WHY WE'RE HERE: OURSELVES, FGM, AND SOME THOUGHTS ON CHANGE

He who learns, teaches.

-Ethiopia

Overview

In this module, trainers help participants begin to focus on themselves, their interpretation of the FGM "problem," and their hopes for this training. We also explore the core of the curriculum, a participatory approach to community education or community change. This approach is based on a philosophy of trust in each other and our communities. We enable people to make positive changes in their lives when we:

- Trust in the potential that already exists in people, whether they are aware of it or not;
- Trust that given the right enabling environment people's potential will become manifest; and
- Trust in ourselves as facilitators to provide the kind of environment and experience which permits that potential to unfold.

The workshop begins with trust-building exercises to help participants realize the environment and experience they need to unfold as communicators, trainers, educators, listeners, program planners, advocates, and enablers of change. During this segment of the workshop, participants will become acquainted with their own expectations of the workshop and their FGM project. They will also begin to select the tools they need to fulfill their expectations and solve the problem of FGM in their respective communities.

Among these tools is a workshop kit. The main purpose of the kit is to give participants a package of supplies and materials that can be used during the workshop and later, on their respective projects. The kit can be basic or elaborate, depending on funds and scope of the workshop and project. Some suggestions for contents include:

Basic: closed plastic or canvas bag, vinyl or cloth zippered portfolio, or receptacle for papers and contents of the kit (this can carry the workshop or project logo)
- pencil
- pencil sharpener
- eraser
- pen
- colored pens or markers
- steno notebook or journal
- binder for handouts

Other: tape recorder, camera, batteries, materials for developing facilitation aids (scissors, flannelgraph material, etc.)
(Workshop kits can be assembled with certain items (tape recorders or cameras) going to one person per team, if groups are arranged by teams).

Objectives

By the end of this module, participants will:

- Be acquainted with their fellow participants, training staff, and others' expectations for

the workshop.

- Be familiar with the contents of the workshop kit.
- Have developed working "ground rules" or "conventions" for the workshop.
- Have participated in developing objectives for the workshop.
- Be acquainted with the health, socio-economic, legal, and ethical implications of FGM as these relate to women's and children's physical, sexual, mental, and social well-being.
- Be acquainted with the general FGM situation in their locality, country, and world.
- Apply a personal definition of the problem of FGM and discuss it in the context of related issues.
- Have explored the ethical implications of the practice of FGM as these affect medical and health personnel, parents, and children.
- Relate their vision for society and have thought about how it guides the FGM project they are working on.
- Distinguish and critique participatory approaches and traditional educational approaches.

Activities

Workshop Introductions	30-45 minutes
Workshop Kit	10-15 minutes
Workshop Ground Rules	20-30 minutes
FGM Facts and Figures	1-2 hours
Workshop Objectives	20-30 minutes
Defining the "Problem" in Context	60 minutes
Whose Rights?	40-50 minutes
Envisioning	60-90 minutes
Frameworks for Change: Traditional (directed) Education vs. Growth-Centered (Participatory) Approaches	45 minutes
Estimated module length	6-8 hours

Materials

Handouts

HO I.1	Workshop Kit*
HO I.2	Copies of workshop goal and objectives*
HO I.3	Fact Packet (compiled by trainers, to include Country Fact Sheet, newspaper articles, copies of FGM information as appropriate to this group); reports of quantitative or other studies relevant to region.*
HO I.4	"Conventions: Convention on the Rights of the Child; Convention on the Elimination of all forms of Discrimination Against Women; African Charter on Human and People's Rights"
HO I.5	"Code for Nurses" of the American Nurses' Association
HO I.6	Vision Questions
HO I.7	Attributes, Benefits, and Requirements of Growth-Centered Approaches to Change
HO I.8	Key Points Summary, Module I

Training Aids

TA I.1	Workshop Ground Rules
TA I.2	Sample Statement of Workshop Goal and Objectives
TA 1.3a	FGM Facts: narrative of world situation, effects, trends (10 pages)
TA 1.3b	FGM Facts: embryonic development of genitals, FGM pelvic models, photo (8 pages)
TA 1.4	Islam and Female Circumcision
TA I.5	Whose Rights? Case Study 1, 2, 3, 4
TA I.6	A comparison of traditional and growth-centered educational approaches

Recommended Resource Materials (not included):

IAC: "Specific Resolutions of the Inter-African Committee Regional Conference"
ICAF/Passages Field Note: "FGM: A continuing violation of the human rights of young women"
Pop Reports Supplement: "FGM: A reproductive health concern"
Journal of the Canadian Medical Association: "Viewpoint: Female circumcision: When medical ethics confront cultural values"

* Where * appears next to a HO or TA, it is not included but must be assembled before or as part of the workshop.

Activity

WORKSHOP INTRODUCTIONS

Purpose:	Participants and facilitators will be acquainted with each other and expectations.
Format:	Icebreaker Game
Suggested Time:	Depends on number of participants (30-45 minutes)
Materials:	Newsprint or chalkboard and markers
Preparation:	None

Procedure:

➢ Use an icebreaker to introduce workshop facilitators and participants to one another. Options include any variation on the following:

- Round robin: each person states name, region or organization, something he or she would like to share, an experience related to FGM, and one expectation of the workshop.

- Brainstorming and Interviews: The group agrees on what they would like to know about their fellow participants to work well together as a team. The participants then pair off with someone they don't know well for a 5 minute interview on these topics. Each member of the pair introduces his or her partner in a one-minute presentation that touches on the desired information.

Key Point:

- Workshop activities as well as future project activities will be more enjoyable, helpful, and rewarding if participants and facilitators are well acquainted with one another.

Activity
WORKSHOP KIT

Purpose:	Participants will be familiar with the contents of their workshop kit.
Format:	Hands on
Suggested Time:	10-15 minutes
Materials:	HO I.1, the Workshop Kit
Preparation:	Prior to the workshop, purchase components and assemble kits. See module overview for contents and details.

Procedure:

- Hand out kits and review the contents with the participants.
- Explain that it is a good idea to start keeping a journal of the workshop process and content as practice for keeping the same record of project process and content.

Key point:

- The purpose of the workshop kit is to make learning, workshop activities, community assessment, project planning, and project implementation easier and more organized by providing participants with the basic tools of research and materials development.

Activity

WORKSHOP GROUND RULES

Purpose:	Participants and trainers will have developed working ground rules or "conventions" for the workshop.

Format:	Large group discussion
Suggested Time:	20-30 minutes
Materials:	TA I.1: "Workshop Ground Rules"
Preparation:	Read TA I.1

Procedure:

Following introductions, ask participants to suggest "ground rules" for all participants to follow during the workshop to ensure that expectations are met. Examples appear in TA I.1. This TA can be presented as an example to save time or participants can start from scratch. Aim for consensus and write these in newsprint, to be posted where all can see them.

Key Point:

- Group-designed ground rules or conventions contribute to the workshop flow and learning by creating a comfortable and reasonably orderly atmosphere.

Workshop Ground Rules

- All participants are encouraged to contribute to the workshop to the extent they are able.
- Participants and facilitators have an equal part in creating an environment in which all feel free to speak and contribute.
- All participants (including facilitators) listen with an open mind and encourage input.
- Participants will make it a point to share the accomplishments of this workshop with team members who aren't present.
- Everyone's opinion will be valued and respected—disagreements are welcome but must be nonjudgmental in tone.
- Everyone has the right to pass up any question.
- Two participants will be responsible for keeping the group energized each day.
- One person will volunteer to give a summary of the day's achievement at the end of the day.
- In general, discussion should focus on general situations and not divulge private or sensitive information about known persons outside the group; disclosure of personal information should occur only with the consent of the person involved, and personal disclosures by group members should not be discussed outside the workshop setting.
- I-statements--it is preferable to share our feelings our values using "I-statements."
- All honest questions are valid and participants should respect each others' informational needs. If participants wish, workshop facilitators will maintain a confidential question box for anonymous questions, and all questions will be answered.
- It is acceptable to feel uncomfortable with the topics under discussion—one purpose of the workshop is to help reduce that feeling.

Activity

WORKSHOP OBJECTIVES

Purpose:	Participants will have participated in developing the objectives of this workshop.
Format:	Presentation and discussion
Suggested Time:	20-30 minutes
Materials:	TA I.2, "Sample Statement of Workshop Goal and Objectives" HO I.2, Copies of workshop goal and objectives*
Preparation:	Review "How to use this curriculum" and options below. Review TA I.2, sample workshop objectives. * HO I.2 is not included. It will be your list or the list developed during this session. *At least one week in advance, administer a workshop pretest. • Option 1: Using the curriculum objectives (TA I.2), project goals, and pretest results as the basis, the entire team of workshop facilitators should draft a workshop goal and set of workshop objectives. The goal and objectives document should be typed and copied for participants. • Option 2: Review pretest results and "How to use this curriculum" and develop a working draft of workshop participants (The difference is that you are drafting with workshop goals and objectives with participants rather than with workshop facilitators alone. It is still advisable to have a draft prepared beforehand.)

Procedure:

Option 1: (This option is based on the authoritarian/consultative leadership model.) Pass out copies of the workshop objectives you have drafted. Read them aloud to participants and ask for feedback, including additions or requests for clarification. Put any additions or changes to the group for consideration. If the group agrees on modifications, ask participants to write in changes on their handout.

Option 2: (This option is based on the democratic or enabling leadership model. Allow at least 40 minutes.) Work with participants to develop workshop objectives as follows: Present the pretest results (compiled) with the workshop expectations to the group. Provide the project goal, if one has been developed. Provide (handout or overhead) sample workshop objectives (TA I.2, for example) to guide/assist group. Ask the group to develop workshop objectives. Write objectives down collectively on newsprint and place on wall. Type objectives for later distribution to participants as HO I.2.

➢ Explain that over the amount of time given (number of days or hours) this goal and these objectives will be met with the participants' contributions. Periodic reviews to determine how we are doing will keep the workshop on track.

Key Point:
The value of the workshop is ensured by the ability of participants and trainers to accomplish a set of agreed-upon objectives as well as create a productive learning atmosphere.

STATEMENT OF WORKSHOP GOAL AND OBJECTIVES

Workshop goal: Participants will be equipped with the knowledge about female genital mutilation and the participatory philosophy, framework, and skills to advocate effectively with individuals, families, and groups for the elimination of the practice of FGM in their communities.

Workshop objectives:
At the end of this workshop, participants will have:

1. Developed a sense of trust in their own abilities and those of their teammates and their communities through the sharing of their own experiences, concerns, and hopes for the elimination of FGM.
2. Demonstrated an understanding of the health, socio-economic, legal, and ethical implications of FGM as these relate to women's and children's physical, sexual, mental, and social well-being.
3. Demonstrated an understanding of the role and interactions of culture, as expressed in personal and community values, in shaping perceptions of and attitudes toward the practice of FGM.
4. Demonstrated skill in helping individuals and groups interpret and reframe those values that serve to support FGM in the communities in which they are working.
5. Compared and critically evaluated approaches to social change.
6. Demonstrated skill in using at least two participatory research methods.
7. Demonstrated skill in developing program objectives.
8. Identified potential community change agents and key stakeholder, or interest, groups specific to their communities.
9. Demonstrated skill in developing community-specific strategies appropriate to various interest groups to achieve these objectives.
10. Demonstrated ability in choosing appropriate communication approaches.
11. Demonstrated skill in interpersonal communication and group facilitation for social change.
12. Drafted evaluation indicators and plan.
13. Gained knowledge in managing and implementing a local communication for change program.

14. Developed an appreciation for the meaning and value of team approaches to program development and implementation.

Activity

FGM FACTS AND FIGURES

Purpose:	- Participants will be acquainted with the health, socio-economic, legal, and ethical implications of FGM as these relate to women's and children's physical, sexual, mental, and social well-being, and - Participants will be acquainted with the general FGM situation in their locality, country, and world.
Format:	Lecture, question and answer
Suggested Time:	1 to 2 hours, depending on knowledge of participants and previous exposure to FGM education
Materials:	HO I.3, Fact Packet (compiled by trainers, to include Country Fact Sheet, newspaper articles, copies of FGM information as appropriate to this group; reports of quantitative or other studies relevant to region; reference materials listed below) TA I.3, FGM Facts (general background, effects, and trends) TA 1.4, Statement on Islam and FGM (which can be added to the fact packet or used as an overhead or reference) *Additional recommended reference materials (RM): *"Specific resolutions of the Inter-African Committee Regional Conference" *"ICAF/Passages field note: FGM: A continuing violation of the human rights of young women" *"Pop Reports Supplement: FGM: A reproductive health concern" *Viewpoint: "When medical ethics confronts cultural values" Overhead projector
Preparation:	If possible, enlist a participant or project leader to give a brief presentation on the status of FGM in the area, including a description of any FGM programs that have been undertaken. If using an overhead projector, make transparencies of TA I.3.

Procedure:

- Drawing upon resource people, knowledgeable participants, the training aids provided, or any other resource applicable to the setting of your workshop, give a presentation on FGM that is relevant to the needs of workshop participants. The presentation may include: general information about FGM (types, graphics, consequences, prevalence); information about the incidence and type of FGM in the project area, including trends in practice and perceptions, if known; project goal, if developed; brief project history, if relevant.

**These materials may be presented at this time or in "Defining the Problem in Context," if that activity is included.

Key Points:

- FGM is a procedure with many variations, all of which involve immediate and long-term psycho-social and physical risks. Key points of this activity will vary according to the prevalence of FGM and its practice in the community or communities where the workshop is being held.
- Many cultures equate male and female circumcision in the language they use and the ceremonial and social value they give each. But comparisons of the two procedures promote the erroneous assumption that they are similar in their anatomical, physiological, and psychological effects. In short- and long-term effects, the procedures differ widely.
- Although some methods of FGM appear to be less invasive or severe, all methods, including "sunna" and clitoridectomy, carry physical health risks and threaten women's sexual functioning and mental health.
- Neither Islam nor Christianity support the practice of FGM. Many people are under the impression that a form of female circumcision is condoned by Islam, but in fact none, including "sunna" is required.

Female Genital Mutilation (FGM):

***FGM is an internationally accepted term for operations that involve cutting away part, or all, of the female external genitalia.**

***The practice is erroneously termed "female circumcision," which implies equivalence to male circumcision.**

***Between 85 and 114 million women and girls living today have undergone FGM, and approximately 2 million are subjected to it annually.**

***The origin of FGM is unknown.**

***Practiced by:**

- **Moslems (not in many Moslem countries like Saudi Arabia)**
- **Christians**

- **Animists, etc.**

Why We Practice FGM

Reasons for practicing FGM are based on:

- Myths and ancient cultural beliefs
- Religion
- Aesthetics
- Sociological and psycho-sexual issues

Types of FGM

- Type I: Excision of the prepuce, (clitoral hood) with or without excision of part or all of the clitoris.

- Type II: Excision of the clitoris together with partial or total excision of the labia minora.

- Type III: (Infibulation) Excision of part or all of the external genitalia and stitching and/ or narrowing of the vaginal opening leaving a small hole for urine and menstrual flow.

- Type IV: (Unclassified) All others, including:
  - Pricking, piercing, or incision of the clitoris and/ or labia
  - Stretching of the clitoris and/ or labia
  - Cauterization by burning of the clitoris and surrounding tissues
  - Incisions to the vaginal wall
  - Scraping (angurya cuts) or cutting (gishiri cuts) of the vagina and surrounding tissues
  - Introduction of corrosive substances or herbs into the vagina

Age of circumcision

- FGM was traditionally associated with rites of passage ceremonies.
- DHS findings:

  — Average Age - 7to 10 years (Egypt, Somalia, Sudan, Central African Republic)
During infancy - under one year (Eritrea and Mali)

Who circumcises?

- Traditional circumcisers

  — (Mali 82%, Eritrea 91%, Somalia 92%)
- Traditional birth attendants (TBAs)

  — (Mali 2%, Eritrea 0.2%, Sudan 35.6%, Egypt 17.3%, Somalia 6.5%)

  — Egypt - mothers (17.8%) - girls (54%)
- Health aides, hospital cleaners, etc.

*Statistics obtained from latest DHS conducted in each country

EFFECTS OF FGM

Consequences of FGM vary by:

- ◆ Practitioner
- ◆ Type of FGM (I, II, III, IV)
- ◆ Place and conditions of operation

Immediate Physical Complications of FGM

- Hemorrhage
- Wound infection, including tetanus
- Urine retention from pain, swelling, or blockage of the urethra
- Shock from blood loss and intense pain
- Damage to adjoining organs from unskilled operation and/or use of blunt instruments
- Possible death

Long-term Health Effects of FGM

- Exacerbation or development of anemia
- Overgrowth of scar tissue, causing formation of dermoid cysts or keloids
- Abscesses
- Recurrent urinary tract infections
- Infertility

Impact of FGM on Reproductive Health and Sexuality

- Painful or blocked menses
- Risk of HIV
- Recurrent reproductive tract infections
- Difficult or impossible gynecological exams and limited contraceptive choices
- Painful sexual intercourse and reduced sexual fulfillment due to partial or total destruction of vulvar nerve endings
- Increased risk of morbidity and mortality to a mother and child due to obstructed labor
- Fistula formation (unusual opening between vagina and rectum or bladder)

Psychological Effects of FGM

- Diminished self-esteem
- Post-traumatic stress disorder
- Severe depression and anxiety
- Psychosomatic illness
- Chronic physical ailments
- Strain on marital relations

Economic implications of FGM

- Cost of treating initiates
- Treatment of long-term health effects
- Increase in school dropout rates due to marriage immediately following circumcision
- Lost productivity leads to slowed economic development

Trends with Both Positive and Negative Effects

- Medicalization of FGM (health providers)
- Sanitation conditions (+)
- Use of anesthesia (+)
- Use of pain killers and anti-tetanus drugs (+)
- Less cutting of tissue/ less trauma (+)
- Does not address long-term FGM complications (-)
- Incentive for health providers to pick up the practice (-)
- Does not discourage the traditional circumcisions to stop the practice (economic conflict) (-)

Emerging Positive Trends

- Some communities, although small, have already abandoned the practice. Reasons for abandoning:
  - Against religious conviction
  - Formal education
  - Harmful effects of FGM
  - Loss of significance (not rite of passage)
- Less severe form of circumcisions preferred (e.g. type I, IV)
- Younger and more educated females tend to disapprove of the practice more than their parents
- Percentage of circumcised women seems to decrease with age
- More agencies are becoming involved in eradication
- FGM addressed in national, regional and international fora

Conclusion

- FGM does affect women's health throughout their lifetime.
- Female circumcision is not equal to male circumcision.
- The serious complications of FGM override its cultural significance and beauty and make it a health and human rights issue.
- The term "mutilation" is not synonymous with "circumcision" because the operation does involve the mutilation of a girls' sexual organs with the intention of eliminating her sexuality.

THE END: THANK YOU!

ISLAM AND FEMALE CIRCUMCISION

Statement by a sheikh from the Al Azhar University, Cairo:

- Islam puts the woman in a very esteemed place.
- Islam particularly honors the girl: today she is a girl, tomorrow a wife, later she will be a mother.
- The girl has a very considerable status in the family.
- The prophet urges us to take care of the girl.
- If girls have this importance in Islam, why should parents hurt them by removing parts of their bodies without a health reason, as is done by female circumcision?
- The medical viewpoint is that the girl suffers no harm from any part of her sexual organs and this viewpoint is completely respected in Islam.
- Though many functions connected with women—pregnancy, childbirth, breastfeeding, divorce, menstruation—are mentioned in the Koran, it contains no special mention of female circumcision.
- There is nothing that makes female circumcision a required tradition. This is why we find that many Islamic states that follow strictly the Islamic law do not circumcise female children (for instance, Saudi Arabia, Iraq, Iran, Syria, Libya, Morocco).
- Since it has been proved that circumcision is a harmful attack on the girl's body, then it becomes neither an order from God nor an order from tradition.
- If the little girl whose parents want to circumcise her can express herself, she cries out loudly: please leave me alone, do not torture me! Islam prohibits torture.
- I would request all Moslems all over the world to desist from this evil practice, female circumcision, and not hurt their daughters in their early life.

CONVENTIONS

CONVENTION ON THE RIGHTS OF THE CHILD

The Convention on the Rights of the Child was adopted by the General Assembly of the United Nations on 20/11/89. Most African governments are signatories to this convention. The convention reaffirms the fact that children, because of their vulnerability, need special care and protection, and it places special emphasis on the primary caring and protective responsibility of the family. The following are some of the rights of the child as stipulated in the convention:

- the inherent right to life;
- the right to express his/her opinion freely and to have that opinion taken into account, in any matter or procedure affecting the child;
- to express his/her views, obtain information, and to make ideas or information known;
- the right to meet with others and to join or form associations;
- the right to the highest standard of health and medical care;
- the right to education;
- the right to protection from sexual exploitation and abuse;
- the right to protection from all other forms of exploitation prejudicial to any aspects of the child's welfare.

CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN

This 30 article convention is a major step towards the attainment of the goal of equal rights for women. The convention was adopted by the General Assembly of the United Nationals in December, 1979. It sets out in legally binding form internationally accepted principles and measures to achieve equal rights for women everywhere. Most African nations are signatories to the Convention. The Convention reflects the depth of the exclusion and restriction practiced against women solely on the basis of their gender, by calling for equal rights for women, regardless of their marital status, in all fields. It calls for national legislation to ban discrimination, recommends temporary special measures to speed equality between men and women, and action to modify social and cultural patterns that perpetuate discrimination. The Convention also underlines the equal responsibilities of men and women in the context of family life. Additional articles call for nondiscriminatory health services for women, including services related to sexual and reproductive health. To this end, the signatories agreed to take all appropriate measures to modify the social and cultural patterns of conduct of men and women with a view to achieving the elimination of prejudices and customs and all other practices which are based on the idea of the inferiority or superiority of either of the two sexes or on stereotyped roles for men and women.

AFRICAN CHARTER ON HUMAN AND PEOPLE'S RIGHTS

The African Charter on Human and People's Rights was adopted by the 18th Assembly of the Organization of African Unity in June 1981. The Charter provides for the establishment of a body called the African Commission on Human and People's Rights whose task is to promote human and people's rights and to ensure their protection in Africa. The Commission's tasks include the promotion and protection of human rights. The Charter emphasizes the following rights, among others:

- Every individual has the right to education and the right to enjoy the best attainable state of physical and mental health;
- Every individual has the right to receive information, and the right to express and disseminate his/her opinions within the law;
- The state shall ensure the elimination of every discrimination against women and also ensure the protection of the rights of the woman and child as stipulated in international declarations and conventions.

Activity

DEFINING THE "PROBLEM" IN CONTEXT

Purpose:	Participants will be able to define the problem of the eradication of FGM and discuss it in the context of related issues.
Format:	Group discussion and exercise
Suggested Time:	60 minutes
Materials:	Notebooks and pencils Flipchart and markers HO I.4, "Conventions: Convention on the Rights of the Child; Convention on the Elimination of all forms of Discrimination Against Women; African Charter on Human and People's Rights" HO I.5, "Code for Nurses" of the American Nurses' Association *Recommended reference materials (RM): *"Specific resolutions of the Inter-African Committee Regional Conference" *ICAF/Passages field note: "FGM: A continuing violation of the human rights of young women" *Pop Reports Supplement: "FGM: A reproductive health concern" *Canadian Medical Association: "Viewpoint: When medical ethics confronts cultural values"
Preparation:	Prior to the start of the workshop, write in large letters on a chalkboard or a piece of newsprint, "WHY AM I HERE TODAY?"
**	Hand out reference materials for participants to read during the evening prior to this exercise (if they haven't already been distributed as part of the fact packet HO, I.3). Ask participants also to think about and begin working on a personal statement about what they are willing to do as representatives of an organization and as individuals toward the eradication of FGM. Tell them that they will present their thoughts at various times during the workshop. This personal statement should be considered a "homework" assignment.

Procedure:

- Ask everyone to write down on a piece of paper a one-sentence statement that answers the question, "Why am I here today?" Give participants 3 minutes. Ask any participants who volunteer to read their statements. Ask participants to keep their statements in mind for the rest of the exercise.

- Lead a group discussion on the question: Is the eradication of FGM a medical ethics issue, a women's empowerment issue, a health issue, or a human rights issue? Write responses on a flipchart.

Questions for discussion:

1. Are these categories adequate?

2. How else do people define the issue? [For example, political, cultural heritage, public health?]
3. Does the way we characterize FGM relate to why participants are involved in its eradication and participating in the workshop? Note: try to tie the "Why am I here?" response to how participants perceive FGM.
4. Is there a consensus among the group?
5. Is any one of these descriptions of the issue more appropriate in the local context? In a particular district or region?
6. How would participants present FGM eradication in their communities?
7. Where does FGM fit on a continuum with other human rights, women's empowerment, health or medical ethics issues? Note: Be prepared for discussion of other community/change issues, such as democracy, education, or equal opportunity employment, that participants raise.
8. What are we prepared to do about FGM?

Key Points:

- The debate about the practice of FGM spans many areas—human rights, women's rights, medical ethics, mental and reproductive health, and cultural preservation, to name a few, but people see the issue differently depending on their background and exposure to different ideas.
- It is almost universally accepted that medical personnel have an obligation to look after the best interests of their patients. Doctors trained in most countries are required to take the "Hippocratic Oath," (or a variant on it) the primary tenet of which is, "First, do no harm." Nurses in the American Nurses' Association are expected to abide by a code that requires that they provide services with respect for human dignity and the uniqueness of the client and safeguard the client and the public when health care and safety are affected by the incompetent, unethical, or illegal practice of any person. How this relates to FGM is a matter for debate among medical ethicists.
- For many, an understanding of the physical harm FGM does is the key to unlocking other ways of thinking about FGM. This is usually the starting point, but if it is the stopping point as well, we won't succeed in reaching at "conscientisation" about the problems associated with FGM—one outgrowth of this limited approach is the increased use of medical professionals to perform FGM.

- HO I.5

"CODE FOR NURSES" OF THE AMERICAN NURSES' ASSOCIATION

The nurse provides services with respect for human dignity and the uniqueness of the client, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.

The nurse safeguards the client's right to privacy by judiciously protecting information of a confidential nature.

The nurse assumes responsibility and accountability for individual nursing judgments and actions.

The nurse maintains competence in nursing.

The nurse exercises informed judgment and uses individual competence and qualifications as criteria in seeking consultation, accepting responsibilities, and delegating nursing activities to others.

The nurse participates in activities that contribute to the ongoing development of the profession's body of knowledge.

The nurse participates in the profession's efforts to implement and improve standards of nursing.

The nurse participates in the profession's efforts to establish and maintain conditions of employment conducive to high quality nursing care.

The nurse participates in the profession's effort to protect the public from misinformation and misrepresentation and to maintain the integrity of nursing.

The nurse collaborates with members of the health professions and other citizens in promoting community and national efforts to meet the health needs of the public.

Activity
WHOSE RIGHTS?

Purpose:	Participants will have explored the ethical implications of the practice of FGM as these affect medical and health personnel, parents, and children.
Format:	Small group discussion
Suggested Time:	50-60 minutes
Materials:	Newsprint and markers TA I.5, "Whose Rights?: Case Study 1, 2, 3, and 4" HO I.4, "Conventions: Convention on the Rights of the Child; Convention on the Elimination of all forms of Discrimination Against Women; African Charter on Human and People's Rights" HO I.5, "Code for Nurses" of the American Nurses' Association. Recommended Resource Materials: *"ICAF/Passages field note: FGM: A continuing violation of the human rights of young women" *Canadian Medical Association: "Viewpoint: Female circumcision: When medical ethics confronts cultural values."
Preparation:	Review the Case Studies (TA I.5), copy and divide them for 3 different groups, or develop alternative case studies that address the same concerns.

Procedure:

- Ask the group to brainstorm a definition of human rights. This definition should comprise specific rights (for example, to life, to self-determination or autonomy of decisions regarding...). If the issue of rights has not been explored earlier, go into some depth and discuss concepts on the guarantee of rights as well as examples (see HO I.4) from a range of conventions, charters, and constitutions worldwide.

Questions for discussion:

1. Do participants believe this definition to be universal or culture-specific? Give reasons.
2. What specific rights are guaranteed by their country's judicial system, if any?
3. Are these rights respected?
4. Where do rights "come from"?
5. Do people "lose" or "earn" rights, or are they unchanging?
6. Are there rights that are not guaranteed that they feel should be?

- After about 15-20 minutes of large-group discussion, ask the group to form 3 groups of equal or near-equal size.

- Give each group a sheet of paper containing a different scenario, found in TA I.5. Ask them to discuss for another 15 minutes. Questions are included with each scenario. One person in each group should take notes and summarize the discussion.

- Reconvene the large group and ask each group to summarize their scenario and conclusions. Review the similarities and differences in each case and ask the group to return to their

definition.

Questions for discussion:

1. Is there anything they would like to add to their definitions?
2. How does their definition of human rights relate to women? Children? Persons of other cultures?
3. Should human rights be considered absolute or conditional?
4. What are some helpful ethical guidelines for medical personnel struggling with the issue of "to circumcise or not to circumcise"?

Key Points:

The concept of human rights in general, and women's and children's rights in particular, is not interpreted the same way universally. An absolute right to bodily integrity or self-determination, for example, is simply not perceived in cultures that practice any form of mutilation on infants and children. This does not mean that children are not valued and loved, but that children are not perceived as being competent to make decisions involving their persons.

While most cultures adhere to some concept of human rights, such rights may be conditional. Community rights may supersede individual rights, or rights to inclusion in society may be predicated on adherence to specific customs. For example, in countries where the death penalty is applied, the right to life is interpreted as conditional on adherence to a certain code of behavior. In some societies where male and female circumcision are practiced, customary law denies privileges (marriage, elder status, decision-making power) to uncircumcised men and women.

Where medical/health professionals are involved in the practice of mutilating traditions, health practitioners may believe that they are faced with a dilemma of "lesser evils." By performing a disfiguring operation, they are violating the right to self-determination and bodily integrity of the child. On the other hand, they may believe that, at least within their culture, the parent is granted proxy status in all decisions affecting his/her children. Furthermore, they may justify the practice as "a lesser harm" by citing the likelihood that the child will receive a greater harm from an unqualified traditional practitioner or that the child will suffer later when he/she is denied a place in society.

Whose Rights?
CASE STUDY 1

A young girl of 7 is brought to a nurse-midwife by her mother to be circumcised. The nurse performs a clitoridectomy under sterile conditions, sutures a bleeder, treats her with a pain reliever, and sends her home. In the night, the pain relievers lose their effectiveness, the girl is unable to sleep, and as she writhes with pain, she begins to bleed. Her mother doesn't recognize the seriousness of her condition until her daughter is weak from the loss of blood. In shock, the girl is taken to a clinic by her mother.

1. Have anyone's rights been violated?
1. If so, what rights have been violated?
2. If so, who is (are) the violators?
3. Should there be a punishment for such a violation?
4. Should there be restitution to the victim(s)?

Whose Rights?
CASE STUDY 2

Fadumo was infibulated when she was about 11 and married a few years later at 15. She never completed secondary school. When she was first married, her husband was unable to penetrate her for several days. She did not know her husband well before their marriage and had difficulty forming a bond with him. After much frustration, he de-infibulated her with a knife, lacerating the scar tissue and causing her pain. Her first sexual experiences were intensely painful and her husband did not seem to notice or show compassion. Even as time passed, she could not seem to overcome the trauma of her de-infibulation and found sexual intercourse unpleasant, but she became pregnant right away and gave birth to a daughter with some difficulty.

The first time she ran away to her parents was after leaving the maternity with her new daughter. Her parents could not understand her reasons for leaving and after six weeks, sent her back to her husband. The process of de-infibulation started over again, with painful sexual relations that she could barely tolerate. Fadumo became depressed. She asked a younger sister to come live with them, to help with the baby and to keep her company, but she found that she couldn't confide her fears and dislikes to her sister, who thought her husband was a wonderful man. She ran away again, and her parents immediately sent her back, telling her she was a bad wife and mother. She continued to be depressed, having nightmares and thinking about death. Her husband told her that she was not satisfying him and that he would take another wife. After that, she sent her sister home with the baby and ran away for the last time. Instead of returning to her parents, she ended up on the streets, where she is now a market woman, unmarried, at age 30. She would like to have saved her daughter from the same fate, but her parents will not let her near the girl, saying that Fadumo has disgraced the family.

1. Have any rights been violated?
2. If so, whose rights have been violated?
3. If so, who is (are) the violators?
4. Should there be a punishment for such a violation?
5. Should there be restitution to the victim(s)?

Whose Rights?
CASE STUDY 3

Lucy was 24 when she married James. They were not from the same ethnic group, but they had met at the University. Lucy's people did not traditionally circumcise women, but she had heard about the practice from circumcised friends. James's people traditionally circumcised girls before marriage, but James had decided as a teenager that the practice was "old-fashioned" and cruel. When Lucy and James married, James's parents told him they were upset about his marrying an uncircumcised "girl," but he informed them that he had no intention of marrying a woman just because she was circumcised. The parents dropped the issue, and the couple were married. They thought no more about it. They were excited when Lucy conceived during the first year they were married, and hoped James's family would be thrilled that Lucy was giving them a grandchild—the first. Lucy planned to go to a maternity to give birth, but James's family wanted her to stay at their home and have a midwife come in to attend her. She reluctantly agreed because she wanted to show the family that she was a respectful daughter-in-law. During the last stage of labor, without Lucy's knowledge of what was happening or her consent, the midwife performed a clitoridectomy on her. When Lucy cried out in pain and tried to resist, the midwife explained that she was "doing something to ease the birth." Later, when James found out that his parents had hired the midwife to circumcise his wife, he filed criminal and civil charges against his parents and the midwife.

1. Have any rights been violated?
2. If so, whose rights have been violated?
3. If so, who is (are) the violators?
4. Should there be a punishment for such a violation?
5. Should there be restitution to the victim(s)?

Whose Rights?
CASE STUDY 4

A doctor in town performed circumcisions under anesthesia in the past but has decided that the practice is harmful and in conflict with the oath he took as a doctor to "do no harm". A woman comes to him with a 5-year-old daughter and asks him to perform "sunna." He explains that he no longer performs circumcisions on girls because circumcision is harmful. He tells her that there is no valid reason to continue the practice. He asks her to spare her daughter. She says she will think about it and leaves. Later, he learns that the girl was circumcised by a traditional circumciser back in the mother's village. He finds out that she suffered a serious infection as a result of a septic procedure. The doctor is upset. He wonders if he made the right decision in sending the girl and her mother away. After all, if he had performed the circumcision, it would have been done hygienically, under anesthesia, and the girl would have suffered less.

1. Have any rights been violated?
2. If so, whose rights?
3. And which right(s)?
4. Is there a conflict? Why or why not?
   (Hint: Does the doctor have an ethical dilemma and if so, what is it?)
5. If there is a violation of rights, should anyone be punished?
6. If so, who?
7. Should there be restitution to the victim(s)?

Activity

FROM VISION TO PROGRAM: ENVISIONING

(adapted from *Training for Transformation 3*)

Purpose:	Participants will have a guiding vision of the future toward which they plan to work.
Format:	Team task
Suggested Time:	60-90 minutes
Materials:	Notebooks, writing utensils, newsprint and markers HO I.6, Vision Questions
Preparation:	Read through the activity in advance.

Procedure:

➢ Write on the board: What kind of society would we like ours to be?
What is the connection between the society we desire and our being here today?

Ask participants to keep these central questions in mind as they form small teams (by locality or project, if possible). Explain that:
In their small groups, they can use the questions in HO I.6, Vision Questions, to clarify the kind of society they would like to see.
This list is not exhaustive, but is meant as a starting point for discussion.
They do not have to answer every question; the list is meant to offer a way to think about the desirable characteristics of the "ideal" society and how these are like or different from the society they live in.
Each group should reach consensus on a vision, (for example, "A society where women and men live as equals") and should draw up a list of 3 to 5 recommendations, with a visual demonstration (diagram, poster, model, short play) as to why they have offered a particular recommendation.

Workshop trainers can circulate to observe and help participants, if desired. Give participants 40 minutes and reconvene.

Ask each group to explain its vision and give its presentation. Note key points of group presentations on newsprint. Highlight similar or common visions and recommendations (if any) among groups. Provide time for discussion.

Key Points:

- A vision is a sort of "guiding star" for a project. It is essential to keep us going in the right direction.
- Every dream or vision is based on assumptions, values, and judgments, such as the idea that every human being has the right to self-determination. We often assume that everybody agrees with these values, while this is not always so. Very often we use the same words but mean different things. It is important to clarify assumptions about values, making sure there is real agreement where possible, and recognizing differences clearly.

HO I.6

VISION QUESTIONS

In the Ideal Society ...

1. Social Customs
   Do all women and all men marry?
   Is it acceptable not to marry?
   What happens to a woman who cannot bear children?
   Are there topics that cannot be discussed between generations?
   Are there topics that cannot be discussed between genders?
   Are modes of communication between genders adequate or could they improve?
   Is FGM widely practiced, occasionally practiced, or not practiced at all?
   Do men and women undergo ritual initiation to the community? What are the practices?
   Are rites of passage common at different points of life? How do they differ for women and men?

2. Rights of Women
   What are the laws governing property ownership?
   What are the laws governing inheritance?
   What are the laws governing custody of children?
   What are the laws governing spouse-beating?
   What are the laws governing reproductive and sexual health?

3. Rights of Children
   Is child abuse a recognized problem?
   What are the laws governing serious bodily harm to children?
   What decision-making power does a child have in procedures done to him or her?
   At what age do children pass into adulthood?
   What rights accrue to children when they reach the age of majority?

4. Family Relationships
   What type of family relationships and loyalties would we like to see in the future?
   Is the "nuclear family unit" (father, mother, and children) the ideal model?
   How can we retain what is good in the local concept of extended family?
   How can we deal with the pressures put upon the family (both nuclear and extended) by modern life, urbanization, migrant labor, etc?
   In what ways are the role expectations of women and men changing? Can anything be done to encourage the positive changes and discourage the negative ones?
   What needs to be done to help make marriage a satisfying relationship for both men and women?
   What could be done to encourage communication between different generations? In a rapidly changing society how can we help to make the "gap" in outlook a less painful experience?
   What could be done to help make old age a happy time?

5. Economics
Who works?
What are the major sources of income?
How is the work of women recognized and rewarded?
Who controls money?
Who owns land?
How are jobs awarded?
What transactions of land or property occur in marriage?

6. Health
When someone falls ill, what is the first course of action people take?
Do people see illness and injury as inevitable, the will of God, or the act of some unseen player?
What can be done to encourage community responsibility for health?
Do people prefer traditional or western medicine?
To what extent is preventive health care valued?
Who is more likely to die first, the husband or the wife?
Do people expect to lose a child or children during the early years of life?
What meaning, if any, do people attach to pain and suffering?

7. Cultural Values
What aspects of traditional African culture and custom do we value and wish to keep?
Which aspects do we feel are negative and should be changed?
Which Western values (or values of the scientific technological society) do we value and wish to keep?
How could people be helped to make choices about cultural values in life?
What were the high points of celebration of life, joy, community, in traditional society?
Should anything be done to retain or adapt these in modern life?
In what ways could creative expression in art, music, dance, drama, and other forms be encouraged?

Activity

FRAMEWORKS FOR CHANGE: TRADITIONAL (DIRECTED) EDUCATION VS. GROWTH-CENTERED (PARTICIPATORY) APPROACHES

Purpose:	Participants will be able to distinguish and critique participatory approaches and traditional educational approaches
Format:	Mini-lecture and discussion
Suggested Time:	45 minutes
Materials:	Newsprint and pen TA 1.6, "Comparison of traditional and growth-centered educational approaches" HO I.7, "Attributes, Benefits, and Requirements of Growth-Centered Approaches to Change"
Preparation:	On the board, write in two columns the information on TA I.6, or make this TA into a transparency.

Procedure:

Refer to TA I.6 and explain that different theoretical frameworks can be applied to social change. Explain that the first is traditionally what happens in education and community development that is driven by a preconceived, external goal. The second reflects a growth-oriented program that involves community members as participants or partners in change.

Facilitate a discussion of the characteristics of each approach and whether one is more appropriate than another.

Questions for discussion:

1. What are some examples of each?
2. Are there problems with each model? Ask participants to explain responses.
3. Can approaches be mixed?
4. For long-term results, which do they think will work best and why?
5. Brainstorm some expected outcomes of a growth-oriented program. Pass out HO I.7.

Key Points:
A growth-oriented program enables participants to develop their self-image, confidence, resourcefulness, creativity, judgement, problem-solving, and planning skills.
Growth-centered, participatory approaches to change rely on trust in three things:

- Trust in the potential that already exists in people, whether they are aware of it or not.
- Trust that given the right enabling environment people's potential will become manifest; and
- Trust in oneself as a facilitator to provide the kind of environment and experience which permits that potential to unfold.

Participatory, growth-centered approaches tend to decentralized and group-focused rather than leader-focused. They are flexible, keeping structure to a minimum.

A COMPARISON OF TRADITIONAL AND GROWTH-ORIENTED EDUCATION APPROACHES

In **a traditional** education program, the approach uses:	In a **growth-oriented**, participatory program, the approach uses:
Rational decision-making (If X is true, then we must do Y.)	Process model: (How we do it matters as much as what we do)
Linear interventions (First a, then b)	Contextual/dialectic action (What fits with this community's needs, way of life?)
Focus on specific behaviors (Mothers must do X)	Focus on social interactions (Who depends on, talks to, matters to whom?)
Expert orientation (We know because we're health professionals)	Learner orientation (The people here have good ideas and real concerns)
Changing people (You must think/act this way)	Enabling people (We'll work together to find a way)

ATTRIBUTES, BENEFITS, AND REQUIREMENTS OF GROWTH-CENTERED APPROACHES TO CHANGE

- A growth-oriented program enables participants to:
  - develop an increased sense of self-worth, dignity, and awareness of their own strengths.
  - be more resourceful, inventive and creative, more open to trying new things, more capable of generating solutions.
  - grow in judgment, including the ability to examine critically their own beliefs and practices and make sound decisions on a course of action.
  - be better able to solve problems based on fuller exploration of their causes and alternative solutions.
  - acquire planning skills relevant to their situation, including setting goals and selecting means to attain them.

- Growth-centered, participatory approaches to change rely on trust in three things:
  - Trust in the potential that already exists in people, whether they are aware of it or not.
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  - Trust in oneself as a facilitator to provide the kind of environment and experience which permits that potential to unfold.

- Some attributes of a participatory, growth-centered approach to change include:
  - Decentralized decision-making—trusting those on the ground to make informed decisions
  - Low-key role of facilitator—letting others create, interpret, share, receive credit
  - Flexibility—being able to adjust course as needed
  - Keeping structure to a minimum

KEY POINTS SUMMARY, MODULE I

WORKSHOP INTRODUCTIONS

- Workshop activities as well as future project activities will be more enjoyable, helpful, and rewarding if participants and facilitators are well acquainted with one another.

WORKSHOP KIT

- The purpose of the workshop kit is to make learning, workshop activities, community assessment, project planning, and project implementation easier and more organized.

WORKSHOP GROUND RULES

- Group-designed ground rules or conventions contribute to the workshop flow and learning by creating a comfortable and reasonably orderly atmosphere.

WORKSHOP OBJECTIVES

- The value of the workshop is ensured by the ability of participants and trainers to accomplish a set of agreed-upon objectives as well as create a productive learning atmosphere.

DEFINING THE PROBLEM IN CONTEXT

- The debate about the practice of FGM spans many areas—human rights, women's rights, medical ethics, mental and reproductive health, and cultural preservation, to name a few, but people see the issue differently depending on their background and exposure to different ideas.
- It is almost universally accepted that medical personnel have an obligation to look after the best interests of their patients. Doctors trained in most countries are required to take the "Hippocratic Oath," (or a variant on it) the primary tenet of which is, "First, do no harm." Nurses in the American Nurses' Association are expected to abide by a code that requires that they provide services with respect for human dignity and the uniqueness of the client and safeguard the client and the public when health care and safety are affected by the incompetent, unethical, or illegal practice of any person. How this relates to FGM is a matter for debate among medical ethicists.
- For many, an understanding of the physical harm FGM does is the key to unlocking other ways of thinking about FGM. This is usually the starting point, but if it is the stopping point as well, we won't succeed in reaching at "conscientisation" about the problems associated with FGM—one outgrowth of this limited approach is the increased use of medical professionals to perform FGM.

WHOSE RIGHTS?

- The concept of human rights in general, and women's and children's rights in particular, is not interpreted the same way universally. An absolute right to bodily integrity or self-determination, for example, is simply not perceived in cultures that practice any form of mutilation on infants and children. This does not mean that children are not valued and loved, but that children are not perceived as being competent to make decisions involving their persons.

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