

Working with Women and Girls Who Have Experienced Female Genital Cutting/ Female Genital Mutilation

Culturally Sensitive Counselling

Introduction

When working with women from immigrant and refugee populations, there are a number of factors to consider. The experience of FGC/FGM is only one event in a woman's life, which may or may not be affecting her currently.

It is helpful to know the population groups that are most likely to practice FGC/FGM and to realize that not all women from all cultures that practice it or from every country where it is practiced, will have undergone the procedure. Women who experience the most severe health problems and psychologically damaging effects are those that have been infibulated. Infibulation constitutes only about 20% of all affected women and is most likely to be seen in women from Somalia, Northern Sudan and Djibouti.¹

Women that you may see in your counselling or community outreach work will be unlikely to initiate discussion around their genitals or their experiences of genital cutting. Often newcomers to Canada are amazed at the media and government attention that has been placed on FGC/FGM while so little attention is paid to their other experiences of poverty, war, racism and resettlement into a new country. Many women who have experienced FGC, especially Types I & II have healthy emotional and sexual lives and do not experience medical complications as a result of FGC.

Terminology

Throughout SERC documents we use the terms Female Genital Cutting/Female Genital Mutilation (FGC/FGM) interchangeably. A need for respectful terminology that is also responsible from a medical and legal perspective led our agency to a thorough examination of the current terminology. Ultimately our decision to use the term "female genital cutting" was in order to acknowledge that not all forms lead to mutilation of the genitals and that mutilation is

¹Toubia Nahid, Caring for Women With Circumcision

not the intent of the action. It is intended to be a more respectful way to describe the procedure. Ideally, counsellors and health care practitioners would use the language most acceptable to the woman they are working with. "Circumcision" is a common English word used by some communities to describe a variety of types of FGM, however it is not medically accurate and has led to confusion for some families who understand it is illegal to circumcise their daughters but not their sons.

In order to facilitate information collection, more effective 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.²

World Health Organization Definition

Female Genital Mutilation 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 reason.

Classification of FGM

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| Type I | Excision of the prepuce with or without excision of part or all of the clitoris. |
| 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.) |
| Type IV | Unclassified <ul style="list-style-type: none"> • 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. |

Working With Refugee & Immigrant Women

Whenever counsellors work with clients or populations that are from a different cultural group than their own, they must be consistently aware of their own cultural biases. It may also be necessary to challenge racism and other forms of oppression within their organizations. Effective service delivery promotes responsible and genuine sensitivity to all clients. Skills and

² Female Genital Mutilation, Report of a WHO Technical Working Group, Geneva, July 1995

knowledge are important but lose their effectiveness if service providers are unaware of their own misconceptions and the impact these have on their clients.

When working with women from other cultures, it is important to learn as much as you can about the context of their lives before and after arriving in Canada. Women's experiences will vary from each other depending on their individual background with regard to race, socio-economic background, education, and sexual orientation. Immigrant/Refugee women may be facing obstacles due to gender discrimination, language difficulties, lack of employment and support systems related to housing and child rearing.

In addition, the experience of refugees differs from that of immigrants. While an immigrant makes a conscious decision to resettle elsewhere, usually with their family, a refugee often leaves her home suddenly under extreme circumstances, is often separated from family and has experienced significant personal trauma. When war has been a factor, women have often been subjected to rape and other violence. All of these may be issues that arise in counselling/outreach and may certainly take precedence over childhood experiences such as FGC/FGM.

When FGC/FGM is acknowledged and does become a part of the counselling discussion these are some of the issues that may arise:

Possible Emotions Arising As A Result of FGC/FGM

- Lack of trust
- Fear of strangers
- Fear of being touched
- Fear of knives, razors
- Fear of operations
- Fear of doctors, midwives
- Fear of getting married, having sex
- Fear of having children
- Fear of new situations
- Separation from friends - older and younger
- Isolation from other family members including mother and sisters
- Believing that it is wrong to cry, to shout, or to be angry
- Believing there is something wrong with being female
- Believing that being a woman is synonymous with pain

Also, be aware that there may be positive emotions associated with this experience:

- Pride
- Believing oneself to be virtuous
- Happy to be like other women in her culture
- Feeling beautiful and desirable to men
- Pleasant memories of the ritual associated with the procedure and "coming of age" (not all cultures have a ritual, or practice it at adolescence.)

Sexuality Education

A woman's sexuality is affected according to the extent of the genital cutting and the degree to which she has internalized social messages inhibiting sexual expression. Many women who have experienced FGC will not have sexual problems and many will be able to achieve orgasm.

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.³

With clitoridectomy, some of the sensitive tissue at the base of the clitoris, along the inner lips and around the floor of the vulva, remains intact and capable of arousing sensations if properly stimulated. Infibulation usually leaves the woman with no sexually sensitive genital tissue; however FGC/FGM does not affect the hormonal stimulants for sexual desire and arousal.

Pain during intercourse is very common among infibulated women. This may be caused by either physical discomfort or psychological trauma or both. There may be difficulty with penetration due to the tiny size of the vaginal opening. An infibulated woman must undergo gradual dilation by her partner. This can be very painful and may take days or even weeks. Sometimes this can also be painful for the male partner but in some cultures is considered to be a "test of manhood." Excessive force during the first experience of intercourse can damage surrounding tissue and cause severe bleeding, shock, infection and urine retention. In some women the scar tissue needs to be cut with a knife or other sharp instrument to allow for penetration.

Women with FGC/FGM who are sexually active should be advised to use water-based lubrication during any form of penetration to minimize lacerations around the vagina. In addition, infibulated women should be counselled to have an anterior opening to reduce pain during sexual intercourse. To reduce the risk of infection after difibulation, women should be counselled to abstain from intercourse until the vulva has healed.

It is important to explain birth control methods so that affected women can make an informed decision. It is unlikely that an infibulated woman would be able to use a diaphragm, cervical cap, contraceptive sponge or IUD. Women affected by FGC/FGM will need information on alternative methods such as the contraceptive pill, Norplant, Depo Provera and male condoms.

Working With Adolescents

The priority in working with adolescent girls is to remember that they are similar to other teens growing up in Canada, with many of the same concerns and needs. Adolescent girls who underwent FGC/FGM and now live in Canada may or may not experience problems as a result

³ The Canadian Journal of Human Sexuality, Vol. 4(2)

of the procedure. There are no studies on the experiences of these young women growing up in North America, but anecdotal information suggests that their concerns about FGC/FGM are intertwined with the normal adolescent concerns of sexuality, body image, looks, identity and “fitting in.” Girls who went through the ritual at a young age sometimes have only vague or no memories of the procedure. Girls who don’t remember may discover that they were genitally cut, while examining themselves or based on information that they hear from their peers or the media.

A counsellor or health care practitioner may become aware that a girl has undergone FGC/FGM in the context of sexuality education or contraceptive counselling. If the young woman mentions this 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. It is important not to assume that the young woman is experiencing any emotional or psychological problems due to her experience.

This kind of discussion is an ideal opportunity to help the young woman identify if she is having any physical discomfort or medical problems that are related to the FGC/FGM. Some young women need extra time for bathroom breaks at school due to difficult or slow urination. Others have especially painful menstrual cramps and may take more time off than other students when menstruating. These are areas to explore and if necessary to offer to advocate for her to have the time required to care for herself.

Some adolescent girls may be sexually active or considering becoming so. They may be confused about how they are different from their friends. They will need accurate information about their bodies, sexuality, and how to protect themselves from pregnancy and sexually transmitted infections. Young women who have been infibulated may wish to seek deinfibulation; the counsellor should support her in this choice and help her to find appropriate medical services.

The greatest challenge for any immigrant and refugee adolescents are that they are often torn between the values of their culture of origin and those of their new country. The resulting communication gaps between these young people and their families can be devastating. Counsellors working with families need to pay special attention to facilitating dialogue between parents and children to help reduce family conflicts and tension.

Outreach workers, teachers or counsellors who are providing sexuality education in schools or other community settings need to be aware of their student population and the possibility of having students who have experienced some form of FGC/FGM. When teaching about the anatomy and physiology of reproductive organs, it is helpful to show these young women diagrams of normal female genitalia and genitalia that has been altered by infibulation, and to make adjustments to the teaching in order to include the range of women’s bodies and experiences.

Working With Families With Young Daughters

You may suspect that parents are planning to have FGC/FGM carried out on their daughter or you may learn that a girl’s parents are struggling to decide about it. In this case, it **must** be

discussed, as it is illegal to practice FGC/FGM in Canada or to send a girl out of the country to have the procedure done. As a social worker, counsellor or health care practitioner you have legal responsibilities to protect the child and to make a report to Child and Family Services if you believe her to be at risk of FGC/FGM.

Initiating a Dialogue & Building Mutual Respect

Do not attack, threaten or blame the parents. Try to develop the relationship so that you all 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. 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 constant physical contact, children welcomed as a natural part of almost all activities, and often being cared for by the whole community.

Teach the Facts

Parents have a right to understand the legal implications as well as the health risks of this procedure.

Within Canada, FGC/FGM is illegal under the criminal code. Mutilation of female genitalia is considered an aggravated sexual assault. If a person performs the procedure in Canada, s/he could be charged with sexual assault causing bodily harm or aggravated sexual assault. The girl's parents/guardians could be charged with being parties to the offence (same potential legal penalty). After the procedure is performed, if the parents do not seek medical treatment for the girl's wounds they could be considered not to have provided the necessities of life. This could potentially lead to a charge of criminal negligence causing bodily harm.

The performance of FGC/ FGM on a child meets the definition of child abuse in The Child and Family Services Act of 1984. A child is in need of protection under Part III, Sections 2(a) and (b), of The Child and Family Services Act if there is a belief that FGM is about to be considered or undertaken on a child.

(Please refer to the SERC fact sheet on the Health Risks of FGC/FGM.)

Know What Reactions to Expect

Some of the comments that may be made:

Why pick on us? All the families in our community do it. It is our tradition. You don't understand our culture. Your culture is corrupt – you are obsessed with sex. You have no right to tell us what to do.

Some parents will have little knowledge of Canadian law. Parents who regard the practice as normal cultural practice may be angry and/or defensive. If you are not from a culture that currently practices FGC, they will question your beliefs and values and will not expect you to understand.

Fathers 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. Sometimes they will be anxious over losing control of their teenage daughters.

Mothers likely will not have dealt with their feelings about their own experiences of FGC. The more time and space they have to talk through their own feelings, they will be able to release their own pain and thus be better able to see other points of view. They may be more comfortable doing this alone with you or in the company of other women rather than with their husbands present.

When working with families, avoid using children as interpreters. A trained health interpreter is more appropriate. If a health interpreter is unavailable, another woman who has the family’s respect and trust may be acceptable.

Know What Parents May Say About the Practice

It is good. Religion requires it. It is healthy. Uncircumcised women are prostitutes. Her husband will not be sexually satisfied. Her clitoris may grow too big. She may not remain a virgin. The uncircumcised woman is dirty.

Maintain a firm stance on the issue. Listen and provide as much time to talk as possible, but occasionally repeat the facts. However well intended and loving the parents are, the procedure is still child abuse under Canadian law. This is similar to working with parents who beat their children and justify it because they love their children and want to be sure that they learn certain values. Their love will not diminish the impact of the abuse.

Be ready to talk about damaging practices in other cultures, which have now been abandoned due to education and recognition of the medical risks and human rights violations. Examples of these things are chastity belts, clitoridectomy (practiced in Victorian times and as recently as the 1950’s in North America to protect against such things as masturbation, promiscuity, lesbianism, and depression), stoning women for adultery, Chinese foot binding, etc.

Group Work

Discussion groups can be used for educating women and men about the health risks of FGC/FGM. SERC has copies in English and French of a workshop manual produced by the National Organization of Immigrant and Visible Minority Women In Canada.

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

- Women's Reproductive Health
- The Human Body
- Rights of Children and Young People
- Puberty
- Sexuality

- Birth Control
- Spirituality
- Pre-Natal Classes
- General Politics

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