding female genital cutting is happening everywhere – in countries of origin and in Canada. The Community Reports that have been developed through the Our Selves, Our Daughters project provide us with insight into the diverse beliefs and practices regarding the historical and current contexts of female genital cutting. They also provide information about the dynamics that help create change.

The ultimate goal of the *Our Selves, Our Daughters* project is to end the practice, but at the same time to educate service providers so that women who have been circumcised in the past can access and receive respectful sexual and reproductive health care. As service providers, we can increase our own awareness about how every interaction with an immigrant or refugee woman either helps her in her process of adapting to a new culture or stigmatizes and isolates her. There are negative consequences that follow and service providers have a responsibility to mitigate these negative outcomes whenever possible.

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