Global Woman® Center
Where Ending FGM is Our Priority

Training Manual

A Guide to the Prevention and Rehabilitation of

Female Genital Mutilation (FGM)
Acknowledgments, Sources & Appreciation

This manual is dedicated to all the survivors and at-risk girls of FGM.

It is also dedicated to the little girls who were not fortunate to survive the heinous and atrocious practice of female genital mutilation (FGM).

It is also dedicated to Mrs. Efua Dorkenoo (“Mama Efua”) who devoted most of her life campaigning against FGM and Mrs. Florence Ali, an Activist against FGM. Both of these heroines died in October and June 2014 respectfully.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
Mrs. Barbara Mhangami-Ruwende
Daughters of Eve
Office of Juvenile Justice and Delinquency Prevention
U.S. Department of Education
Department of Population and International Health, Harvard University
Sanctuary for Families (Mariama Diallo, MSW)
U.S. Department of Justice
American Community Survey
Dr. Marci L. Bowers
Clitoraid, Inc.
Center for Reproductive Rights
Mariam Bojang (Ambassador on FGM for Global Woman P.E.A.C.E. Foundation)
Eva Flomo (Spokesperson on FGM, Liberia)
Dr. Morissanda Kouyaté, Executive Director of the Inter-African Committee
The Guardian
Tostan
Wikipedia
Training Manual
A Guide to the Prevention and Rehabilitation of Female Genital Mutilation (FGM)

Researched, Compiled and Written by the Training Committee of the Board of Directors of Global Woman P.E.A.C.E. Foundation

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Global Woman P.E.A.C.E. Foundation
14001A Grumble Jones Court
Centreville, Virginia 20121
Tel: (703) 818-3787
Email: info@globalwomanpeacefoundation.org
www.globalwomanpeacefoundation.org
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Introduction

FGM is the partial or total removal of the female external genitalia for non-medical reasons. External genitals include the clitoris, labia, pubis (the fatty tissue over the pubic bone), and the urethral and vaginal openings. The practice of FGM is often called "female circumcision" (FC), implying that it is similar to male circumcision. However, the degree of cutting is much more extensive, often impairing a woman’s sexual and reproductive functions.

Most girls undergo FGM when they are between 7 and 13 years old. However, FGM seems to be occurring at earlier ages in several countries because parents want to reduce the trauma to their children. They also want to avoid government interference and/or resistance from children as they get older and form their own opinions against the practice.

FGM is practiced in 28 of the 43 African countries; in addition, it is practiced in Oman, Yemen, UAE, Indonesia, India, Malaysia, Australia, Canada, England, France, United States, Sweden, Brazil and Germany. FGM made its way to Europe, the U.K. and North America due to the continuation of the practice by immigrants from countries where FGM is common.

The UN has recognized FGM as torture and calls for its elimination as a form of cruel, inhumane and degrading treatment of girls and women. Efforts to eliminate FGM have been gathering pace globally, reflected in the UN General Assembly’s call for intensifying global efforts for the elimination of female genital mutilation issued in 2012. Global Woman P.E.A.C.E. Foundation will launch the services of a special support center in Washington, D.C. metropolitan area, servicing FGM survivors and at-risk victims in Northern Virginia, Maryland and the District of Columbia. The purpose of a support center of this nature is to help prevent and respond to female genital mutilation. The center will build individual knowledge, while identifying the strengths, gaps and needs in the prevention and response to FGM in the United States. The center will offer 2 phases: the corrective and the preventive phases.

The center will first assess the individual needs of the candidates for the programs by our application forms and one-on-one interviews. The next step is the round circle focus group sessions to help get the candidates to a comfort level, where they are able to freely speak about their experiences with FGM. (The survivors of FGM are told never to tell anyone what happened to them) As a result, most of the candidates might be divulging their experiences for the first time after more than 30 or 40 years. A toll-free emergency hotline will be established to where the candidates will have the first point of contact. From that initial phone call, our counselor(s) will qualify the call; if the local police needs to be contacted or if an appointment is to be made with a counselor. Our initial counselors will be volunteers, such as social workers and school counselors until the program receives funding to engage specialized counselors.
Overview

Purpose of This Manual
The purpose of the training is to offer knowledge and familiarize the teachers and school counselors of at-risk girls in the school system of the United States with female genital mutilation (FGM). The manual builds individual knowledge, understanding, and skills in detecting imminent danger of girls between the ages of 7 and 15.

Objectives
Following the training in this manual, the trainee will be able to:

<table>
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<tr>
<th>Objective</th>
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<tr>
<td>1. Define and explain female genital mutilation</td>
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<td>2. Identify the 4 types of FGM and their psychological and physical affects</td>
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<tr>
<td>3. Identify the locations of practice in the United States</td>
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<td>4. Identify the dangers and health risks and when girls are in imminent danger</td>
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<tr>
<td>5. Identify strengths, gaps, and needs in the setting for prevention and response to FGM.</td>
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<tr>
<td>6. The long-term and short-term health problems</td>
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Trainees
The training curriculum is designed for school teachers, school counselors, health providers, social workers, law enforcement, volunteers at FGM support centers, and community leaders.

Trainer Qualifications
The trainers will be extremely knowledgeable about female genital mutilation in all aspects of the practice, such prevention and rehabilitation.

Pre-evaluation of Speakers/Trainers
1. Our trainers must be involved in the campaign to prevent and end FGM
2. They must be committed to the cause of preventing and ending FGM
3. They must exhibit a passion for the cause
4. They must complete a special questionnaire provided in this manual
5. Trainers can be healthcare professionals with knowledge of FGM, counselors with FGM knowledge, teachers, lecturers, activists, advocates, campaigners, and social workers with knowledge of FGM

Training Methods
Our training methods are to hold training workshops, webinars and 2-day retreats. The workshops include small and large group discussions, pretend-games, exercises, and lectures.
Training Room
Our workshops will take place in a room, preferably at a school campus environment or a meeting room at a center or public library or at our Global Woman Center location. The trainees should sit in a semi-circle or horseshoe shape at a table facing each other. Our webinars will be conducted remotely where trainees will have the ability to see the computer screen of the trainer. Privacy and confidentiality of the survivors and at-risk girls are crucial to the success of our work and this program.

The Procedure
Female genital mutilation (FGM) is referred to as “the procedure” in many societies. The procedure is commonly performed on girls between the ages of seven and fifteen. However in some societies, it is performed as early as infancy.

The most common question from Americans is “Why is it practiced?” There are various answers given by practicing societies, such as: “It is the rite of passage to womanhood.” Most FGM societies feel that unless a girl has had the procedure done, she is not a woman, and is not marriageable because she is unclean. In some societies, it is believed that the procedure will reduce a woman’s desire for sex and in doing so, will reduce the chance of sex prior to marriage. In other societies, the clitoris and labia are viewed as male parts on the female body, thus the removal of these parts enhances the femininity of the girl. Then there are those societies that believe that if the clitoris touches the baby’s head during birth, the baby will die and the mother’s milk would be poisonous, while some believe that an unmutilated female cannot conceive. It is also believed that the primary reason is to preserve the girl’s virginity. An intact clitoris will generate sexual arousal in women and such societies believe that the woman’s body was only intended for reproductive purposes and not for the enjoyment of sexual intercourse.

The Types of FGM
The World Health Organization (WHO) has grouped the types of FGM into four broad categories:

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<tr>
<th>Type I (commonly referred to as “Clitoridectomy”)</th>
<th>the excision of the prepuce with or without excision of the clitoris.</th>
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<tr>
<td>Type II (commonly referred to as “Excision”)</td>
<td>the excision of the prepuce and clitoris together with partial or total excision of the labia minora.</td>
</tr>
<tr>
<td>Type III (commonly referred to as “Infibulation”)</td>
<td>the excision of part or all of the external genitalia and stitching or narrowing of the vaginal opening.</td>
</tr>
<tr>
<td>Type IV All other procedures involving partial or total removal of the female external genitalia for cultural or any other non-therapeutic reasons.</td>
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A Human Rights Violation
The United Nations has recognized FGM as a violation of human rights on women and girls. It is a violation of a girl's rights as a child and her entitlement to her bodily
integrity. The UN has recognized FGM as torture and calls for its elimination as a form of cruel, inhumane and degrading treatment of girls and women.

The U.S. Government opposes FGM, no matter the type, degree, or severity, and no matter what the motivation for performing it. The U.S. Government understands that FGM may be carried out in accordance with traditional beliefs and as part of adulthood initiation rites. Nevertheless, the U.S. Government considers FGM to be a serious human rights abuse, and a form of gender-based violence and child abuse.

**Understanding & Preventing FGM**

Another frequently asked question about FGM is “how do we stop it from occurring?” Global Woman P.E.A.C.E. Foundation (GWPF) is committed to ending the practice of FGM, not only in the United States but around the world as well. GWPF believes in educating the public on FGM, and that through education it is possible to end FGM within one generation of women and men.

The girls are held down forcibly while screaming and struggling while the Exciser cuts off their clitorises and in most cases, their labia as well. In some cultures, they proceed by pulling whatever skin is left and they stitch it up together, leaving a very tiny opening to accommodate urination and later menstruation. One survivor told us that it takes her half an hour to urinate because it comes out in drops instead of a flow like normal urination is supposed to flow. There are high risks of infection, hemorrhaging, cysts, convulsions that can end in death at times.

In order to find a mean to the end, we must first determine the mindset of the practicing communities and why they continue to practice it. Is it religion, a cultural practice, a tradition, a rite to passage, an act of love, a form of livelihood, or is it an ignorant evil and wicked act? Finding the answers to these questions will help us find the road to preventing and ending the practice of FGM. It is not religion, although some practicing communities tend to hide behind religion. It is not a cultural practice but in most cultures, they do believe it to be a rite of passage. Unfortunately, FGM is not considered an act of love, although grandmothers and other village elders believe that holding down their daughters and granddaughters to be cut is a demonstration of love. Although it is a deeply rooted tradition of more than 5000 years, it is a form of livelihood for the Exciser (the person performing FGM). In most cases, the parents of the girls can pay at least $200 to $300 per girl. The Exciser can perform FGM on up to 100 girls a day. That is a great deal of money for someone in a developing country. FGM is a traditional practice.

There is a deeply-rooted secrecy in most of the FGM practicing societies. The Excisers, the parents and/or grandparents swear the girls to secrecy, and tell them that they will die if they tell anyone what happened to them. Most women live with the secret for 80 plus years, if they live that long. This is one of the reasons why the practice of FGM has lasted for more than 5 centuries, while the rest of the world remained ignorant to it.
So how do we convince the Excisers to stop performing FGM on innocent little girls? Be mindful that it is the way of making a living for them. Prosecuting and convicting the Excisers is the obvious solution. In some African countries, the Excisers are encouraged to train for an alternate career, such as farming, sewing, hair design, and others to replace the practice of FGM. This alternate solution is one step to preventing and ending the practice.

How do we protect girls from their own parents? The governments of the United States and other countries cannot remove every at-risk girl from her parents. However we can educate the parents, and show them the lifetime affects that FGM will have on their daughters. Ending this heinous practice does not only depend on protecting the girls and enforcing the laws against this practice. It entails educating the girls, their parents, the communities, the neighbors of the at-risk girls, their classmates, teachers, counselors, school nurses and everyone in the societies in which the girls live.

Education is the key to ending the practice of FGM. The Kids Reach Program is designed for that purpose. This program is the preventive phase of the Global Woman Center. It targets the at-risk girls from the ages of 6 through 16. Without frightening the girls, our program will explain to them what FGM is and how they can detect when they are in danger of FGM. It is a difficult situation because we are telling them how to be guarded against their own parents. We want them to know that they are protected by the United States Government, and if anyone, including their parents attempts to have FGM done to them, they will be protected from it, if they tell their teachers their school counselors, the school nurse or even a trusted neighbor. We want them to know that there are people they can trust and ask for help. We will equip the teachers, nurses and counselors with telephone hotline numbers, email addresses and the contact information to the Global Woman Center.

The Kids Reach Program is not an immediate end to the practice of FGM. It is a slow process to eliminating it but it is a sure one. The Kids Reach Program starts with 6 and 7 year old girls. They are the future mothers and grandmothers. When the program is successful in protecting and preventing the first set of girls from the practice of FGM, those future women will not have their own daughters mutilated. That is how we can end FGM within one generation of girls.

**Vacation Cutting**

Vacation Cutting is when immigrant parents take their daughters to their countries of origin during the summer, and have FGM performed on them.

Suspicions may arise in a number of ways that a girl is being prepared for FGM to take place overseas. These include knowing both that the family comes from a country in which FGM is practiced (see the Map of Africa in this manual to identify practicing countries) and is making preparations for the child to take a vacation,
arranging vaccinations or planning absence from school. The child may also talk about a special ceremony that is going to take place in her parents' homeland.

Indicators that FGM may already have occurred include prolonged absence from school or other activities with noticeable behavior change on return, possibly with bladder or menstrual problems. Some teachers in the U.S. have described how girls find it difficult to sit still and seem uncomfortable, or may complain about pain between their legs, or talk of something somebody did to them that they are not allowed to talk about.

**Examples of Vacation Cutting from the Kids Reach Program**

A girl we call Fatu is born in the United States to immigrant parents, which makes her a U.S. citizen. Fatu spends the first 7 years of her life a happy, friendly and smart girl. Her best friend we call Lisa in her suburban school is a 7-year old born to American-born parents. Fatu is taken to her parents’ country of origin at the age of 7, under the pretense of a vacation trip to visit her grandparents. Once in her parent’s home country, Fatu is forcibly taken to the Exciser and mutilated.

| 1. Do you think this scenario could really happen in the U.S.? |
| 2. Would you have any idea or suspicions of her parents’ plans? |
| 3. Had Fatu suspected her parents’ plan, would she have told Lisa? |
| 4. Had both Fatu and Lisa been knowledgeable about FGM and vacation cutting, would it have saved Fatu from being mutilated? |
| 5. If you answered “yes” to question 4, explain how the girls’ knowledge would have made a difference. |

Fatu and her parents return to the United States, and she returns to school after the summer. Lisa is excited to reunite with her best friend on the first day of school, but she notices a difference in Fatu’s behavior. Fatu is withdrawn and distant, and is no longer interested in playing with her best friend. Lisa is confused and offended, and worries that she has lost her best friend, and she is lost without Fatu, who never smiles anymore. Furthermore, their teachers notice the difference in Fatu’s studies, and are also confused.

| 1. Do you think if Fatu and Lisa had gone through the Kids Reach Program, Lisa would have known what had happened to Fatu? |
| 2. Do you think that Lisa is just as affected as Fatu and how? |
| 3. If Lisa had gone through the Kids Reach Program, would she have talked freely to their teacher or her parents about Fatu’s behavior? |
| 4. Would their teachers have been confused by Fatu’s behavior and sudden change in her grades had they already been educated about FGM and vacation cutting? |
Teachers & Counselors Exercises

1. If your friend tells you she’s going on a trip to visit her parents’ family, what will you do?
   Answer: Ask her questions about the trip and tell your teacher or counselor or your parents.

2. If she tells you that she’s going away for a ceremony, what should you do?
   Answer: Ask her if she knows what kind of ceremony it is. You should mention it to your teacher or counselor or your parents. Such suspicions should be brought to the attention of a trusted adult without delay.

3. If your parents take you to the doctor to get blood from you, will you tell anyone or will you keep it a secret, even if they tell you not to tell anyone?
   Answer: Do not keep it a secret; Tell your teacher or your school counselor or the school nurse.

4. If your parents take you to take pictures for a passport and to get vaccinations (shots) for travel, you must tell your teacher or your counselor. Do not keep it a secret. Tell your best friend or her parents.

If you are a school teacher, counselor, law enforcer, health professional, neighbor, community leader, parent, etc. and you are concerned about someone who you suspect is at risk of FGM, please talk to her about your concerns, but use simple language and straightforward questions. Be sensitive and let her know that she can talk to you again. Consult Global Woman P.E.A.C.E. Foundation at (703) 818-3787 or email us at info@globalwomanpeacefoundation.org.

Global Woman P.E.A.C.E. Foundation is committed to assisting girls and young women to get through the threats, risks, physical scars, as well as the psychological scars they tend to live with the rest of their lives. The Global Woman Center opening in June 2015 in the Washington, D.C. area is a place where women and girls can find refuge, counseling, OB/GYN referrals and other assistance. We will invite immigrant mothers to visit the center where we will educate them on the dangers of FGM without antagonizing them. We feel that by educating the mothers, it is one way to help prevent FGM in the future.

At the center, we will work with the survivors to get them talking about FGM and sharing their personal stories. The round-circle meetings work for alcoholics, drug addicts, gamblers, etc. therefore it will work for FGM survivors. The girls are sworn to secrecy at time of FGM and they are afraid to talk about it. Furthermore, communities feel that it is a difficult topic to discuss. The public prefers not to speak about the female genitals. We have to bring the communities to a level of comfort where everyone can talk about it. It is the intention of our organization to get the communities talking so that FGM will be discussed around the water cooler, at the dinner table, in the living room, on television and radio, in the newspapers, on the internet, in schools, in churches during sporting events and in the bedrooms.
If you are a survivor of FGM and you need to talk with someone about what happened to you, or if you know a survivor, please contact us at the Global Woman Center for consultation. We work with Clitoraid International and a network of OB/GYNs in the U.S. that are trained to handle post-FGM cases. The Global Woman Center raises funds to sponsor reconstructive surgeries for FGM survivors.

If you are worried and think that you are at risk of FGM being done to you, please talk to someone you trust, such as a teacher, a school counselor, a school nurse, or even a trusted next-door neighbor. We are all here to help and protect you. Remember that no one is allowed to hurt you physically and emotionally, and FGM is a crime in this country.

Female Genital Mutilation (FGM) is an extremely harmful practice with devastating health consequences for girls and women. Some girls actually die from loss of blood or infection as a direct result of the procedure. Women who have undergone FGM are also likely to experience difficulty in menstruation and childbirth.

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<th>Some reasons for suspicions are:</th>
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<td>• If you notice a girl having difficulties walking or sitting</td>
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<td>• If she suddenly refuses to change for gym or to participate in physical activities</td>
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<tr>
<td>• If she exhibits withdrawal, depression and has poor peer relationships</td>
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<tr>
<td>• If she experiences a drop in academic performance</td>
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**FGM Survivor Stories**

Fatima was only 11 and her sister was 9 when their parents took them to Guinea under the pretense to learn about their culture. Once they arrived in Guinea, the girls were taken to an Exciser and mutilated. Fatima survived but her sister died as a result of FGM. Fatima said that her sister was never taken to a doctor even when she had a high fever and bled exceedingly. Instead, the elders criticized her for not being strong enough. She said when she returned to the U.S. with her parents, she was instructed to tell no one and they never talked about her sister, as though she never existed. She missed her sister and cried herself to sleep every night.

NayNay’s parents said they had a special treat for her for summer break since she had performed so well in school. She was excited at the prospect of going to her parents’ home country of Somalia for the first time. She was going to meet her grandparents and other relatives for the first time. Once in Somalia, NayNay was taken to a remote village, mutilated and stitched up. NayNay recalls how she was held down, and with no anesthesia, the Exciser cut off her clitoris and labia. She tells how no gloves were used, no pain medication, and no nurse to take care of her. She explained how painful and frightening it was as she screamed. She wondered why her own parents had deceived her.
Weena was 9 years old when she was taken to Kenya by her parents and forcibly underwent FGM in their village. Her parents told her they had a big surprise for her. She could not wait for school to close for the summer to see what her surprise was. They finally told her about her first trip to Kenya. It was certainly a big surprise but a terrifying one for Weena. She had difficulty sitting in class when she returned to the U.S. Her teachers did not understand why she was so restless in class. She did not tell anyone because she had been told she would die if she told anyone what had been done to her during her summer vacation.

Three-year old Adaobi was not fortunate enough to live and tell her story. Her father, an immigrant from Nigeria and a resident of Atlanta took a pair of unsterilized scissors and cut her clitoris without any numbing or anesthesia, right in his home. He only took her to the emergency room after the bleeding did not stop and she fell into unconsciousness.

**FGM Laws in the United States**

FGM is a federal crime in the United States; it carries a minimum of a 5-year imprisonment term and/or a fine, for anyone caught practicing FGM on U.S. soil and/or transporting girls to another country from the U.S. for that purpose. According to the law, practicing FGM is defined as knowingly circumcising, excising, or infibulating the whole or any part of the labia majora or labia minora or clitoris of another person.

Most FGM statutes in the U.S. were enacted between 1996 and 1999. The deeply ingrained cultural attitudes underlying FGM cannot be changed simply by outlawing the practice. On September 30, 1996, Congress passed several legislative measures relating to FGM. First, the practice of FGM on a minor was defined as a federal criminal offense, unless necessary to protect a young person’s health. Second, the Department of Health and Human Services (HHS) was required both to compile data on FGM and to engage in education and outreach to relevant communities. Third, the Immigration and Naturalization Service (INS) was directed to provide information to all foreigners issued U.S. visas on the health and psychological effects of FGM, as well as on the legal consequences of FGM under criminal or child-protection statutes. Finally, U.S. executive directors of international financial institutions, such as the World Bank and the International Monetary Fund, were required by federal law to oppose non-humanitarian loans to countries that had not undertaken educational measures designed to prevent FGM. To date, 23 states in the United States have criminalized the practice of FGM on a minor (under 18).

**Post FGM Affects**

Usually it is a girl’s parents or her grandparents who are responsible for arranging FGM. They tend to justify their decision with such reasons as protecting their family honor, preserving tradition, ensuring a woman’s chastity, cleanliness and as a preparation for marriage. FGM causes significant harm and constitutes physical and
emotional abuse. FGM is considered to be child abuse in the United States and is a violation of the child’s right to life.

FGM causes a range of health problems, both short-term and long-term. The kinds of problems that develop depend upon the degree of the excision, the cleanliness of the tools used to do the excision, and the health of the girl or woman receiving the excision. In most countries, FGM is performed in unclean conditions by mainly traditional practitioners who use unsterilized scissors, razor blades, or knives. Most girls who undergo FGM experience extreme pain and bleeding.

There is a growing movement across the world against FGM, people are speaking out and protesting against the practice. As awareness spreads and support grows we are seeing a change of attitudes. The shame and secrecy which surrounds FGM is being challenged by the western world.

An important part of the campaign against FGM is fighting the taboo. By bravely talking about their experiences, women and girls break the secrecy around FGM and stop the misunderstandings. These testimonies are so important to give voice to silenced women and give us all the honest truth about FGM. Speaking out and sharing with others is an important act.

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<th>Short-Term Health Problems:</th>
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<td>• Bleeding or hemorrhaging: If the bleeding is severe, girls can die.</td>
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<tr>
<td>• Infection: The wound can get infected and develop into an abscess (a collection of pus). Girls can get fevers, sepsis (a blood infection), shock, and even die, if the infection is not treated.</td>
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<tr>
<td>• Pain: Girls are routinely excised without first being numbed or having anesthesia. The worst pain tends to occur the day after, when they have to urinate onto the wound.</td>
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<tr>
<td>• Trauma: Girls are held down during the procedure, which can be physically and psychologically traumatic.</td>
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<th>Long-Term Health Problems:</th>
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<td>• Problems going to the bathroom: In severe cases, women are stitched up after the excision and left with only a small opening for urinating and menstrual bleeding. This can slow or strain the normal flow of urine, which can cause infections.</td>
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<tr>
<td>• Not being able to have sex normally: The most severe form of FGM leaves women with scars that cover most of their vagina. This makes sex very</td>
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painful. These scars can also develop into bumps (cysts or abscesses) or thickened scars (keloids) that can be uncomfortable.

- Problems with gynecological health: Women who have had FGM most times have painful menstruation. They may not be able to pass all of their menstrual blood. They may also have infections over and over again. It can also be difficult for a health care professional to examine a woman’s reproductive organs if she has had a more severe form of FGM. Normal tools cannot be used to perform a Pap test or a pelvic exam.

- Increased risk of sexually transmitted infections (STIs), including HIV: Excisers who have no medical training, under unclean conditions, perform most forms of FGM. Many times, one tool is used for several procedures without sterilization. There is a growing concern that these conditions greatly increase the chance of spreading life-threatening infections such as hepatitis and HIV. Also, damage to the female sex organs during FGM can cause the tissue more likely to tear during sex, which could also increase risk of STIs or HIV.

- Problems getting pregnant and problems during pregnancy and labor: Infertility rates among women who have had FGM are as high as 25 to 30 percent and are mostly related to problems with being able to achieve sexual intercourse. The scar that covers the vagina makes this very difficult. Once pregnant, a woman can have drawn out labor, tears, heavy bleeding, and infection during delivery — all causing distress to the infant and the mother. Health care professionals who are unfamiliar with the scar will sometimes recommend a cesarean section. This is not necessary if the scar is cut open and women will be able to deliver vaginally. With rising numbers of young women immigrating to the United States from FGM practicing countries, U.S. doctors have begun caring for more and more patients who have been excised and facing some of these challenges. Based on a study of more than 28,000 women in 6 African countries, FGM is related to cesarean section, post-partum hemorrhage, and episiotomy, extended hospital stays, the need for infant resuscitation, and death. While about 5% of babies born to women without FGM were stillborn or died shortly after delivery, this figure increased to 6.4% in babies born to women after FGM.

- Psychological and emotional stress: FGM is typically performed on very young girls. Most girls are so young that they do not understand what is being done to them or why. The psychological effects of this painful experience are similar to those of post-traumatic stress disorder (PTSD). Although very rare, girls and women who have had FGM may have problems sleeping, have more anxiety, and become depressed.

<table>
<thead>
<tr>
<th>Statistics on FGM</th>
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<tr>
<td>- At least 8000 girls are cut daily around the world</td>
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<tr>
<td>- In 2014, it was discovered that FGM is practiced in the United States where immigrants are heavily concentrated. The report revealed that approximately 228,000 girls in the U.S. are at risk of FGM or are living with the</td>
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</tbody>
</table>
In 2015, it was reported that the figure had increased tremendously to 513,000 girls in the U.S. being at risk of FGM or are living with the consequences of FGM.

As of 1997, 135 million women and girls had been mutilated in the world.

In Africa, an estimated 92 million girls from 10 years of age and above have undergone FGM.

FGM is mostly performed on girls between infancy and 15 years.

An estimated 130 to 140 million girls and women worldwide are currently living with the consequences of FGM.

FGM is concentrated in a swathe of 29 countries from the Atlantic coast to the Horn of Africa, with wide variations in prevalence. The practice is almost universal in Somalia, Guinea, Djibouti and Egypt, with levels above 90 per cent, while it affects only 1 per cent of girls and women in Cameroon and Uganda.
Women and Girls at Risk of Female Genital Mutilation in the US

Although FGM is most prevalent in sub-Saharan Africa, global migration patterns have increased the risk of FGM among women and girls living in developed countries, including the United States.

Virginia is one of the states in the United States with the highest rate of at-risk women and girls of FGM.

The statistics on the map above comes from the latest report on female genital mutilation from the Centers for Disease Control and Prevention (soon to be released).

In 2013, about three-fifths of all women and girls at risk of FGM lived in eight states: California, Maryland, Minnesota, New Jersey, New York, Texas, Virginia, and Washington.
Female genital mutilation (FGM), involving partial or total removal of the external genitals of girls and women for cultural, or other nonmedical reasons, has devastating immediate and long-term health and social effects, especially related to childbirth. This type of violence against women violates women’s human rights. There are more than 3 million girls, the majority in sub-Saharan Africa, who are at risk of mutilation each year.

The U.S. Congress passed a law in 1996 making it illegal to perform FGM, and 23 states currently have laws against the practice. Despite decades of work in the United States and globally to prevent FGM, it remains a significant harmful tradition for millions of girls and women.

In the United States, efforts to stop immigrant families from sending their daughters to their home countries to be cut led to a 2013 law making it illegal to knowingly transport a girl out of the United States for the purpose of genital mutilation. FGM has gained attention in the United States in part because of the rising number of immigrants from countries where FGM is prevalent, especially sub-Saharan Africa. (See Map of Africa in this manual) Between 2000 and 2013, the foreign-born population from Africa to the U.S. more than doubled, from 881,000 to 1.8 million.

Most women and girls at risk of FGM are living in cities or suburbs of large metropolitan areas. In 2013, 40 percent of the population at risk lived in five metro areas: New York, Washington, D.C. and adjacent cities, Minneapolis-St. Paul, Los Angeles, and Seattle (see Table below).

A Survivor of FGM recently wrote, “America, do you want to be labeled as the nation that stood by and watched countless little girls get mutilated or die, simply because it doesn't affect you directly? You lead the free world; make it freer for little girls and women in Africa and other parts of the world actively practicing FGM.”
Girls under age 18 made up one-third of all females at risk of FGM in 2013 in the U.S. While some of these girls were born in other countries with high prevalence rates, the majority are children born to parents from high-prevalence countries. Anecdotal reports tell of U.S.-born girls being taken out of the U.S. to their parents’ countries under the pretense of vacationing. While on vacation in their parents’ countries of origin, FGM is performed on them. The parents also collectively pay for the transportation of the mutilator or Exciser to the United States to perform FGM on their daughters, right here in the U.S.

There is a growing movement across the world against FGM, people are speaking out and protesting against the practice. As awareness spreads and support grows we are seeing a change of attitudes. The shame and secrecy which surrounds FGM is being challenged by the western world.

It is crucial that we study the perceptions, beliefs and attitudes towards FGM in the American communities. Obtaining such knowledge will help us create evidence-based counseling and educational programs. School counselors and teachers as well as the police force need to be culturally trained to competent methods of how to deal with FGM in the communities. In order for school teachers and counselors and police officers to assist in the prevention of FGM, they need to fully understand the cultures and traditions of the parents of the at-risk girls.
The Steps to Preventing FGM in the United States

From the time you suspect the threat or risk of FGM in the U.S., please act smartly without delay and take these steps:

You are a neighbor, a parent of another child, a community member or leader. You suspect the risk or threat of FGM in your community. What do you do?

Contact the school of the at-risk or threatened child, and tell them in detail what you suspect and why you suspect it. If the school is in session at the time of your suspicion, ask to speak with a teacher, counselor or school nurse.

The next step after you have reported your suspicions to the school, the school will contact the parents of the at-risk student and request a meeting with the parents. The school will also contact the Global Woman Center and advise us of the suspicious report, and invite us to the meeting.

During the meeting, the parents will be advised by the school representative and the representative from the Global Woman Center what has been reported. The suspicion might be from vaccinations for travel, passport application, and an upcoming overseas trip to a practicing FGM country, talks of a big surprise, talks of a special ceremony, visits to the grandparents, or even talks of expecting a visitor from a practicing FGM country. The representatives at the meeting will advise the parents of the FGM laws of the United States. They will advise them that should they take their daughter out of the country; the child will be subject to medical examination by a physician upon their return. The representatives will also advise the parents that if the medical exam results show the aftermath of FGM on their daughter(s), they will face 5-year imprisonment and a fine.

If the parents deny the suspicions and the representatives are convinced after speaking with them that the child is indeed at risk, we will consider moving it to another step to law enforcement for further interrogation. Let us be mindful that the purpose of working with the schools and communities is to protect the girls that are at-risk. If we suspect a problem of risks it is our responsibility to do everything within the parameters of the law to protect the girls, even if it is from their own parents.

There are situations surrounding other types of child abuse in the homes in the U.S. where children have been immediately removed from the home to protect the children. FGM situation should be treated no differently since it is recognized as a form of child abuse in the United States.

If the school is not in session at the time, and it is a matter of urgency, call the Global Woman Center and report the reason for your suspicion. We can be reached at 703.818.3787 and by email at info@globalwomanpeacefoundation.org. In this case,
the Center will follow the same step above and work with the school to advise the parents.

If the situation is far more than a suspicion, and there is proof that the child is at risk or has already been mutilated, the action taken will not be a meeting with the parents. The case then is considered an emergency situation, and authorities will need to be notified immediately. In an emergency situation, you may contact the school and the Global Woman Center but you are to also contact your local police.

### What Teachers Should Know

- **How and Why FGM is performed** (already stated in Understanding & Preventing FGM)
- **Where FGM is performed** – at least 28 African countries, Asia, the Middle East, Europe, Australia and the United States.
- **The prevalence** (5% to 95+ %)
- **The consequences** (physical and psychological, which have already been outlined on pages 13-14)
- **Know your students** (teachers should know where each student is from or where their parents are from originally)
- **Familiarize yourself with these countries, their cultures and traditions**
- **Assess the risks and know who exactly is at risk, and who is not**
- **Know how to initiate a conversation with the students**
- **Know how to address FGM with parents and families of students**
- **What to avoid with families of girls at risk**
- **What to do when a student is in imminent danger**
- **Know that triple threats are cultural barriers, limited English & low health literacy**

### Target Groups to Watch

The three main groups affected by FGM are identified by frontline professionals as:

- A girl at risk of having FGM
- A Girl who has undergone FGM
- A baby girl born to a mother who has undergone FGM

### Risks to the child must be considered if:

- Any female child born to a woman who has undergone FGM
- Any female child whose older sibling has undergone FGM must be considered at immediate risk
- Risk to other female children in the woman’s or child’s household must also be considered
In addition to school teachers, counselors, nurses, community members and leaders, neighbors, parents, this manual must be made accessible to the following professionals:

- General Practitioners
- Pediatricians
- Midwives
- Health Visitors
- Accident & Emergency Professionals
- Daycare & Preschool Staff

Additional Places of Interest are specific health settings such as:

- Sexual Health Clinics
- Sexual Assault Referral Centers
- Community Contraception Services

When FGM is identified in a girl or a young woman, the following information should be assessed:

| What type of FGM was performed on the girl or young woman (this is relevant to healthcare workers) |
| Country of origin of the girl or parents |
| When FGM was performed |
| Where it was performed |
| Referral to the appropriate services |

**Additional Steps the Global Woman Center Takes**

1. Treat FGM as Child Abuse: The U.S. government regards FGM as a form of child abuse.
2. Document and collect information: The healthcare providers, school teachers, school counselors and school nurses should document and collect information on FGM and its associated complications in a consistent and rigorous way, when they come across such cases.
3. Share that information systematically: The Global Woman Center will continue to develop protocols for sharing information about girls at risk and girls who have undergone FGM on an annual basis. Such information will be shared with healthcare providers, schools, the police and the communities to keep them updated and informed of any changes in the law and practice.
4. Empower frontline professionals: The Global Woman Center is committed to developing the competence, knowledge and awareness of frontline health professionals to ensure prevention and protection of at-risk girls of FGM. Also ensure that health professionals know how to provide quality care for girls and women who suffer complications of FGM. We will accomplish this empowerment of frontline professionals through our network of OB/GYNs and other related health professionals.
5. Identify girls at risk and refer them as part of child safeguarding obligation: The Global Woman Center will work with health professionals to ensure that girls at risk
of FGM are identified as early as possible. All suspected cases will be referred as part of existing child safeguarding obligations.

6. Report cases of FGM: All girls and women with FGM within the US healthcare system must be considered as potential victims of crime, and must be referred to the police and the Global Woman Center.

7. Hold frontline professionals accountable: The Global Woman Center will request that health care professionals and local authorities systematically measure the performance of frontline health professionals against agreed standards for addressing FGM.

8. Empower and support affected girls and young women (both of those at risk and survivors): This is a priority for the Global Woman Center, which fits in our Kids Reach Program (preventive) and our Post-FGM Buddy Program (rehabilitation). We will make all efforts to work closely with public health and education professionals to integrate FGM into prevention messages.

9. Implement awareness campaign: The Global Woman Center plans to implement a national public health and legal awareness publicity campaign on FGM, similar to domestic violence and HIV campaigns, once the proper funding is raised and available.

**Research Counseling and Education**

Global Woman P.E.A.C.E. Foundation realizes that it is crucial to study the perceptions, beliefs and attitudes towards FGM in community members. We will use this knowledge to create evidence-based counseling and education programs for the Global Woman Center.

There is a need for our Center’s counselors and school counselors to be trained in culturally competent methods to dealing with FGM in the community. It is important that we secure funding to ensure the comprehensive training of these counselors.

<table>
<thead>
<tr>
<th>Types of Counseling</th>
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<tbody>
<tr>
<td>• The Center will offer detailed assessments of the therapeutic needs of FGM survivors and at-risk girls</td>
</tr>
<tr>
<td>• Long term psychodynamic counseling for survivors and girls who will respond to this</td>
</tr>
<tr>
<td>• Psychodynamic and also therapeutic group work. This is where the round circle group meetings will be applied. The Center will also host 2-day retreats with survivors, at-risk girls, counselors, teachers, health professionals, parents and community members from which all attendees will benefit.</td>
</tr>
</tbody>
</table>

**Education at 2-Day Retreats**

1. Awareness-raising campaigns and community education programs are important so that people know where to go when they need assistance or when they need to refer a friend or family member for services. These retreats expect to raise awareness while educating a wide range
of people in communities. We will mobilize our retreats and take them to a different targeted state each time.

2. Education on the harmful effects of FGM on women and girls dealing with both the physical and the psychological aspects of the issue. Survivors will benefit from the retreats as well as the at-risk girls. It is our hope that the parents of at-risk girls will benefit from the retreats and will be persuaded and convinced of the dangers of FGM.

3. The OB/GYNs and other related healthcare providers will be invited to attend the retreat, and even participate as speakers and trainers. This will ensure that all health professionals will know what to do if and when they come across FGM in patients, school children, etc.

**Statistics and History on U.S. Immigration**
Immigrants from Africa constitute a highly diverse and rapidly growing group in the United States. As Census data demonstrate, the African foreign-born population doubled in size between the years 2000 and 2010. Nearly half of African immigrants are naturalized U.S. citizens, and seven-in-ten speak only English or speak it “very well.” Just a little less than three-quarters of African immigrants are black, while roughly one-fifth are white. The largest numbers of African immigrants are found in California, New York, Texas, Maryland, and Virginia. The top countries of origin for African immigrants are Nigeria, Ethiopia, Egypt, Ghana, and Kenya. Two-fifths of African immigrants have at least a Bachelor’s Degree and more than one-third work in professional jobs.

The number of African immigrants in the United States grew from 881,300 in 2000 to 1.6 million in 2010.

![Figure 1: African Foreign-Born Population in the U.S., 2000 & 2010](image)

Source: Census 2000 Special Tabulations (STF-159), Table FBP-1; 2010 American Community Survey, Table S0504.
Between 2000 and 2010, the African foreign-born population increased in size by 111.1% in Texas, 110% in Virginia, 100.1% in Maryland, 40.3% in California, and 35.9% in New York.

Most African immigrants come from Western and Eastern Africa.

As of 2010, 573,791 African immigrants came from Western Africa and 475,832 from Eastern Africa.

By 2009, there were about 830,000 immigrants in the United States from the Middle East and North Africa. Accounting for just 2.2 percent of all immigrants in the United States, immigrants from the region have received growing attention in the post-9/11 era, particularly with U.S. military action in the Middle East and the recent string of uprisings and political unrest in North Africa that have displaced thousands of refugees.

Iraqis are the largest single immigrant population from the Middle East and North Africa in the United States, followed closely by Egyptians. The number of immigrants from Saudi Arabia and Yemen, however, has also grown rapidly over the past decade.

This spotlight focuses on the foreign born from the Middle East and North Africa residing in the United States, and examines the population's size, geographic distribution, and socioeconomic characteristics using data from the U.S. Census
Bureau’s, American Community Survey (ACS) and the Decennial Censuses. The first section is based for the most part on ACS data, while a sample of pooled ACS data was used in the second section in order to generate a sufficiently large sample size.

**Figure 8: Increase in African Foreign-Born Populations in Top-Five States, 2000-2010**

Iraqi, Egyptian, and Lebanese immigrants accounted for over half of the foreign born from the Middle East and North Africa.

Over the past decade, the fastest-growing immigrant groups from the Middle East and North Africa have been Saudis, Yemenis, Sudanese, and Iraqis.

Nearly half of all immigrants from the Middle East and North Africa reside in California, Michigan, New York, and Texas.

Only the New York area has more African immigrants than the Washington, D.C. region, as the last 12 years saw the largest increase in America’s African-born population.

According to the report, Maryland and Virginia are top destinations for African-born immigrants, and those from “Nigeria, Ethiopia, Egypt and Ghana make up 41 percent of the African-born total.” The report also found that:
The four states with African-born populations over 100,000 were New York (164,000), California (155,000), Texas (134,000), and Maryland (120,000).

Of the 10 states with the largest African-born populations, Minnesota (19 percent), Maryland (15 percent), Virginia (9 percent), Georgia (8 percent), and Massachusetts (8 percent) had percentages of African-born in their foreign-born populations that were at least twice the national percentage of 4 percent.

Metropolitan areas with the largest African-born populations were New York (212,000), Washington (161,000), Atlanta (68,000), Los Angeles (68,000), Minneapolis-St. Paul (64,000), Dallas-Fort Worth (61,000), and Boston (60,000).

Nigerians “were the most populous group and constituted a high proportion (20 percent or more) of the African-born in the Atlanta, Chicago, Dallas-Fort Worth and Houston metro areas;” Ethiopians “were a high proportion and the largest group in the Washington D.C. metro” area; and Liberians were the largest group in the Philadelphia area. The largest Liberian population in the U.S. is found in Minnesota, while the 2nd largest from that country is found in Rhodes Island.

For additional service to report suspected FGM abuse if you are unable to reach the Global Woman Center or any of the other listed agencies, you may also call the Department of Social Services in the area in which the child lives. Ask for Child Protective Services. If you feel that the child is in immediate and severe physical danger, call Child Protective Services and/or local law enforcement immediately.

**Images of the Female Genital Anatomy**

The image to the left shows the parts of the vagina. The images to the right show a normal vagina and after stitching
This is an actual vagina after mutilation and stitching. As you see, everything is stitched up except for a tiny opening to accommodate urination.

<table>
<thead>
<tr>
<th>State</th>
<th>Total</th>
<th>Under 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S.</td>
<td>506,795</td>
<td>166,173</td>
</tr>
<tr>
<td>California</td>
<td>56,872</td>
<td>16,557</td>
</tr>
<tr>
<td>New York</td>
<td>48,418</td>
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<tr>
<td>Minnesota</td>
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<td>New Jersey</td>
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<tr>
<td>Virginia</td>
<td>30,830</td>
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</tr>
<tr>
<td>Washington</td>
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**Uncomplicated Counseling**

If we are filled with love, whenever we talk with people or even think of them, our first, instinctive move would be to think well of them, to find things to admire and praise in them and to overlook or excuse any shortcomings they may have. Sadly, such an attitude is far from natural to us. Most would-be counselors come up with half-baked solutions that will never work and when their advice fails to instantly transform a person’s life, instead of humbly recognizing the limitation of their approach, they blame the person they were trying to help! When progress is not as fast as we expect, we should consider that the problem may be our inadequate “solution,” not their inadequate application.

With a little common sense, however, there is much we can safely do. Without any training we could spread cheer in the world and find many valuable ways of bringing comfort to those in need of it. In addition to discovering valuable ways in which we can offer comfort and support, we can identify the boundaries within which we can safely labor. Is this what we call counseling?

What if you were treating the open wounds of an accident victim? You would realize that the most gentle, well-meaning touch could send the patient reeling. What if the wounds were invisible and the patient appeared uninjured? You would not know that the patient is in pain just from appearance. Emotionally wounded individuals are just as sensitive as the physically wounded. A verbally abused woman once said that her husband’s abuse would probably have been better had he physically abused her. She said the verbal abuse never healed.

To be in physical or emotional pain is one of the loneliest experiences on earth. And yet at the time when people need us most, many of us flee from or neglect them. Many of us shun them because we feel awkward. We would love to help but we are afraid we will say the wrong thing and add to their pain. Remember that advice is cheap but love is precious.
We must be careful when we choose to offer advice. Giving advice is taking upon us the role of a superior. Often, it is selfishly inflicting our opinion on a vulnerable person. And it is usually being judgmental. It is considering people to be ignorant. We almost inevitably overvalue our advice and undervalue our companionship. And the biggest part of good companionship is being a warm listener. And a significant part is simply being there. The perfect friend, however, remains sensitive to the person’s need for space, which is likely to change with the person’s mood. Everyone should be quick to listen, slow to speak and slow to become angry. This describes the most vital of all counseling skills and we should give top priority to honing it.

Quick to listen gives the impression of having acted that way so often that listening, rather than reacting or butting in, has become an instinctive reaction. A good counselor listens intently, and hangs on to people’s every word. How much you listen shows how much you value the other person. Often, how much you talk, shows how full of yourself you are. And it is not just how much you listen but how you listen that shows how important someone is to you. True listening is not sterile silence. It is savoring and feeling a person’s every word.

The most difficult task of all is distinguishing between what is comfortable silence for the other person and what is uncomfortable silence. Often we should endure silences that are to us uncomfortable but are comfortable to the other person. When, in the other person’s perception, silences begin to become uncomfortable, then chatting can become valuable, provided we stay alert for the affect our words are having.

When someone is hurting it is not a time to blurt out the first thing that comes into our heads. Most of us have a natural tendency to lapse into a preaching or lecturing mode when trying to help a hurting friend. By so doing, however, we give the impression of elevating ourselves from the position of a warm-hearted friend to that of a cold superior. People crave love and understanding, not sermons. That is why encouragement is of such great value. It lifts people. In contrast, one-on-one preaching tends to weigh people down, adding to their feelings of inadequacy and aloneness. Preaching, of course, is perfectly acceptable when addressing a body of people. It’s when talking with an individual that it becomes an inappropriate mode of address.

If people are brimming with joy and confidence, and they feel loved and accepted by nearly everyone, then we could safely say almost anything without devastating them. However it is very different with someone reeling under life’s blows, the safety margin evaporates. It becomes essential to avoid saying anything that could possibly be interpreted as critical, or a put down.

A factor seriously affecting the safety margin is the extent of a person’s emotional attachment to you. If someone sees you as an insignificant stranger and couldn’t care less what you think about him/her, you could safely say things that a treasured friend could never get away with. With a person whose emotional well-being hinges on
your opinion of him/her, the slightest slip could be disastrous. The bigger the place
someone has given you in his/her heart, the less you can safely say about sensitive
issues, and the more critical it is that you carefully listen and be supportive. This in
no way implies a diminished role in helping people you are emotionally involved
with, it simply means you need to lean more heavily than ever upon means other
than giving advice. An enormous obstacle to effective counseling is the counselor’s
own unconscious motives.

It is most powerful for people to know that you have gone through their pain because
of the depth and breadth of your own sufferings. But even if you have been blessed
with such trials, please do not spend too long describing them. Make it obvious that it
is their experience, not yours, that presently most moves you. And, of course, leave it
to them to decide how similar your trial is to theirs.

If you are not willing to stick by hurting people’s side, faithfully believing in them for
literally years if necessary, do not bother to start. Be prepared for their healing to be a
lengthy process with many disappointments and setbacks, but always believe that
they will finally make it.

Love is our great motivator. It keeps us thinking the best of a person and pressing
through for as many weeks, months or years that it takes to see a full breakthrough
in his/her situation. Love remembers people’s kindnesses and forgets their failings.

The time we give has been described as “generous kindliness” and as the antithesis of
envy. We need to be generous with our time and our compliments and to rejoice in
every victory of the other person, displaying the exact opposite spirit of the gossiper,
who delights in someone else’s downfall.

If you are a great listener, compassionate, generous with your time and meet all of the
requirements in this section, then you can be a counselor, and a good one.

Directory of Important Contact Information

Global Woman P.E.A.C.E. Foundation
703.818.3787
info@globalwomanpeacefoundation.org
www.globalwomanpeacefoundation.org
The Global Woman Washington, D.C. Center is located at 3920 Alton Place, N.W.
Washington, D.C. 20016. The Global Woman Northern Virginia Center is located at
901 South Highland Street, Suite 319, Arlington, VA. 22204. For appointments, call
703.818.3787

The U.S. Human Rights Special Prosecution (HRSP)
1.800.813.5863
hrsptips@usdoj.gov
The U.S. Department of Health and Human Services
Office of the Secretary
Office of the Assistant Secretary for Health
Office on Women’s Health FGM
Call Center 1.800.994.9662

National Child Abuse Hotline  800.422.4453

Virginia Fairfax County Special Victims
703-246-2141 for assistant from a Victims Specialist
Fairfax County Police Non-Emergency Number:  703.691.2131
Fairfax County Office for Women:  703.324.5730
Statewide Virginia Crime Victim Assistance  888.887.3418
Fairfax County DFS Child Protective Services
Hotline/Helpline  703.324.7400

Special Victims Units/Bureaus of the Washington, D.C. Metro Area

Alexandria Victim/Witness Program
520 King St., Suite 301
Alexandria, VA 22314
Phone: 703.746.4100
Fax: 703.838.3897

Arlington County Victim/Witness Program
1425 N. Courthouse Road, #5200
Arlington, VA 22201
Phone: 703.228.7273 – Victim Specialist
Fax: 703.228.7118

Fairfax County Victim/Witness Program
10600 Page Avenue
Fairfax, VA 22030
Phone: 703.246.2141
Fax: 703.246.2072

Loudoun County/Leesburg City Victim/Witness Program
18 East Market Street
Leesburg, VA 20175
Phone: 703.777.0417
Fax: 703.737.8844

Prince William County/Cities of Manassas & Manassas Park Victim/Witness Program
9401 Grant Avenue
Manassas, VA 20110
Phone: 703.392.7083
Fax: 703.392.7096

Montgomery County, Maryland Abused Persons Program (APP)
50 Maryland Avenue, 5th Floor
Rockville, MD 20850
Phone: 240.777.4195 Weekdays
Phone: 240.777.4673 24 Hours

Domestic Violence and Sexual Assault Center
at Dimensions Healthcare System
Prince George’s Hospital Center
3001 Hospital Drive
Cheverly, MD 20785; Phone: 301.618.3154

Prince George’s County Child Advocacy Center
805 Brightseat Road
Landover, MD 20785
Phone: 301.909.2089

Baltimore City Child Abuse Center
2300 North Charles St. 4th Floor
Baltimore, MD 21218
Phone: 410.396.6147

Frederick County Child Advocacy Center
12 East Church Street
Frederick, MD. 21701
Phone: 301.600.1758

Howard County the Listening Place
2850 North Ridge Road
Ellicott City, MD 21043
Phone: 410-313-2630

Washington County Child Advocacy Center
Program Manager
24 N. Walnut Street, Suite 206
Hagerstown, MD 21740
Phone: 240-420-4308

District of Columbia Metropolitan Police Department
300 Indiana Avenue, NW, Room 5059
Washington, DC 20001
Phone: (202) 727-9099
Email: mpd@dc.gov
**Glossary**

**FGM:** The acronym for female genital mutilation. The most commonly used term.

**Female Genital Mutilation:** The intentional removal of all or part of the female genitalia for non-medical reasons.

**Female Circumcision:** A more subtle term used to describe female genital mutilation in some societies. However female circumcision is far different from male circumcision.

**Vacation Cutting:** This is when parents and/or guardians transport a girl to their country of origin with the intention of having FGM performed on her during her summer break. In most or all cases, the girl is returned to the U.S. and back to school.

**Exciser:** The person who performs FGM on the girls and women. She could be referred to as the Zoe, the Medicine Woman, etc. Regardless of what she is called, she receives a sizable amount of money for performing FGM.

**Reconstructive Surgery:** The surgery performed on a woman or girl who has undergone FGM. The surgical procedure is relatively simple and short in duration (under one hour) with most patients experiencing improved cosmetic appearance, sensation, reduction in pain and infection.

**Global Woman Center:** The first center of its type in the Washington, D.C. metro area. The center services FGM survivors and at-risk girls of it. Clients can receive counseling, referrals to OB/GYN specialists in treating FGM survivors, and assistance in paying for their reconstructive surgeries.

**Global Woman P.E.A.C.E. Foundation:** A non-profit organization located in the Washington, D.C. area whose mission is to empower women and girls through education to help eradicate gender based violence with emphasis on ending female genital mutilation.

**Clitoraid:** A non-profit association that built a hospital in Burkina Faso, West Africa, which offers free medical services for the physical restoration and rehabilitation of Female Genital Mutilation survivors.

**Clitoris Awareness Week:** The first week in May is declared as Clitoris Awareness Week to observe the importance of the clitoris to the female body, and that it was not intended to be removed from the body.
**Zero Tolerance Day**: February 6th of each year is observed around the world as the day of zero tolerance against female genital mutilation. It is intended to let those who practice FGM that it will no longer be tolerated by the United Nations and all organizations and persons that advocate against the practice of FGM.

**Kids Reach Program**: The preventive program created by the Global Woman Center as part of their outreach program to the public. This particular program is designed to reach children from 6 to 7 years old to make them aware of what FGM entails and what to expect if there are plans to prepare them for FGM.

**Post-FGM Buddy Program**: This is the rehabilitation program which the Global Woman Center has designed to assist the survivors of FGM through counseling, meetings, retreats, referral to proper OB/GYN treatment and reconstructive surgery.

**Rehabilitation**: To restore the women and girls to good health and ability to function in society without the post-traumatic stress (physical and psychological) that FGM causes in girls and women.

**Prevention**: An action taken to reduce or eliminate the probability of specific undesirable events, such as female genital mutilation from happening in the future.

**Walk to End FGM**: This is an annual awareness-raising event against FGM held in Washington, D.C. The first of its kind was held on November 8, 2014. The second Walk to End FGM is being held on October 31, 2015.

**Partnership**: Global Woman P.E.A.C.E. Foundation collaborates with like-minded organizations to form partnerships through events, outreach programs, fundraising, educational programs, etc.

**OB/GYN**: The acronym for Obstetrics/Gynecology is the medical specialty dealing with fields of obstetrics and gynecology through only one postgraduate training program. This combined training prepares the practicing OB/GYN to be adept at the care of female reproductive organs’ health and at the management of obstetric complications, as well as through surgery.
Girls are being prepared for FGM Ceremony

A Little Girl at Risk of FGM

Girls line up as they wait their turn for FGM

Image of an uncut vagina & an infibulated vagina

First Hospital in Africa for FGM Survivors

Burkina Faso Women Celebrate Hospital

13-year old Sohair Al-Batta died as a result of FGM in Egypt in 2014.

Some instruments usually used during FGM
Client Application Form

At the Global Woman Center we regard inquiries and counseling discussions as private and confidential. Any information provided will be treated in confidence. No information of any kind is given to anyone outside of the Center unless specifically requested in writing, although in rare circumstances we reserve the right to widen confidentiality if there appears to be a serious risk of harm. Please complete this form and return to us prior to setting up your appointment. You may also call to request this form.

First Name:                                                     Last Name:
Address:
Zip Code:      Main Telephone:
Date of Birth:                              First Language:
Country of Birth:                             Nationality Status:
Email:
Mobile telephone (if different from main telephone):
Is it ok to write to you?       Yes ☐   No ☐
Is it ok to phone to you?       Yes ☐   No ☐
Is it ok to leave you a message? Yes ☐   No ☐
Is it ok to send a text?       Yes ☐   No ☐
Preferred method of contact: Phone ☐  Email ☐  Text ☐  Postal Mail ☐
Please note: Our first appointment for one-on-one is at 10:00am and our last appointment for one-on-one is at 11:30am, only on Wednesdays & Saturdays. One-on-one appointments last for no more than an hour and no less than 30 minutes.

Do you require one-on-one counseling? Yes ☐ No ☐

If you checked “Yes”, specify the day & time slot you prefer for your appointment:

Wednesday ☐ Saturday ☐
Wednesday slots: 10:00am ☐ 11:00am ☐
Saturday slots: 10:00am ☐ 11:00am ☐

If you checked “No”, you will be included in the Round Circle Discussion. By providing your email address and phone number, you will be sent an invitation to join us in the Round Circle Discussion, which is held once a month. You will be required to respond to the invitation to reserve your seat at the Discussion.

Do you have any special needs?
Hearing impairment ☐ Visual impairment ☐ Wheelchair access ☐ Reading difficulty ☐ Interpreter ☐ (what language?)

Do you have small child or children? Yes ☐ No ☐
If yes, how many do you have?
Will you need to bring them to your appointments? Yes ☐ No ☐
If yes, what are their ages?

What is your current work situation?
Unemployed ☐ Fulltime ☐ Part time ☐ Student ☐ Intern ☐ Volunteer ☐ Retired ☐

Do you have a physician whom you visit regularly? Yes ☐ No ☐
Is he/she an obstetrician/gynecologist (OB/GYN)? Yes ☐ No ☐
Is he/she your primary care physician (PCP)? Yes ☐ No ☐

Have you received professional counseling or psychological treatment? Yes ☐ No ☐
If “Yes”, please indicate how long ago or is it current.

Are you a survivor of female genital mutilation (FGM)? Yes ☐ No ☐
Approximately what year was FGM performed on you? 19 ___ or 20 ___
Where was FGM performed on you? Hospital ☐ Village ☐ Society Bush ☐ House ☐ Other ☐ (explain)
Who performed FGM on you? Physician ☐ Exciser ☐ Grandmother ☐ Mother ☐ Other ☐ (explain)
Do you know someone who has undergone FGM? Yes ☐ No ☐
Approximately what year was FGM performed on her? 19____ or 20____
Where was FGM performed on her? Hospital □ Village □ Society Bush □ House □ Other □ (explain)
Who performed FGM on her? Physician □ Exciser □ Grandmother □ Mother □ Other □ (explain)

Would you be interested in having restorative surgery? Yes □ No □

Please note: Restorative surgery will reverse what FGM did to your vagina. This surgery will be performed by well-trained and experienced OB/GYNs. The cost of this surgery is at least $1700 but by being a client of the Global Woman Center and attending your appointments and the Round Circle Discussion, you could become eligible for assistance with the surgery.

Do you have health insurance? Yes □ No □

Please note: The services at the Global Woman Center are at no cost to our clients. However the cost of the surgery must be paid to the OB/GYN. The Global Woman Center raises funds to support the cost of the surgery for our clients. Our Center will negotiate with insurance companies for possible coverage in whole or in part on behalf of our clients. However the Center is committed to assisting our clients in obtaining the surgery.

**Referral**

Were you referred to the Global Woman Center? Yes □ No □
Name: □ Organization: □
Email: □ Telephone: □
Organization Web Address:

**For Office Use Only**

First Contact Date: □ Case Number: □
Inquiry: □
New Referral: □
On Hold: □
Appointment: □
One-On-One □ Round Circle Discussion □