The background of the cover is a stylized illustration. It features a woman in profile, sitting on a red mound of earth. She is wearing a teal dress and a white headwrap. In the background, there is a white building with a teal roof and a teal cross on its side, representing a clinic. To the left of the building is a black silhouette of a tree. The sky is a textured yellow-orange color. The overall style is graphic and minimalist.

PERSON-CENTRED COMMUNICATION FOR FEMALE GENITAL MUTILATION PREVENTION

A FACILITATOR'S GUIDE FOR TRAINING HEALTH-CARE PROVIDERS

PERSON-CENTRED COMMUNICATION FOR FEMALE GENITAL MUTILATION PREVENTION

**A FACILITATOR'S GUIDE FOR
TRAINING HEALTH-CARE PROVIDERS**



Person-centred communication for female genital mutilation prevention: a facilitator's guide for training health-care providers

ISBN 978-92-4-004107-3 (electronic version)

ISBN 978-92-4-004108-0 (print version)

© World Health Organization 2022

Some rights reserved. This work is available under the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 IGO licence (CC BY-NC-SA 3.0 IGO; <https://creativecommons.org/licenses/by-nc-sa/3.0/igo>).

Under the terms of this licence, you may copy, redistribute and adapt the work for non-commercial purposes, provided the work is appropriately cited, as indicated below. In any use of this work, there should be no suggestion that WHO endorses any specific organization, products or services. The use of the WHO logo is not permitted. If you adapt the work, then you must license your work under the same or equivalent Creative Commons licence. If you create a translation of this work, you should add the following disclaimer along with the suggested citation: "This translation was not created by the World Health Organization (WHO). WHO is not responsible for the content or accuracy of this translation. The original English edition shall be the binding and authentic edition".

Any mediation relating to disputes arising under the licence shall be conducted in accordance with the mediation rules of the World Intellectual Property Organization (<http://www.wipo.int/amc/en/mediation/rules/>).

Suggested citation. Person-centred communication for female genital mutilation prevention: a facilitator's guide for training health-care providers. Geneva: World Health Organization; 2022. Licence: [CC BY-NC-SA 3.0 IGO](https://creativecommons.org/licenses/by-nc-sa/3.0/igo).

Cataloguing-in-Publication (CIP) data. CIP data are available at <http://apps.who.int/iris>.

Sales, rights and licensing. To purchase WHO publications, see <http://apps.who.int/bookorders>. To submit requests for commercial use and queries on rights and licensing, see <https://www.who.int/copyright>.

Third-party materials. If you wish to reuse material from this work that is attributed to a third party, such as tables, figures or images, it is your responsibility to determine whether permission is needed for that reuse and to obtain permission from the copyright holder. The risk of claims resulting from infringement of any third-party-owned component in the work rests solely with the user.

General disclaimers. The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by WHO in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by WHO to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall WHO be liable for damages arising from its use.

CONTENTS

Acknowledgments	iv
Abbreviations	iv
Introduction	1
About this guide	1
About this training	2
Objectives	2
Workshop outline	3
Instructions	6
Symbols and visual elements contained in this guide	
Methods	8
SESSION 1: Introduction	10
SESSION 2: Analysing and influencing traditions	18
SESSION 3: Values clarification exercise	28
SESSION 4: Introduction to key topics	38
SESSION 5: The role of health-care providers	60
SESSION 6: Characteristics and principles of person-centred communication	72
SESSION 7: Beliefs about FGM (and how to respond to them)	102
SESSION 8: Person-centred communication for FGM prevention	114
SESSION 9: Values and ethics on FGM medicalization	140
CLOSING: Closing exercise: Final reflections and next steps	162
ANNEXES: Training aids (non-digital)	166
References	224

ACKNOWLEDGEMENTS

This training manual and related tools were developed by the Department of Sexual and Reproductive Health and Research. Karin Stein wrote the document with technical input from Wisal Ahmed and Christina Pallitto, who oversaw its development. The content builds on existing WHO documents, including *Female genital mutilation: integrating the prevention and the management of the health complications into the curricula of nursing and midwifery: A teacher's guide* (2001) and *Care of girls and women living with female genital mutilation: A clinical handbook* (2018). Katy Newell-Jones reviewed the first draft and provided additional technical inputs. This manual and accompanying materials benefitted from a pilot test in Kenya. Thanks to Patrick Muia Ndavi of the University of Nairobi; Joyce Lavussa and Anabay Mamo of WHO, Kenya; Leyla Hussein who supported facilitation; Erica Lefstad and the following participants of this pilot training: Consolata Chesang Siree, Misonge Elkana, Sadia Isaack, Antonella Leakono, Josephine Lenaigwanae, Evaline Lenaigwansi, Peter L. Lorokon, Catherine Muntet, Wilson Ngaren, Callen Nyabota Tokoni, Halima Saadia Ali Bishar, Hothan Shukri Noor. Their feedback and insights were used to finalize the training manual and its accompanying tools, which were subsequently field tested in an implementation research study in Guinea, Kenya and Somalia.

This document was developed with the financial support of the Government of Norway, the Government of the United Kingdom of Great Britain and Northern Ireland and the UNDP-UNFPA-UNICEF-WHO-World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP) – a co-sponsored programme executed by WHO.

ABBREVIATIONS

FGM	female genital mutilation
HIV	human immunodeficiency virus
ICM	International Confederation of Midwives
VMMC	voluntary medical male circumcision
WHO	World Health Organization

INTRODUCTION

Over 200 million girls and women worldwide are estimated to be living with the effects of female genital mutilation (FGM). The practice is still being reported in 30 countries in Africa, and in a few countries in Asia and the Middle East. The rise in international migration has also increased the number of girls and women around the world who have undergone or may undergo the practice (1).

Evidence shows that FGM can cause several physical, mental and sexual health complications in girls and women, and in newborns (1,2). Health-care providers play an important role in supporting girls and women living with FGM, and improving their health and well-being. They are in a unique position to influence and change the attitudes of their patients about FGM. This is a key step towards preventing new cases of FGM in their communities (3). Yet, health-care providers often lack the necessary support and training to fulfil these important roles.

Complicating the issue, there has been an rising trend in recent years of health-care providers doing FGM. Known as “FGM medicalization”, this is often done under the pretext of harm reduction. In practice, it is a violation of the basic medical ethic to do no harm.

This guide aims to empower health-care providers to support the principles of giving the best-quality health care for women and girls.

ABOUT THIS GUIDE

The World Health Organization (WHO) is committed to scaling up the health-sector response to address FGM prevention and care. One aspect is to strengthen the quality of FGM prevention and care services by building the capacity of health-care providers.

Several guidance materials have been produced to target health-care providers. These include FGM content for training curricula, clinical guidelines and a clinical handbook (1,2,4).

This training manual complements previous publications by building person-centred communication skills specifically for FGM prevention.

ABOUT THIS TRAINING

During this training, participants will explore their values towards FGM. They will hear what FGM means to those who practise it, and start to see why members of some communities, including health-care providers, continue to support FGM. It will also equip participants with the person-centred skills to help them communicate in an effective, empathetic and sensitive way with their patients. Using a person-centred approach, participants will learn how to discuss women's beliefs about FGM during a clinical consultation, including antenatal care visits, and how to encourage women to rethink their beliefs about FGM and empower them to abandon the practice. Finally, participants will have the opportunity to reflect on the ethical implications of medicalized FGM and learn ways to resist requests to do FGM.

OBJECTIVES

The overall aim of this training is to strengthen the knowledge and skills of health-care providers to be active agents of change for the prevention of FGM, including to challenge their own values towards the practice and its prevention.

The training aims to achieve the following objectives:

1. to build the knowledge of health-care providers on FGM, including the types of FGM, the associated health consequences, and the legal and ethical aspects of the practice;
2. to explore and clarify their own values and attitudes towards FGM and the medicalization of the practice;
3. to build the knowledge and skills of health-care providers on person-centred communication for the prevention of FGM; and
4. to address the ethical and legal implications of medicalized FGM, and to build the skills of health-care providers to resist requests to do FGM.

WORKSHOP OUTLINE

The training has six modules divided into 10 sessions which can be delivered in a three-day participatory workshop with 16–20 participants. It can also be used selectively to address knowledge and skills gaps during educational outreach sessions. The target users of this training guide should have basic training, and communication or counselling skills.

OPENING OF THE WORKSHOP

SESSION 1: INTRODUCTION

Activity 1.1: Icebreaker exercise

Activity 1.2: Ground rules

Activity 1.3: Presentation of the training objectives

TRADITIONS AND VALUES

This module deals with the significance of traditions for communities, and ways of influencing these. Participants also explore the values that underpin FGM and its medicalization by examining how they feel about a range of different value statements and behaviours. These participatory activities are also used as a way to build rapport in the group.

SESSION 2: ANALYSING AND INFLUENCING TRADITIONS

Activity 2.1: Storytelling: Tradition! Tradition!

Activity 2.2: Group discussion: Traditions

Activity 2.3: Voting exercise: Traditions – good, bad or a mix of both?

SESSION 3: VALUES CLARIFICATION EXERCISE

Activity 3.1: Group discussion: What are beliefs? What are values?

Activity 3.2: Values clarification exercise

WHAT IS FGM? INTRODUCTION TO KEY TOPICS

This module presents information about FGM and key topics such as:

- definition of the practice
- WHO classification
- terms most often used when discussing FGM with patients.

It also provides information about the health consequences of FGM, and the reasons why the practice occurs.

SESSION 4: INTRODUCTION TO KEY TOPICS

Activity 4.1: Group exercise: Definition of FGM and anatomical structures involved

Activity 4.2: Group discussion: The types of FGM

Activity 4.3: Group discussion: What are the terms used to describe FGM?

Activity 4.4: Mini-lecture: How FGM can damage a girl's or woman's health and well-being: the health consequences of FGM

Activity 4.5: Group discussion: Who performs FGM?

Activity 4.6: Mini-lecture: The medicalization of FGM

THE ROLE OF HEALTH-CARE PROVIDERS

This module discusses the roles of health-care providers at the health-care facility, and within their families and communities. It also aims to engage and empower health-care providers to play a crucial role in the abandonment of FGM, including why they should never do FGM.

SESSION 5: THE ROLE OF HEALTH-CARE PROVIDERS

Activity 5.1: Exercise: The roles of the health-care providers

Activity 5.2: Motivating patients to make positive changes

Check out day 1

PERSON-CENTRED COMMUNICATION SKILLS

This module aims to support health-care providers to improve their provider-patient communication skills, with a focus on person-centred communication.

SESSION 6: CHARACTERISTICS AND PRINCIPLES OF PERSON-CENTRED COMMUNICATION

Activity 6.1: Animation video: The seed of hope

Activity 6.2: Mini-lecture: How can we communicate effectively with our patients?

Activity 6.3: Mini-lecture: What is person-centred communication?

Activity 6.4: Demonstration: Demonstrating person-centred communication

Activity 6.5: Mini-lecture: Why should health-care providers learn person-centred communication?

Activity 6.6: Group exercise and role play: Skills for effective person-centred communication

PERSON-CENTRED COMMUNICATION FOR FGM PREVENTION

This module discusses the drivers of FGM (why genital cutting is practised) and how person-centred communication skills can be used for FGM prevention during antenatal care consultations.

SESSION 7: BELIEFS ABOUT FGM (AND HOW TO RESPOND TO THEM)

Activity 7.1: Brainstorming: Why do some people support FGM?

Activity 7.2: Myth or truth game: Common beliefs about FGM

Activity 7.3: Group discussion: Enabling change within the community

SESSION 8: PERSON-CENTRED COMMUNICATION FOR FGM PREVENTION

Activity 8.1: Mini-lecture: What is person-centred communication for FGM prevention?

Check out day 2

Activity 8.2: Mini-lecture: Person-centred communication for FGM prevention:
description of the technique

Activity 8.3: Role play: Practising person-centred communication for FGM prevention

VALUES AND ETHICS ON FGM MEDICALIZATION

This module addresses the medicalization of FGM, and the ethical and legal implications. It also deals with the various reasons why health-care providers should never do FGM, even if asked to do so.

SESSION 9: VALUES AND ETHICS ON FGM MEDICALIZATION

Activity 9.1. Brainstorming: Why do some patients request medicalized FGM?

Activity 9.2 Group discussion: Why do some health-care providers agree to do FGM?

Activity 9.3: Mini-lecture: Professional ethics

Activity 9.4: Group activity: The ethics circle

Activity 9.5: Mini-lecture: The legal status of FGM in the country

Activity 9.6: Group discussion: Responding to requests for medicalized FGM

Activity 9.7: Role play: Responding to requests for medicalized FGM

CLOSING EXERCISE: FINAL REFLECTIONS AND NEXT STEPS

SESSION 10: CLOSING EXERCISE

Activity 10.1: Final reflections

Activity 10.2: What are my next steps?

INSTRUCTIONS

This guide provides information and step-by-step instructions to facilitators on how to lead the training, including detailed instructions for group work and exercises.

Each of the 10 training sessions is composed of activities. At the beginning of each session, facilitator's will find an introduction section which is made up of the following information:

- Total duration of the session
- Overview of the session: a summary of the content of the session.
- Learning objectives: what participants are expected to learn during each session.
- Outline of activities: a list of session parts and their duration.
- Teaching aids: a list of tools and materials the facilitator should prepare for the sessions.
- Key messages: a summary of the main information that should be emphasized during the session.

For each activity, facilitators will find step-by-step guidance on how to conduct the training, including the timings for each activity. Some activities include "Facilitator's notes". These notes provide additional explanatory and background information, key concepts and concluding remarks to participants which facilitator's can use during the workshop.

For some activities, facilitators will also have to prepare some background information related to the country where the training is taking place for some sessions. These are clearly signalled in the text.

SYMBOLS AND VISUAL ELEMENTS CONTAINED IN THIS GUIDE

Within each session, symbols and coloured elements help facilitators navigate the text and provide further information relevant to guiding the activities.

FACILITATOR'S NOTES

FACILITATOR'S NOTES

The facilitators can use the "Facilitator's notes" for each activity, both during the activity itself and during the "check-out", to ensure that participants are aware of the important points.



IMPORTANT BOX

IMPORTANT! *Facilitators should pay particular attention to ensuring that they communicate the text in boxes headed "Important!"*



ICONS

The following icons are used throughout the guide.

Time required



Training aid



Handout



PPT Slides



Flip chart



Paper & pencil



Film



Role play



Groupwork



Split participants



Be ready with national statistics



Story



METHODS

The training is designed to be led by two co-facilitators. It uses a participatory approach. This means that the activities require the active involvement of all participants. The sessions use a variety of learning methods to transfer knowledge and develop skills, and to start the process of changing participants' attitudes. Examples of the learning methods used in this programme include:

- mini-lectures
- storytelling
- role play
- group work
- brainstorming
- group discussion
- facilitator demonstration
- other group activities.

Facilitators are encouraged to tailor their approach, as long as the main content is covered. They can do this by modifying the training steps and switching exercises according to their time constraints and specific needs.

The role of the facilitators is to guide the participants through learning activities in an interactive way. The facilitators should try to reduce the amount of lecture time and focus on engaging the participants fully in discussion and the group activities.

Participants should be encouraged to use their native language or other local language where this aids communication, for example in group discussion and role plays. If facilitators are unable to understand the language being used, they can invite a participant to provide a brief translation.

At the end of each day, facilitators will conduct a "Check-out" session. This will allow participants to reflect on the topics covered and clarify any questions or comments they may have. It will also help provide a recap of the topic discussed. If needed, facilitators can also provide some time for reflection at the end of a session.

The facilitators can use the "Facilitator's notes" for each activity, both during the activity itself and during the "check-out", to ensure that participants are aware of the important points. The facilitators should pay particular attention to ensuring that they communicate the text in boxes headed "Important!"

IMPORTANT

Important note on participant safety and well-being

- Facilitators should ensure that the training is done in a non-judgemental environment, where participants feel supported and safe at all times.
- They should also be mindful that some participants might have undergone FGM themselves, or been subjected to other forms of abuse or violence. Also, some participants may feel conflicted about the subject, or feel that some of the topics are upsetting.
- The facilitators should let the group know at the outset that everyone has the option to take a break from the session if needed (this is also covered by the ground rules). If the facilitator identifies someone who appears to be upset, they should offer them this option, to sit down or to leave the room. One of the facilitators can take a moment and check on the participant to ensure that they are OK, whilst the other continues the session. Facilitators should also let them know that they will be available to talk during the break or after the training and that this discussion will be kept confidential.
- If any direct confrontation happens between participants, the facilitator should calmly intervene and remind them that all discussions should show respect at all times.

OPENING OF THE WORKSHOP

SESSION 1: INTRODUCTION

1.1: Icebreaker exercise

1.2: Ground rules

1.3: Presentation of the training objectives

1

INTRODUCTION



1 HOUR 30 MINUTES

OVERVIEW OF THE SESSION

The facilitator will introduce the aims of the training and give the ground rules for positive interaction. Participants will also introduce themselves.

LEARNING OBJECTIVES

By the end of this session, participants will have:

- ✓ reviewed the workshop objectives and schedule;
- ✓ introduced themselves to each other; and
- ✓ agreed on ground rules for discussion during the workshop, including ensuring the safety and well-being of participants.

OUTLINE OF ACTIVITIES

1.1 ICEBREAKER EXERCISE

1.2 GROUND RULES

1.3 PRESENTATION OF THE TRAINING OBJECTIVES

TEACHING AIDS

- Flip chart and markers

KEY MESSAGES

- ✓ Participants are encouraged to actively participate during the two-day workshop. Their participation is key to the success of the training.
- ✓ The training aims to strengthen the participants' knowledge about FGM and communication skills so they can communicate effectively with patients to prevent FGM. This will help them provide better care in general.
- ✓ Participants will learn a brief counselling technique to use during antenatal consultations, called "person-centred communication for FGM prevention". This technique will help health-care providers to discuss FGM with their patients and will motivate them to consider abandoning FGM for their daughters.

ACTIVITY 1.1

ICEBREAKER EXERCISE



30 MINUTES

- 1 Start by welcoming participants to the course.
- 2 Introduce yourself (and other trainers if applicable).
- 3 Explain that the icebreaker exercise that will be used for participants to introduce themselves.
- 4 During this exercise, ask each participant to:
 - Briefly introduce themselves
 - Say what they expect to gain from the training

ACTIVITY 1.2

GROUND RULES



15 MINUTES



- 1 Ask participants to propose a set of ground rules.
- 2 Write down the rules proposed by participants. Complete with the list below (5).
 - Listen to one another
 - Do not start side conversations and interrupt
 - Respect and encourage different opinions
 - Support each other – if you see anyone upset please ask if they need any assistance or support.
 - Respect differences
 - Take an active part in the exercises
 - Choose your own language
 - Keep everything confidential – do not disclose personal information about others to the group without permission
 - Phones off or on silent
 - Do not litter
 - If you need to leave the room because you feel distressed, please do so
 - Facilitators are available during breaks
 - Introduce the **“car park”**.
- 3 Post the rules on the wall and make sure they are visible throughout the entire workshop.
- 4 Explain that the set of ground rules must be agreed and respected by the whole group.

FACILITATOR'S NOTES

Background information



- A formal opening to the workshop frames the importance of the day. It also allows participants to understand what they will learn.
- Icebreakers are discussion questions or activities used to help participants to relax. They ease people into a group meeting or learning situation.
- It is a good idea to leave the ground rules posted in the classroom so that you can easily remind participants about these if needed.
- The **“car park”**:
 - Participants may find questions that take the conversation off track
 - But ignoring them is not an option – the car park solves this
 - There will be a large piece of paper on the wall titled “car park”
 - Whenever a question is raised that cannot immediately be discussed, participants can write it on a sticky note and stick it on the car park piece of paper
 - At the end of the day, review the sticky notes and agree the next steps
 - You might want to visit the car park at the start of the day to capture any overnight reflections, too.

ACTIVITY 1.3

PRESENTATION OF THE TRAINING OBJECTIVES



30 MINUTES

- 1 Explain the training objectives (shown in bold below). Describe what it will mean to the participants and their patients.

FACILITATOR'S NOTES

Key concepts

The overall aim of this training is to equip health-care providers with the necessary knowledge and skills to help prevent FGM.

This training aims to:

1. **build the knowledge of participants on FGM**, including:
 - the types of FGM
 - the health consequences, and
 - the legal and ethical aspects of FGM;
2. **clarify participants' own values and attitudes towards FGM and its medicalization**
 - during the training, participants will learn about FGM and why some people, including some health-care providers, support FGM and its medicalization;
3. **build the knowledge and skills of participants on person-centred communication for FGM prevention**
 - these skills will help them discuss FGM with their patients,
 - they will learn and practise the counselling technique called "Person-centred communication for FGM prevention", also known as the "ABCD technique",
 - by using the ABCD technique, they will learn how to talk about FGM with their patients and deliver effective FGM-prevention messages during clinical consultations, including antenatal care;
4. **address the ethical and legal implications of medicalized FGM, and build the skills of participants to respond to requests to do FGM.**
 - Health-care providers working in antenatal care have frequent opportunities to talk to women about FGM. Therefore, they are in an ideal position to start a discussion about the practice and the risks involved in cutting their daughters.



TRADITIONS AND VALUES

This module deals with the significance of traditions for communities, and ways of influencing these. Participants also explore the values that underpin FGM and its medicalization by examining how they feel about a range of different value statements and behaviours. These participatory activities are also used as a way to build rapport in the group.

SESSION 2: ANALYSING AND INFLUENCING TRADITIONS

2.1: Storytelling: Tradition! Tradition!

2.2: Group discussion: Traditions

2.3: Voting exercise: Traditions – good, bad or a mix of both?

SESSION 3: VALUES CLARIFICATION EXERCISE

3.1: Group discussion: What are beliefs? What are values?

3.2: Values clarification exercise

2

ANALYSING AND INFLUENCING TRADITIONS



1 HOUR 30 MINUTES

OVERVIEW OF THE SESSION

Through storytelling, participants will look at the origin and significance of community traditions and ways of influencing them. They will also explore the positive and negative aspects of traditions.

LEARNING OBJECTIVES

By the end of this session, participants will have:

- ✓ a broad understanding of the meaning of “tradition”
- ✓ identified beneficial, neutral and harmful traditions
- ✓ reflected on constructive ideas for how to question harmful traditions and bring about change.

OUTLINE OF ACTIVITIES

2.1 TRADITION! TRADITION! (STORYTELLING)

2.2 TRADITIONS (GROUP DISCUSSION)

2.3 TRADITIONS – GOOD, BAD OR A MIX OF BOTH? (VOTING EXERCISE)

TEACHING AIDS

- Flip chart and markers
- Computer and projector
- **TRAINING AID** ★ Slides: “Tradition, tradition!”

KEY MESSAGES

- ✓ Traditions are important in many communities.
- ✓ They can be beneficial, neutral or harmful – or a combination of these.
- ✓ Traditions can be changed.
- ✓ Constructive approaches to changing a harmful tradition, such as FGM, include:
 - raising awareness about the problems associated with a harmful tradition;
 - improving the health-care provider's effective communication skills;
 - training health-care providers on how to educate people about the negative consequences of the practice; and
 - recognizing that breaking away from a long-held tradition can be difficult.

ACTIVITY 2.1

TRADITION! TRADITION! A STORY ABOUT THE TRADITIONS OF THE LAND OF ZANBA (STORYTELLING)




15 MINUTES



PPT



- 1 Tell participants that they will hear a story about traditions.
- 2 Remind them of the ground rules.
- 3 Project the storyboard images *Tradition! Tradition!* (**TRAINING AID**  "Slides Tradition, tradition!") (4).

BOX 2.1.1 TRADITION! TRADITION!

Once upon a time, there was a kingdom known as the Land of Zanba. The proud people here had deep-rooted traditions. One tradition was for the women of Zanba to be one-legged. »»



One day, an old wise woman arrived in the Land of Zanba. She wanted to know why women in Zanba had only one leg.

Some people told her that if one of the legs of a little girl was not cut off, it would grow and grow – and before long, it would become as big as a tree! Others told her that a woman with both legs was unable to bear a child. Yet others explained that a woman needed protection from herself; and somehow having one leg cut off helped.

Some people explained that the Great Creator said that women would behave better if they only had one leg. »»

But there was one very old woman in the Land of Zanba who could remember how this habit started: "A long time ago", she said, "in the reign of Moussa, the Land of Zanba was enjoying a period of plenty and there were great festivities. Each year, colourful, exotic dance festivals were held to select the person who would be Ruler of the Land. In those days, men and women competed equally and the best dancer would be crowned. »»

“For 5 years, Moussa won all the competitions. Then a beautiful woman who could dance far better than Moussa wanted to compete and become leader. »»

“Moussa got very worried,” the old woman continued. “He decided something had to be done! In desperation, he decided that all women should have one leg cut off. »» This seemed to solve his problem, for dancing on one leg put women out of the competition. Moussa was able to continue his reign for another 20 years.

“Ever since, the generations of Zanba have followed this tradition handed down by their ancestors.” »»

The wise woman stood thinking for a while, and then replied: “I have known of many traditions, some good, some bad – as for this one, I am not sure.”

Then she asked: “Are women comfortable with this tradition?”

“Oh no,” said the old woman. “We have so many difficulties carrying out our daily chores with one leg!

“But when it was ordered by Moussa, everybody was afraid. Some said you could only be beautiful with one leg! Others claimed you could only be clean with one leg! Many claimed a woman could only be pure with one leg!” »»

The wise woman was curious to know what the men had to say about all this. She discovered that men believed that not following the tradition would destroy family honour and dignity.

Then the wise woman asked the rulers of the land if they might stop this bad tradition. But they were afraid to challenge such a deep-rooted tradition. »»

Meanwhile, the land of Zanba was stricken by drought that became worse every year. Women found it difficult to work the land and help their community.

As the situation got worse, the people of Zanba began to question things. A few men and women were coming together to discuss what they could do to stop this bad tradition. As they talked among themselves, they discovered myths about the tradition. And as time went on, they gathered the strength to challenge the myths. »»

But all this time there had been a spy among them, who revealed their plans to the rulers. And so the guards came and took away the ringleaders. And that was the end of the effort of the people of Zanba to come together to stop this evil tradition.

Little girls continue to be mutilated to this day. In fact, it has been going on for so long now that people just take it for granted. They have stopped questioning their tradition.

Adapted from *Tradition! Tradition! A story of Mother Earth*, by Efua Dorkenoo, FORWARD Ltd., London 1992

ACTIVITY 2.2

TRADITIONS

(GROUP DISCUSSION)



30 MINUTES

- 1 Ask participants what they thought of the story.
- 2 Encourage different participants to contribute.
- 3 Use the questions in **BOX 2.2.1** to guide the discussion.
- 4 Close the session by emphasizing that the story has many similarities with the **practice of FGM**.

FACILITATOR'S NOTES

Key concepts

- If during the discussion some points are not covered, you can use the questions below to guide the discussion (**Box 2.2.1**).
- Remember that different participants may interpret the story in different ways and that there are no right or wrong answers.



BOX 2.2.1

1. What was the role of the old wise woman?

RESPONSE: The old wise woman made the community reflect on the tradition of the one-legged women. After she had questioned them, some members of the community also began reflecting on this. It is important to recognize that the old wise woman could not bring about change on her own – the community was key.

2. List some of the reasons given by the community for the one-legged tradition.

RESPONSES: It was the tradition to cut one leg off the women of Zanba because they believed that:

- otherwise the leg could grow as tall as a tree;
- it made a girl behave better;
- it protected women from themselves; and
- only one-legged women could bear children.

FACILITATOR'S NOTES

Remind participants that according to the old woman, however, the truth was that being one-legged prevented women from competing and winning during the annual dance festivals. It meant that they were unable to become leaders.



3. Is this situation familiar? What other tradition is comparable to cutting off legs?

RESPONSE: The practice of FGM.

(Continued on next page ...)

4. What are your general thoughts on this?

5. What is this story all about?

RESPONSE: The story is about traditions.

6. What is the definition of 'tradition'?

RESPONSES: Traditions are the customs, beliefs and values of a community that govern and influence members' behaviour. Traditions are learnt habits, which are passed on from generation to generation and which form part of the identity of a particular community. People adhere to these patterns of behaviour, believing that they are the right things to do. Traditions are often guarded by taboos and are not easy to change. Some traditions are good, others are neutral, but some can be harmful. Other traditions can even have a mix of beneficial and harmful elements.

7. Are all traditions beneficial?

RESPONSES: Some traditions are good for the community, but some can also be harmful. This is not always easy to identify. By reflecting on traditions (asking questions about them) we can begin to understand whether traditions are good or harmful.

FACILITATOR'S NOTES

Background information



- The old wise woman represents all of us with our individual and collective responsibility for the actions of society.
- The old wise woman's exploration of the tradition depended on her ability to relate effectively to the community:
 - she asked questions
 - she was non-judgmental
 - she listened with empathy
 - she reflected carefully
 - she used a positive approach.
- This motivated people in the community to think again about the tradition.
- Rethinking traditions allows us to ask ourselves if these are good, neutral or harmful traditions.
- Even if traditions have been around for centuries, if they are harmful to the community, questioning them is OK.
- Change is possible!



ACTIVITY 2.3

TRADITIONS – GOOD, BAD OR A MIX OF BOTH? (VOTING EXERCISE)



45 MINUTES



- 1 Divide participants into three groups. 
- 2 Explain that during this exercise the groups will discuss some local traditions and the good and bad aspects of them.
- 3 Ask participants to think of three local traditions.
(Give 3 minutes for this.) 
- 4 Write or draw the traditions proposed by participants on a flip chart.
- 5 If participants cannot think of a local tradition straight away, you can start by giving one of these examples:
 - It is not proper for young people to look straight into the eyes of a respected elder; they should instead cast their eyes downward.
 - Girls who have not yet undergone FGM by a particular age should be cut as soon as possible.
 - Men should not show emotions.
 - A woman should wear white clothes if her husband dies.
 - Meat should be reserved only for men; women should not eat meat.
- 6 For each tradition, ask each small group to briefly say what the good and bad aspects are.



- 7 Ask participants to reach a final decision through voting (by raising hands) if they consider the traditions they discussed to be good, bad or a mix of both.

FACILITATOR'S NOTES



If participants are unsure of how to vote, encourage them to further discuss so they can consider all the possible aspects of the tradition. It is OK for participants to change their minds during the exercise.

- 8 Encourage them to consider all aspects discussed during the exercise (good and bad).

3

VALUES CLARIFICATION EXERCISE



1 HOUR

OVERVIEW OF THE SESSION

Participants will explore the meaning of values and beliefs, and discuss their own values towards FGM.

LEARNING OBJECTIVES

By the end of this session, participants will have:

- ✓ learnt the meaning of values and beliefs and how these are gained;
- ✓ explored their own values on FGM;
- ✓ heard about the values of other participants;
- ✓ introduced to the idea that traditions can be questioned and changed, especially if they are harmful;
- ✓ explored how personal views and experiences affect how they communicate with others.

OUTLINE OF ACTIVITIES

3.1 WHAT ARE BELIEFS? WHAT ARE VALUES?
(GROUP DISCUSSION)

3.2 VALUES CLARIFICATION (EXERCISE)

TEACHING AIDS

- Flip chart and markers

KEY MESSAGES

- ✓ Values are leading principles that can guide and motivate people (6).
- ✓ People have different values – sometimes even the people who are closest to us (family, friend, partner) have values that differ from our own. This is OK.
- ✓ Examining where these values come from can help us to understand if we actually support them or if we feel they should be changed.
- ✓ This can be summarized as questioning our values. Questioning our values will help us to identify those we wish to keep and those we feel may no longer be valid.
- ✓ Dialogue and openness can help people to question their beliefs and values, which may then lead to positive change.

ACTIVITY 3.1

WHAT ARE BELIEFS? WHAT ARE VALUES?

(GROUP DISCUSSION)



15 MIN

- 1 Start the session by asking participants:
“What are beliefs? And values?”
- 2 Ask for a few answers.
- 3 Explain that you will define two important concepts:
beliefs and values. (see definitions on next page)
- 4 Ask participants for a few examples.
- 5 Close the activity by highlighting the information contained in the facilitator’s notes.

FACILITATOR’S NOTES

Concluding remarks



- People are a mix of unique characteristics:
 - physical characteristics (body, face, hair colour, etc.)
 - personality (introvert, extrovert, etc.)
 - beliefs and values.
- The traditions of a group of people who live in a community are guided by the beliefs and values of the women and men in the community.
- Only by fully understanding our own values can we recognize which behaviours are from rational choice and which are from other influences.
- Trying to change behaviour alone is not enough if the social factors that shape it are not challenged. In other words, if we do not question the values and beliefs that support a behaviour, it will be difficult to change it.



Beliefs:

- A conviction, or an idea accepted as true or real, even without positive proof.
- Some beliefs are religious, others are related to cultural things. Beliefs are formed by experience and other influences.
- Examples of beliefs:
 - *“Men being the breadwinners of the family should be served first and given the best portions of meals.”*
 - *“All people are equal, regardless of race, sex, age or social status.”*



Values:

- Values are things that we consider important. They are principles that guide the way we behave towards our friends, family, the environment and even ourselves.
- We inherit many of our values from our families, but they are also influenced by religion, culture, friends, education and personal experiences (4).
- Examples of values:
 - Honesty
 - Faithfulness
 - Equality.

ACTIVITY 3.2

VALUES CLARIFICATION EXERCISE

(GROUP EXERCISE)



45 MIN



- 1 Explain that this activity will give participants a general understanding of their own and each other's values and attitudes about different topics, including FGM.
- 2 Post two signs on the wall: AGREE and DISAGREE.
- 3 Choose 10 to 12 statements from **Box 3.2.1** designed to explore values. Choose the ones you think will lead to discussion.
- 4 Read the first statement aloud.
- 5 Write the statement on the flip chart.
- 6 Ask participants to move to the sign matching their opinion: AGREE or DISAGREE.

IMPORTANT! *Tell participants that the exercise is not about finding right or wrong answers. It is about how they feel about each statement.*



(CONTINUED ON NEXT PAGE)

- 7 Let any participants who do not know whether they agree or disagree stand to the side of the room as a (third) “UNSURE” group.

FACILITATOR'S NOTES

If all the participants agree about any of the statements, express an opinion that is different, to encourage the discussion.



- 8 Ask a representative from each group to explain why they are standing there. Why do they feel this way about the statement you read?

- 9 Repeat this process with all the statements, as time allows.

- 10 Summarize the exercise by asking participants the following questions:

- *What was the most striking experience for you when you did this exercise? Think about both your own reaction to the questions, and those of others in the class.*
- *Were you surprised with the responses of your peers?*
- *How did you feel when others disagreed with you?*

BOX 3.2.1 LIST OF VALUE STATEMENTS

1. People listen to and respect health-care providers.
2. Young people should always agree with older people. Disagreeing with them is disrespectful.
3. If a tradition is very old and most people approve of it, it is better not to question it.
4. In life, it is important to remain open to change.
5. Health-care providers should never deliberately harm their patients.
6. FGM is an essential part of culture.
7. Pricking of the clitoris (drawing blood by a single tiny prick) is also a form of FGM.
8. Young women who do not undergo FGM will never find a husband.
9. The role of women is to obey men.
10. Doing FGM in a hospital is more hygienic and less painful for the girl.
11. Some 'minor' forms of FGM are not harmful.
12. FGM is a religious obligation.
13. FGM causes health, mental and sexual problems for girls and women.
14. Girls who do not undergo FGM are not respectable.
15. Men prefer women who are cut.
16. FGM prevents women from being 'loose'.
17. FGM has beneficial effects on health and sexual matters
 - FGM improves fertility
 - FGM prevents maternal and infant mortality
 - FGM helps keep the genitalia clean
 - FGM is done to please husbands.
18. FGM is a health issue.
19. The satisfaction of a woman during sex is not relevant.

FACILITATOR'S NOTES

Background information



- A values clarification exercise is a process that helps participants to identify the values that guide their actions. They do this by examining how they feel about a range of different behaviours and thoughts.
- This is an important exercise since individuals are often unaware of what guides their behaviour and choices.
- Even in a group of people from similar backgrounds, with similar educational levels and professions, there is likely to be a wide range of attitudes and values.
- Each person develops a unique set of values and attitudes that guides them through life and gives them their cultural identity. Greater understanding of their own values will help health-care providers to understand and respect the values and belief systems of their patients.
- Listening to patients will give health-care providers a better idea of how best to communicate with them about the dangers of FGM.
- The best way to find out what someone's real interests are is to talk directly with the person.

WHAT IS FGM? INTRODUCTION TO KEY TOPICS

This module presents information about FGM and key topics such as:

- definition of the practice
- WHO classification
- terms most often used when discussing FGM with patients.

It also provides information about the health consequences of FGM, and the reasons why the practice occurs.

SESSION 4: INTRODUCTION TO KEY TOPICS

4.1: Group exercise: Definition of FGM and anatomical structures involved

4.2: Group discussion: The types of FGM

4.3: Group discussion: What are the terms used to describe FGM?

4.4: Mini-lecture: How FGM can damage a girl's or woman's health and well-being; the health consequences of FGM

4.5: Group discussion: Who performs FGM?

4.6: Mini-lecture: The medicalization of FGM

4

INTRODUCTION TO KEY TOPICS



1 HOUR 45 MINUTES

OVERVIEW OF THE SESSION

The goal of this session is to agree on the use of language and key concepts when discussing FGM with patients. It will also introduce the reasons for doing FGM, the people at risk of FGM, and the health problems it can cause.

LEARNING OBJECTIVES

By the end of this session, participants will have:

- ✓ defined what FGM is
- ✓ reviewed common terms used to address FGM
- ✓ identified who performs FGM and at what age girls undergo the procedure in their community
- ✓ identified the reasons why some people practise FGM
- ✓ discussed the health effects of FGM on a girl/woman.

OUTLINE OF ACTIVITIES

4.1 DEFINITION OF FGM AND ANATOMICAL STRUCTURES INVOLVED (GROUP EXERCISE)

4.2 THE TYPES OF FGM (GROUP DISCUSSION)

4.3 WHAT ARE THE TERMS USED TO DESCRIBE FGM? (GROUP DISCUSSION)

4.4 HOW FGM CAN DAMAGE A GIRL'S OR WOMAN'S HEALTH AND WELL-BEING: THE HEALTH CONSEQUENCES OF FGM (MINI-LECTURE)

4.5 WHO PERFORMS FGM? (GROUP DISCUSSION)

4.6 THE MEDICALIZATION OF FGM (MINI-LECTURE)

TEACHING AIDS

- Computer and projector
- Flip chart and markers
- Sticky notes
- **TRAINING AID** ★ Flip chart poster with diagram of the unaltered female genitalia
- **TRAINING AID** ★ Handout of four types of FGM
- **TRAINING AID** ★ The health consequences of FGM

KEY MESSAGES

- ✓ Female genital mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.
- ✓ WHO describes four types of FGM.
- ✓ The different types of FGM damage different important female anatomical structures. This can lead to a number of potentially serious health complications for women and their newborn babies.
- ✓ When discussing FGM, it is important to use terms that are non-judgemental and familiar to the patient.
- ✓ FGM is done for a variety of reasons, that differ from one region and ethnic group to another.
- ✓ It is important to know the reasons why some people support the practice – then you will be able to see through your patients' eyes and understand why some may support this practice, despite the fact that it damages girls and women.
- ✓ The medicalization of FGM is FGM by a health-care provider. It also includes the procedure of re-infibulation (reclosure) at any time in a woman's life.

ACTIVITY 4.1

DEFINITION OF FGM AND THE ANATOMICAL STRUCTURES INVOLVED (GROUP EXERCISE)




15 MINUTES



IMPORTANT! Explain to participants that there will be detailed descriptions of FGM and its impact. If anyone needs to leave the room, that is OK.



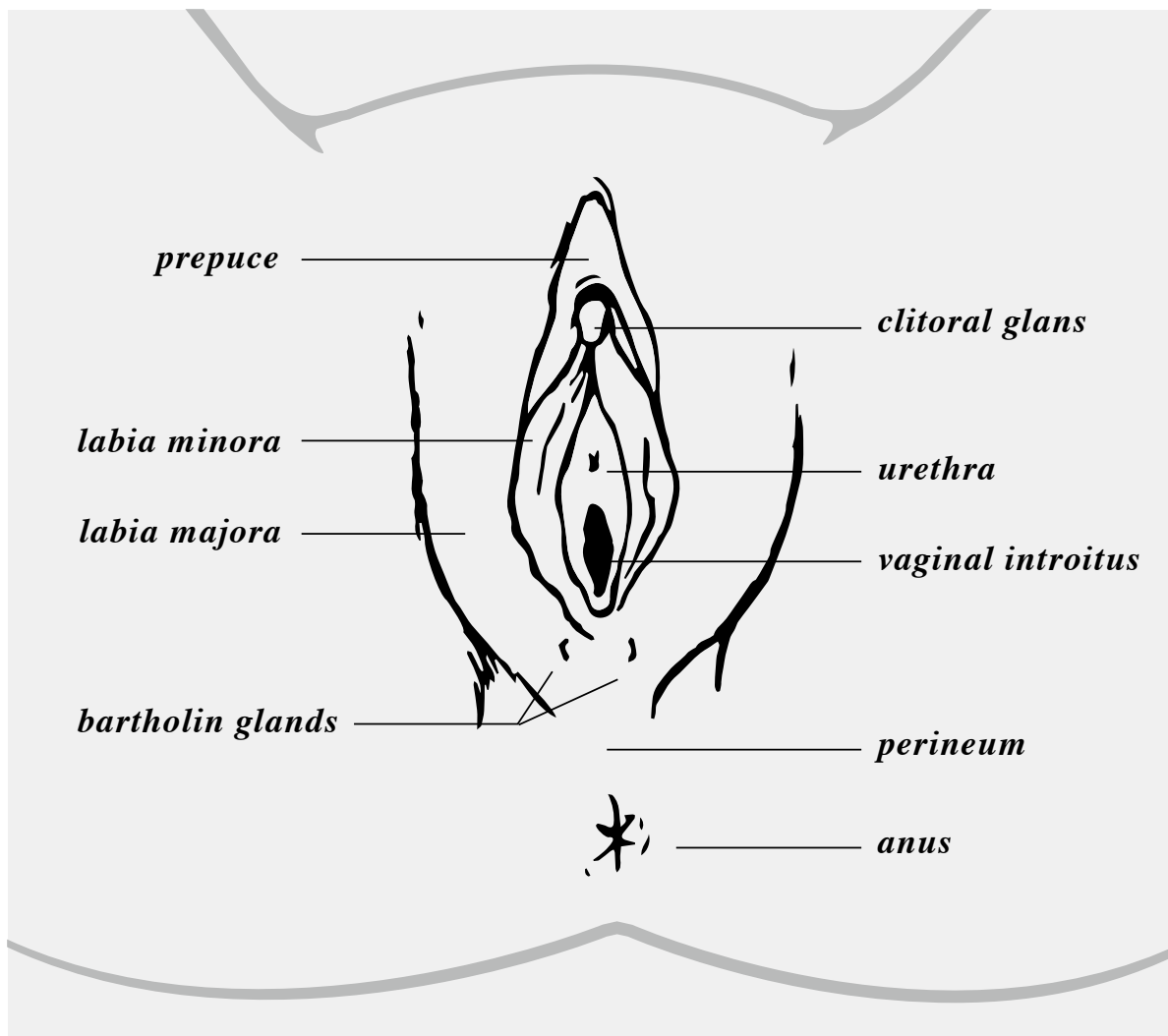
- 1 Ask participants: *“Do you know what FGM means?”*
- 2 Ask a few volunteers to describe the term using her own words.
- 3 Using **TRAINING AID**  “Flip chart poster with diagram of the unaltered female genitalia”, introduce the anatomical structures of the female genitalia by drawing these on the flip chart.
- 4 Ask participants to help you label the structures.

FACILITATOR’S NOTES

Be sure to label at least the structures given in **Box 4.1.2**



(CONTINUED ON NEXT PAGE)

BOX 4.1.1 UNALTERED FEMALE GENITALIA

BOX 4.1.2 FEMALE GENITAL ANATOMICAL STRUCTURES AND THEIR FUNCTION

Structure	Description	Function
Vaginal orifice	External opening of the vagina	Allows sex, exit of the menstrual blood and delivery of the baby
Labia minora	Finer inside pair of labia surrounding the vaginal orifice	Protects the inner structures and openings
Labia majora	Larger outside pair of labia surrounding the vaginal orifice	Protects the inner structures and openings
Urethral meatus	Opening of the urethra. The urethra is the canal that carries urine from the bladder to the exterior	Allows emptying of the bladder
Clitoris	A V-shaped organ below the pubic bone. It has external and internal structures	Assists women to achieve sexual satisfaction
Prepuce	Fold of skin that surrounds the clitoral glans	Protects the clitoral glans
Perineum	The area between the anus and the vulva	Supports the pelvic organs and separates the vagina from the anus
Skene's and Bartholin's glands	Glands around the vaginal orifice. They produce mucus	Lubrication of the vagina to enable sex

- 5 Once the structures have been labelled, provide the WHO official definition of FGM:



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

- 6 Highlight that an injury can be cutting, snipping, removing, pricking or scraping. In other words, it means damaging the genital tissue in any way.

ACTIVITY 4.2

TYPES OF FGM

(GROUP DISCUSSION)



15 MINUTES



1

Ask participants:

”How many types of FGM do you know?”

2

Ask for a few responses.

3

Clarify and correct misunderstandings using **TRAINING AID** 

“Handout of four types of FGM” and **Box 4.2.1**

FACILITATOR'S NOTES

Key concepts



Make sure you remind participants of the following.

- The term FGM covers all interventions, minor and major, affecting the female genitalia, no matter what structures are involved.
- Any form of damage is potentially harmful for the child or woman.

BOX 4.2.1 TYPES OF FGM AND THE ANATOMICAL STRUCTURES INVOLVED

Type of FGM	Structures removed / altered
Type 1	<ul style="list-style-type: none"> • Prepuce (clitoral hood) • Clitoral glans (tip of the clitoris)
Type 2	<ul style="list-style-type: none"> • Labia minora • Labia majora (may or may not be affected) • Prepuce (clitoral hood) (may or may not be affected) • Clitoral glans (tip of the clitoris) (may or may not be affected)
Type 3	<ul style="list-style-type: none"> • Labia majora – and sometimes labia minora – are stitched together
Type 4	<ul style="list-style-type: none"> • Pricking, incising, scraping and cauterization of genital structures such as the clitoral hood, clitoral glans, labia minora, and so on

ACTIVITY 4.3

WHAT ARE THE TERMS USED TO DESCRIBE FGM? (GROUP DISCUSSION)



15 MINUTES



- 1 Ask participants:
“What terms do you use when discussing FGM with your patients?”
- 2 Ask for a few responses and write them on the flip chart.
- 3 Tell participants that WHO uses the term “FGM”.
- 4 Explain that different communities have different names for FGM (words and phrases in their local language to describe genital cutting).

FACILITATOR’S NOTES

The term “female circumcision” should be avoided



IMPORTANT! *If relevant, discuss sunna and pharaonic (Box 4.3.1)*



- 5 Close the discussion by emphasizing the concluding remarks contained in the facilitator’s notes:

BOX 4.3.1 SUNNA AND PHARAONIC

In certain Islamic communities, some forms of FGM (usually types 1 and 4) are called “sunna”, and some see them as purifying practices under Islam. Type 3 FGM is often called “pharaonic”, implying its deep cultural roots. When discussing FGM with a patient, colleagues or other members of the community, you may hear these terms. It is important to understand that different people interpret them differently. Also, regardless of the terms used, FGM is not mandated by any religious text such as the Koran or the Bible.

Many senior religious leaders (sheikhs) have decided not to cut their daughters and want to see the end of all types of cutting. They think people should feel free to leave their daughters unharmed and not cut them.

FACILITATOR'S NOTES

Concluding remarks

- The term “female circumcision” draws a parallel with male circumcision and, as a result, creates confusion between these two distinct practices.
- “Mutilation” reinforces the fact that the practice is a serious violation of girls’ and women’s rights. Note that some communities may find the word “mutilation” judgemental.



ACTIVITY 4.4

THE HEALTH CONSEQUENCES OF FGM

(MINI-LECTURE)




30 MINUTES



PPT



- 1 Ask participants: *“Can FGM have negative health consequences?”*
- 2 Ask for a few responses.
- 3 Then ask: *“What would you say if I told you that all girls and women who undergo FGM will suffer some form of negative health consequence associated with the practice?”*
- 4 Allow for participants to respond.
- 5 Clarify: Even when no direct complication arises, girls go through intense pain and psychological distress. In addition, healthy tissue is being damaged. These are all negative health consequences.
- 6 Using **TRAINING AID**  (Slides: “The Health consequences of FGM”), discuss the following health complications from FGM summarized in **Box 4.4.1** (1,2):
- 7 To conclude this section, tell participants:
 - Years of scientific evidence compiled by WHO and other researchers has consistently shown that these negative health consequences are real – and can be preventable if girls remain uncut;
 - religious leaders have also highlighted the negative health effects of FGM.

BOX 4.4.1

1. Immediate and short-term health conditions that require rapid medical treatment:

- severe pain and injury to tissues
- bleeding (severe bleeding can lead to anaemia)
- haemorrhagic shock after bleeding
- infection and septicaemia
- genital tissue swelling
- acute urine retention

(Many of these are life-threatening!)

2. Gynaecological and urogynaecological complications:

- chronic vulvar (genital) pain
- clitoral neuroma (a growth/lump in the nerve tissue)
- reproductive tract infections
- menstrual problems such as dysmenorrhoea (painful menstruation) and difficulty in passing menstrual blood
- urinary tract infections, often recurrent
- painful or difficult urination
- epidermal inclusion cysts (lumps in the surface tissue)
- keloids in the genital area (overgrowth of scar tissue).

Girls and women who experience long-term health complications caused by FGM often live with the symptoms of these conditions for months or even years without seeking care. This happens because they learn to live with the complications or because many other women in the community suffer the same complications. This is called normalization.

(CONTINUED ON NEXT PAGE)

3. Obstetric risks faced by women with FGM and their babies:

Women who have undergone FGM have a higher risk of:

- caesarean section
- postpartum haemorrhage
- episiotomy
- longer or more difficult labour
- obstetric tears and lacerations
- instrumental childbirth (use of forceps or suction to assist delivery).

Babies born to women who have undergone FGM have a higher risk of:

- stillbirth and early neonatal death
- asphyxia and resuscitation of the baby at birth.

4. Mental health

Studies have found that girls and women who have experienced FGM may have higher rates of mental health disorders, particularly:

- depression
- anxiety disorders
- post-traumatic stress disorder (PTSD)
- somatic (physical) complaints with no organic cause (e.g. aches and pain).
- flash backs.

5. Sexual health

- Evidence shows that, compared with women without FGM, women who have undergone genital cutting are more likely to experience:
 - dyspareunia (pain during sex)
 - less satisfaction with sex
 - less desire for sex.
- Women and men should be able to enjoy a healthy sexual relationship. Sexual health complications can lead to relationship problems and marital difficulties.

FACILITATOR'S NOTES

Background information



- Health-care providers may be very interested by this section and may want to have detailed information on each of these conditions.
- The facilitator should be mindful not to extend the discussion on health complications for too long.
- Instead, remind participants that a detailed explanation of the health complications associated with FGM and their management can be found in the WHO FGM clinical handbook (2).

ACTIVITY 4.5

WHO PERFORMS FGM?

(GROUP DISCUSSION)



15 MINUTES

- 1 Start by asking participants:
“Who in the community is at risk of FGM?”
- 2 Ask for a few answers
- 3 Now ask participants:
“Who performs FGM in your communities?”
- 4 Use the information contained in the facilitator’s notes to guide the discussion.

IMPORTANT! *Participants should remember that their role is to work towards stopping FGM.*



FACILITATOR'S NOTES

Background information



- **Who is at risk of FGM?**

FGM is usually done on girls. The age at which girls experience FGM varies across countries and cultural groups. In some communities, FGM is done before girls turn 5 years old, but in others, girls are cut when they are between the ages of 5 and 14 years, or before marriage.

- **Who is at risk of FGM?**

FGM is performed by different people in different communities:

- **Traditional cutters:** Traditionally, FGM is done by traditional excisors or cutters. These are often older women in the community specially identified for this task. Sometimes, traditional birth attendants do FGM.
- **Others:** For example barbers, grandmothers and blacksmiths.
- **Health-care professionals:** FGM is increasingly being done in hospitals, health clinics and elsewhere (e.g. at home) by health-care professionals who may use anaesthetics and antiseptics. This is called “medicalization of FGM”.

- Medicalization is FGM carried out by any category of health-care provider, whether in a public or a private clinic, at home or elsewhere. It also includes the procedure of re-infibulation (reclosure) at any time in a woman's life.

ACTIVITY 4.6

THE MEDICALIZATION OF FGM

(MINI-LECTURE)



15 MINUTES

- 1 Ask participants:
“What do you understand by the medicalization of FGM?”
- 2 Once they have provided some answers, read out the WHO definition of medicalized FGM (1):



Medicalized FGM: Situations in which FGM is done by any category of **health-care provider**, whether in a **public or a private clinic, at home or elsewhere**. It also includes the procedure of **re-infibulation** (reclosure) **at any point** in a woman’s life.

- 3 Highlight the following sections of the definition and explain.
 - **Health-care provider:** includes all trained health-care providers (paramedical or medical staff – in particular, doctors, nurses, midwives and technicians).
 - **Public or private clinic:** all types of health-care facility are included.
 - **Home or elsewhere:** even if the health-care provider does FGM in the woman’s home or elsewhere, it is still medicalized FGM.
 - **Re-infibulation:** reclosure of the external labia after childbirth is also a form of FGM.
 - **At any point:** even if the woman was re-infibulated before, this does not mean it should be done again.

- 4 Ask participants to think of reasons why people support FGM.
- 5 Ask for a few responses.
- 6 Close the session by explaining that FGM is done for a variety of reasons, that vary from one region and ethnic group to another. **Box 4.6.1** gives the main reasons why communities support FGM.



It is important to know why some people support FGM as this will be discussed with patients when delivering the “ABCD counselling technique”.

BOX 4.6.1: REASONS GIVEN FOR DOING FGM

Respect for tradition	FGM is often seen as part of the history and cultural tradition of some communities. People, including the women, often support and continue the practice because they see it as a sign of respect.
Rite of passage	In many cultures, FGM is an important rite of passage into adulthood for girls. Often, the event is marked with a ceremony and/or celebration. It may be considered a necessary step towards being viewed as a respectable adult woman.
Social norm/convention	Where FGM is done widely, it is considered a social convention. Those who adhere to the practice may be better accepted socially, while those who do not may face condemnation, harassment and exclusion.
Enhance fertility	Sometimes, women and men believe that if a woman is not cut, she will not be able to get pregnant, or may face difficulties during labour.
Marriageability	There is often an expectation that men will marry only women who have had FGM. The desire and pressure to be married, and the economic and social security that may come with marriage, can perpetuate the practice in some settings.
Ensure virginity, chastity and faithfulness	FGM is believed to safeguard a girl's or woman's virginity prior to marriage and ensure fidelity after marriage. Families may therefore believe that FGM protects a girl's and her family's honour.
Control female sexuality	FGM is believed to reduce or remove a women's sexual drive and pleasure. A woman who has sexual desire is often seen as bad and not suitable as a good wife.
Cleanliness, beauty and purity	FGM may be done to make girls "clean" or pure and beautiful. Cleanliness may refer to the body; female genitals that are cut or closed are sometimes seen as more hygienic and beautiful. But cleanliness may also refer to spiritual purity.
Femininity	The removal of genital parts that are considered masculine (i.e. the clitoris) is considered to make girls more feminine, respectable and beautiful.
Religion	Some people believe that FGM is a religious requirement. Some religious leaders may promote the practice, even though it is not mentioned in any major religious texts.

FACILITATOR'S NOTES

Background information



- FGM is done for a variety of reasons, that vary from one region and ethnic group to another. Some consider it a rite of passage into womanhood. Others believe it helps to keep a girl's virginity until marriage. In most communities where it is done, parents see it as essential to their daughter's acceptance into society.
- FGM is neither a religious rite nor an African practice. It is practised by people from different religions and was even done in Europe a long time ago.
- It is important to know why some people support FGM. We call this being "equipped".
- Many of these reasons are based on traditions and values shared across generations for centuries. This does not mean we should not question these reasons.
- Listening to patients will give participants a better idea of how to best communicate with patients about the dangers of FGM.
- Later in the workshop, we will revisit these reasons and discuss ways of talking about them with patients.

THE ROLE OF HEALTH-CARE PROVIDERS

This module discusses the roles of health-care providers at the health-care facility, and within their families and communities. It also aims to engage and empower health-care providers to play a crucial role in the abandonment of FGM, including why they should never do FGM.

SESSION 5: THE ROLE OF HEALTH-CARE PROVIDERS

5.1: Exercise: The roles of the health-care providers

5.2: Motivating patients to make positive changes

Check out day 1

5

THE ROLE OF HEALTH-CARE PROVIDERS



2.5 HOURS

OVERVIEW OF THE SESSION

This session aims to engage and empower health-care providers to act as agents of change through communication and education. They can play a key role in stopping FGM, including medicalized FGM, by helping to bring about behaviour change.

LEARNING OBJECTIVES

By the end of this session, participants will have:

- ✓ discussed their roles as health-care providers;
- ✓ discussed behaviour change and how this can be achieved; and
- ✓ understood the importance of communication in the process of bringing about change in patients, including in the prevention of FGM.

OUTLINE OF ACTIVITIES

5.1 THE ROLES OF HEALTH-CARE PROVIDERS (EXERCISE)

5.2 MOTIVATING PATIENTS TO MAKE POSITIVE CHANGES (DEMONSTRATION)

TEACHING AIDS

- Computer and projector
- Flip chart and markers
- Two chairs
- **TRAINING AID 5** (Slides “The roles of health-care providers”)
- **TRAINING AID 6** (Semi-scripted role play handout)

KEY MESSAGES

- ✓ Changing a behaviour is not always easy.
- ✓ This is due to a number of reasons, including:
 - people are not always aware that a certain behaviour is harmful and therefore do not think about changing it;
 - some people may want to change, but do not think they will have the strength or the support to do so (e.g. fear of being excluded and losing family support); and
 - some people do not want to change (e.g. they make money from FGM, they gain power and status through it).
- ✓ Health-care providers, as respected members of the community, can play an important role in helping members of the community to make positive changes.
- ✓ This applies to any change we would like our patients to make (quit smoking, attend antenatal visits, etc.).
- ✓ They also have a major role to play in promoting education against FGM.
- ✓ To achieve this, health-care providers need to be effective communicators:
 - in different settings: the health-facility, at community events, etc.
 - with different audiences: colleagues, patients, community members.

ACTIVITY 5.1

THE ROLES OF HEALTH-CARE PROVIDERS

(EXERCISE)



45 MIN



PPT



- 1** Start the session by asking participants to brainstorm about the roles of health-care providers.
Encourage them to consider roles beyond medical care.
- 2** Write down the answers on the flip chart.
- 3** Once all the answers have been collected, project **TRAINING AID 5** (Slides: “The roles of health-care providers”) which illustrates the roles included in **Box 5.1.1**.
- 4** Check how many of the roles listed in **Box 5.1.1** (and Training aid 5) were mentioned.
- 5** Ask participants:
“How did this make you feel?”
- 6** Highlight that many of these roles are carried out in different settings: the health-care facility, at home or in the community
Provide some examples using **Box 5.1.1** as a reference.

(CONTINUED ON NEXT PAGE)



BOX 5.1.1 THE ROLES OF MIDWIVES AND NURSES

Structure	Health facility	At home	In the community
1. Provider of health care to patients	X	X	
2. Provider of guidance to solve problems	X	X	
3. Administrative functions (e.g. booking appointments)	X		X
4. Caregiver	X	X	
5. Income provider	X	X	
6. Educator (provider of information and education)	X	X	X
7. Representative of the health system	X		X
8. Spouse/partner		X	X
9. Provider of emotional support and guidance	X	X	
10. Opinion leader	X		X
11. Mother/Father		X	X
12. Daughter/Son		X	X
13. Trainer (peer)	X		X
14. Mediator in conflicts	X	X	X
15. Friend	X	X	X

THE ROLES OF HEALTH-CARE PROVIDERS IN RELATION TO FGM

- 7 Now invite participants to think of the roles health-care providers have in relation to FGM.
- 8 Use **Box 5.1.2** to guide the discussion – but allow participants to start the discussion with their own ideas.

IMPORTANT



- **The following roles may be mentioned by participants:**
 - doing re-infibulation (reclosure) after childbirth
 - doing FGM with clean instruments if families request this
 - doing minor forms of FGM (nicking, drawing blood, mini-cut, etc.)
 - teaching girls to pretend they have undergone FGM in order to ‘protect’ them.
- **If any of these roles are mentioned by participants, it is important to address these and not shy away from the discussion.**
- **The facilitator should remain non-judgemental and respectfully clarify that such roles are not ethically acceptable.**
- **While it is important to respect the patient’s perspective, the health-care provider should always remember their role is to work towards stopping FGM.**
- **Teaching girls to pretend having undergone FGM is a risky practice, as health-care providers may be accused of having performed FGM on these girls.**

BOX 5.1.2 THE ROLES OF HEALTH-CARE PROVIDERS IN RELATION TO FGM

- ✓ Providing health care to girls and women who suffer from FGM health complications
- ✓ Reversing closure (de-infibulation) during childbirth for mothers with FGM type 3
- ✓ Providing safe houses for girls who are at risk of FGM
- ✓ Educating women about the health complications of FGM
- ✓ Educating their own daughters about the risks of FGM
- ✓ Supporting women who wish to abandon FGM for their daughters
- ✓ Advocating against FGM in the community
- ✓ Raising awareness among men about the risks of FGM
- ✓ Raising awareness among other midwives about the health risks of FGM
- ✓ Supporting alternative rites of passage

FACILITATOR'S NOTES

Background information

- Health-care providers play a number of important roles, not only in the health-care centre, but also across wider society.
- They are a bridge between the health-care facility and the community.
- Health-care providers also have knowledge and skills that are highly valued, and they are respected and listened to by individuals and families.
- As valuable members of the community, they have a unique position of influence.
- This is why health-care providers can play a key role in bringing about positive change.



ACTIVITY 5.2

MOTIVATING PATIENTS TO MAKE POSITIVE CHANGES (DEMONSTRATION)



1 HOUR



- 1 Explain that the facilitators will represent two situations in which a midwife discusses with a patient the importance of changing an unhealthy behaviour.
- 2 Use the semi-scripted text included in **TRAINING AID 6** (Semi-scripted role play handout), **Boxes 5.2.1** and **5.2.2** to guide the demonstrations, as appropriate.
- 3 Explain that participants should pay attention to how the midwife and the patient interact during the consultation.

BOX 5.2.1 SEMI-SCRIPTED ROLE PLAY 1

- A pregnant woman comes to an antenatal clinic because she has noticed that her baby is moving less.
- A midwife calls her to the consultation room.
- Without introducing herself, the midwife looks at the medical record and notices that the patient has missed several antenatal visits.
- The woman explains that she had been feeling well up until now and that she did not see the need to come to the clinic.
- The midwife, using an unfriendly tone, tells her that she has been an irresponsible mother by not coming, and that she must not skip any more visits.
- The woman responds that she thought that antenatal visits were only for mothers who had a problem during pregnancy.
- The midwife responds that antenatal visits are for all women and that she should “follow the instructions of those who know more about these things”.
- The patient leaves feeling very worried.



AFTER ROLE PLAY 1 ...

4 Discuss the following with participants.

ASK: *How did the midwife motivate the woman to attend the antenatal visits?*

RESPONSE: By ordering her to do so ("follow the instruction of those who know more about these things").

ASK: *Do you think this will be effective? In the short term? In the long term?*

RESPONSE: The patient may try not to skip any more antenatal visits. However, she may also not return at all because of the shame. In future pregnancies, this might negatively affect her antenatal attendance.

ASK: *Is the patient aware of the risks of not attending antenatal visits?*

RESPONSE: No, in fact she thinks that antenatal visits were only for mothers who have a problem during pregnancy. And the midwife does not take the time to explain why antenatal visits are important.

ASK: *What might the midwife have done differently to motivate the patient to attend?*

RESPONSE: The midwife could have communicated more effectively with the patient. For example (several examples are possible), she could have introduced herself and tried to build a rapport with the patient. She could have explained the importance of antenatal visits as a way of detecting any complications at an early stage. She could have asked the patient why she had difficulties attending the visits, and if she needed any support to attend.

KEY MESSAGE

It is not enough to tell someone what to do and to show them how to act for the person to change their behaviour. The new behaviour must be agreed by the person before they can adopt it.



BOX 5.2.2 SEMI-SCRIPTED ROLE PLAY 2



- A pregnant woman comes to an antenatal care clinic because she has noticed that her baby is moving less.
- A midwife calls her to the consultation room.
- After introducing herself, the midwife asks the patient how she is feeling.
- The patient responds that she is feeling well.
- The midwife looks at the medical record and notices that the patient has missed several antenatal visits.
- She asks the patient why she has not attended the visits.
- The woman responds that she had been feeling well up until now and that she did not see the need of coming to the clinic.
- The midwife tells her that antenatal visits are important, both for her and her baby.
- The woman responds that she thought that antenatal visits were only for mothers who had a problem during pregnancy.
- The midwife says that antenatal visits are for all women, not only for women who have complications during pregnancy. It allows the midwife to detect potential complications at an early stage and to treat them. Overall, they make the pregnancy safer for the mother and the baby.
- The midwife then asks her if there are any other reasons why she has not been able to attend.
- The patient explains that, sometimes, because she needs to travel far, she skips visits that are too early in the morning.
- The midwife tells her that she can request an afternoon appointment next time.
- The patient says that she thinks this may be a good idea and thanks the midwife.
- They both say goodbye and the patient leaves the room with a peaceful look on her face.

AFTER ROLE PLAY 2 ...

5 Discuss the following with participants.

ASK: *How did the midwife motivate the woman to attend the antenatal visits?*

RESPONSE: By talking to her about the importance of antenatal visits and explaining the benefits of attending them. She also motivated the patient by trying to understand any difficulties she had that stopped her attending regularly.

ASK: *Do you think this will be effective?*

RESPONSE: Even though changing long-standing behaviours can be challenging, when the change comes from the person themselves, it is more likely to be successful. People must be allowed to change in their own way and at their own speed. Therefore, they must be involved in all stages of the process.

ASK: *How did the midwife communicate with the patient?*

RESPONSE: She communicated by encouraging a dialogue with the patient, and involved her in the change process. She asked about her difficulties and explored how these could be overcome.

KEY MESSAGE

When the change comes from the person themselves, it is more likely to be successful. Communicating effectively with our patients can help us motivate them to change unhealthy or bad behaviours.



6 Close the session by emphasizing the important role of health-care providers in bringing about change.

FACILITATOR'S NOTES

Background information



- Changing a behaviour is not always easy.
- This is due to a number of reasons, including:
 - people are not always aware that a certain behaviour is harmful, and so do not think about changing it; and
 - some people may want to change, but do not think they will have the strength or the support to do so.
- Health-care providers – as respected members of the community – can play an important role in helping people to make changes.
- This applies to any change we would like our patients to make.
- They also have a major role to play in promoting education against FGM.
- To achieve this, health-care providers need to be effective communicators:
 - in different settings – at the health-care facility and in the community
 - with different audiences – colleagues, patients and others.

CHECK OUT (DAY 1) 30 MIN

- 1 Close the day by inviting participants to reflect on the topics discussed during the first day of the training.
- 2 Ask them to consider whether the training objectives were achieved.
- 3 Encourage them to express any comments they may have.

PERSON-CENTRED COMMUNICATION SKILLS

This module aims to support health-care providers to improve their provider–patient communication skills, with a focus on person-centred communication.

SESSION 6: CHARACTERISTICS AND PRINCIPLES OF PERSON-CENTRED COMMUNICATION

- 6.1: Animation video: The seed of hope
- 6.2: Mini-lecture: How can we communicate effectively with our patients?
- 6.3: Mini-lecture: What is person-centred communication?
- 6.4: Demonstration: Demonstrating person-centred communication
- 6.5: Mini-lecture: Why should health-care providers learn person-centred communication?
- 6.6: Group exercise and role play: Skills for effective person-centred communication

6

CHARACTERISTICS AND PRINCIPLES OF PERSON-CENTRED COMMUNICATION



2 HOURS 30 MINUTES

OVERVIEW OF THE SESSION

This session focuses on communication and the verbal and non-verbal skills needed to communicate effectively with women attending for antenatal care. It also introduces person-centred communication. Participants will develop skills for discussing FGM with their female patients, and for delivering FGM-prevention messages. They will also be introduced to the concept of enabling women to change their beliefs and values about FGM.

LEARNING OBJECTIVES

By the end of this session, participants will have:

- ✓ discussed the importance of effective communication during a clinical consultation;
- ✓ understood the meaning of person-centred communication in the context of a clinical consultation;
- ✓ identified and practised the skills for person-centred communication during role plays, including verbal and non-verbal communication techniques;
- ✓ discussed the importance of making the clinical consultation a safe space for open discussion; and
- ✓ discussed appropriate interviewing techniques to facilitate effective provider–patient communication for the prevention of FGM.

OUTLINE OF ACTIVITIES

- 6.1 THE SEED OF HOPE (ANIMATION VIDEO)**
- 6.2 HOW CAN WE COMMUNICATE EFFECTIVELY WITH OUR PATIENTS? (MINI-LECTURE)**
- 6.3 PERSON-CENTRED COMMUNICATION (MINI-LECTURE)**
- 6.4 DEMONSTRATING PERSON-CENTRED COMMUNICATION (DEMONSTRATION)**
- 6.5 WHY SHOULD HEALTH-CARE PROVIDERS LEARN PERSON-CENTRED COMMUNICATION? (MINI-LECTURE)**
- 6.6 SKILLS FOR EFFECTIVE PERSON-CENTRED COMMUNICATION (GROUP EXERCISE AND ROLE PLAY)**

- Computer and projector
- Flip chart and markers
- Two chairs
- **TRAINING AID** ★ (Slides: “Effective communication”)
- **TRAINING AID** ★₈ (Slides: “Person-centred communication”)
- **TRAINING AID** ★₉ (Handout with example dialogues)
- **TRAINING AID** ★₁₀ (Slides: “Why health-care providers should learn person-centred communication”)
- **TRAINING AID** ★₁₁ (Slides: “Skills for effective person-centred communication”)

TRAINING AIDS

KEY MESSAGES

- ✓ Effective communication happens when people discuss an issue together to try to reach mutual understanding.
- ✓ The skills needed for effective communication can be learnt.
- ✓ Effective communication has several benefits, for the patient and for the provider.
- ✓ Learning effective communication skills helps health-care providers to become more successful communicators, better health-care professionals and more trusted colleagues.
- ✓ Person-centred communication means communicating with female patients in ways that allows the health-care provider to understand the patient's perspective.
- ✓ Person-centred communication helps patients to feel safer and less anxious, which allows them to better understand medical instructions.
- ✓ Key skills for effective person-centred communication during a clinical consultation include:
 - creating a welcoming and safe environment;
 - speaking clearly and simply;
 - active listening (truly hearing what the patient is saying by paying close attention to her words and body language, and making sure she feels that you are registering what she is saying);
 - using effective interviewing skills: clarifying, summarizing and giving encouragement;
 - asking open-ended questions;
 - expressing empathy; and
 - being non-judgmental, and promoting dignity and respect.

ACTIVITY 6.1

THE SEED OF HOPE

(ANIMATION VIDEO)



15 MIN



- 1 Tell participants that they will watch an animation video about a midwife named Lea.
- 2 Project the animation video.
- 3 Ask participants how they felt after watching the animation video.

ACTIVITY 6.2

HOW CAN WE COMMUNICATE EFFECTIVELY WITH OUR PATIENTS? (MINI-LECTURE)



15 MINUTES



PPT



1 Start by reminding participants that during day two of the training they will learn and practice:

- how to communicate effectively with women, including during antenatal care;
- how to discuss FGM and its prevention in an effective, comfortable and person-centred way.



It is important to know why some people support FGM as this will be discussed with patients when delivering the “ABCD counselling technique”.

2 Ask participants:

“What is effective communication?”

(allow 3 minutes for discussion). 

3 Write down the answers on a flip chart.

4 Highlight any answers that emphasize the use of effective communication skills, such as:

- listening attentively
- being empathetic
- treating people with respect.

5 Using **TRAINING AID**  (Slides: “Effective communication”), explain effective communication.

FACILITATOR'S NOTES

Key concepts



Effective communication is a two-way process

- Effective communication is a two-way process whereby people share information or discuss an issue together to try to reach mutual understanding.
- It is two-way because when the sender transmits the message, the receiver generally provides feedback that the message has been understood.
- This feedback can be verbal (e.g. "Aha") or non-verbal (e.g. a gentle head nod or eye contact).
- In other words, effective communication takes place when a message is delivered, received and understood in the way it was intended.
- Both the health-care provider and the patient can be the sender and the receiver of information. These roles alternate throughout the consultation.

Communication during the clinical encounter is inevitable

- During the clinical encounter, communication is inevitable. Even if we try to avoid communicating by not replying to something the patient has said, we are still sending a message – in this case, a negative one: "My silence means I am not interested in what you are saying."
- Therefore, the only choice we can make about communication is whether or not we are going to attempt to communicate effectively (4).
- Important aspects to highlight with participants:
 - effective communication is a two-way process;
 - it is usually face-to-face during a clinical encounter;
 - it is verbal (i.e. words) and non-verbal (e.g. facial expression);
 - feedback allows the sender to know whether the receiver has understood the message; and
 - this can also be defined as having a dialogue.

Health-care providers can learn the necessary skills to communicate effectively

- To communicate effectively, health-care providers can learn some simple yet effective skills that will help during the clinical encounter.
- These skills should be used for everyone seeking health care, including women attending antenatal clinics.
- Health-care providers who are effective communicators, who can express themselves clearly, respectfully and in a simple manner, are essential to quality health care, including antenatal care, services (7).
- During the training, participants will be introduced to ideas and skills that can help them to become effective communicators.

ACTIVITY 6.3

WHAT IS PERSON-CENTRED COMMUNICATION? (MINI-LECTURE)




15 MINUTES



PPT



- 1 Start by telling participants that the communication skills that will be discussed during the training are based on a very important concept: person-centred communication.
- 2 Ask participants:
“What do you understand by ‘person-centred communication?’”
- 3 Using **TRAINING AID**  (Slides: “Person-centred communication”), introduce the concept of person-centred communication.

FACILITATOR'S NOTES

Key concepts



All of the following needs to be conveyed in the mini-lecture.

- Person-centred communication means communicating with patients in ways that allow the health-care provider to understand the patient's perspective.
- This means trying to understand not only the patient's medical concerns, but also:
 - who they are as a person;
 - what their personal beliefs and values are; and
 - what their expectations, needs and feelings are about their health and well-being.
- By understanding the patient's life circumstances and personal uniqueness, the health-care provider will be better prepared to motivate them to follow recommendations (8).
- Person-centred communication also means involving the patient in their own care management.
- The care and support provided to a patient should always be guided by their needs and unique circumstances (2).

- When we communicate in a person-centred way, the chance that the patient will follow a treatment plan or planned behaviour change is much greater as they feel that it was planned with them, rather than simply for them.
- It means having two experts in the room: the patient as an expert about their own body and health, and the health-care provider as an expert in medical issues who can advise on health-care choices.

IMPORTANT! *The health-care provider should remember that, while respecting the patient's perspective is important, their role is always to work towards stopping FGM.*







ACTIVITY 6.4

DEMONSTRATING PERSON-CENTRED COMMUNICATION (9) (ROLE PLAY)



45 MINUTES



- 1 Tell participants that they will role play two different clinical interactions.
- 2 Divide participants into two groups (groups A and B).  
Ask each group to pick two volunteers.
- 3 Give **TRAINING AID**  (Handout with example dialogues) to each group. Group A will prepare role-play A (**Box 6.4.1**) and group B, role play B (**Box 6.4.2**).
- 4 In each group one volunteer will play the role of a nurse, and the other will play the role of a woman seeking care at a local health-care centre for persistent lower back pain. The rest of the participants will act as observers, but are encouraged to help prepare the role-play. Participants can use the example dialogues A and B (*see boxes on following pages*) to prepare the exercise, but are encouraged to develop their own role-play.
- 5 Allow 10 minutes of preparation. 
- 6 Tell participants that they should pay attention to how the nurse and the patient interact during the consultation.
- 7 After each role-play, ask participants these questions:

How did the health-care provider communicate with the patient?

Did the health-care provider:

- introduce herself (name and role)?
- greet the patient?
- act patiently or in a hurry?
- say goodbye?
- listen attentively?
- interrupt the patient?

Did the health-care provider do anything that made this communication provider-centred? (Use the following list to guide the discussion.)

Did the health-care provider:

- ask all the questions and make all the decisions during the consultation?
- focus only on the patient's symptoms?
- allow the patient to explain why she was worried?
- ask the patient if she had any additional concerns?
- order a treatment and give the woman any information about how she could prevent back pain?
- make sure the patient had understood the treatment?

What could the health-care provider have done to make this dialogue more person-centred? (Use the following list to guide the discussion.)

The health-care provider could have:

- asked the patient how she was feeling
- allowed the patient to express her concerns
- showed the patient that she understood her concerns
- made sure the patient had understood the treatment indications.

8 To close the activity, ask participants to compare the behaviours they saw during the two interactions.

9 Ask participants to think of what made the second interaction more person-centred. Use the following list to guide the discussion.

The health-care provider:

- introduced herself and greeted the woman warmly
- broke the ice by asking the woman about how she came to the clinic (bus)
- allowed the woman to speak without interruptions
- validated the woman's feelings.

10 Add anything relevant to the list of effective communication skills.

BOX 6.4.1 ROLE PLAY A

Example of a 'provider-centred' dialogue

A woman comes to the health facility because she has had lower back pain for a few weeks.

The nurse calls her into the consultation room. When she enters, the nurse seems quite busy and neither greets her nor introduces herself to the patient. Without even asking the patient's name, the nurse asks her straightaway what brings her to the health facility. The woman, who seems a little nervous, explains she has had pain but has difficulties in explaining what kind of pain it is and where she feels it. The nurse seems a little irritated that the woman cannot provide more details and decides to examine the patient without explaining what she will do.

During the examination, the patient, who feels very uncomfortable, tells the nurse that she is worried she may have kidney problems. The nurse dismisses the woman's idea and tells her 'not to worry so much about these things'. Without sharing the results of the physical examination, the nurse tells the patient that she will give her pain killers and that this should be enough for now. Without asking the woman if she has any questions, she tells her the consultation is over and asks her to call the next patient when she leaves.

EXAMPLE DIALOGUE A:

NURSE: Hello, what brings you here today? [The nurse/midwife does not introduce herself, look at the patient nor does she ask the woman's name.]

WOMAN: Hello. Well, I have been feeling a lot of pain in the past few weeks.

NURSE: Where do you feel the pain?

WOMAN: Well, it is hard to explain. [The woman sounds a little unsure.]

NURSE: But you can surely tell me what part of your body hurts, right?

WOMAN: think it's my back, but...

NURSE: Can you tell me what part of your back?

WOMAN: It is the lower back.

NURSE: OK, let me have a look. [The nurse examines the patient's lower back.]

WOMAN: I was a little worried it could be something else – like my kidneys"
[The woman sounds worried.]

NURSE: Your kidneys? Why do you mention that?

WOMAN: Well, it's just that I heard it could be that also and I have felt a little worried.

NURSE: Your kidneys! Have you had kidney problems before?

WOMAN: No, it's just that I was worried...

NURSE: I see. So how long have you had the back pain?

WOMAN: More than a month now.

NURSE: OK, let's see if with pain medication you feel better and then we'll go from there.
[The nurse starts getting up and seems a little in a hurry.]

WOMAN: OK. It's just that I'm a little worried because...

NURSE: No need to worry. I am sure you'll be fine.

WOMAN: OK. Thank you. [The woman leaves looking a little uneasy.]



BOX 6.4.2 ROLE PLAY B

Example of a 'person-centred' dialogue

A pregnant woman comes to the health facility because she has had lower back pain for a few weeks. The nurse calls her to enter the consultation room. When she enters, the nurse stands up, introduces herself and warmly greets the patient. After asking the patient's name, the nurse asks her if the journey to the health facility had been OK.

The nurse then asks the patient how her pregnancy is going. The patient explains that the pregnancy has been going well but lately she has been feeling back pain. The nurse acknowledges this by saying 'I see, you feel pain in your lower back. Anything else you have noticed?'. The woman says that she has also been having sleep problems because she is worried. The nurse invites her to further explain why she is worried. The woman answers that her husband has lost his job. The nurse once again acknowledges the woman's concerns and tells her that she will give her something for her back pain so she can sleep better.

Before bringing the consultation to an end, the nurse asks the patient if she has any questions and invites her to come back if the pain continues. The patient thanks the nurse and leaves the room.

(Continued on next page)

EXAMPLE DIALOGUE B:



NURSE: Hello, Ms Okoye. My name is Amara. Please take a seat.
[The nurse or midwife offers her a chair.]

WOMAN: Hello. Thank you.

NURSE: Did it take you long to get here today?

WOMAN: No, it was alright. I only waited 10 minutes for the bus and there were no delays.

NURSE: Oh, that's great. So, I see that this is your first antenatal consultation. Can you tell me a little bit about how your pregnancy is going?

WOMAN: Until now the pregnancy is going well.

NURSE: That's good. Do you have any issues or questions? I know this is your second baby but not all pregnancies are the same!

WOMAN: Well, in fact I have felt a lot of back pain these past few weeks. Especially when I am lying down.

NURSE: I see. Apart from the back pain, anything else you have been experiencing?

WOMAN: I also have had some trouble sleeping these past few weeks.

NURSE: So, difficulty falling asleep and back pain that you feel when lying down. Anything else?

WOMAN: No, that's it in fact. Except that I am a little worried about my husband who just lost his job.

NURSE: Right. You are worried about your husband. I imagine how that can be. Especially with a new baby on the way.

WOMAN: Yes, it has been difficult for us.

NURSE: I understand. Let's start by seeing what we can do about the back pain, because that will allow you to sleep better. Does that sound OK to you?

WOMAN: Yes, I think that might help me a get a good night's sleep.

FACILITATOR'S NOTES

Background information



Person-centred versus provider-centred communication

- Sometimes, health-care providers ask all the questions, guide the whole clinical consultation and focus only on the patient's medical complaint or disease. By doing so, they can forget to ask about the woman's perspective.
- We call this "provider-centred communication". In other words, all the decisions made during the consultation are made by the health-care provider, not the patient. This is very different from person-centred communication, as it fails to consider the woman's preferences, needs and values. These should guide all medical decisions alongside the medical expertise of the health-care provider.
- Remember! The woman's needs, not her medical complaint, should guide the conversation.
- You are probably communicating in a person-centred way if you:
 - allow the woman to tell you her concerns without immediately interrupting her
 - listen to her attentively and pay genuine attention to her ideas and problems
 - give her the information she needs so she can make informed decisions about her care
 - check whether she has understood what you are telling her
 - encourage her to ask questions
 - support her to make decisions
 - facilitate the choices she makes
 - speak in solidarity with her.
- Participants should try to remember these signs and adopt them during their daily clinical practice.

ACTIVITY 6.5

WHY SHOULD HEALTH-CARE PROVIDERS LEARN PERSON-CENTRED COMMUNICATION?

(MINI-LECTURE)




15 MINUTES



PPT



- 1 Ask participants: “*Why do you think health-care providers should learn person-centred communication?*”
- 2 Using **TRAINING AID**  (Slides: “Why health-care providers should learn person-centred communication”), explain why health-care providers should learn person-centred communication.

FACILITATOR’S NOTES

Key concepts



All of the following needs to be conveyed in the mini-lecture.

- Communication is very important in everything we do in life. It does not matter who we are communicating with – spouse, children, parents, peers, boss, neighbours – it is the process that influences the quality of relationships.
- Many of our problems in our personal and professional relationships result from poor communication.
- Learning person-centred communication skills will help you to become a more effective communicator, a better health-care professional and a more trusted colleague.
- Person-centred communication skills has several benefits, for the patient and for the provider (10):

Benefits for the patient:

- increased satisfaction with care
- better relationships with health-care providers
- less anxiety and feeling more secure

- greater comfort and ability of patients to discuss their needs
- trust that the health-care provider is competent (10)
- improved understanding of medical instructions, making it easier for patients to follow indications and continue the treatment
- increased effectiveness of medical treatment.

Benefits for the health-care provider:

- improves the quality of care provided to patients
- improves relationships with patients
- allows providers to better understand the needs of their patients (11)
- providers who communicate effectively feel more self-confident
- improves job satisfaction.

ACTIVITY 6.6

SKILLS FOR EFFECTIVE PERSON-CENTRED COMMUNICATION (GROUP EXERCISE AND ROLE PLAY)



45 MINUTES



PPT



OPENING THE ACTIVITY

1 Open the activity by explaining that:

- one of the main goals of effective person-centred communication is to build trust and rapport between the health-care provider and the patient;
- a trusting relationship between health-care provider and patient creates the comfortable environment needed for a successful antenatal contact.

GROUP EXERCISE

2 Brainstorm with participants about what skills are needed for effective person-centred communication.

3 Record participants' answers on the flip chart.

4 Emphasize answers that address the following skills:


- Creating a welcoming environment
- Speaking clearly and simply
- Active listening
- Using effective interviewing skills: clarification, summarizing and encouragement
- Asking open questions
- Expressing empathy
- Being non-judgmental and promoting dignity and respect

FACILITATOR'S NOTES

Participants probably already use some of the skills that will be discussed, although many may not be aware of them. Other communication skills that participants do not currently use can be developed or strengthened by studying and practising them.



PRACTISING KEY SKILLS FOR EFFECTIVE PERSON-CENTRED COMMUNICATION

- 5 Using **TRAINING AID**  (Slides: “Skills for effective person-centred communication”) and **Box 6.6.1**, carry out the following exercises.

FACILITATOR'S NOTES

Box 6.6.1 contains both the information you need to convey, and instructions on conducting the session with the participants.



BOX 6.6.1 KEY SKILLS FOR EFFECTIVE PERSON-CENTRED COMMUNICATION IN THE ANTENATAL SETTING (4,8,12-14)

1. CREATING A WELCOMING ENVIRONMENT

TELL PARTICIPANTS:


- If a woman does not feel welcomed or at ease, it will be almost impossible to communicate effectively with her.
- By creating a welcoming environment, the woman will feel safer and less anxious. This will allow her to express her needs and concerns with less difficulty. It will improve the provider-patient relationship.

TIPS FOR CREATING A WELCOMING ENVIRONMENT

- Always greet and welcome the patient in a friendly yet professional manner.
- Positive remarks about non-medical issues such as the weather, generalities about the day, or general, encouraging observations can help to build rapport.
- Example: “Was your journey here OK?”
- Use the patient’s name (you can look it up in her medical record or in the patient list).
- Introduce yourself, giving your name and your role.
- Ensure patient privacy (if possible, close the door or draw the curtain). If absolute privacy is not possible (e.g. you are in a shared consultation room), move closer to the patient and speak loudly enough for her to hear you, but not for other people to overhear.

EXERCISE: ROLE PLAY CREATING A WELCOMING ENVIRONMENT



- 1 Invite one or two participants to carry out a role-play exercise.
- 2 One participant will play the role of a nurse or midwife and another (or the facilitator if needed) will play the role of a woman seeking care at a local health-care centre. Allow 3 minutes to prepare the role-play. 
- 3 Tell participants they should create a welcoming environment using the recommendations discussed.
- 4 Once they have finished, ask participants to provide feedback.

2. SPEAKING CLEARLY AND SIMPLY

TELL PARTICIPANTS:

- Speaking clearly means using terms and speaking in a way that the patient understands.

TIPS FOR SPEAKING CLEARLY AND SIMPLY

- Avoid using complex medical terms.
- Speak slowly, giving time for the patient to ask questions.
- Regularly check whether the patient has understood the indications given. Before bringing the consultation to an end, make sure you ask the woman if she has understood and if she has any extra questions.

EXERCISE: ROLE PLAY SPEAKING CLEARLY AND SIMPLY



- 1 Ask for two volunteers
- 2 One will play the role of the midwife/nurse; the other will be the patient who is very worried about her urine test results.
- 3 Tell the participant who is playing the provider, to describe in simple words what the following lab result means:

URIANALYSIS RESULTS:

Component	Result	Reference range
Proteins	Negative	Negative
Red blood cells (RBC)	8 per high-power field	0–4 per high power field
White blood cells (WBC)	50 per high-power field	0–5 per high-power field



- 4 Ask participants: “*What is the possible diagnosis?*”
- 5 Tell participants to explain the meaning of these results to the patient in simple words.

3. ACTIVE LISTENING: HEARING WHAT IS BEING SAID

TELL PARTICIPANTS:

- Active listening means truly hearing what the patient is saying by paying close attention to her words and body language.

EXERCISE: ACTIVE LISTENING (adapted from MhGap guide (13))

- 1 Divide participants into pairs.  Spread the pairs around the room and ensure they face each other.
- 2 Assign one as person A and the other as person B.
- 3 Person A will have 2 minutes  to talk about something important to them. Advise participants to avoid discussing controversial topics such as politics or religion, and select a topic they find interesting and want to discuss. They could choose from the following topics:
 - their family – children
 - their professional work
 - hobbies and activities that they enjoy doing during their free time.
- 4 Person B will listen. After 2 minutes, they swap roles.
- 5 Bring the whole group together and ask for a few volunteers playing person A to briefly repeat what they heard. Check with their partners that the information is correct.
- 6 Swap and ask a few volunteers playing person B to briefly describe what A told them, also checking that the information is correct.
- 7 After the feedback, facilitate a quick discussion about the experience of listening. Ask participants to be honest and state how many times they were distracted when they were listening, and if they had other thoughts while listening.
- 8 Explain that it is normal to get distracted while listening to another person, but it can lead to missing out on a lot of information.
- 9 Ask participants to reflect on how it felt to have someone listen to them.

TIPS FOR ACTIVE LISTENING

- Listen and pay close attention to what is being said.
- Listen without being distracted (not looking at the phone, computer, etc.).
- Pay attention to the verbal and non-verbal messages to understand the true meaning of what the patient is saying.
 - For example, people often express their feelings through their actions, facial expressions and body language, but struggle to name or express those emotions. Therefore, concentrating, listening, asking questions and taking time to really hear and clarify what people are telling you are core skills.
- Do not rush the patient and do not be afraid of silences. Although 10 seconds of silence can feel like a long time to you, it can give the person enough time and space to begin talking about their experience.
- Do not interrupt, correct or speak over the patient when she is speaking.
- Use non-verbal encouragement such as:
 - head nodding
 - appropriate eye contact
 - avoiding crossed arms or legs.
- Use continuers to encourage her to speak – words and sounds such as:
 - “go on”
 - “hmmmm”
 - “aha”.

4. USING EFFECTIVE INTERVIEWING SKILLS: CLARIFICATION, SUMMARIZING AND ENCOURAGEMENT

TELL PARTICIPANTS:

- A few simple interviewing and counselling techniques can help health-care providers to communicate more effectively with patients.
- These techniques can be used during any health consultation, including antenatal care.
- They can also be used when delivering preventive care to patients.

TIPS FOR EFFECTIVE INTERVIEWING AND COUNSELLING

Use the following interviewing and counselling skills:

- 1. Clarification:** Respectfully asking questions during the interview to clarify ideas and emotions expressed by the patient. This can be used to clarify words and ideas and also emotions if needed:
 - Clarifying words and ideas – for example:
 - “Could you please repeat what you just said?”
 - “Does this mean that you are ready to take this decision in your life?”
 - Clarifying emotions – for example:
 - “How does this make you feel?”
 - “How did this affect you?”
- 2. Summarizing:** Another very useful technique when trying to understand the details about what the person is saying and clarifying whether you understood it correctly. This can be achieved in the following ways.
 - Restate the main points (the content) of what the patient has said.
 - Do not just repeat – put into your own words how you have understood the person’s situation.
 - Do not state as fact – use words that show you are checking whether you have understood correctly.
 - Summaries offered during the course of the session help us to keep our focus on the important areas and also to make transitions to other relevant topics.

- You can start summarizing by using the phrases:
 - “What I am understanding is...”
 - “In other words...”
 - “So, what you are saying is...”
 - “It sounds as if...”
 - “I am not sure that I am understanding you correctly, but I hear you say...”
 - “You sound...”
- 3. Encouragement:** These phrases help to give recognition to a patient’s feelings and actions, highlighting these in a positive way.
- “You’ve had a difficult time and handled it well.”
 - “That’s great that you have decided to talk to your family about this issue.”

EXERCISE: IDENTIFY THE INTERVIEWING SKILLS

- 1 Tell participants that you will show slides with brief dialogues between a health-care provider and a patient.
- 2 Read each slide out loud and ask participants to indicate which one of the three interviewing skills – clarification, summarizing or encouragement – is being used by the nurse.

SLIDE 1:

Woman: And after talking to my husband, I decided I was ready.

Nurse: Can you please tell me what you mean by “being ready”?

Woman: I mean I was ready to talk to my mother-in-law about our decision not to cut our daughter.

Nurse: I see.

Answer 1: *Clarification*

Note: In this case, the health-care provider was not sure what the woman meant by “being ready”. By asking, she gained fuller information.

(Continued on next page)



SLIDE 2:

Woman: I think I could talk to my sisters about this. Yes, they would be able to help me. Or even my aunt. She would also listen.

Nurse: It sounds like you have a few family members you trust and could talk to.

Answer 2: *Summarizing*

Note: The nurse uses her own words to summarize the main idea behind this sentence. Notice that she uses different words to summarize this idea.



SLIDE 3:

Woman: And after I told her about my plans, my mother-in-law got very angry and yelled at me. I told her that I did not want to upset her but that it was my decision after all.

Nurse: I can see you've had a difficult time and handled it very well. You are strong.

Answer 3: *Encouragement*

Note: The nurse is acknowledging the fact that having a fight with a mother-in-law can be difficult but that she handled things very well.



SLIDE 4:

Woman: I just don't feel comfortable talking about "that"?

Nurse: May I ask you what do you mean by "that"?

Woman: I mean about intimate things such as sex.

Nurse: I see what you mean.

Answer 4: *Clarification*



SLIDE 5:

Woman: It is difficult for me to find a solution. My family is angry at me, I cannot speak to my friends and I feel I don't have the time or the necessary resources.

Nurse: I see. It seems to me that the main problem is that you have several issues to deal with at the same time. Perhaps we can start talking about them one by one?

Woman: Exactly – it's as if it is all too much to deal with at the same time.

Answer 5: *Summarizing*

5. ASKING OPEN QUESTIONS

TELL PARTICIPANTS:

- During a consultation, both the health-care provider and the patient ask questions.
- For the health-care provider, it is easier to communicate effectively with a patient when using open rather than closed questions.
 - **Closed questions shut down conversation** (they are usually answered with yes or no). They can, however, be used when precise information is needed, for example when asking about a woman's FGM status or other precise obstetric information.

Examples: Did you come here by bus? What is your name? Have you been cut in the genital area?

- **Open questions open up communication.**

Examples: How are you feeling today? How did you travel here? Tell me about yourself?

- When asking open questions, the health-care provider can use words such as "then?" or "and?" to encourage patients to keep talking if they have difficulties responding.
- **Open and closed questions can work well together.**
- **Open questions are very useful when:**
 - Starting a consultation:
"Hello, Ms. Okoye. How can I help you today?"
 - We want to gain a broader perspective on a patient's situation and context:
"I would like to try and find out why you feel you should cut your daughter? Can you tell me some of the reasons?"
"How does this make you feel?"
"Can you share with me some of the reasons why you think it is important that you do that?"
"What do you think about this option?"

(Continued on next page)

EXERCISE: IDENTIFY THE TYPE OF QUESTION

- 1 Tell participants that you will show slides with different types of question.
- 2 Ask for a volunteer to read each question out loud and ask if it is open or closed:
 - *“Tell me how your pregnancy is going”* - open
 - *“Tell me how you feel about cutting your daughter”* - open
 - *“Is your pregnancy going well?”* - closed
 - *“Please tell me more about that”* - open
 - *“Do you think FGM should continue?”* - closed
 - *“Describe to me why you are feeling this way”* - open
 - *“How would you like to plan this?”* - open

6. EXPRESSING EMPATHY

TELL PARTICIPANTS:



Empathy: Empathy is the ability to understand and share the feelings of another person.

- **Empathy is important because it:**
 - enables us to recognize the feelings of another person and communicate that we understand – building rapport;
 - allows us to understand the individual’s perspective, and so provide person-centred care; and
 - shows respect and gives emotional support to the woman by letting her know that you really understand her feelings.
- **Highlight the difference between “empathy” and “sympathy”:** “Sympathy” can be described as feelings of pity and sorrow for someone else’s misfortune; this is different from empathy, which involves trying to understand the other person’s perspective.

EXERCISE: PROVIDING EMPATHETIC ANSWERS

(adapted from MhGAP guide (13))

- 1 Tell participants that you will show slides with different quotes from patients.
- 2 Ask them to give examples of how they could respond with empathy.
- 3 After participants' answers, reveal the answer.
- 4 Give participants a few attempts before revealing the response.



SLIDE 1:

“My husband has lost his job again – I don’t know what we are going to do now.”

Answer 1: “That must be difficult for you. Tell me more about how you are feeling. Can you tell me what you have discussed as a solution to this problem?”



SLIDE 2:

“My mother-in-law is insisting that I cut my daughter, but I think this can cause her harm. I do not want to cut her, but my mother-in-law will not be happy. What should I do?”

Answer 2: “It sounds as if you are having a hard time with this decision. Many women feel pressured by family members to cut their daughters, but many women resist this pressure because they do not want to hurt their child. Can you think of somebody who could support your decision and help you resist this pressure?”

- Emphasize that these are just two examples of an empathetic response, as there are lots of different ways to express empathy. With practice, participants will develop their own way to express empathy.
- This response recognizes that this is a difficult time for the person. It gives emotional support by acknowledging that seeking help is good, while it also starts to build rapport with the person by inviting them to talk more.
- In both examples, the person has been invited to talk more and explain more. This is a key point and the best way to do this is to use open questions.

7. BEING NON-JUDGMENTAL AND PROMOTING DIGNITY AND RESPECT

TELL PARTICIPANTS:

- The health-care provider should try to remain non-judgmental at all times, even if the woman's views are different from their own.
- Always treat patients with dignity and respect. It is the health-care provider's ethical duty to do so.
- Examples of judgemental answers:
 - "I cannot believe you did something like that. What were you possibly thinking?"
 - "That is definitely not OK. I am sure a lot of people would agree with me that that is not something that you can say".

TIPS FOR BEING NON-JUDGEMENTAL AND PROMOTING DIGNITY AND RESPECT

- Do not pass judgment. If you find yourself being judgmental, stop yourself.
- Instead of judging, try to understand.
- When asking sensitive questions, always ask for the patient's permission and make sure she is comfortable discussing the topic. For example, you can say:
 - "I would like to ask you a question about FGM. Would that be OK with you?"
 - "I wonder if we could spend a few minutes talking about FGM?"
- Note that each of these questions is formulated in a polite manner and gives the woman the chance to say if she is not willing to talk or is uncomfortable.

PERSON-CENTRED COMMUNICATION FOR FGM PREVENTION

This module discusses the drivers of FGM (why genital cutting is practised) and how person-centred communication skills can be used for FGM prevention during antenatal care consultations.

SESSION 7: BELIEFS ABOUT FGM (AND HOW TO RESPOND TO THEM)

- 7.1: Brainstorming: Why do some people support FGM?
- 7.2: Myth or truth game: Common beliefs about FGM
- 7.3: Enabling change within the community

SESSION 8: PERSON-CENTRED COMMUNICATION FOR FGM PREVENTION

- 8.1: Mini-lecture: What is person-centred communication for FGM prevention?
- 8.2: Mini-lecture: Person-centred communication for FGM prevention – description of the technique
- 8.3: Role play: Practising person-centred communication for FGM prevention

7

OVERVIEW OF THE SESSION

LEARNING OBJECTIVES

OUTLINE OF ACTIVITIES

TEACHING AIDS

BELIEFS ABOUT FGM (AND HOW TO RESPOND TO THEM)



This session explores the main reasons why some people support FGM. Participants will also learn to identify if support is based on myths or truths, and how to respond.

By the end of this session, participants will have:


- ✓ discussed why FGM is practised
- ✓ discussed common beliefs about FGM
- ✓ identified whether these beliefs are myths or facts.

7.1 WHY DO SOME PEOPLE SUPPORT FGM? (BRAINSTORMING)

7.2 COMMON BELIEFS ABOUT FGM (MYTH OR TRUTH GAME)

7.3 ENABLING CHANGE WITHIN THE COMMUNITY (GROUP DISCUSSION)

CHECK OUT DAY 2

- Computer and projector
- Chairs
- **TRAINING AID**  12 Myth or truth game

KEY MESSAGES

- ✓ Parents support FGM for their daughters for many reasons.
- ✓ People's attitudes towards FGM are often guided by long-held beliefs.
- ✓ These beliefs have often been around for generations and, because most people in a certain community share them, it can be difficult to challenge them, even when many of the beliefs are untrue.
- ✓ As a health-care provider, it is important to know about such beliefs and to recognize whether or not they are supported by evidence.

ACTIVITY 7.1

WHY DO SOME PEOPLE SUPPORT FGM?

(BRAINSTORMING)



15 MINUTES

1 Ask participants:
“Why do some communities carry out FGM on their daughters?”

2 This list will help you guide the discussion:

- respect for tradition
- rite of passage
- social convention
- enhance fertility
- marriageability
- ensure virginity, chastity and faithfulness
- control female sexuality
- cleanliness, beauty, purity
- femininity
- religion.

3 Explain that behind these reasons (drivers) there are long-held beliefs that tend to influence people’s attitudes to the practice.



Tell participants that it is important to understand and remember these reasons as they will be used when delivering the “ABCD counselling technique”.

FACILITATOR'S NOTES

Background information



- In communities that support FGM, girls, their mothers and families are generally under social pressure from their peers and family members to be cut. They are threatened with rejection by the group or family if they do not follow tradition.
- Typically, the traditional cutter is a powerful and well-respected member of the community, and FGM is her source of income. She therefore has a personal interest in keeping the tradition alive (4).
- Sometimes, other community members also have a financial interest as they receive a fee for each girl cut (e.g. the Council of Elders in Kuria, Kenya).
- Explain that behind these reasons (drivers) there are long-held beliefs that tend to influence people's attitudes to the practice.
- These beliefs have often been around for generations and, because they are widely shared, it is difficult to challenge them, even when many of the beliefs are untrue.
- As a health-care provider, it is important to know about such beliefs and to recognize whether they are supported by evidence or not.

ACTIVITY 7.2

COMMON BELIEFS ABOUT FGM

(MYTH OR TRUTH GAME)



OPENING THE ACTIVITY

- 1 Ask participants to think of some common beliefs about FGM and to say if they think they are true or false.

FACILITATOR'S NOTES

If participants feel it is hard to start the exercise, you can provide an example to start the conversation (see [Box 7.2.1](#)).



- 2 Write down two or three common beliefs mentioned by participants, using [Box 7.2.1](#) to help guide the discussion.
- 3 Remind participants about the concept of “being equipped” with adequate knowledge and information in order to be able to respond to these common beliefs.



FACILITATOR'S NOTES

Background information

- [Box 7.2.1](#) lists the most common shared beliefs about FGM and explains why some are false. It also describes the reasons why the practice should be discouraged.
- Facilitators should be ready to present and discuss national statistics.



BOX 7.2.1 BELIEFS ABOUT FGM AND HOW TO RESPOND TO THEM

Belief	True or False?	How to respond to this belief
FGM is a religious mandate	False	<ul style="list-style-type: none"> • FGM is not mentioned in religious texts such as the Koran or the Bible. • Many religious leaders think this tradition should end. They have not cut their own daughters, and work towards the complete abandonment of FGM.
If a girl is not cut, she will not find a husband and marry	False	<ul style="list-style-type: none"> • Recent surveys show that men in many communities would like FGM to end. • Globally, 63% of boys and men would like FGM to end (15). <p> <i>Facilitators should be ready to present and discuss national statistics.</i></p>
Girls who do not have FGM cannot enter womanhood and become respectable women	False	<ul style="list-style-type: none"> • Rites of passage are important for community members because they mark the transition from one phase of life to another. • However, rites of passage can take many forms. • In many cultures where FGM is not practised, girls take part in different rites of passage to mark their entrance into womanhood and become respectable members of the community. These rites need not be harmful or dangerous to a girl's health and well-being. • Pride in and celebration of one's culture does not have to mean the harming of girls. <p> <i>Facilitators should be ready to present and discuss national statistics.</i></p>
FGM has no health benefits	True	<ul style="list-style-type: none"> • There is no medical indication for FGM. • On the contrary, FGM can cause several health complications some of which are life-threatening.



(CONTINUED ON NEXT PAGE)

ACTIVITY 7.2 COMMON BELIEFS ABOUT FGM

Belief	True or False?	How to respond to this belief
FGM helps to ensure a women's faithfulness/ ensures women will not have extramarital sex	False	<ul style="list-style-type: none"> • Marital faithfulness is based on personal commitment and respect, not genital cutting. Couples who share these values, regardless of the woman's FGM status, are more likely to remain faithful to each other. • These are values that can be taught by parents to girls and boys at home. • FGM can affect a woman's capacity to enjoy a healthy and pleasurable sexual relationship with her husband or partner. It may prevent both partners from having a fulfilling sex life, thereby damaging the marital relationship.
By removing the clitoris, girls will not have premarital sex	False	<ul style="list-style-type: none"> • This is a myth. Ensuring a girl's honour has nothing to do with cutting her genitalia. • Removing parts of the clitoris does not mean a girl cannot engage in premarital sex. • These are values that can be taught by parents to girls and boys at home. • Infibulation (closure) does not protect against rape.
If FGM is done by a health-care professional, there is no long-term physical damage	False	<ul style="list-style-type: none"> • FGM has no health benefits. • Health complications can arise in the short and long term, regardless of who does it. • Health-care providers who do FGM are violating the basic medical ethic to do no harm and the principle of giving the highest-quality health care. • Health-care providers are never trained to perform FGM, therefore it is not part of their competencies.
FGM is no different from voluntary medical male circumcision (VMMC)	False	<ul style="list-style-type: none"> • Male circumcision is the surgical removal of the foreskin, the fold of tissue that covers the head of the penis. • Male circumcision does not interfere with sexual function and pleasure. • The inside of the foreskin is susceptible to HIV infection. • Evidence shows that VMMC reduces the risk of female-to-male sexual transmission of HIV. WHO and the Joint United Nations Programme on HIV/AIDS (UNAIDS) therefore recommend VMMC as an important strategy in HIV prevention.

Belief	True or False?	How to respond to this belief
If a woman is de infibulated (closure reversed), the baby may fall out during pregnancy	False	<ul style="list-style-type: none"> • The baby grows and develops inside the uterus. • The lower part of the uterus, called the cervix, keeps the baby inside. • FGM does not affect the integrity of the cervix.
A woman who is not cut cannot become pregnant	False	<ul style="list-style-type: none"> • Women from parts of the world where FGM is not practised do become pregnant and deliver healthy babies.
FGM has health benefits for the baby	False	<ul style="list-style-type: none"> • There are no health benefits to FGM, either for the mother or for the baby. • Studies by WHO and others found that babies born to mothers who have type 3 FGM are more likely to need resuscitation at birth, and have a higher risk of perinatal death.
If the clitoris is not removed, it can hurt the baby during delivery	False	<ul style="list-style-type: none"> • This is a myth. • The clitoris can cause no harm to the baby or the mother. • There is no evidence of this in any study.
If the clitoris is not cut, it will grow and may look like a male penis	False	<ul style="list-style-type: none"> • The clitoris is a female sexual organ and an important anatomical source of sexual pleasure in women. • The clitoris stops growing after puberty. • At this stage, its visible part – the clitoral glans – is still a small, round, seed-like structure above the opening of the urethra, covered by the prepuce.
FGM makes women silent and obedient	False	<ul style="list-style-type: none"> • There are strong role models who are speaking out against FGM. • Women who have had FGM have led full and successful lives, for example Nawal El Sadawi, the Egyptian doctor, author and campaigner.
Women who have had FGM can enjoy sex	True	<ul style="list-style-type: none"> • A pleasurable sexual life is also related to a mental state of mind. • With adequate support, women who have had FGM can also enjoy sex. • Women who have not been cut can sometimes also suffer from sexual dysfunction.

MYTH OR TRUTH GAME: COMMON BELIEFS ABOUT FGM TRAINING AID

- 1 Post three signs around the room: “Myth”, “Truth” and “Unsure”.
- 2 Hand each participant a folded card (**TRAINING AID** ) and tell them not to open it yet.
- 3 Ask a first participant to read aloud the statement printed on the card and to decide if it is a myth, truth or somewhere in the middle (unsure).
- 4 Tell the participant to stand beneath the sign that matches their opinion and to explain why they chose to stand where they did.
- 5 Ask the other participants if they agree. Allow 2–3 minutes  of debate if people disagree and to see whether the reader changes their mind.

FACILITATOR'S NOTES

Use the beliefs in [Box 7.2.1](#) to help the group think about the evidence, but do not try too hard to convince them. What is important is to get the debate flowing and to demonstrate how challenging these issues are.



- 6 Once debate ends, ask the participant holding the card to open it and to read the inside answer aloud.

- 7 Ask the reader whether the information just read out makes them want to move towards a different sign.

FACILITATOR'S NOTES

Always let the reader decide where they finally stand.



- 8 Repeat the same exercise with each participant.

FACILITATOR'S NOTES

Background information

- Participants will use the information presented in [Box 7.2.1](#) and heard during the session when discussing FGM with women and members of their families.
- It is important to discuss all beliefs with participants, so that they are well-equipped with all the information they will need.
- Remind participants that there are many more beliefs about FGM that may not have been covered in the session. However, they have the knowledge to respond to these beliefs and can play an important role in changing people's views on FGM.



ACTIVITY 7.3

ENABLING CHANGE WITHIN THE COMMUNITY

(GROUP DISCUSSION)



30 MINUTES



- 1 Let participants sit in four small groups to discuss the question:  | 

“How can we as health-care providers help people to change their beliefs and values towards FGM?”

- 2 Ask participants to write down their answers.

Allow two minutes for this. 

- 3 Ask each individual group to present their work to the whole group.

- 4 Allow 5 minutes  for each presentation and discussion.

FACILITATOR'S NOTES

You can use the facilitator's notes to guide the discussion.



FACILITATOR'S NOTES

Background information



- People have their own reasons for valuing FGM.
- These values and attitudes develop over a lifetime. Changing them may not be an easy or quick process.
- Encouraging people to discuss their feelings about FGM will help them to see which values and attitudes they might no longer see as valid.
- Health-care providers are in a good position to do this.
- They can act as a bridge with the community by speaking to women who come for antenatal care.
- Women who get information about FGM and are given support can deliver messages to their communities.
- Only by fully understanding our own values can we recognize which behaviours are from rational choice and which are from other influences.
- Trying to change behaviour alone is not enough if the social factors that shape it are not challenged. In other words, if we do not question the values and beliefs that support a behaviour, it will be difficult to change it.

8

OVERVIEW OF THE SESSION

LEARNING OBJECTIVES

OUTLINE OF ACTIVITIES

PERSON-CENTRED COMMUNICATION FOR FGM PREVENTION



4 HOURS

This session introduces person-centred communication for FGM prevention and explores how health-care providers can use it during clinical consultations to talk about FGM with patients. Health-care providers will learn how real changes come from the women themselves, rather than being put on them.

By the end of this session, participants will have:





- ✓ discussed the principles behind person-centred communication for FGM prevention;
- ✓ identified the essential messages about FGM that need to be delivered during the prevention sessions;
- ✓ practised how to ask about FGM and its drivers; and
- ✓ practised the delivery of person-centred communication for FGM prevention, including how to respond to common beliefs about FGM.

8.1 WHAT IS PERSON-CENTRED COMMUNICATION FOR FGM PREVENTION? (MINI-LECTURE)

8.2 PERSON-CENTRED COMMUNICATION FOR FGM PREVENTION: DESCRIPTION OF THE TECHNIQUE (MINI-LECTURE)

8.3 PRACTISING PERSON-CENTRED COMMUNICATION FOR FGM PREVENTION (ROLE PLAY)

TEACHING AIDS

- Computer and projector
- Chairs
- **TRAINING AID**  **13** (Slides: “Person-centred communication for FGM prevention”)
- **TRAINING AID**  **14** (Slides: “The technique in detail”)
- **TRAINING AID**  **15** (Handout with ABCD steps)
- **TRAINING AID**  **16** (Situation cards with beliefs about FGM)

KEY MESSAGES

- ✓ Person-centred communication for FGM prevention is a person-centred approach designed to empower women to abandon the practice for their daughter(s).
- ✓ The goal of person-centred communication for FGM prevention is to help women make well-informed and voluntary decisions about FGM for their daughters.
- ✓ It is not about convincing, but about encouraging women to choose not to cut their daughters.
- ✓ Women should be encouraged to explore and resolve internal conflict about FGM beliefs.
- ✓ Health-care providers working in antenatal care settings are in a good position to deliver person-centred communication for FGM prevention.

ACTIVITY 8.1

WHAT IS PERSON-CENTRED COMMUNICATION FOR FGM PREVENTION? (MINI-LECTURE)




30 MINUTES



PPT



1

Using **TRAINING AID**  (Slides: “Person-centred communication for FGM prevention”), introduce the concept of person-centred communication for the prevention of FGM.

FACILITATOR'S NOTES

All of the concepts in the facilitator's notes to the right need to be conveyed in the mini-lecture.



FACILITATOR'S NOTES

Key concepts



OVERVIEW OF THE TECHNIQUE

- Person-centred communication for FGM prevention is a counselling technique designed to empower women to abandon the practice of FGM.
- It can be used during any clinical encounter, including antenatal care.
- Through this technique, the health-care provider encourages the woman to explore her main reasons for supporting FGM and to reassess her beliefs on the practice. These reasons are then contrasted with facts.

OBJECTIVES

- The main goal of person-centred communication for FGM prevention is to empower women to reassess their beliefs on FGM in order to abandon genital cutting.
- The specific objectives of person-centred communication for FGM prevention are to:
 - enable a respectful discussion about FGM between health-care providers and patients
 - explore and understand the woman's personal views and beliefs about FGM
 - provide information to the woman, including alternative views to her personal beliefs on FGM
 - motivate her to consider and discuss 'change'
 - plan for follow-up and refer to links with outside agencies and organizations if these are available.

KEY PRINCIPLES BEHIND THE TECHNIQUE

- The technique, delivered by health-care providers, is based on the following key principles:
 - FGM is a medically unnecessary practice that can severely harm girls' health and well-being;
 - people who support FGM share a number of beliefs and values that influence their attitudes towards the practice;

ACTIVITY 8.1 WHAT IS PERSON-CENTRED COMMUNICATION FOR FGM PREVENTION?

- to change a behaviour, women must first reflect on and question the beliefs and values that support this behaviour; and
- decisions made by the woman rather than the health-care provider will determine the patient's ongoing behaviours (16).
- The woman's personal beliefs about FGM are revealed by using a semi-structured interviewing technique. This aims to motivate her to think about the real reasons why she supports FGM for her daughter(s).
- The goal of the technique is not to convince women that they should abandon FGM based on the rational reasons that we give. Rather, it is to identify the patient's own values and goals to stimulate behaviour change.
- In other words, motivation to change comes from the women themselves and cannot be imposed on them.

CONTEXT OF THE TECHNIQUE

- Health-care providers working in antenatal care settings have frequent opportunities to talk to women about FGM and the risks involved in cutting their daughters.
- Person-centred communication for FGM prevention uses the antenatal encounter as a chance to start talking to the woman specifically about her views on FGM and the reasons behind these.
- Nevertheless, the technique can also be used in other clinical encounters.

IMPORTANT! *Participants should remember that, while it is important to respect patients' perspectives, their role is to work towards stopping FGM.*



CHECK OUT (DAY 2)



30 MIN

- 1 Close the day by inviting participants to reflect on the topics discussed during the second day of the training.
- 2 Ask them to consider whether the training objectives were achieved.
- 3 Encourage them to express any comments they may have.

ACTIVITY 8.2

PERSON-CENTRED COMMUNICATION FOR FGM PREVENTION:

Description of the technique




1 HOUR 30 MINUTES



PPT



OPENING THE ACTIVITY

- 1 Using **TRAINING AID**  14 (Slides: “The technique in detail”), introduce the steps of person-centred communication for FGM prevention.
- 2 Tell participants that they can use the ABCD abbreviation to memorize the steps of the technique (see [Box 8.2.1](#)).
- 3 Explain that the technique takes between 10 and 15 minutes to be delivered

FACILITATOR'S NOTES

Key concepts





- **Person-centred communication for FGM prevention has five steps.**
 1. Address FGM – confirm the woman’s FGM status and health conditions potentially related to FGM.
 2. Assess the woman’s views – if she supports FGM, what are her reasons?
 3. Discuss and challenge beliefs about FGM – what are the woman’s beliefs about FGM?
 4. Explore the possibility of change.
 5. Discuss and decide – support the woman in talking to other members of her community about FGM.
- **These five steps are summarized in the initialism ABCD, as shown in [Box 8.2.1](#).**

BOX 8.2.1: PERSON-CENTRED COMMUNICATION FOR FGM PREVENTION – ABCD

A	Address and assess	Steps 1 and 2	Address FGM – confirm the woman’s FGM status and health conditions potentially related to FGM. Assess the woman’s views – if she supports FGM, what are her reasons?
B	Beliefs	Step 3	Discuss and challenge beliefs about FGM – what are the woman’s beliefs about FGM?
C	Change	Step 4	Explore the possibility of change.
D	Discuss and decide	Step 5	Discuss with the woman about, and support in, talking to other members of her community about FGM.

DETAILED DESCRIPTION OF THE TECHNIQUE

- 1 Using **TRAINING AID**  14 (Slides: “The technique in detail”), go through each step of the counselling technique.
- 2 Hand out **TRAINING AID**  15 (Handout with ABCD steps)
- 3 For each step, describe the key actions and provide some example statements.
- 4 Use the facilitator’s notes located next to each step to complement the information provided on the following pages.

(Continued on next page)

ADDRESS FGM

Confirm the woman's FGM status and health conditions potentially related to FGM

1

Welcome the woman in an approachable way

"Hello Ms Okoye. Thank you for coming today"

"My name is Amara and I am the nurse/midwife looking after you today"

"Please come in. Have a seat"

"Was your journey here OK today?"

2

Ask the woman about her FGM status, during clinical history taking

"Have you heard of female genital cutting? Can I ask you a few questions about this?"

"Do you know if you have been cut in the genital area?"

"Have you had any kind of traditional or cultural practice done on your genital area?"

"Were you cut (in the genital area)?"

3

If you confirm that the woman has had FGM, ask her about these clinical symptoms and concerns:

- vaginal discharge
- urinary symptoms
- previous complications during pregnancy and childbirth
- worries or fears about the pregnancy or childbirth
- past experience of de-infibulation (reversing FGM) and/or re-infibulation
- psychological or sexual complications

"Some women who have undergone the type of genital cutting you have experience symptoms such as... Do you have any of these problems?"

ADDRESS FGM: FACILITATOR'S NOTES



STEP 1

- Remind participants of the importance of always greeting the patient and creating a welcoming environment.
- Checking if the patient is OK (e.g. they may have had a difficult journey or be stressed about the appointment, which could affect the whole consultation) gives a chance to identify issues and move on.

STEP 2

- In countries where FGM is prevalent, health-care providers are strongly advised to politely ask about and record the FGM status of all women during their first antenatal visit (2). This part of the antenatal visit is therefore the starting point for the delivery of person-centred communication for FGM prevention.
- Avoid making assumptions – always check by politely asking the woman if she has had FGM.

IMPORTANT!

Remind participants that some women may not consider FGM types 1 and 4 as forms of FGM. If they are asked about their FGM status, they may therefore respond that they have not been cut, despite having had FGM. It is important to confirm that she has not been cut, by asking for further details. Ask, for example, about taking part in special rituals as a girl, or about health complications such as scar tissue or other alterations of her genital area.

STEP 3

- Routine antenatal care for women in these settings should include further assessment against these questions (2):
 - has the woman had FGM? (what is her FGM status?)
 - what health conditions does the woman have and are they potentially related to FGM?
- More information on taking a clinical history during pregnancy (pages 158–165) and treating FGM complications (pages 168–177) are available in the WHO FGM clinical handbook (2).
- Remind participants of the importance of documenting the findings (FGM status and type) in the patient's medical record.

ASSESS

Assess the woman's views. If she supports FGM, what are her reasons?

1

Assess how the woman feels about FGM and if she thinks the practice should continue

"I would like to ask you a question (some more questions) about FGM. Would this be OK with you?"

"How do you feel about FGM/genital cutting? Is this something girls should have done to them? Do you think FGM should continue?"

"Do you support the continuation of FGM?"

2b

Patient is unsure or thinks FGM should continue:

Ask the woman what her reasons are for supporting FGM

"Thanks for sharing this with me. I would like to try and find out why you feel FGM should continue. Can we talk about this for a minute?"

"I wonder if we could spend a few more minutes talking about FGM. Could you tell me some of the reasons why you think it is important for girls to be cut?"

"If it is OK with you, can you tell me your own experience with FGM?"

"Are there any specific reasons why you think it's important that girls have FGM?"

"Can you share with me some of the reasons why you think why FGM is important for girls?"

3

Summarize the woman's reasons in your own words – as a statement, not a question

"Let me see if I can summarize what you just said. The main reasons why you think girls should be cut are..."

"If I understood correctly, you think FGM is important for girls because..."

2a

Patient thinks FGM should stop:

- give positive reinforcement
- check whether the woman thinks she might have difficulty keeping her position towards ending FGM. If yes, move to step 5, "Discuss and decide"; and
- before ending the conversation, and moving to the next part of the antenatal consultation, remind her that she can come back for support at any time and give a phone number if available

"That's great that you do not support FGM!"

"If you have a daughter in the future, do you think it would be possible for you to decide not to cut her? Do you think you might have any difficulty sticking to your decision?"

"If you would like to discuss anything else about FGM or your pregnancy, please come back to the clinic. We are always available for you."

"Just in case you need any support, here is a number that you could call."

ASSESS: FACILITATOR'S NOTES



STEP 1

- Once the health-care provider has confirmed the woman has had FGM (by history taking and/or physical examination), the next step involves assessing whether she supports FGM and if she thinks the practice should continue.
- The health-care provider should remain non-judgemental at all times.
- Avoid asking her if she thinks her own daughter(s) should be cut – it is best to ask her if she thinks “other girls” should be cut.
- If she is open to discuss FGM, give some statement of appreciation to encourage the discussion. For example: “I appreciate that you are willing to talk to me about your thoughts on FGM”, or “Thanks for sharing this with me. I know these are personal questions.”

IMPORTANT! What do to if the woman does not wish to discuss FGM

If the woman responds that she does not want to discuss this topic, the health-care provider should try to encourage her to do so, but without being overly pushy; the health-care provider must reassure the patient that the conversation will be kept private and that they can stop at any time if desired. For example, they could say: “Please be assured that anything we discuss here is in the strictest confidence. Does that change your mind about talking about this subject?”

If she continues to decline the conversation, the health-care provider should respect her wishes and offer her the chance to return if she changes her mind. She must also offer her any available support numbers and move on to the next part of the clinical consultation.

STEP 2

- Difficulties in keeping the woman's position against FGM could be due to family resistance, fear of community judgement, fear that the baby will be taken away, and so on.
- If the woman mentions any potential difficulty in keeping her position against FGM, the health-care provider moves on to **step 5** (“Discuss and decide”).

(Continued on next page)

ASSESS: FACILITATOR'S NOTES *(continued)*



IMPORTANT!

Some women are likely to minimize the negative effects on themselves of FGM and may say something like: "I had FGM, and nothing bad happened to me. Why would it be bad for other girls?" This is a chance to further ask her about her own experience:

- the health-care provider first asks the woman if she could share her own experience with FGM,*
- or she could ask why she thinks FGM is good for girls;*
- the health-care provider explores the reasons that seem most relevant to the woman – her reason(s) could be personal or community-driven.*

STEP 3

- When the health-care provider summarizes the woman's reasons using their own words in the form of a statement it allows the woman to hear her own reasons reflected by the health-care provider (17).
- It is possible that some women will mention more than one reason why they support FGM. If this is the case, and if there is enough time, the health-care provider should try to address the main reasons.

BELIEFS

Discuss and challenge beliefs about FGM.
What are the woman's beliefs about FGM?

1

Invite the woman to rethink the aspects of FGM that she sees as positive, by introducing the concept of BELIEFS

"You have just mentioned the reasons why you think genital cutting should continue ..."

"However, did you know that many of the reasons given by community members for supporting FGM are ideas passed on from generation to generation in a community, without anyone ever questioning them? We can call these 'beliefs'."

2

Contrast the woman's reasons for supporting FGM with facts

"I would like to share some interesting facts about beliefs with you. For example ..."

**EXAMPLE 1:
IF THE WOMAN MENTIONS HONOUR ...**

"This is interesting, so if I understand correctly, you see FGM as the only way to ensure your daughter becomes a respectable woman. This is a very important issue. Would it be OK if we discussed this a bit?"

In fact, for a girl to grow up to become a respectable woman, her upbringing is the most important thing. If at home she receives the correct values, she will become a respectable girl!"

"Do you know girls who have had premarital sex in your community? If so, what does this tell you? Even girls who have had parts of their genitals removed or have been closed up can still have premarital sex. FGM does not really prevent this from happening!"

**EXAMPLE 2:
IF THE WOMAN MENTIONS RELIGION ...**

**EXAMPLE 3:
IF THE WOMAN MENTIONS THE IMPORTANCE
OF FGM AS A RITE OF PASSAGE ...**

"Did you know that there are communities who have successfully agreed to use alternative rites of passage that do not include any cutting, but that celebrate a girl's passage to womanhood?"

Rites of passage can take many forms. The pride and celebration of culture doesn't have to mean harming girls"

"... you mentioned religion as an important reason for cutting your daughter. Let's focus on religion for a minute. Would that be OK?"

Did you know that FGM is not mentioned in religious texts such as the Koran or the Bible?"

In fact, many religious leaders think this tradition should end?"

3

Ask her how she feels about what you have just discussed

(This should be done after discussing each reason)

"How does this make you feel?"

"I understand that this is a lot of new information to process. How do you feel right now?"

BELIEFS: FACILITATOR'S NOTES



STEP 1

- At this stage, the health-care provider respectfully invites the woman to re-evaluate her beliefs about FGM.
- The health-care provider first introduces the concept of beliefs that surround FGM:
 - Many of the reasons given by community members for supporting FGM are not based on any evidence or facts. They are beliefs.
 - **Beliefs** are ideas passed on from generation to generation in a community, without anyone questioning them.
- It is important that the health-care provider validates the woman's reasons (does not try to dismiss them). They should then ask for permission to share some interesting facts about possible alternatives to the beliefs given by the woman.
- It might be the first time that the woman has had this conversation, and the first time she may see FGM as negative.

STEP 2

- Using the woman's reasons, the health-care provider delivers facts that aim to clarify FGM.
- These help the patient evaluate and use the facts when deciding about cutting her daughter (14).
- This, in turn, is a chance for the woman to reflect on the reasons why she thinks FGM should continue. It allows her to consider the fact that not supporting FGM may also be a valid belief.

STEP 3

- The woman must be given a few minutes to think about what she has just heard before moving on to the next step.

CHANGE

Explore the possibility of change

1

Invite the woman to reflect on change by highlighting that changing traditions is possible

"Before we end the conversation, I would like to take a minute to discuss change with you. Would this be OK?"

"Sometimes, when we take a closer look at our beliefs and we see them from a different angle – like we did today – we may consider changing them. I would like to invite you to reflect on this and on the things we discussed today about FGM."

"Change, and changing our beliefs, is possible, even if these are long-held beliefs. Change is especially possible if, after thinking again about some of our beliefs about these traditions, we decide that we no longer support them."

"A good example of this is FGM. Today, we discussed other aspects of it – new points of view."

2

... invite her to think about what was discussed and remind her that the role of health-care providers is to promote the end of FGM

"As health-care providers who care about your well-being and the well-being of the community, we promote the end of FGM."

3

Ask her how she feels about what you have just discussed

"How does this make you feel?"

"I understand that this is a lot of new information to process. How do you feel right now?"

CHANGE: FACILITATOR'S NOTES



STEP 1

- At this stage, the health-care provider invites the woman to explore the possibility of change – in this case, changing beliefs about FGM for her daughter.
- When people take a moment to reflect on FGM as a tradition, and they consider their beliefs but also other aspects of the practice, they can truly decide if this is a tradition worth keeping.
- If they identify negative aspects, then the community might consider changing this tradition and finding more positive ways of honouring girls.

STEPS 2 & 3

IMPORTANT!

At this stage, the woman may or may not think changing her views on FGM is important or possible. She will need time to think about what has been discussed.

The health-care provider should avoid trying too hard to convince her that change can happen. Their role is to listen attentively and to offer support. The health-care provider can ask if the woman would like to think about what was discussed during the session and perhaps come back for another consultation.

In such cases, the health-care provider should remember to tell the woman that even if she needs more time to think about this, "As health-care providers who care about your well-being and the well-being of the community, we promote the end of FGM."

DISCUSS AND DECIDE

Support the woman in talking to other members of her community about FGM

1

Invite the woman to discuss change with a person she trusts and who may also be supportive of ending FGM

"Before we end the consultation, I would like to invite you to reflect on the things we discussed today when you go back home. Perhaps you could share them with someone you trust?"

"Perhaps someone in your family, a close friend or a community member who you know thinks FGM should end?"

"If you were to consider not cutting your daughter, what could pressure you to do it? Who would you need to talk to about this decision to make it a reality? Who is the person who decides if your daughter will be cut? Is it perhaps your mother? Or your mother-in-law? Or your husband?"

"Are there any community or religious leaders you could approach for help or support?"

"Who or what else may help you?"

2

Document key findings

CLOSURE

Follow-up and referrals

1

Check if the woman has understood, and if she has questions

"Do you have any further questions? You can ask me anything that is not clear"

2

Offer other support services and/or a follow-up session

"The following support groups are available if you need any help or more information"

DISCUSS AND DECIDE: FACILITATOR'S NOTES

STEP 1

- During this final step, the health-care provider will help the woman to identify where she can get support from within her family or community to make change happen.
- If needed, the health-care provider can give examples of people who could be supportive of her decision against FGM. This could be a close friend, a family member, local nongovernmental organizations, or community or religious leaders.
- Whoever she talks to must be a trusted person and should keep the discussion confidential until they both decide to discuss it openly.
- Each patient is unique and will need different solutions or support for considering abandoning FGM for her daughter - the idea is for the woman to identify strategies for change that she feels will work in her own life.
- In the case of abandoning FGM, this includes changing her own views, but also dealing with her family's and/or the community's potential resistance to change.
- At all times, the health-care provider must validate the woman's thoughts and emotions and encourage her to find solutions that are in harmony with her own values.

STEP 2

- Key findings health-care providers should document include noting whether the ABCD counselling technique was delivered and the position of the woman towards FGM.

CLOSURE: FACILITATOR'S NOTES

STEP 1

- Before bringing the session to an end, the health-care provider should:
 - check that the woman has understood everything and ask if she has any extra questions or requests;
 - remind her that what you have discussed is confidential, unless she asks the health-care provider to talk to another person or if a child is in danger of being cut; and
 - arrange for more support if needed (from support services, if available).

STEP 2

- The health-care provider should know about other services, if available, that offer information and support to girls and women who wish to prevent FGM for themselves or their daughters.
- It is important that the health-care provider lets the woman know that they are there for her should she wish to clarify anything or get more support.
- A follow-up session can be offered if the woman would like it.

ACTIVITY 8.3


PRACTISING PERSON-CENTRED COMMUNICATION FOR FGM PREVENTION (ROLE PLAY)



1 HOUR 30 MINUTES



OPENING THE ACTIVITY

1 Ask participants to carefully read through the steps of delivering person-centred communication. Allow 5 minutes for this. 



2 Remind participants that:

- women will give different reasons for supporting FGM for their daughter(s);
- depending on the main reasons given, the health-care provider will offer different alternative arguments;
- therefore, even though the intervention has five distinct parts, the discussion will change slightly depending on the context unique to each woman; and
- the key is to identify which arguments are useful in different situations.

PRACTISING PARTS A AND B

PREPARING THE ROLE PLAY

1 Tell participants that they will first practise parts A and B of the intervention.

2 Divide participants into groups of three  and give each group **TRAINING AID**  (Situation cards with beliefs about FGM).

3 The cards will contain illustrations that show the following beliefs about FGM.

1. FGM is a religious requirement.
2. If a girl is not cut, she will not find a husband and marry.
3. Girls who do not have FGM cannot enter womanhood and become respectable women.
4. FGM helps ensure a woman's faithfulness/controls the sexuality of women.
5. If FGM is done by a health-care professional, there is no long-term physical damage.
6. A woman who is not cut cannot become pregnant.

4 One participant will play the role of health-care provider, the second will play the woman, and the third will be an observer.


5 All must participate in the preparation of the story.

IMPORTANT! *The facilitator will pick one volunteer to partner with and prepare one of the situations. The facilitator will be the patient, a woman who is very convinced about her belief about FGM; this is therefore an intentionally difficult scenario.* **!**

6 Ask groups to decide what their situation card is illustrating, and to make up a story about what they are seeing.

7 Remind them that they must stick to the specific situation card they have received.

8 After creating a story, ask groups to develop a role play between a midwife/nurse and a patient, using the steps covered in the ABCD of person-centred communication for FGM prevention.

9 Give pairs 15 minutes to practise their role play. 

(Continued on next page)

PRESENTING THE ROLE PLAY

- 10** First, participants should present only the first two parts of the intervention.

FACILITATOR'S NOTES

Make sure each group presents their role play within 5–10 minutes.




- 11** The facilitator will open the presentations by role playing one of the situation cards with a volunteer.

- 12** Following this first role play, all groups will present their own role plays.



- 13** Invite participants to share all their concerns and questions, until all the role plays are finished.

- 14** Afterwards, ask the group which aspects of person-centred communication for FGM prevention were done well.

PRACTISING PARTS C, D AND CLOSURE

- 1 Once participants feel confident practising parts A and B, invite them to practise steps C, D and Closure
- 2 Instruct the groups of three to continue developing the situation they presented during the first part of the exercise.
- 3 Give 15 minutes for this. 
- 4 Ask each group to present their role play.

FACILITATOR'S NOTES

Make sure each group presents their role play within 5-10 minutes.  

- 5 Again, the facilitator will open the presentations by role playing parts C and D of one of the situation cards with a volunteer.
- 6 Invite participants to share all their concerns and questions, until all the role plays are finished.
- 7 Afterwards, ask the group which aspects of person-centred communication for FGM prevention were done well.

VALUES AND ETHICS ON FGM MEDICALIZATION

This module addresses the medicalization of FGM, and the ethical and legal implications. It also deals with the various reasons why health-care providers should never do FGM, even if asked to do so.

SESSION 9: VALUES AND ETHICS ON FGM MEDICALIZATION

- 9.1. Brainstorming: Why do some patients request medicalized FGM?
- 9.2 Group discussion: Why do some health-care providers agree to do FGM?
- 9.3: Mini-lecture: Professional ethics
- 9.4: Group activity: The ethics circle
- 9.5: Mini-lecture: The legal status of FGM in the country
- 9.6: Group discussion: Responding to requests for medicalized FGM
- 9.7: Role play: Responding to requests for medicalized FGM

9

VALUES AND ETHICS ON FGM MEDICALIZATION



3 HOURS 30 MINUTES

OVERVIEW OF THE SESSION

This session addresses the medicalization of FGM and its ethical and legal implications, including the professional codes of conduct and relevant laws. It also explores the various reasons why health-care providers should never do FGM, and how to respond to any requests to do so.

LEARNING OBJECTIVES

By the end of this session, participants will have:

- ✓ understood what is meant by the medicalization of FGM and why it should never be done;
- ✓ identified what the ethical standards are for health-care providers in relation to FGM;
- ✓ recognized existing laws that address FGM in the country; and
- ✓ discussed how to respond to requests for medicalization.

OUTLINE OF ACTIVITIES

9.1 WHY DO SOME PATIENTS REQUEST MEDICALIZED FGM? (BRAINSTORMING)

9.2 WHY DO SOME HEALTH-CARE PROVIDERS AGREE TO DO FGM? (GROUP DISCUSSION)

9.3 PROFESSIONAL ETHICS (MINI-LECTURE)




9.4 THE ETHICS CIRCLE (GROUP ACTIVITY)

9.5 THE LEGAL STATUS OF FGM IN THE COUNTRY (MINI-LECTURE)

9.6 RESPONDING TO REQUESTS FOR MEDICALIZED FGM (GROUP DISCUSSION)

9.7 RESPONDING TO REQUESTS FOR MEDICALIZED FGM (ROLE PLAY)

TRAINING AIDS

- Computer and projector
- Flip chart and markers
- **TRAINING AID**  17 (Slides: “Professional ethics”)
- **TRAINING AID**  18 (Pre-printed ethics statements plus response sheets)
- **TRAINING AID**  19 (Handout with role play script)

KEY MESSAGES

- ✓ The medicalization of FGM is never acceptable.
- ✓ Health-care providers who do FGM are breaking the basic medical ethical principles of doing no harm and always giving the highest-quality health care.
- ✓ Most countries have national laws against FGM that make it a criminal offence.
- ✓ Laws on FGM aim to protect girls from this harmful practice.
- ✓ Laws also help health-care providers to justify their opposition to FGM, giving them a good reason not to do it.
- ✓ FGM should never be done by health-care providers – by resisting requests to do FGM, health-care providers are doing the right thing.
- ✓ A request to do FGM can be a chance to talk about FGM and promote stopping it.

ACTIVITY 9.1

WHY DO SOME PATIENTS REQUEST MEDICALIZED FGM? (BRAINSTORMING)



15 MINUTES



1 Remind participants of the definition of FGM medicalization:



FGM medicalization: Situations in which FGM is practised by any category of health-care provider, whether in a public or a private clinic, at home or elsewhere. It also includes the procedure of re-infibulation (reclosure) at any point in time in a woman's life.

2 Ask participants: “*Why do some families request health-care providers to cut their daughters?*”

3 Write down some answers.

FACILITATOR'S NOTES

Use local examples prepared by the facilitator prior to the training.



4 To conclude, highlight the information contained in the Facilitator's notes.

FACILITATOR'S NOTES

Concluding remarks



- **Medicalized FGM exists because there is demand and supply** – demand from women and/or their families for FGM, and supply when health-care providers accept doing FGM.
- **People request medicalized FGM for several reasons**, but mainly because they think it is safer to have it done by a health-care provider. In other words, this is a belief in less harm.
- **Health-care providers may feel strong pressure from their patients to do FGM;** this can be difficult to deal with.
- Remind participants that:
 - **FGM is never a safe procedure**, even when done with sterile instruments;
 - **it can cause several short- and long-term health complications**, some of which are life-threatening; and
 - **the health-care provider should not accept any request for FGM.**

IMPORTANT! *Participants should remember that, while person-centred communication always considers the patients' views, as health-care providers it is their role is to work towards stopping FGM.*



ACTIVITY 9.2

WHY DO SOME HEALTH-CARE PROVIDERS AGREE TO DO FGM? (GROUP DISCUSSION)



30 MINUTES





- 1 Asking participants:
“Why are some health-care providers in favour of medicalizing genital cutting?”
- 2 Write down some answers.
Use the list of beliefs in [Box 9.2.1](#) to guide the discussion.

FACILITATOR'S NOTES

Tell participants that there are many beliefs about FGM, and also about medicalized FGM.



- 3 Agree on four or five beliefs around medicalized FGM and write them on the flipchart.
- 4 Split participants into groups of four. 
- 5 Ask groups to come up with statements to respond to these beliefs – provide 10 minutes for this. 
- 6 Ask each group to share the statements they prepared for each belief.
- 7 Use the list in [Box 9.2.1](#) to fill any gaps.

BOX 9.2.1 HEALTH-CARE PROVIDERS' BELIEFS ABOUT MEDICALIZED FGM

1. REDUCED PAIN AND RISKS

HEALTH-CARE PROVIDER BELIEF:

If FGM is done by a health-care provider, it reduces the pain and the risks to the girl's or woman's health, because the cutting is done hygienically.

Possible answers:

- ✓ Any type of intervention that involves removing a part of the body can have potential complications.
- ✓ FGM is not a surgical intervention. It is the cutting and removal of healthy genital tissue – it is not medically indicated.
- ✓ FGM has no health benefits for the girl/woman.
- ✓ Even if it is done with sterile instruments, some complications cannot be reduced. This includes the pain and the effects on the mental health of girls.

2. FIRST STEP TOWARDS THE ELIMINATION OF FGM

HEALTH-CARE PROVIDER BELIEF:

If FGM is done by a health-care provider, it can be the first step towards the elimination of the practice by giving control of it to health-care providers in a safer way.

Possible answers:

- ✓ When health-care providers do FGM, they are showing community members that they support it, which suggests it is an acceptable practice.
- ✓ This is a step in the opposite direction.
- ✓ For FGM to stop, all forms of FGM must be eliminated.

(Continued on next page)

3. PATIENT WILL TURN TO TRADITIONAL CUTTER

HEALTH-CARE PROVIDER BELIEF:

If a health-care provider refuses to do FGM, the family will simply have it done by a traditional cutter, under unhygienic conditions and without pain relief.

Possible answers:

- ✓ If a health-care provider is asked to do FGM, it is an ideal moment to counsel the family about the risks and to offer support in stopping this harmful practice.

4. REDUCED AMOUNT OF CUTTING

HEALTH-CARE PROVIDER BELIEF:

If FGM is done by a health-care provider, they can reduce the amount of cutting and damage to the genital tissues.

Possible answers:

- ✓ No amount of cutting is OK.
- ✓ The female genital organs should stay intact to keep their function.

5. RESPECT FOR CULTURAL INDENTITY

HEALTH-CARE PROVIDER BELIEF:

By performing FGM, I am respecting the cultural identity of my patients.

Possible answers:

- ✓ FGM cannot be justified on the basis of historical, traditional, religious or cultural grounds because it is harmful and violent, and it violates the right of girls and women to bodily integrity.

ACTIVITY 9.3

PROFESSIONAL ETHICS

(MINI-LECTURE)



15 MINUTES



PPT



1 Using **TRAINING AID**  (Slides: “Professional ethics”), briefly introduce the concept of professional ethics.



2 Read to participants the professional regulations that are in place at the national and subnational levels.

3 Ask participants if they have any questions or comments.

FACILITATOR'S NOTES

Key concepts



All of the following needs to be conveyed in the mini-lecture.

What are professional ethics?

- Professional ethics are principles that guide the behaviour of professionals.
- In health care, examples include maintaining confidentiality and showing respect for patients as individuals, regardless of their cultural background, socioeconomic status or religion.
- Health-care ethics include the principle of doing no harm.
- Professional ethics help professionals to make decisions in difficult situations.
- Ethics are distinct from laws.
- Most countries have a professional body that governs medicine, midwifery and nursing, to maintain the ethical standards of each profession.



Here, the facilitator should be prepared to read to participants the professional regulations that are in place at the national or subnational level.

ACTIVITY 9.4





THE ETHICS CIRCLE

(GROUP ACTIVITY)



45 MINUTES



- 1 Tell participants that during this activity they will familiarize themselves with some key paragraphs from the code of ethics set by the International Confederation of Midwives (ICM) (18) contained in [Box 9.4.1](#).
- 2 Write each of the statements in [Box 9.4.1](#) (p. 150) on a large piece of flip chart paper.
- 3 Post the ethics statements contained in **TRAINING AID**  (Pre-printed ethics statements plus response sheets) around the room.
- 4 Divide the participants into five groups  |  that rotate around the ethics statements, with 5 minutes at each station. 
- 5 At each station, the group will discuss the statement and what it means in the case of caring for women who are at risk of FGM or who have had it.

FACILITATOR'S NOTES

The facilitator can start the activity by providing an example using the information contained in [Box 6.4.2](#) in Session 6.



- 6 Ask groups to write their responses on a sheet of paper (with five boxes – one for each statement).
- 7 To end the activity, read one statement at a time and ask each group to share their responses.

- 8 Add any points missing by using [Box 9.4.1](#) (p. 150).
- 9 To conclude, highlight the information contained in the facilitator's notes.

FACILITATOR'S NOTES

Concluding remarks



- The role of health-care providers is to care for, not to cause damage to girls and women.
- There is no medical indication for FGM (it is done for non-therapeutic reasons).
- Doing FGM breaks professional ethics.
- WHO, other United Nations agencies, and international professional bodies, all oppose the medicalization of FGM. They all say FGM should never, under any circumstances, be done in health-care facilities or by health-care professionals.

IMPORTANT!

FGM by a health-care provider is against to two basic medical ethical principles:

- *doing no harm; and*
- *serving the best interests of the patient and promoting their well-being.*

BOX 9.4.1 MIDWIFERY ETHICS STATEMENTS

- 1. The role of midwives is to give the best possible care to women, babies and their families.***

ORIGINAL ICM STATEMENT:

“The role of the midwife is to improve the standard of care provided to women, babies and families throughout the world”.

EXPLAIN TO PARTICIPANTS:

This means that midwives care for women, not harm them. FGM is a harmful practice.

- 2. Midwives should respect women’s cultural identities, but still work hard to prevent harmful practices.***

ORIGINAL ICM STATEMENT:

“Midwives provide care for women and childbearing families with respect for cultural diversity while also working to eliminate harmful practices within those same cultures.”

EXPLAIN TO PARTICIPANTS:

FGM cannot be justified for historical, religious or cultural reasons. FGM is harmful and violent to girls and women.

- 3. Midwives will not tolerate any violation to the human rights of women and their children.***

ORIGINAL ICM STATEMENT:

“Midwives understand the adverse consequences that ethical and human rights violations have on the health of women and infants, and will work to eliminate these violations.”

EXPLAIN TO PARTICIPANTS:

FGM is a violation of the human rights of children and women. Therefore, midwives should never agree to do FGM.

4. *Midwives will always be role models for health.*

ORIGINAL ICM STATEMENT:

“Midwives act as effective role models of health promotion for women throughout their life cycle, for families and for other health professionals.”

EXPLAIN TO PARTICIPANTS:

By opposing FGM, midwives act as important role models for their communities.

5. *Midwives are responsible for their decisions and actions, and how these may affect the well-being of women.*

ORIGINAL ICM STATEMENT:

“Midwives are responsible for their decisions and actions, and are accountable for the related outcomes in their care of women.”

EXPLAIN TO PARTICIPANTS:

If a midwife agrees to do FGM, she can be held accountable and sanctioned. She could even lose her licence to practise midwifery.

ACTIVITY 9.5

THE LEGAL STATUS OF FGM IN THE COUNTRY (MINI-LECTURE)



15 MINUTES



1 Discuss with participants the legal status of FGM in the country.

2 Here, facilitators should be prepared to discuss local examples

Relevant information includes:

- What laws are in place at national level?
- When were these laws issued?
- Are these laws part of the children's protection act?
- What penalties do health-care providers who practise FGM face?
- Are health-care providers enforcers of the law?
 - If they suspect a girl will be cut, must they report?
 - Do they only report if the girl has already been cut?

FACILITATOR'S NOTES

Background information



- FGM is illegal in most countries of the world. This includes most African countries.
- Many countries have national laws against FGM that make it a criminal offence.
- These laws protect girls from harmful traditional practices and bodily harm.
- Laws against FGM give health-care providers a good reason not to do the procedure (2).

ACTIVITY 9.6

RESPONDING TO REQUESTS FOR MEDICALIZED FGM (GROUP DISCUSSION)



45 MINUTES



OPENING THE ACTIVITY

- 1 Highlight that some participants may get requests to do FGM. Others may have already experienced this.
- 2 Remind them that health-care provider should always decline these requests. This is not always an easy task.

DISCUSSION 1:

The challenges of saying no to a request to do FGM

- 3 Ask participants to think of challenges a health-care provider might face when asked to cut a girl.
- 4 Start the discussion by asking the following questions:
 - Is it easy to resist a request from a family member?
 - Why is this?
 - How do families react if a health-care provider says no?
- 5 Allow a few minutes for discussion and write down some of the challenges mentioned.

DISCUSSION 2:

Finding effective arguments to respond to requests

- 1 Tell participants that, by using a few effective arguments, the health-care provider can:
 - respectfully decline these requests;
 - counsel the family about the risks of FGM, and offer support to help them abandon this harmful practice.
- 2 Ask participants to suggest answers they can give if requested to do FGM.
- 3 Write down the answers on a flip chart.
- 4 Group the answers provided into five categories:
 - false beliefs about lesser harm
 - law
 - professional ethics
 - health
 - human rights/rights of the child
- 5 Discuss these responses with participants and ask if they can think of additional arguments they could give to resist a request for FGM.

FACILITATOR'S NOTES

Use [Box 9.6.1](#) on the next page to guide the discussion.



(Continued on next page)

BOX 9.6.1. SOME ARGUMENTS FOR HEALTH-CARE PROVIDERS TO RESIST DOING FGM

REASON	EXAMPLE ANSWER
False belief about lesser harm	<p>“FGM is never a safe procedure. It has no health benefits. So, it is not something for a health-care provider to do.”</p> <p>“The ‘doing less harm’ argument is not valid, as health-care providers should be doing zero harm.”</p>
Law	<p>“Unfortunately, I cannot accept your request. FGM is illegal in this country. No one should do FGM, especially health-care providers. Those who do agree to do FGM can get into serious trouble with the authorities.”</p>
Professional ethics	<p>“As a health-care provider, my role is to provide the best possible care to my patients. FGM is harmful. It can seriously affect your daughter’s health. By doing FGM, I would be harming her.”</p>
Health reasons	<p>“FGM can seriously affect your daughter’s health. This can be so severe, she could even die. As a health-care provider, I cannot support something that damages the health of my patients.”</p>
Human rights/ rights of the child	<p>“FGM goes against the human rights of girls and women. Examples of these are the right to health, the right to life and the right to freedom from cruel treatment. As a health-care provider, it is my duty to protect the human rights of girls and women.”</p>

DISCUSSION 3:

Using a person-centred approach to respond to requests

- 6 Tell participants that, by using a person-centred approach, they can respectfully decline a request for cutting a girl.
- 7 To close the discussion, remind participants that advising a girl to “pretend she has had FGM” in order to “protect” her from undergoing FGM is not ethically acceptable. This can have serious consequences for the provider as they could be blamed of having carried out FGM. Providers who do this may be held accountable by law.

FACILITATOR'S NOTES

Background information



- Using a person-centred approach, a health-care provider can respectfully decline a request for cutting a girl by trying to understand the patient's point of view and responding with an alternative argument.
- Advising a girl to pretend she has undergone FGM to protect her can have serious consequences for the provider as they could be blamed of having carried out FGM. Providers who do this may be held accountable by law.


ACTIVITY 9.7

RESPONDING TO REQUESTS FOR MEDICALIZED FGM (ROLE PLAY)



45 MINUTES



- 1 Explain to participants that they will practise responding to requests for FGM.
- 2 Pick three volunteers:
 - The facilitator will play the role of a grandmother who comes to the clinic and asks the midwife to cut her grand daughter
 - The volunteers will play the role of the midwife.
- 3 First, invite one volunteer to role play with you using the example in [Box 9.7.1](#) and **TRAINING AID**  19 (Handout with role play script).
- 4 **Using the text in red as a starting point**, do three more role plays with three different volunteers playing the role of the midwife.
- 5 Tell volunteers that they should respond using arguments other than health complications, as learnt at the beginning of the session. These could be related to:
 - the law
 - professional ethics
 - human rights / the rights of the child.
- 6 To close the activity, tell participants:
 - FGM should never be done by health-care providers
 - By resisting requests to do FGM, you are doing the right thing
 - Professional ethics and, in many countries, the law are both on your side and can help you to justify your opposition.

BOX 9.7.1 ROLE PLAY

Responding to a request for FGM



GRANDMOTHER: Good morning. I have come to see you today because I have a problem and I think you can help me.

MIDWIFE: Good morning. How can I help you?

GRANDMOTHER: My granddaughter is turning 10 next week and I am worried.

MIDWIFE: Why are you worried?

GRANDMOTHER: Because she is still untouched.

MIDWIFE: I see. So, she has not been cut you mean?

GRANDMOTHER: Yes. I think it is time to cut, her but my daughter is worried and she wants a midwife to cut her.

MIDWIFE: I see. May I ask you why you want a midwife to cut your granddaughter?

GRANDMOTHER: Because it is safer if a health-care professional cuts her.

MIDWIFE: I see. So, you feel that she may have health complications from the cutting?

GRANDMOTHER: Yes. That's why I would like to make sure that someone from the clinic, perhaps you, does the cut.

MIDWIFE: So, you feel that if your daughter is cut by a midwife it will be safer for her?

GRANDMOTHER: Yes.

MIDWIFE: I understand your worry. FGM is a dangerous practice. It can cause severely affect the health of your granddaughter, immediately but also in the future.

GRANDMOTHER: That is why I have come to see you.

MIDWIFE: Did you know that FGM is never a safe practice? There is always a risk of something going wrong.

GRANDMOTHER: Really? I did not know that.

MIDWIFE: Yes. So, as a midwife, I cannot support a practice that damages the health of my patients. My role is to always care for girls, not harm them.

GRANDMOTHER: But I have heard that others say this is safe ...

MIDWIFE: In fact, I know that there are other people in the community who do not wish to cut their daughters. Things are slowly changing. I know it takes courage to say no to FGM, but as midwife, I am here to support you in the process.

CLOSING EXERCISE: FINAL REFLECTIONS AND NEXT STEPS

SESSION 10: CLOSING EXERCISE

10.1: Final reflections

10.2: What are my next steps?

CLOSING
EXERCISE

FINAL REFLECTIONS AND NEXT STEPS



1 HOUR

OVERVIEW OF
THE SESSION

Participants will take a moment to think about how they have felt throughout the training. They will also be asked to reflect on immediate changes they could make as a result of their training. The facilitator will also suggest ways of dealing with difficulties should they arise.

OUTLINE OF
ACTIVITIES

10.1 FINAL REFLECTIONS

10.2 WHAT ARE MY NEXT STEPS?

TEACHING AIDS

- Blank sheets of paper and pens
- Sticky notes


ACTIVITY 10.1

FINAL REFLECTIONS (19)



30 MINUTES




- 1 If possible, find a quiet place to take participants that is different from the normal training room. This could be a garden, a room with comfortable furniture, or some other peaceful, quiet location in the building.
- 2 Hand a piece of paper and a pen to each participant.
- 3 Ask them to take a moment to think about how they have been feeling about the training. Have any difficult emotions appeared (e.g. fear, optimism, empowerment, hopelessness, sadness)?
- 4 Ask each participant to take 3 minutes  to write down or draw any of these emotions and what they feel about them. They can use any language they prefer to do this.

IMPORTANT!

Tell participants that no one will read what they write. This is a personal exercise and they can keep the papers to themselves unless they wish to share something with the group.



- 5 After 3 minutes,  invite everyone to come back into a circle.
- 6 Tell participants that if they wish to share what they have written, they are welcome to do so. However, there is no obligation to do so.

FACILITATOR'S NOTES

Background information




- Changing a long-held tradition like FGM will need the commitment of the health-care facility workers and members of the community.
- Change is possible, and it can start at the health-care facility level.
- Remind participants that they can play a key role in this process. They can be agents of change.
- But this task can bring up many emotions. Sometimes, it is helpful to share these emotions with a colleague or mental health-care provider. At other times, it is just as helpful to reflect on the emotions quietly and to make sense of them in our own words.
- Remind participants that there is always someone who can support them. A family member, a friend or the health-care provider at the local clinic are all examples.
- Reflection notes or a journal can help participants to write down their personal journeys of assisting women with ending FGM.

ACTIVITY 10.2

WHAT ARE MY NEXT STEPS?



30 MINUTES

- 1 Tell participants that this is the closing exercise.
- 2 Ask them to think of one thing they might do differently as a result of this training.
- 3 Give them a couple of minutes to reflect. 
- 4 Ask each participant to share this with the group:
 - If the group is small (under 10 participants) they could share it out loud.
 - If it is a large group, each can write their own idea on a sticky note and put it up so all participants can read the response.
- 5 Close the workshop and thank the participants.

FACILITATOR'S NOTES


Concluding remarks





The advantage of this kind of activity is that participants commit to putting into practice what they have learnt and decide on one of the first steps.


ANNEXES

TRAINING AIDS


TRAINING AID  **2** Flip chart poster with diagram of the unaltered female genitalia


TRAINING AID  **3** Handout of four types of FGM


TRAINING AID  **6** Semi-scripted role play handout


TRAINING AID  **9** Handout with example dialogues

TRAINING AID  **12** Myth or truth game

TRAINING AID  **15** Handout with ABCD steps

TRAINING AID  **16** Situation cards with beliefs about FGM

TRAINING AID  **18** Pre-printed ethics statements plus response sheets

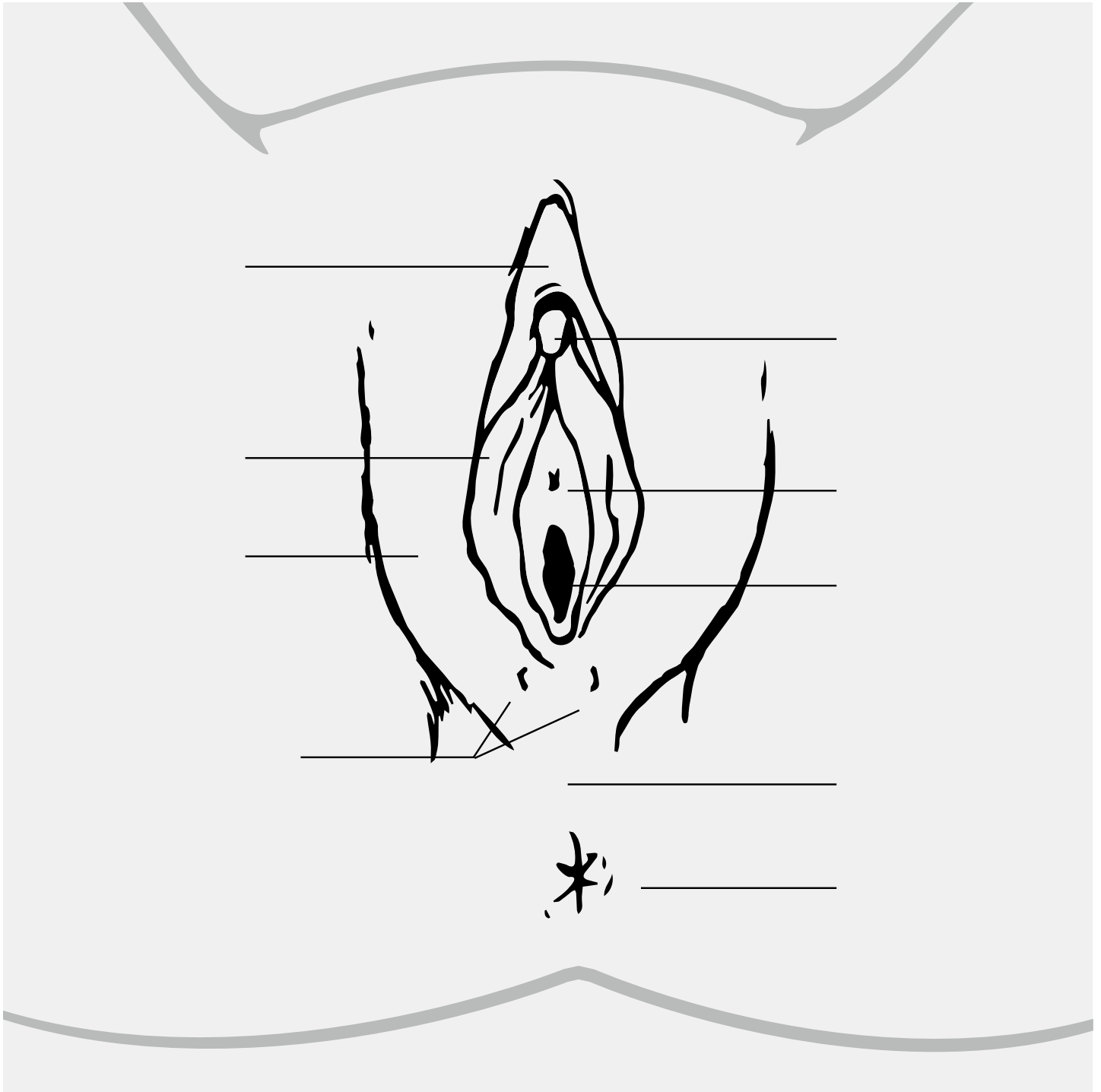
TRAINING AID  **19** Handout with role play script

TRAINING AID

FLIP CHART POSTER WITH DIAGRAM OF THE UNALTERED FEMALE GENITALIA

Print and enlarge the diagram on the right for use as a poster during Activity 4.1

UNALTERED FEMALE GENITALIA



TRAINING AID

HANDOUT OF THE FOUR TYPES OF FGM

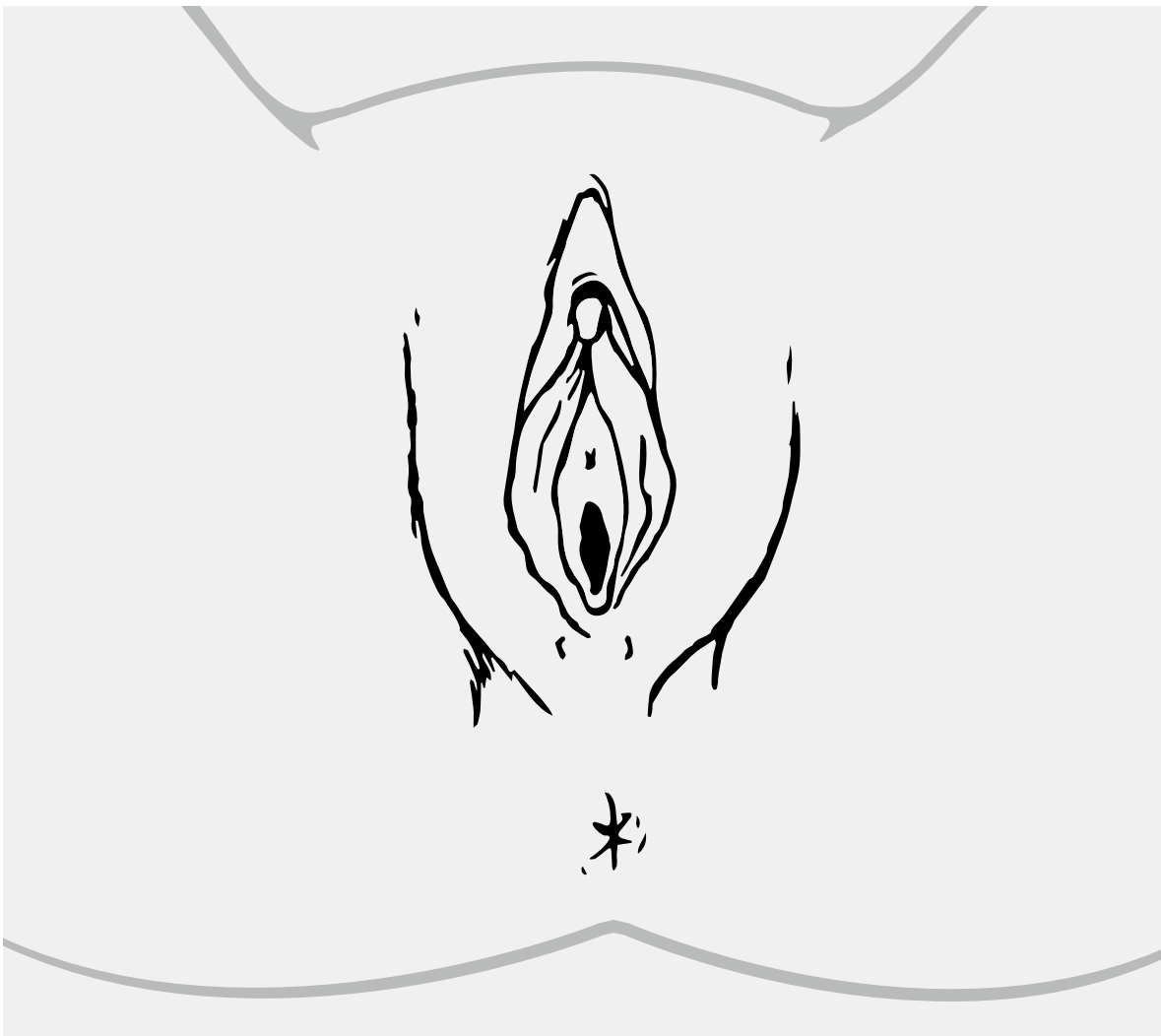
Each participant should receive a copy of Training Aid 3 (6 pages in total) for use during Activity 4.2.

*The training aid is available in both **color** (pp. 171-176) or in **black and white** (pp. 177-182).*

TRAINING AID  3

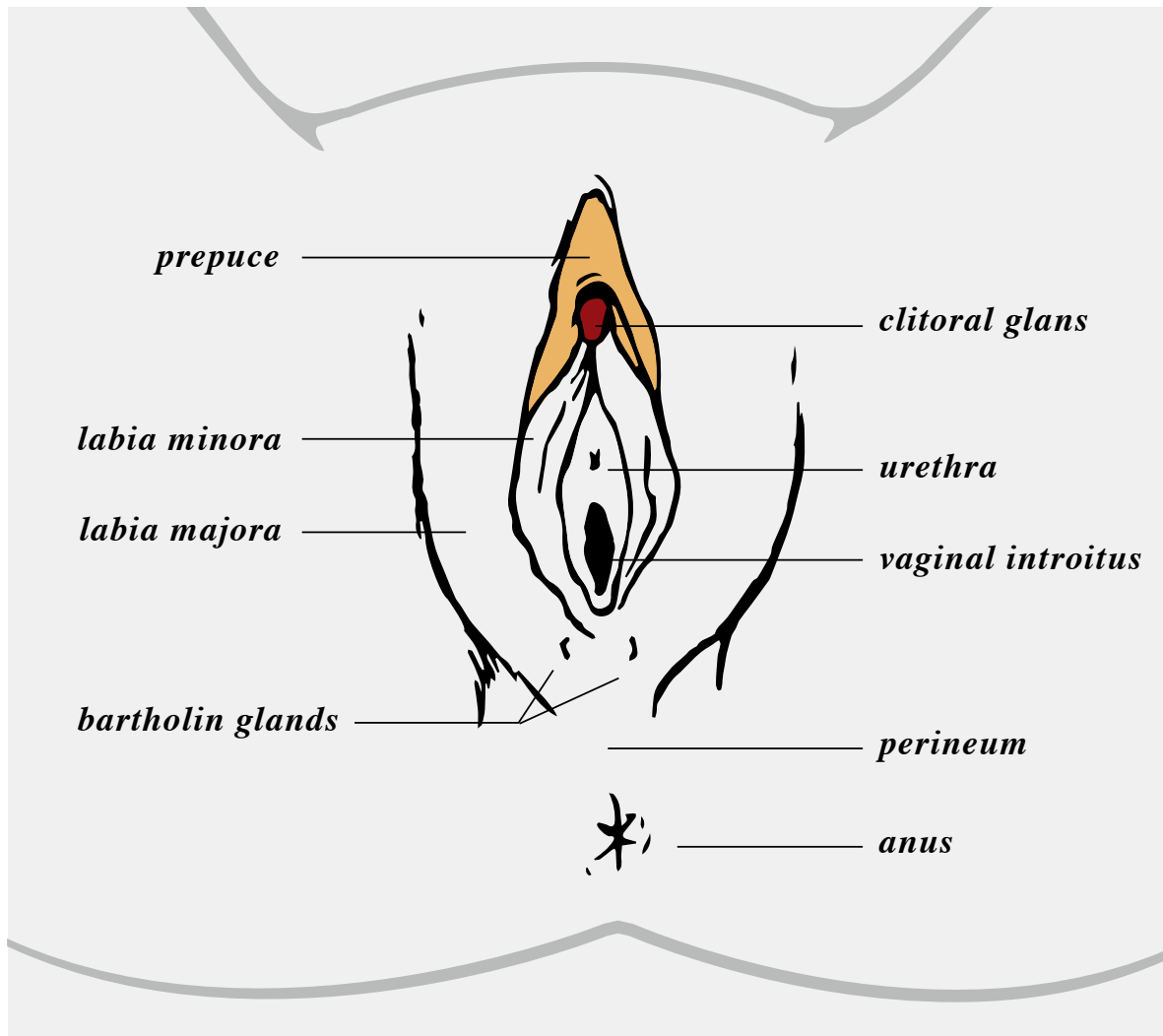
THE FOUR TYPES OF FGM

UNALTERED FEMALE GENITALIA



TYPE I

Partial or total removal of the clitoral glans (clitoridectomy) and/or the prepuce

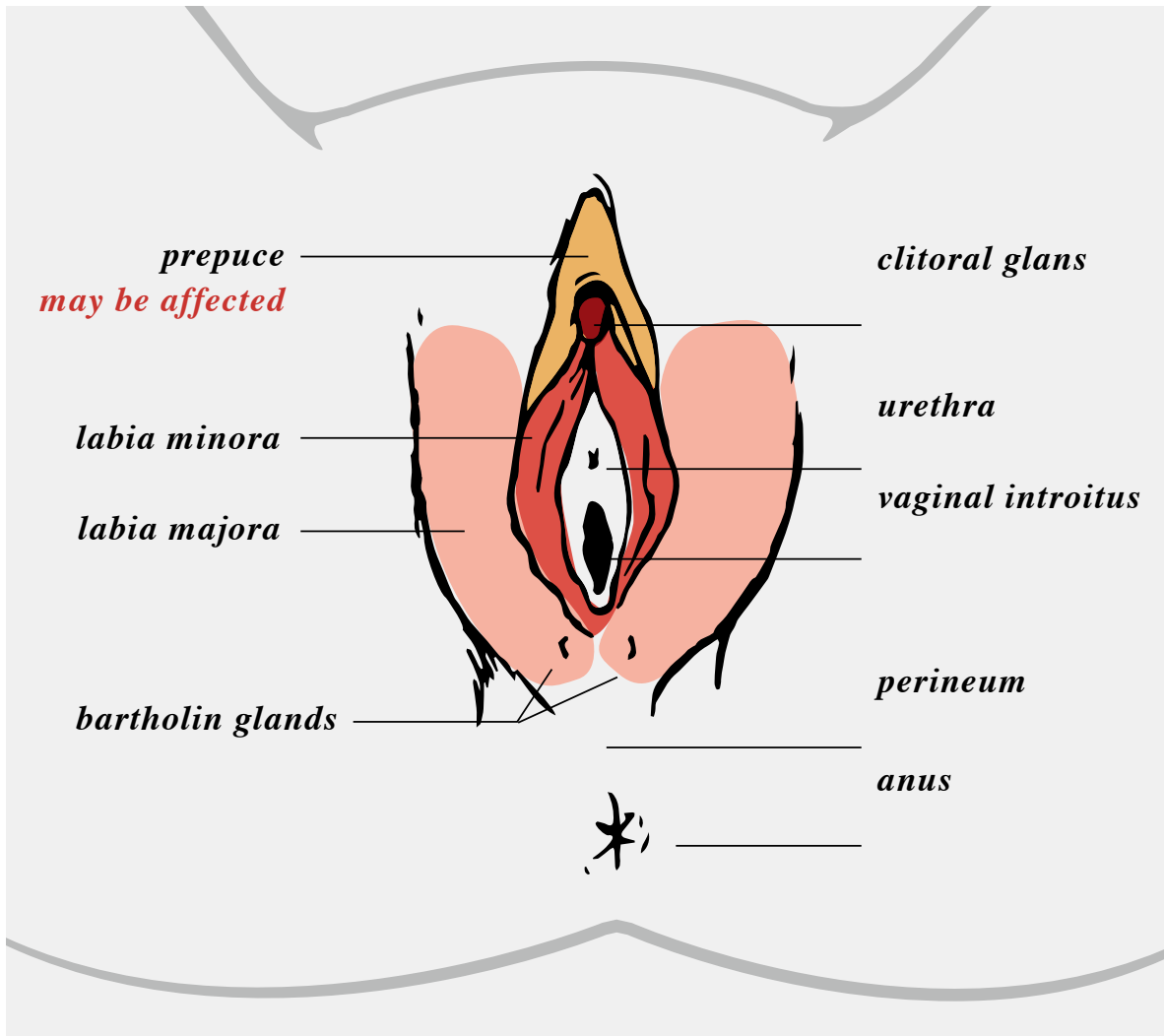


■ **Type Ia:** removal of the prepuce/clitoral hood (circumcision)

■ + ■ **Type Ib:** removal of the clitoral glans with the prepuce (clitoridectomy)

TYPE II

Partial or total removal of the clitoral glans and the labia minora, with or without excision of the labia majora (excision)



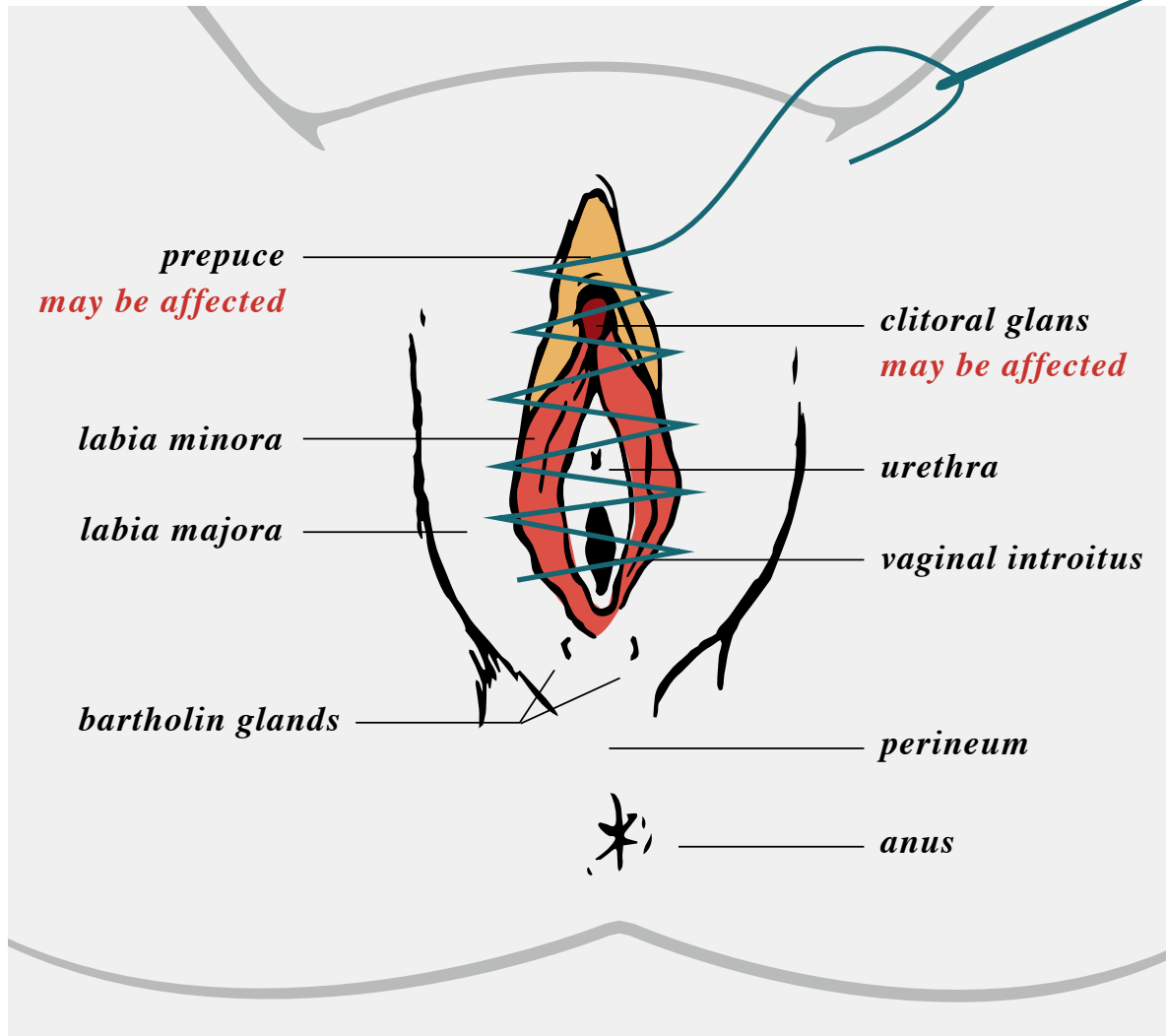
■ **Type IIa:** removal of the labia minora only

■ + ■ + ■ **Type IIb:** partial or total removal of the clitoral glans and the labia minora
(*prepuce may be affected*)

■ + ■ + ■ + ■ **Type IIc:** partial or total removal of the clitoral glans, the labia minora and the labia majora
(*prepuce may be affected*)

TYPE III

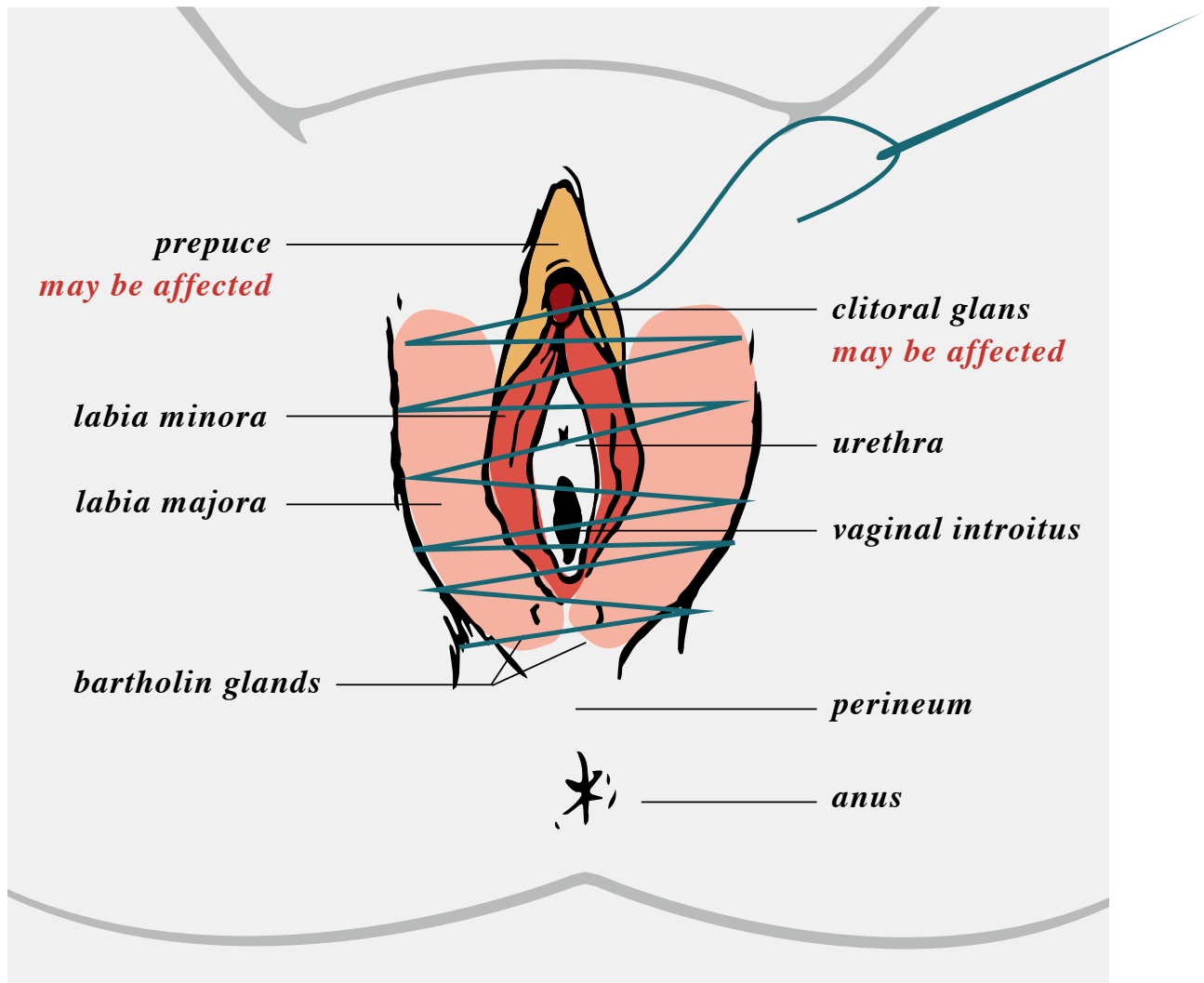
Narrowing of the vaginal opening with the creation of a covering seal by cutting and appositioning the labia minora or labia majora with or without excision of the clitoral prepuce and glans (infibulation)



Type IIIa: ■ + ■ + ■ + appositioning of the labia minora

TYPE III

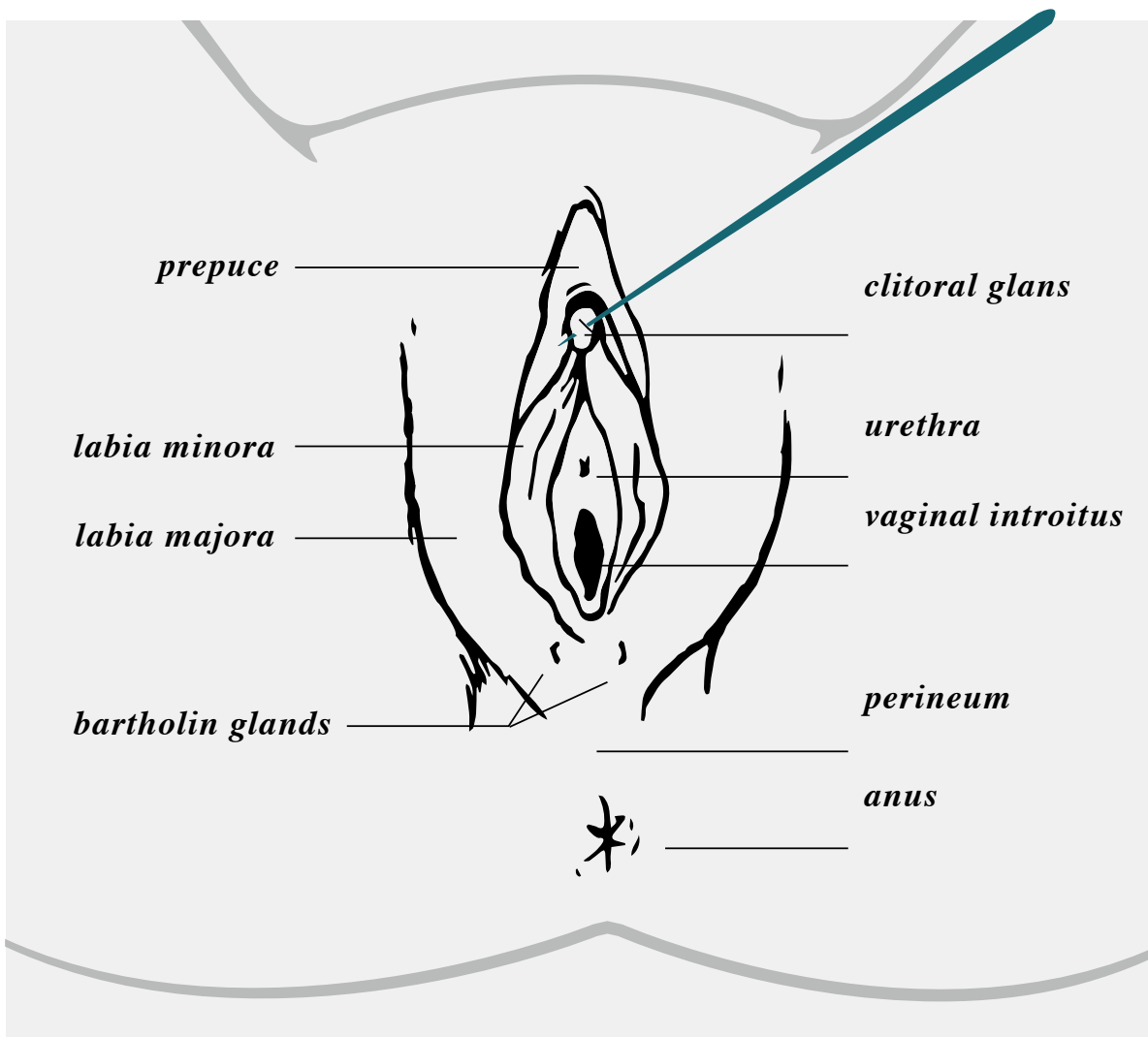
Narrowing of the vaginal opening with the creation of a covering seal by cutting and appositioning the labia minora or labia majora with or without excision of the clitoral prepuce and glans (infibulation)



Type IIIb: ■ + ■ + ■ + ■ + appositioning of the labia majora

TYPE IV

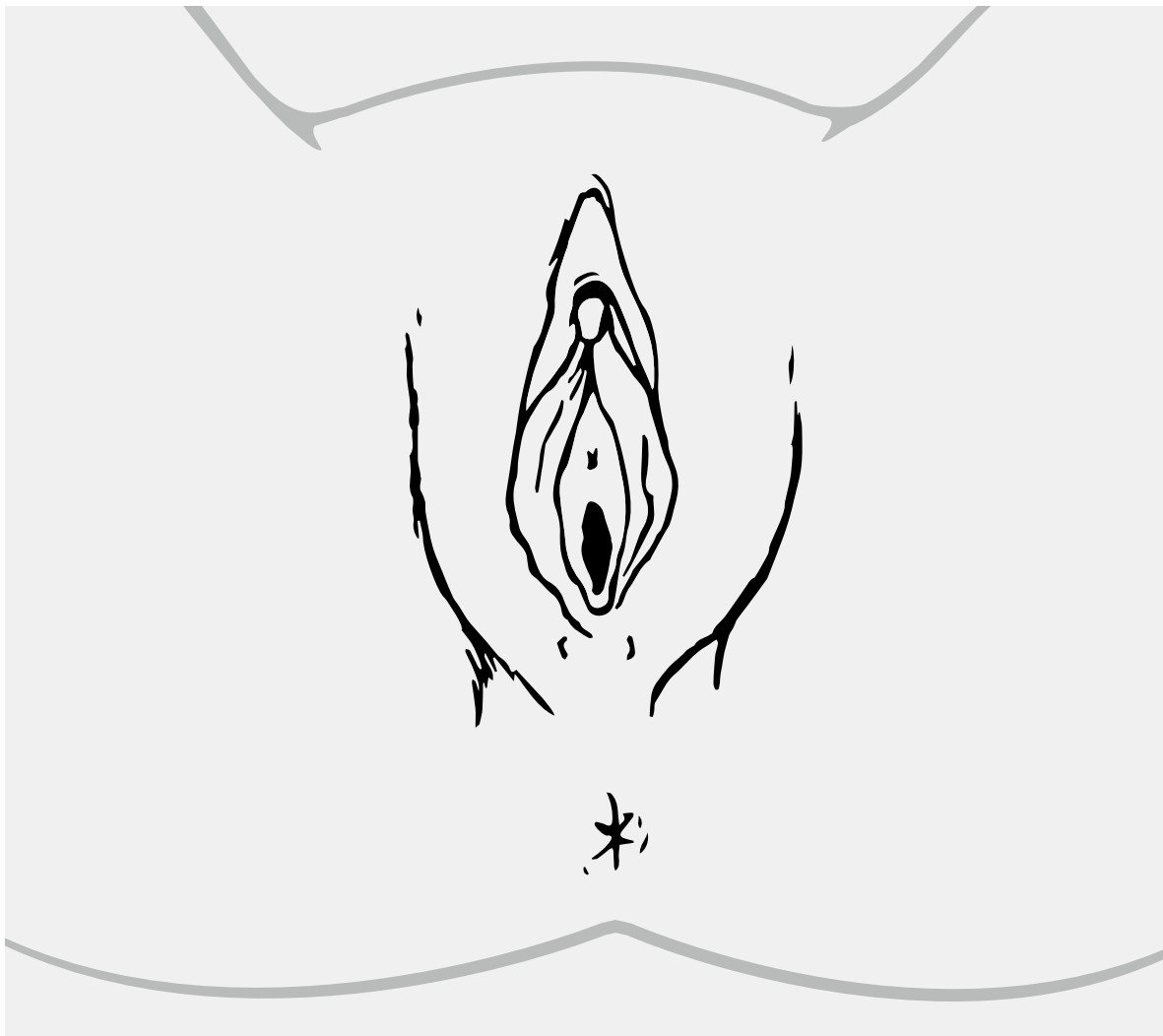
All other harmful procedures to the female genitalia for non-medical purposes, for example pricking, piercing, incising, scraping and cauterization



TRAINING AID **3**

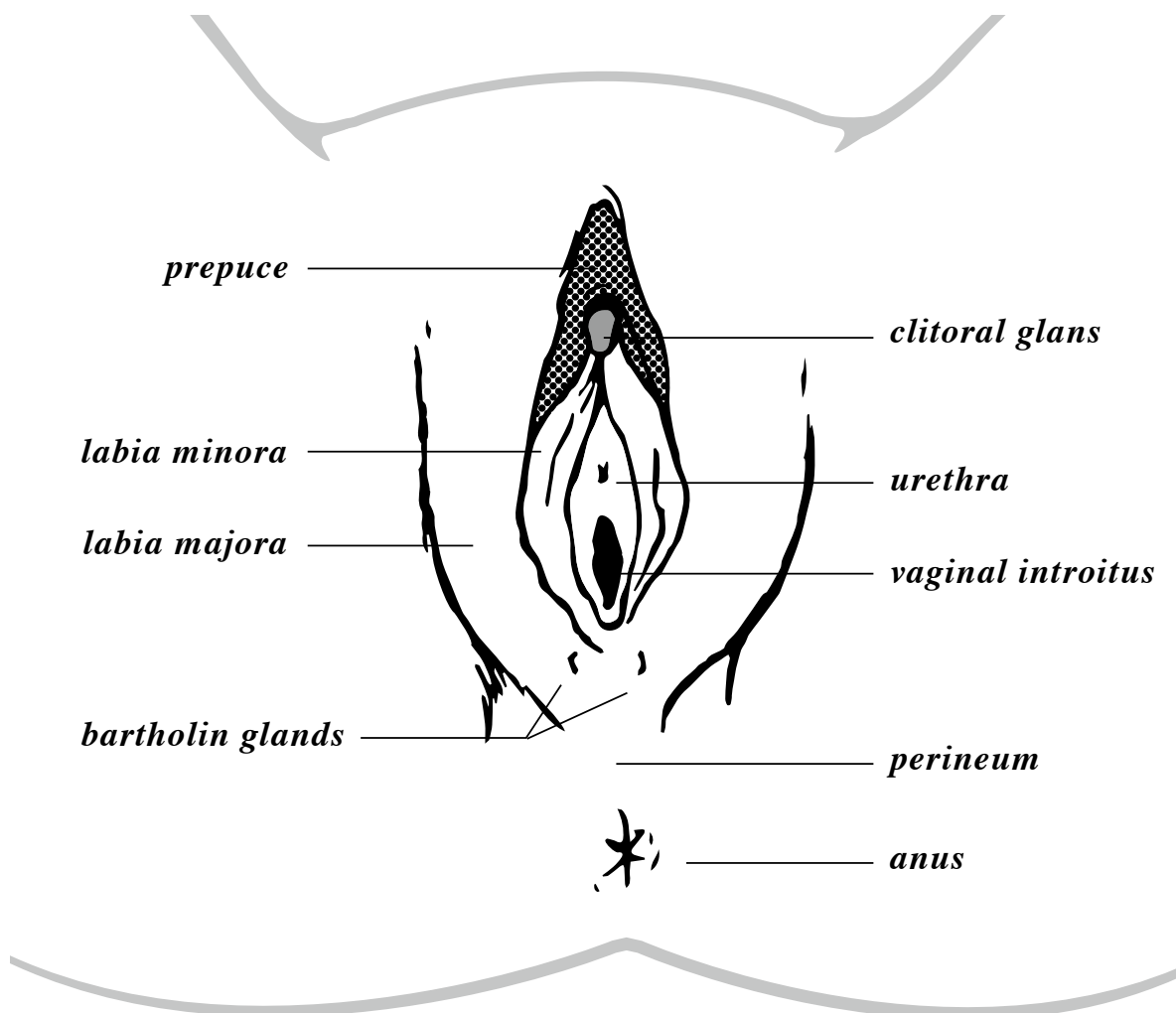
THE FOUR TYPES OF FGM

UNALTERED FEMALE GENITALIA



TYPE I

Partial or total removal of the clitoral glans (clitoridectomy) and/or the prepuce

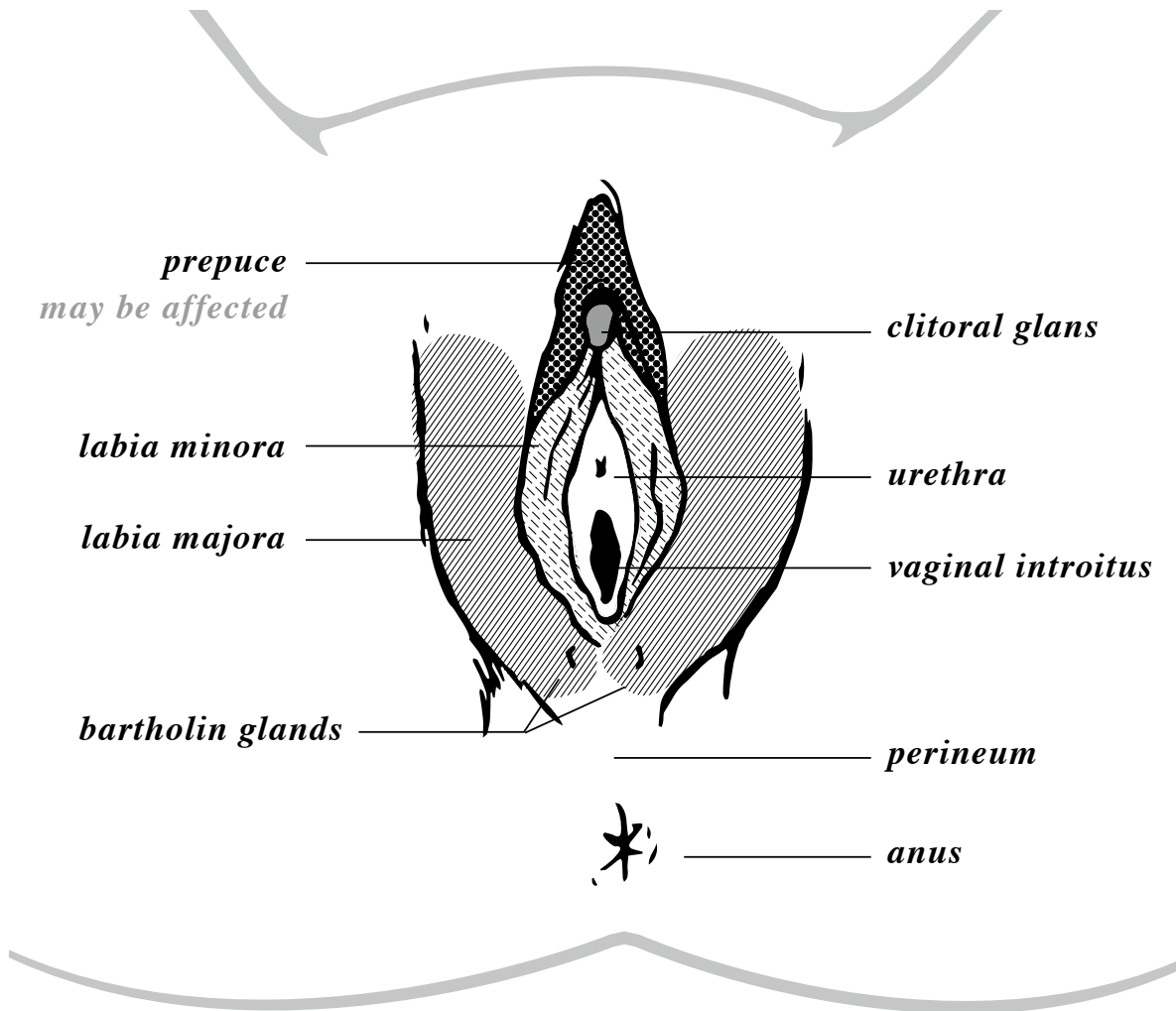



▣ **Type Ia:** removal of the prepuce/clitoral hood (circumcision)




▣ + ▣ **Type Ib:** removal of the clitoral glans with the prepuce (clitoridectomy)





TYPE II

Partial or total removal of the clitoral glans and the labia minora, with or without excision of the labia majora (excision)



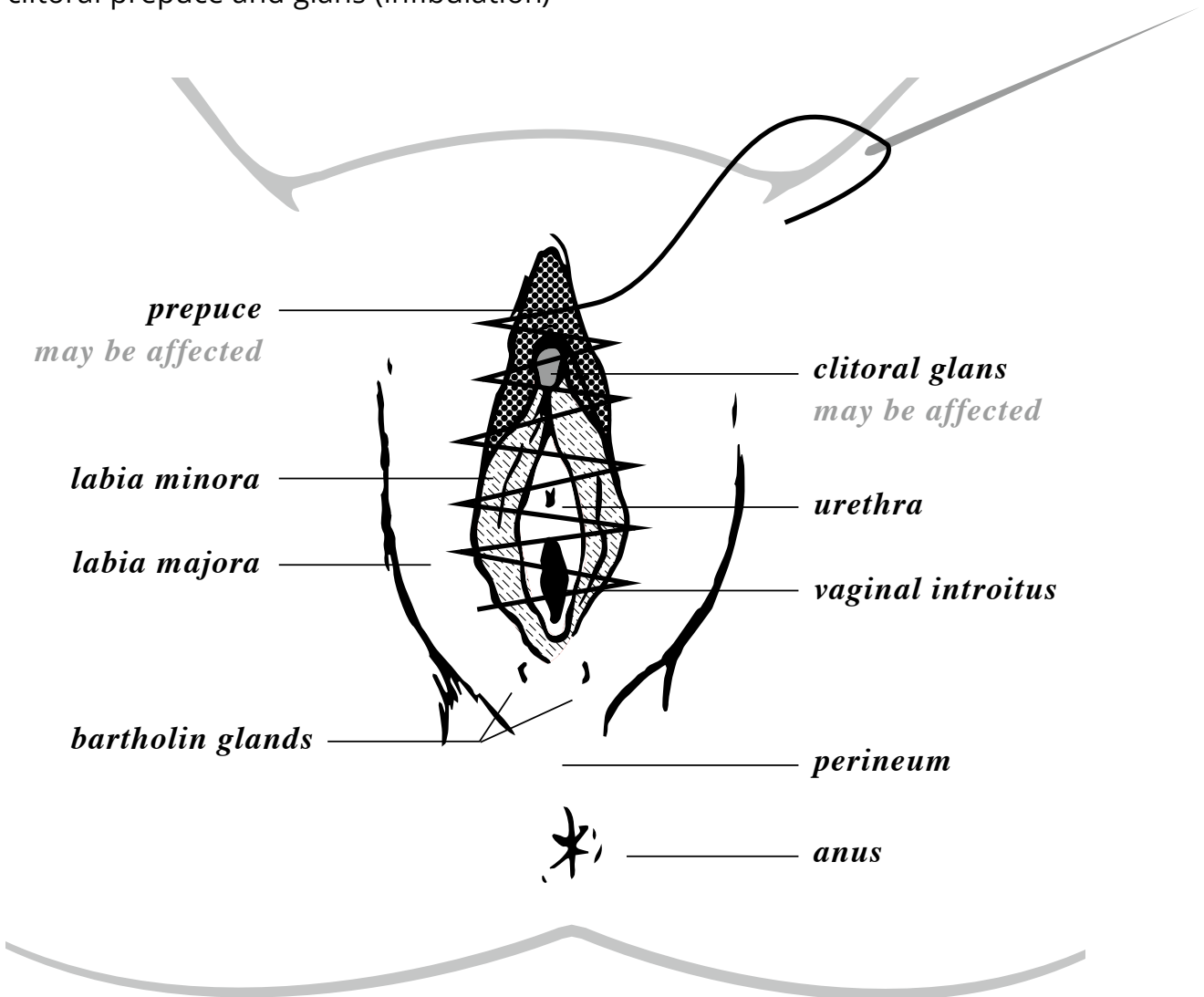
 **Type IIa:** removal of the labia minora only




 +  +  **Type IIb:** partial or total removal of the clitoral glans and the labia minora
(*prepuce may be affected*)

 +  +  +  **Type IIc:** partial or total removal of the clitoral glans, the labia minora and the labia majora (*prepuce may be affected*)

TYPE III

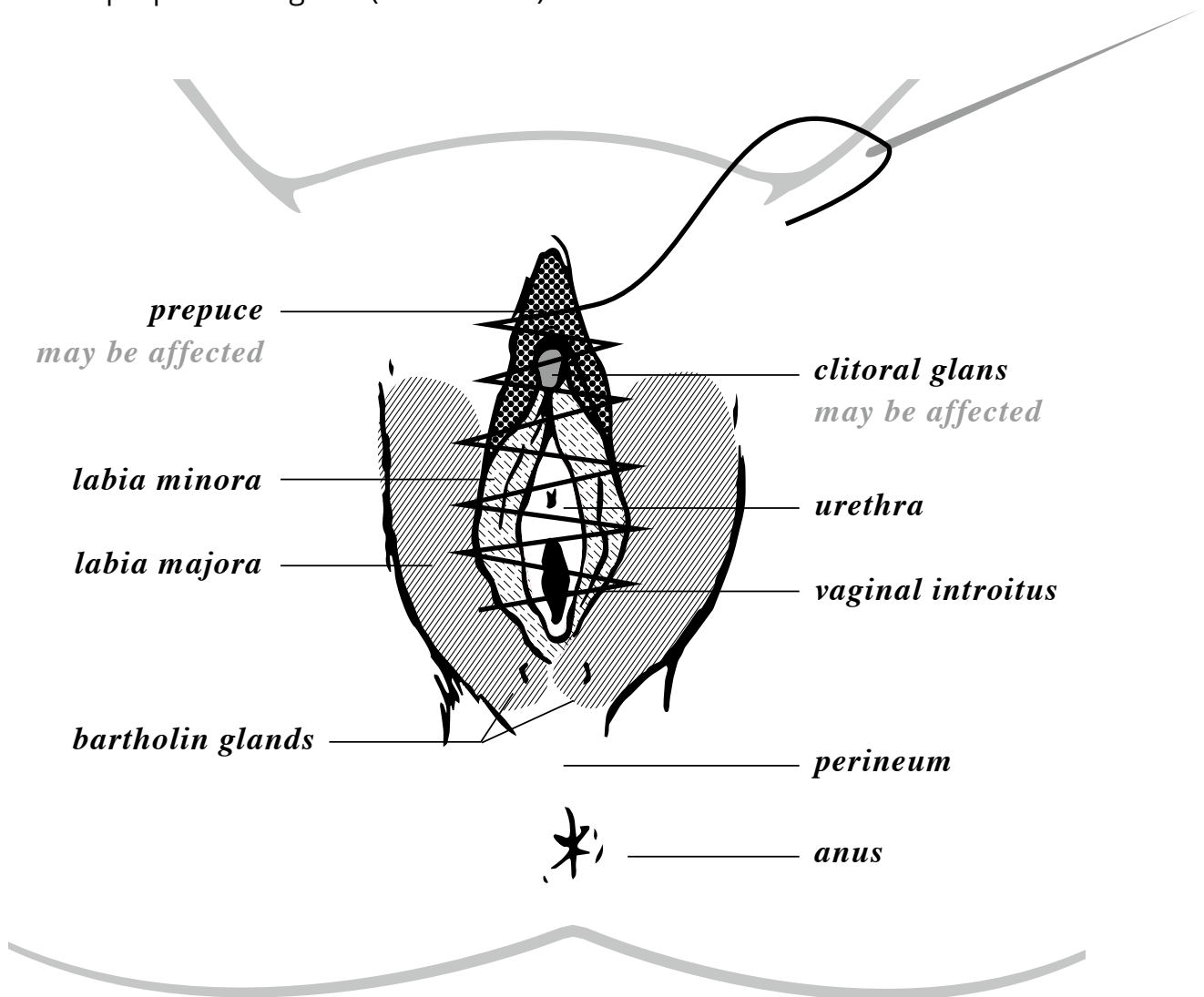
Narrowing of the vaginal opening with the creation of a covering seal by cutting and appositioning the labia minora or labia majora with or without excision of the clitoral prepuce and glans (infibulation)



Type IIIa:  +  +  + appositioning of the labia minora

TYPE III

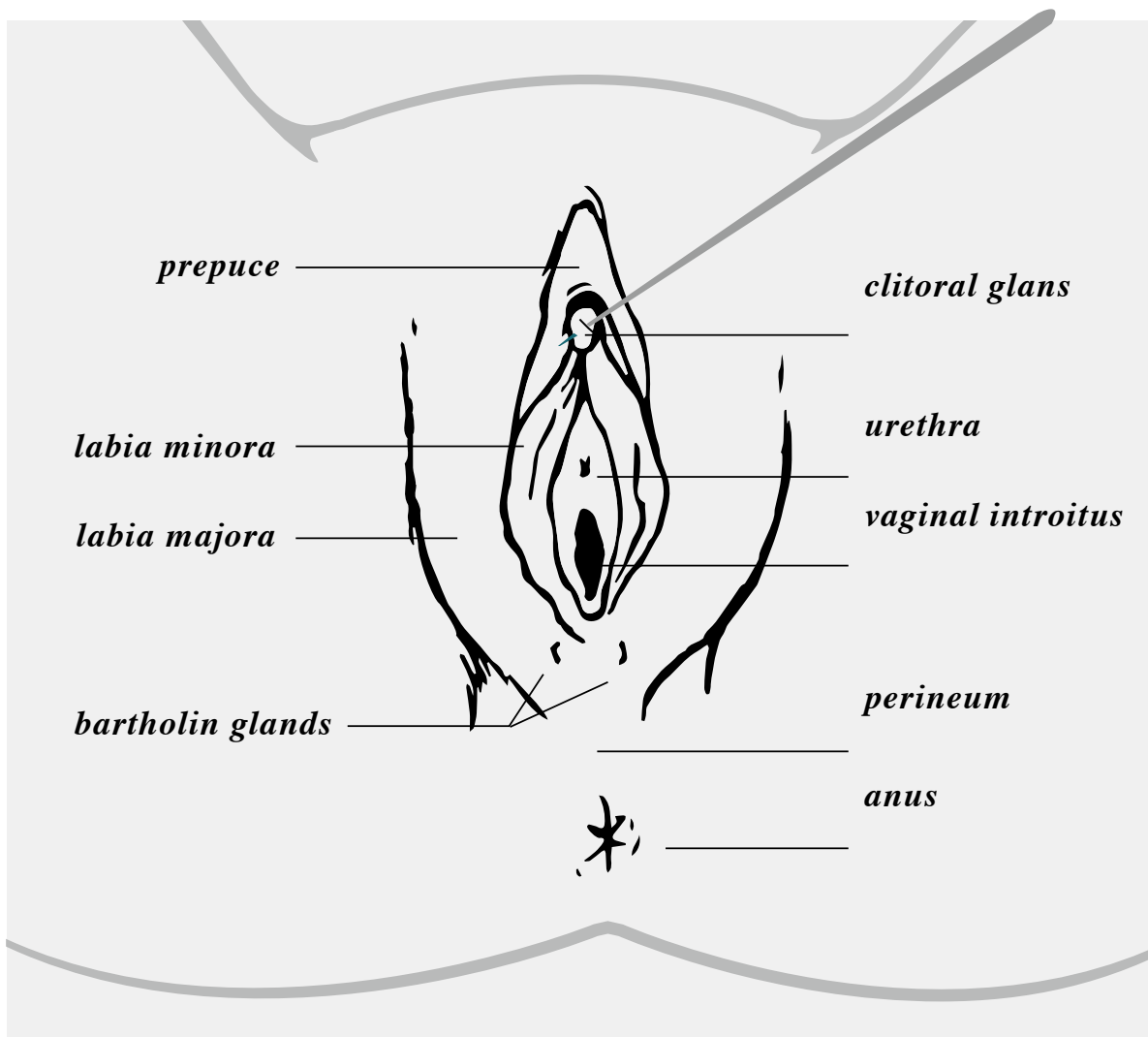
Narrowing of the vaginal opening with the creation of a covering seal by cutting and appositioning the labia minora or labia majora with or without excision of the clitoral prepuce and glans (infibulation)



Type IIIb: [diagonal lines] + [solid black] + [cross-hatch] + [horizontal lines] + appositioning of the labia majora

TYPE IV

All other harmful procedures to the female genitalia for non-medical purposes, for example pricking, piercing, incising, scraping and cauterization



TRAINING AID

SEMI-SCRIPTED ROLE PLAY HANDOUT

Print two copies of Training Aid 6 for use during Activity 5.2.
Make sure you print both role plays (1 and 2).

TRAINING AID  6**SEMI-SCRIPTED ROLE PLAY 1**

- A pregnant woman comes to an antenatal clinic because she has noticed that her baby is moving less.
- A midwife calls her to the consultation room.
- Without introducing herself, the midwife looks at the medical record and notices that the patient has missed several antenatal visits.
- The woman explains that she had been feeling well up until now and that she did not see the need to come to the clinic.
- The midwife, using an unfriendly tone, tells her that she has been an irresponsible mother by not coming, and that she must not skip any more visits.
- The woman responds that she thought that antenatal visits were only for mothers who had a problem during pregnancy.
- The midwife responds that antenatal visits are for all women and that she should “follow the instructions of those who know more about these things”.
- The patient leaves feeling very worried.



SEMI-SCRIPTED ROLE PLAY 2



- A pregnant woman comes to an antenatal care clinic because she has noticed that her baby is moving less.
- A midwife calls her to the consultation room.
- After introducing herself, the midwife asks the patient how she is feeling.
- The patient responds that she is feeling well.
- The midwife looks at the medical record and notices that the patient has missed several antenatal visits.
- She asks the patient why she has not attended the visits.
- The woman responds that she had been feeling well up until now and that she did not see the need of coming to the clinic.
- The midwife tells her that antenatal visits are important, both for her and her baby.
- The woman responds that she thought that antenatal visits were only for mothers who had a problem during pregnancy.
- The midwife says that antenatal visits are for all women, not only for women who have complications during pregnancy. It allows the midwife to detect potential complications at an early stage and to treat them. Overall, they make the pregnancy safer for the mother and the baby.
- The midwife then asks her if there are any other reasons why she has not been able to attend.
- The patient explains that, sometimes, because she needs to travel far, she skips visits that are too early in the morning.
- The midwife tells her that she can request an afternoon appointment next time.
- The patient says that she thinks this may be a good idea and thanks the midwife.
- They both say goodbye and the patient leaves the room with a peaceful look on her face.

TRAINING AID

HANDOUT EXAMPLE DIALOGUES

Print four copies of Training Aid 9 for use during Activity 6.4.
Make sure you print both dialogues (A and B).

TRAINING AID 9

EXAMPLE DIALOGUE A

Example of a 'provider-centred' dialogue

A woman comes to the health facility because she has had lower back pain for a few weeks.



The nurse calls her into the consultation room. When she enters, the nurse seems quite busy and neither greets her nor introduces herself to the patient. Without even asking the patient's name, the nurse asks her straightaway what brings her to the health facility. The woman, who seems a little nervous, explains she has had pain but has difficulties in explaining what kind of pain it is and where she feels it. The nurse seems a little irritated that the woman cannot provide more details and decides to examine the patient without explaining what she will do.

During the examination, the patient, who feels very uncomfortable, tells the nurse that she is worried she may have kidney problems. The nurse dismisses the woman's idea and tells her 'not to worry so much about these things'. Without sharing the results of the physical examination, the nurse tells the patient that she will give her pain killers and that this should be enough for now. Without asking the woman if she has any questions, she tells her the consultation is over and asks her to call the next patient when she leaves.

EXAMPLE DIALOGUE A:

NURSE: Hello, what brings you here today? [The nurse/midwife does not introduce herself, look at the patient nor does she ask the woman's name.]

WOMAN: Hello. Well, I have been feeling a lot of pain in the past few weeks.

NURSE: Where do you feel the pain?

WOMAN: Well, it is hard to explain. [The woman sounds a little unsure.]

NURSE: But you can surely tell me what part of your body hurts, right?

WOMAN: think it's my back, but...

NURSE: Can you tell me what part of your back?

WOMAN: It is the lower back.

Continued on next page

EXAMPLE DIALOGUE A

continued...

NURSE: OK, let me have a look. [The nurse examines the patient's lower back.]

WOMAN: I was a little worried it could be something else – like my kidneys”
[The woman sounds worried.]

NURSE: Your kidneys? Why do you mention that?

WOMAN: Well, it's just that I heard it could be that also and I have felt a little worried.

NURSE: Your kidneys! Have you had kidney problems before?

WOMAN: No, it's just that I was worried...

NURSE: I see. So how long have you had the back pain?

WOMAN: More than a month now.

NURSE: OK, let's see if with pain medication you feel better and then we'll go from there. [The nurse starts getting up and seems a little in a hurry.]

WOMAN: OK. It's just that I'm a little worried because...

NURSE: No need to worry. I am sure you'll be fine.

WOMAN: OK. Thank you. [The woman leaves looking a little uneasy.]

TRAINING AID 9

EXAMPLE DIALOGUE B

Example of a 'person-centred' dialogue

A pregnant woman comes to the health facility because she has had lower back pain for a few weeks. The nurse calls her to enter the consultation room. When she enters, the nurse stands up, introduces herself and warmly greets the patient. After asking the patient's name, the nurse asks her if the journey to the health facility had been OK.

The nurse then asks the patient how her pregnancy is going. The patient explains that the pregnancy has been going well but lately she has been feeling back pain. The nurse acknowledges this by saying 'I see, you feel pain in your lower back. Anything else you have noticed?'. The woman says that she has also been having sleep problems because she is worried. The nurse invites her to further explain why she is worried. The woman answers that her husband has lost his job. The nurse once again acknowledges the woman's concerns and tells her that she will give her something for her back pain so she can sleep better.

Before bringing the consultation to an end, the nurse asks the patient if she has any questions and invites her to come back if the pain continues. The patient thanks the nurse and leaves the room.

EXAMPLE DIALOGUE B:

NURSE: Hello, Ms Okoye. My name is Amara. Please take a seat.
[The nurse or midwife offers her a chair.]

WOMAN: Hello. Thank you.

NURSE: Did it take you long to get here today?

WOMAN: No, it was alright. I only waited 10 minutes for the bus and there were no delays.

NURSE: Oh, that's great. So, I see that this is your first antenatal consultation. Can you tell me a little bit about how your pregnancy is going?

WOMAN: Until now the pregnancy is going well.

Continued on next page

EXAMPLE DIALOGUE B

continued...

NURSE: That's good. Do you have any issues or questions? I know this is your second baby but not all pregnancies are the same!

WOMAN: Well, in fact I have felt a lot of back pain these past few weeks. Especially when I am lying down.

NURSE: I see. Apart from the back pain, anything else you have been experiencing?

WOMAN: I also have had some trouble sleeping these past few weeks.

NURSE: So, difficulty falling asleep and back pain that you feel when lying down. Anything else?

WOMAN: No, that's it in fact. Except that I am a little worried about my husband who just lost his job.

NURSE: Right. You are worried about your husband. I imagine how that can be. Especially with a new baby on the way.

WOMAN: Yes, it has been difficult for us.

NURSE: I understand. Let's start by seeing what we can do about the back pain, because that will allow you to sleep better. Does that sound OK to you?

WOMAN: Yes, I think that might help me get a good night's sleep.

TRAINING AID 12

MYTH OR TRUTH GAME

Print and cut-out the cards on the following pages to use during Activity 7.2.

On the back of each card fill in the corresponding answer (True or False) using Table 7.2.1.

“FGM has no health benefits.”

*“Women who have had FGM
can enjoy sex.”*

*“FGM has health benefits
for the baby.”*

ACTIVITY 7.2

TRAINING AID  12
MYTH OR TRUTH GAME



Answer: _____

Answer: _____

Answer: _____

Answer: _____

“If a girl is not cut, she will not find a husband and marry.”

“Girls who do not have FGM cannot enter womanhood and become respectable women.”

“FGM helps to ensure a women’s faithfulness/ensures women will not have extramarital sex.”

“By removing the clitoris, girls will not have premarital sex.”

Answer: _____

Answer: _____

Answer: _____

Answer: _____

“If FGM is done by a health-care professional, there is no long-term physical damage.”

“FGM is no different from voluntary medical male circumcision (VMMC).”

“If a girl is not cut, she will not find a husband and marry.”

“If a woman is deinfibulated (closure reversed), the baby may fall out during pregnancy.”

Answer: _____

Answer: _____

Answer: _____

Answer: _____

*“If the clitoris is not removed,
it can hurt the baby during
delivery.”*

*“A woman who is not cut
cannot become pregnant.”*

*“FGM makes women silent
and compliant.”*

*“If the clitoris is not cut,
it will grow and may look like
a male penis.”*

Answer: _____

Answer: _____

Answer: _____

Answer: _____

TRAINING AID 15

HANDOUT WITH ABCD STEPS

Each participant should receive a copy of Training Aid 15 (6 pages in total) for use during Activity 8.2

TRAINING AID  15

THE **ABCD** OF PERSON-CENTRED COMMUNICATION FOR FGM PREVENTION



ADDRESS FGM

Confirm the woman's FGM status and health conditions potentially related to FGM

1

Welcome the woman in an approachable way

"Hello Ms Okoye. Thank you for coming today"

"My name is Amara and I am the nurse/midwife looking after you today"

"Please come in. Have a seat"

"Was your journey here OK today?"

2

Ask the woman about her FGM status, during clinical history taking

"Have you heard of female genital cutting? Can I ask you a few questions about this?"

"Do you know if you have been cut in the genital area?"

"Have you had any kind of traditional or cultural practice done on your genital area?"

"Were you cut (in the genital area)?"

3

If you confirm that the woman has had FGM, ask her about these clinical symptoms and concerns:

- vaginal discharge
- urinary symptoms
- previous complications during pregnancy and childbirth
- worries or fears about the pregnancy or childbirth
- past experience of de-infibulation (reversing FGM) and/or re-infibulation
- psychological or sexual complications

"Some women who have undergone the type of genital cutting you have experience symptoms such as... Do you have any of these problems?"

ASSESS

Assess the woman's views. If she supports FGM, what are her reasons?

1

Assess how the woman feels about FGM and if she thinks the practice should continue

"I would like to ask you a question (some more questions) about FGM. Would this be OK with you?"

"How do you feel about FGM/genital cutting? Is this something girls should have done to them? Do you think FGM should continue?"

"Do you support the continuation of FGM?"

Patient is unsure or thinks FGM should continue:

2b

Ask the woman what her reasons are for supporting FGM

"Thanks for sharing this with me. I would like to try and find out why you feel FGM should continue. Can we talk about this for a minute?"

"I wonder if we could spend a few more minutes talking about FGM. Could you tell me some of the reasons why you think it is important for girls to be cut?"

"If it is OK with you, can you tell me your own experience with FGM?"

"Are there any specific reasons why you think it's important that girls have FGM?"

"Can you share with me some of the reasons why you think why FGM is important for girls?"

3

Summarize the woman's reasons in your own words – as a statement, not a question

"Let me see if I can summarize what you just said. The main reasons why you think girls should be cut are..."

"If I understood correctly, you think FGM is important for girls because..."

2a

Patient thinks FGM should stop:

- give positive reinforcement
- check whether the woman thinks she might have difficulty keeping her position towards ending FGM. If yes, move to step 5, "Discuss and decide"; and
- before ending the conversation, and moving to the next part of the antenatal consultation, remind her that she can come back for support at any time and give a phone number if available

"That's great that you do not support FGM!"

"If you have a daughter in the future, do you think it would be possible for you to decide not to cut her? Do you think you might have any difficulty sticking to your decision?"

"If you would like to discuss anything else about FGM or your pregnancy, please come back to the clinic. We are always available for you."

"Just in case you need any support, here is a number that you could call."

BELIEFS

Discuss and challenge beliefs about FGM.
What are the woman's beliefs about FGM?

1

Invite the woman to rethink the aspects of FGM that she sees as positive, by introducing the concept of BELIEFS

"You have just mentioned the reasons why you think genital cutting should continue ..."

"However, did you know that many of the reasons given by community members for supporting FGM are ideas passed on from generation to generation in a community, without anyone ever questioning them? We can call these 'beliefs'."

2

Contrast the woman's reasons for supporting FGM with facts

"I would like to share some interesting facts about beliefs with you. For example ..."

EXAMPLE 1:

IF THE WOMAN MENTIONS HONOUR ...

"This is interesting, so if I understand correctly, you see FGM as the only way to ensure your daughter becomes a respectable woman. This is a very important issue. Would it be OK if we discussed this a bit?"

In fact, for a girl to grow up to become a respectable woman, her upbringing is the most important thing. If at home she receives the correct values, she will become a respectable girl!"

"Do you know girls who have had premarital sex in your community? If so, what does this tell you? Even girls who have had parts of their genitals removed or have been closed up can still have premarital sex. FGM does not really prevent this from happening!"

EXAMPLE 2:

IF THE WOMAN MENTIONS RELIGION ...

"... you mentioned religion as an important reason for cutting your daughter. Let's focus on religion for a minute. Would that be OK?"

Did you know that FGM is not mentioned in religious texts such as the Koran or the Bible?"

In fact, many religious leaders think this tradition should end?"

EXAMPLE 3:

IF THE WOMAN MENTIONS THE IMPORTANCE OF FGM AS A RITE OF PASSAGE ...

"Did you know that there are communities who have successfully agreed to use alternative rites of passage that do not include any cutting, but that celebrate a girl's passage to womanhood?"

Rites of passage can take many forms. The pride and celebration of culture doesn't have to mean harming girls"

3

Ask her how she feels about what you have just discussed

(This should be done after discussing each reason)

"How does this make you feel?"

"I understand that this is a lot of new information to process. How do you feel right now?"

CHANGE

Explore the possibility of change

1

Invite the woman to reflect on change by highlighting that changing traditions is possible

"Before we end the conversation, I would like to take a minute to discuss change with you. Would this be OK?"

"Sometimes, when we take a closer look at our beliefs and we see them from a different angle – like we did today – we may consider changing them. I would like to invite you to reflect on this and on the things we discussed today about FGM."

"Change, and changing our beliefs, is possible, even if these are long-held beliefs. Change is especially possible if, after thinking again about some of our beliefs about these traditions, we decide that we no longer support them."

"A good example of this is FGM. Today, we discussed other aspects of it – new points of view."

2

... invite her to think about what was discussed and remind her that the role of health-care providers is to promote the end of FGM

"As health-care providers who care about your well-being and the well-being of the community, we promote the end of FGM."

3

Ask her how she feels about what you have just discussed

"How does this make you feel?"

"I understand that this is a lot of new information to process. How do you feel right now?"

DISCUSS AND DECIDE

Support the woman in talking to other members of her community about FGM

1

Invite the woman to discuss change with a person she trusts and who may also be supportive of ending FGM

"Before we end the consultation, I would like to invite you to reflect on the things we discussed today when you go back home. Perhaps you could share them with someone you trust?"

"Perhaps someone in your family, a close friend or a community member who you know thinks FGM should end?"

"If you were to consider not cutting your daughter, what could pressure you to do it? Who would you need to talk to about this decision to make it a reality? Who is the person who decides if your daughter will be cut? Is it perhaps your mother? Or your mother-in-law? Or your husband?"

"Are there any community or religious leaders you could approach for help or support?"

"Who or what else may help you?"

2

Document key findings

CLOSURE

Follow-up and referrals

1

Check if the woman has understood, and if she has questions

"Do you have any further questions? You can ask me anything that is not clear"

2

Offer other support services and/or a follow-up session

"The following support groups are available if you need any help or more information"

TRAINING AID 16

SITUATION CARDS WITH BELIEFS ABOUT FGM

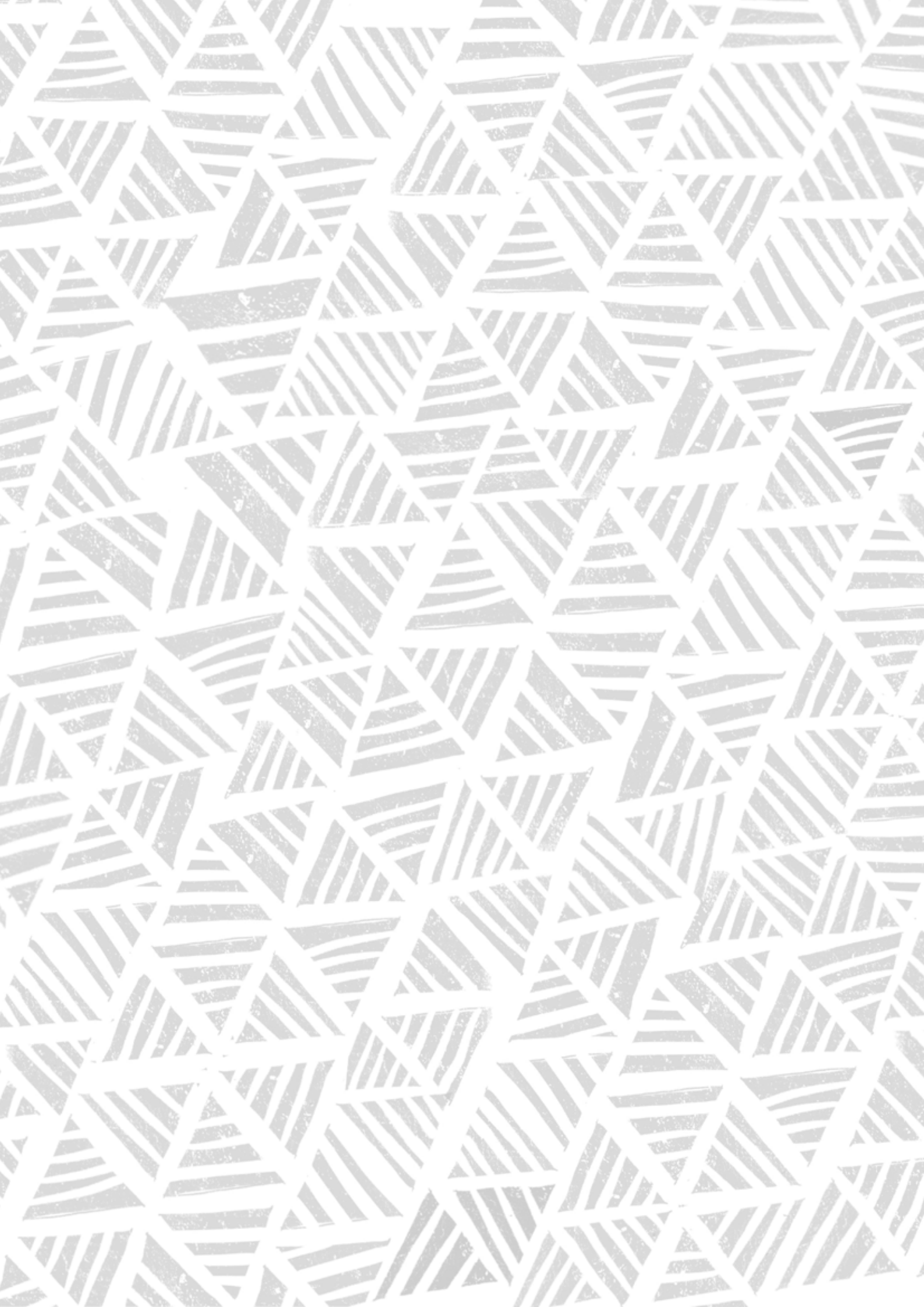
Print and cut-out the cards on the following pages to use during Activity 8.3.
Make sure to print the cards one-sided.



“If FGM is done by a health-care professional, there is no long-term physical damage”

“A woman who is not cut cannot become pregnant”



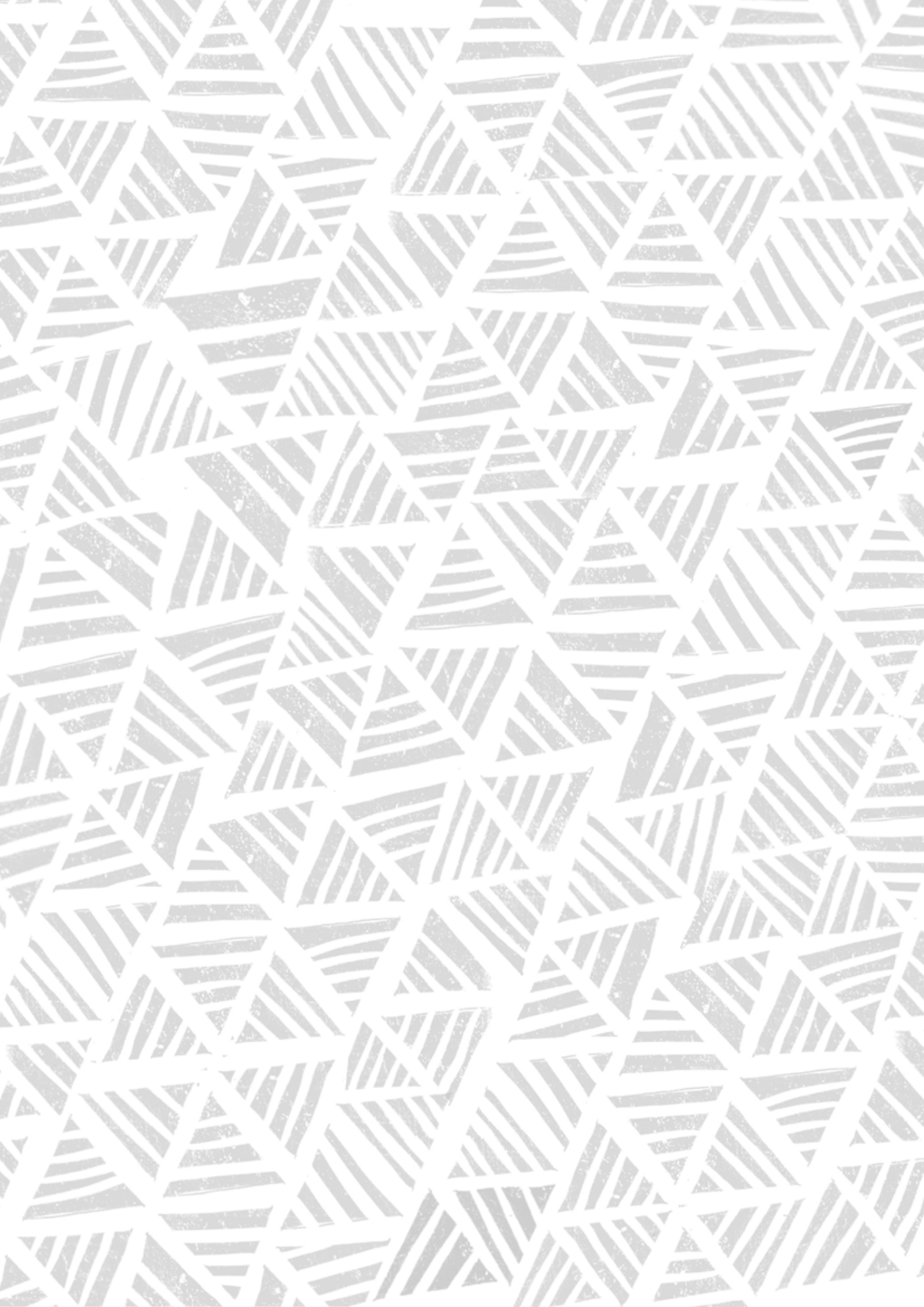




“If a girl is not cut, she will not find a husband and marry.”



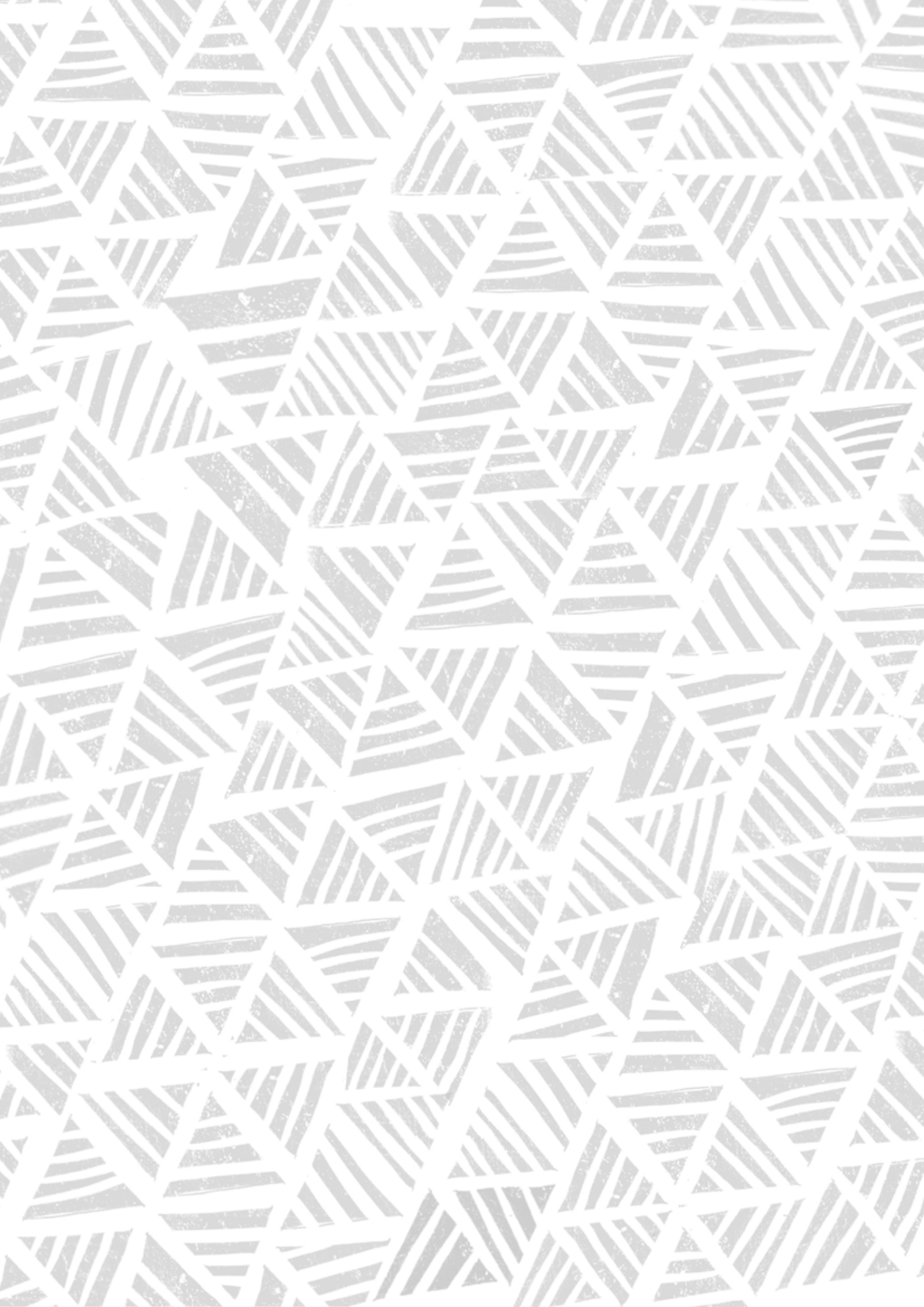
“FGM helps ensure a woman’s faithfulness | controls the sexuality of women.”



“Girls who do not have FGM cannot enter womanhood and become respectable women”



“FGM is a religious requirement.”



TRAINING AID 18

PRE-PRINTED ETHICS STATEMENTS

Print and enlarge the following 5 ethics statements for use as posters during Activity 9.4

TRAINING AID  18

ETHICS STATEMENT #1

The role of midwives is to give the best possible care to women, babies and their families.

TRAINING AID  18

ETHICS STATEMENT #2

Midwives should respect women's cultural identities, but still work hard to prevent harmful practices.

TRAINING AID  18

ETHICS STATEMENT #3

Midwives will not tolerate any violation to the human rights of women and their children.

TRAINING AID  18

ETHICS STATEMENT #4

Midwives will always be role models for health.



World Health
Organization

TRAINING AID  18

ETHICS STATEMENT #5

Midwives are responsible for their decisions and actions, and how these may affect the well-being of women.

TRAINING AID 18

PRE-PRINTED ETHICS STATEMENTS RESPONSE SHEETS

Print five copies of the following response sheets for use during Activity 9.4

TRAINING AID  18**ETHICS STATEMENTS – RESPONSE SHEET**

1. The role of midwives is to give the best possible care to women, babies and their families.

2. Midwives should respect women's cultural identities, but still work hard to prevent harmful practices.

Continued on reverse...

3. Midwives will not tolerate any violation to the human rights of women and their children.

4. Midwives will always be role models for health.

5. Midwives are responsible for their decisions and actions, and how these may affect the well-being of women.

TRAINING AID  **19**

HANDOUT WITH ROLE PLAY SCRIPT

Print two copies of the following role play for use during Activity 9.7

TRAINING AID  19

ROLE PLAY

Responding to a request for FGM

GRANDMOTHER: Good morning. I have come to see you today because I have a problem and I think you can help me.

MIDWIFE: Good morning. How can I help you?

GRANDMOTHER: My granddaughter is turning 10 next week and I am worried.

MIDWIFE: Why are you worried?

GRANDMOTHER: Because she is still untouched.

MIDWIFE: I see. So, she has not been cut you mean?

GRANDMOTHER: Yes. I think it is time to cut, her but my daughter is worried and she wants a midwife to cut her.

MIDWIFE: I see. May I ask you why you want a midwife to cut your granddaughter?

GRANDMOTHER: Because it is safer if a health-care professional cuts her.

MIDWIFE: I see. So, you feel that she may have health complications from the cutting?

GRANDMOTHER: Yes. That's why I would like to make sure that someone from the clinic, perhaps you, does the cut.

MIDWIFE: So, you feel that if your daughter is cut by a midwife it will be safer for her?

GRANDMOTHER: Yes.

MIDWIFE: I understand your worry. FGM is a dangerous practice. It can cause severely affect the health of your granddaughter, immediately but also in the future.



Continued on next page

GRANDMOTHER: That is why I have come to see you.

MIDWIFE: Did you know that FGM is never a safe practice? There is always a risk of something going wrong.

GRANDMOTHER: Really? I did not know that.

MIDWIFE: Yes. So, as a midwife, I cannot support a practice that damages the health of my patients. My role is to always care for girls, not harm them.

GRANDMOTHER: But I have heard that others say this is safe ...

MIDWIFE: In fact, I know that there are other people in the community who do not wish to cut their daughters. Things are slowly changing. I know it takes courage to say no to FGM, but as midwife, I am here to support you in the process.

REFERENCES

1. WHO guidelines on the management of health complications from female genital mutilation. Geneva: World Health Organization; 2016 (www.who.int/reproductivehealth/topics/fgm/management-health-complications-fgm, accessed 17 May 2019).
2. Care of girls and women living with female genital mutilation: a clinical handbook. Geneva: World Health Organization; 2018 (www.who.int/reproductivehealth/publications/health-care-girls-women-living-with-FGM, accessed 17 May 2019).
3. Joint United Nations Programme on HIV/AIDS, United Nations Development Programme, United Nations Population Fund, United Nations Children's Fund, United Nations High Commissioner for Refugees, UN Women, et al. Global strategy to stop health-care providers from performing female genital mutilation. Geneva: World Health Organization; 2010 (www.who.int/reproductivehealth/publications/fgm/rhr_10_9, accessed 17 May 2019).
4. Female genital mutilation: integrating the prevention and the management of the health complications into the curricula of nursing and midwifery: a teacher's guide. Geneva: World Health Organization; 2001 (www.who.int/reproductivehealth/publications/fgm/RHR_01_16, accessed 17 May 2019).
5. PATH. Interpersonal communication and counseling for clients on tuberculosis and HIV and AIDS: training curriculum for TB health workers. Washington (DC): United States Agency for International Development; 2009 (www.path.org/resources/interpersonal-communication-and-counseling-for-clients-on-tuberculosis-and-hiv-and-aids, accessed 17 May 2019).
6. Harris R. Clarifying your values (adapted from Tobias Lundgren's bull's eye worksheet). In: TheHappinessTrap [website] (https://thehappinesstrap.com/upimages/Long_Bull%27s_Eye_Worksheet.pdf, accessed 17 May 2019).
7. de Masi S, Bucagu M, Tunçalp Ö, Peña-Rosas JP, Lawrie T, Oladapo OT, et al. Integrated person-centered health care for all women during pregnancy: implementing World Health Organization recommendations on antenatal care for a positive pregnancy experience. *Glob Health Sci Pract.* 2017;5(2):197–201. doi: 10.9745/GHSP-D-17-00141.
8. Hashim MJ. Patient-centered communication: basic skills. *Am Fam Physician.* 2017;95(1):29–34.
9. Lin CT, Platt FW, Hardee JT, Boyle D, Leslie B, Dwinnell B. The medical inquiry: invite, listen summarize. *J Clin Outcomes Manag.* 2005;12(8):415–8.
10. Symons AB, Swanson A, McGuigan D, Orrange S, Akl EA. A tool for self-assessment of communication skills and professionalism in residents. *BMC Med Educ.* 2009;9(1). doi: 10.1186/1472-6920-9-1.
11. WHO global strategy on people-centred and integrated health services. Geneva: World Health Organization; 2015 (www.who.int/servicedeliverysafety/areas/people-centred-care/global-strategy, accessed 23 May 2019).
12. PATH. Interpersonal communication and counseling for clients on tuberculosis and HIV and AIDS: training curriculum for TB health workers: part III: counseling on TB. Washington (DC): United States Agency for International Development; 2009 (https://path.azureedge.net/media/documents/CP_ukraine_tb_hiv_ipcc_3.pdf, accessed 23 May 2019).
13. mhGAP intervention guide – version 2.0 for mental, neurological and substance use disorders in non-specialized health settings. Geneva: World Health Organization; 2016 (www.who.int/mental_health/mhgap/mhGAP_intervention_guide_02, accessed 17 May 2019).

14. King A, Hoppe RB. "Best practice" for patient-centered communication: a narrative review. *J Grad Med Educ.* 2013;5(3):385–93. doi: 10.4300/JGME-D-13-00072.1.
15. Female genital mutilation/cutting: a statistical overview and exploration of the dynamics of change. New York: United Nations Children's Fund; 2013 (www.unicef.org/publications/index_69875.html, accessed 17 May 2019).
16. Rollnick S, Butler CC, Stott N. Helping smokers make decisions: the enhancement of brief intervention for general medical practice. *Patient Educ Couns.* 1997;31(3):191–203.
17. Brief intervention for problematic substance use: a manual for use in primary care. Draft version 1.1 for field testing. Geneva: World Health Organization; 2003.
18. International code of ethics for midwives. The Hague: International Confederation of Midwives; 2008 (www.internationalmidwives.org/assets/files/general-files/2019/01/cd2008_001-eng-code-of-ethics-for-midwives.pdf, accessed 17 May 2019).
19. Hatcher AM, Woollett N, Pallitto CC, Garcia-Moreno C. Safe & Sound Nurse-led counseling for empowerment and wellbeing: facilitators manual. Johannesburg: Wits Reproductive Health and HIV Institute; 2016.



**World Health
Organization**

For more information,
please contact:

Department of Reproductive
Health and Research

World Health Organization
Avenue Appia 20
CH-1211 Geneva 27
Switzerland

Fax: +41 22 791 4171

E-mail: reproductivehealth@who.int

www.who.int/reproductivehealth

9789240041073

