- Lessons from the Field -

Understanding Female Genital Mutilation and Cutting and How Educators Can Help

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Transcript

Cindy Carraway-Wilson: Good afternoon, everyone. Welcome to today's webinar, Understanding Female Genital Mutilation and How Educators Can Help.

On behalf of the U.S. Department of Education, we're pleased to have you with us today. And in fact, over 400 people have registered for this webinar, so we expect more to log in soon. Some details about who's in the webinar with you will be posted, but they include the majority of you, about 30% who reported that you were school support personnel. And we also have a wonderful variety of school and district professionals, as well as prevention experts, advocates, community-based organizations, law enforcement, legal professionals, and other therapeutic support folks from the community and in schools.

Thank you all for being here today. This webinar is a part of our Lessons from the Field webinar series, and this series highlights effective tools and techniques and strategies that will be employed by everyday practitioners, to address those hot button and hot topic issues that are on the top of educators' minds. You can access recorded webinars from the series on the webpage that's now being shared in chat.

Please be aware that this webinar will include presentations and discussions around the practice of female genital mutilation and cutting that may be upsetting to some participants in the audience. We encourage you to participate as well as you can, and to make sure that you take care of yourself.

Our subject matter experts will explain the practice of FGM/C, or female genital mutilation, including what it is, why it's done, and who's at risk? They will provide some guidance on the rules and approaches that school personnel can take to support students impacted by FGM/C, and that includes laws protecting

women and girls, curriculum development and toolkits, and support groups and other supports that students might take advantage of.

As always, if you have any additional strategies that are working in your community, please reach out to bestpracticesclearinghouse@ed.gov, and share those ideas with us. As we all know, our work is stronger together and we all benefit from sharing those effective strategies.

Please note that the content of this presentation does not necessarily represent policies or views of the US Department of Education, nor does it, by endorsement, by the US Department of Education.

My name is Cindy Carraway-Wilson, and I'm a training specialist at the National Center on Safe Supportive Learning Environments. And we are happy to have you here today, as well. We are supported by the Office of Safe and Supportive Schools within the office of Elementary and Secondary Education.

To learn more about NCSSLE and the types of services and supports that we offer, we encourage you to visit our website. On our website, you'll find a wide range of resources that address school climate and condition for learning. To give you a sense of the website, on the right, you see a screenshot of our current home webpage. And on the left, we have a variety of resources that are some popular resources currently available on our sites. Notice at the bottom of the slide, that we also have the link for this webinar where you can go and get the recording of this webinar within the next few days, and you can also get all of the materials that you see today including the slides, referenced resources, and speaker bios. In fact, some of these items, including the slides in the speaker bios have already been posted to the site. Please note that you can access those previous versions of the Lessons from the Field series by visiting the webpage series also listed here.

Now, I'd like to go over briefly just what our agenda looks like for today. We have a full agenda with five dynamic speakers who begin by helping us understand what female genital mutilation and cutting is, and the prevalence in the United States. Then, we'll learn about supports that students might benefit from, including legal protections, outreach and education, support groups, and other supports.

Information we're providing today is general information about female genital mutilation and cutting, that is important for all of us to know and understand. Each of us will be able to apply that knowledge in our specific communities and schools, to educate students and community members about the consequences of FGM/C, and to help bring the practice to an end.

After the formal closing remarks, we will spend 15 to 20 minutes responding to the questions that you post, so please do use that Q&A icon in your Zoom toolbar to post your questions. We will be able to tune into specific elements about what you're interested for your school and your district.

We have those five speakers that I mentioned. You can see our speakers today represent education and curriculum developers, research legal experts, and prevention and intervention experts. I encourage you to go to the event webpage to read their full biographies.

As we move into that presentation, I can't emphasize enough to please use that Zoom Q&A, so that we can address any questions that you might have.

Now, it's my pleasure to introduce Ms. Elyse Robertson from the Department of Education, who is going to provide our welcome from the department. Elyse?

Elyse Robertson: Thank you so much, Cindy. Hello, everyone, and thank you so much for joining us for this important discussion today.

As was already shared, my name is Elyse Robertson and I work in the Department of Education's Office of Safe and Supportive Schools. Your presence today demonstrates your commitment to ensuring a positive school climate for all students, especially girls who may be at risk of the practice of female genital mutilation and cutting, also known as FGM or FGM/C, as Cindy mentioned.

Today's webinar will focus, specifically, on understanding the practice as another issue of safety for children that is so critically important. The department is committed to continuing to educate and assist stakeholders and communities in addressing FGM/C. Our hope is that, the content shared by our speakers and panelists will help to further educate us on the practice, and identify how educators and school personnel can continue to ensure that our learning environments are places in which all students feel safe, and connected, and build meaningful adult and peer relationships.

In addition to today's webinar, the department has developed some resources to support educators in learning more about FGM/C. The first was a fact sheet released in September 2020, which highlighted some strategies of what educators can do by role. For example, the role of state and local education agency personnel, the role of administrators, the role of school nurses, psychologists, and counselors, and the role of classroom teachers. The second was a blog post from May 2022 that reviewed some current, federal, and state strategies to address FGM/C. Both resources were already included as hyperlinks on the event webpage for this webinar, and I see that they're also being added in the chat, so I certainly would encourage you to review those, if you've not already done so.

And certainly, at the department, we look forward to continuing to support your efforts to ensure that we are all more informed about FGM/C.

Before I close, I'd just like to quickly say that I recognize the important work that you all undertake each day, and I'm grateful for the time that you are taking to prioritize learning more about female genital mutilation and cutting.

With that, I'll turn it back to you. Thank you, Cindy.

Cindy Carraway-Wilson: Thank you, Elyse, for the welcome. We appreciate the ongoing support that the department has on all these important issues, especially the one we have coming up today. Thank you.

Deka, a 16-year-old girl from Brooklyn was subjected to female genital mutilation while visiting her relatives on a family vacation of Somalia. Her story is shared by Odley Jean, of the GoodCapp Arts Ensemble.

Odley Jean: "How was your summer vacation?" It's all teachers ask you in September. What I learned over summer vacation was literally the topic of our first assignment in Ms. Reed's English class, so I wrote about how I learned to play Smells Like Teen Spirit on my guitar, and about the writing class I did at the Y. I got an A, but Ms. Reed called me up after class. I mean... Sorry. Yeah. Ms. Reed called me up after class and said, "Deka, I'm surprised you didn't write about Africa. I've been waiting to hear all about it." "Oh, Africa was lit," I tell her. I went to the village in Somalia where my parents grew up. There was this big celebration in our honor, and I met all these cousins and aunties I didn't even know I had. On the flight back, I promised myself I'd be the regular me around everyone at school. And normally, I'm really fun. I'm that loud girl on the subway. But being that me is becoming hard, it's actually making me sick.

When my parents told me we were going to Africa over the summer, I danced in our kitchen and screamed at the top of my lungs, "Yo, I'm going to my homeland people." And my mom laughed so hard, she cried. My sister, Leyla, didn't even want to go. She kept saying, "I'm not from Africa, I'm from Brooklyn." Yeah, she's nine.

I couldn't even sleep. I was blasting it all over Facebook and Instagram. And I was packing for weeks. Not once did my parents say anything to me. I mean, they said things like, "Deka, I hope you know this will be a very special trip for you girls." And I just kept saying, "Yeah, guys, I know." I don't know. I think they were trying to protect me. The flight was 25 hours long. A whole day of my life spent in the air.

And that first week was the best week of my life, hanging out with my family. Everyone was making a big deal about us. My grandmother even gave us these beautiful necklaces, and I didn't think any of that was about something else, I just thought they were happy to see me. And I know they were. But the first time I heard the word, gudniinka, was the day it happened. My mom said it meant special girls' day. She said, "It was a tradition for girls in Somalia to celebrate womanhood." And I remember, at first, thinking, "Oh, mother-daughter bonding." And my sister did her sassy thing and was like, "Tell us exactly what we're doing. I like having a plan." My mom just ignored her.

When we got to my grandmother's house, all of my aunties were there, and this lady I didn't know. And I remember in the back of my head thinking, "Who is this cute little lady?" She was the woman who would do gudniinka.

The room was almost silent, in a strange way, and my mom squeezed our hands really tight and said she loved us and she needed us to be very brave. The minute she said that, Leyla started to shake, and Leyla said, "Why do we have to be brave for, mom?" And my heart was pounding. And my mom told us, "You are going to have a tiny surgery in between your legs, and it is going to hurt just a bit, but it's very important." And Leyla just ran for the door, and one of my aunties grabbed her, and they're all shushing Leyla and speaking really fast in Somali. And I started to cry because I didn't understand. And my mom was like, "Deka, I need you to go first. I need you to be strong for Leyley, okay? Daddy and I want you to get married one day. We want you to be good and clean for your husband. Okay?"

And I'm watching the cute lady take out her tools, and Leyla's screaming at the top of her lungs, storing her body around, literally staring at me with her eyes banging out and begging, "No, mama. No, Deka. No, mama. No, Deka." And all of a sudden, everyone's pushing me to the ground and I'm crying, "Wait. Mom, wait. No, I'm already a good girl. Mom, wait, I don't want to get married. I swear. I'm already a good girl." And these women I love, pulled my skirt up, and they pulled my underwear down, and spread my legs so far apart. Then, I heard Leyley choke and throw up all over the floor.

I don't know. I don't remember much after that. I remember the look in my mom's eyes, the smell of sweat, the sound of body being cut. I remember screaming so loud that my throat started to bleed. I remember a pain that has no words. There's no words to describe what it felt like to be cut apart, sewn up, wrapped up and taped up, so I couldn't move. I wish I didn't remember Leyla's turn. I would go through it all over again, if she could have been skipped. There was so much blood, I thought she was going to die.

She doesn't really talk much since we've been back. I take her everywhere with me, when I can. And my mom said, "The gudniinka made me want to be responsible and take care of Leyley." But that's not true. And my parents make me promise, all the time, to not say anything to anyone, because they can get in trouble, because America doesn't understand our culture.

Well, I don't understand it, either. And I do want to be true to my roots and my culture, but why is this the way? And I love my parents. I do, but I just don't trust them anymore. They didn't protect us. No one did. How was this even allowed to happen? And I can't sleep now because I can't stop thinking who is protecting girls like me from this thing, from this thing that I didn't even know could possibly happen to me.

So, that's what I really did over the summer. And back in September, I couldn't write that in my essay for Ms. Reed, because I was afraid of what she think of me, or my parents, or what would happen to my family. But there are girls out there, saying out loud what happened to their bodies, because they don't want what happened to them, on a family vacation, to happen to anyone else. And I'm starting to realize, the only way I can be me again, is if I become one of them.

So, that's what I'm going to do next summer.

Cindy Carraway-Wilson: Now, please welcome, Dr. Karen McDonnell, associate professor in the Department of Prevention and Community Health at the Milken Institute's School of Public Health at the George Washington University. Dr. McDonnell?

Karen McDonnell: Thank you. And I think we just all need to take a deep breath after hearing Deka's story.

What I'm going to talk to you about today is, first, thank you for taking the time out of your very busy schedules to talk with us, learning more about female general mutilation and cutting. And I'll be referring to this as FGM/C.

I am proud to work with many on the webinar today on projects to prevent FGM/C. Our goal is to mobilize with communities to end this practice through dialogue, community collaboration, advocacy, and training.

I'm going to spend the first portion of this webinar going over what is FGM/C, what did Deka experienced, and provide some resources for you that our team has developed with survivors, healthcare providers, religious leaders, advocates, law enforcement, and of course educators, such as yourself.

FGM/C, as you heard, is a reality for many women and girls across different communities around the world. And yes, as you will hear from all of our speakers today, here, in the US as well. Yet, many have never heard of FGM/C or been educated on the ABCs of FGM/C, as it's a hidden practice. So, again, thank you for being here to shed light on what has been shrouded in secrecy and shame.

We have a poll for you, before we get started. Before we dive further into the content, we want to ask this question to better understand, what have they experienced with this issue? If everyone could respond to the poll, into this question, how many of you know someone who has been affected by female genital mutilation and cutting? And so, please take your time right now. And it can be yes, no, or for many, don't know. And we'll give everybody just a moment to fill the poll.

And as you're filling that out, I'll talk, I'll give you a little bit about what is FGM/C. To ensure we're all on the same page... I think I went... There. I'm going to share the World Health Organization definition of female genital mutilation and cutting. FGM/C 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. It is recognized, internationally, as a human rights violation. It's a form of torture and an extreme form of violence against women and girls, and is usually performed between birth and puberty.

And throughout this presentation, I'm going to be referring to the practices of FGM/C, but it's important to note that there are many different terms for it.

These can include FGM, female circumcision, Khatna, Bondo, Sunna, and others. But they're all referring to the same thing.

Some of the terms are community's colloquial term for the practice. And one thing to be cognizant of is, if you're working with communities that practice it, is that it can be helpful to refer to the practice in the same way that they refer to it. So, if they say FGM, you say FGM. If they call it khatna, you call it khatna. But I do want to pay particular attention to one term that we do not like to use, and that is female circumcision, because it inaccurately equates male circumcision to FGM.

As you'll see, in this next slide, these are very different. The World Health Organization outlines four major categories of FGM/C. And in general, each of these four categories are very broad. As you can see on the first panel on the left, this is what a normal external female genitalia would represent. Type I is called a clitoridectomy, and that's the removal of the clitoral hood with or without removal of all the clitoris. Type 2 is excision, and that's when the clitoris and/or the labia minora are removed. And then, Type 3 is infibulation, and this occurs when the vaginal opening is sealed by cutting and repositioning the labia minora and/or the labia majora with or without taking out the clitoris as well. But you see that these, what was once a labia, are then sewn together to form scar tissue. And then, we have Type 4, which is includes all other damaging procedures done to the female genitalia for non-medical reasons, and these include pricking, piercing, incising, scraping, and cauterization.

And when we talk about the health impacts, you just witnessed Deka's impact of having been cut. And I will tell you this, there are no known health benefits to having FGM/C. We do know that, at the time of cutting, there are immediate and short-term health impacts, as a result of the cutting procedure itself, including pain, bleeding, shock, and risk of death. And now that we're asking the questions, we do note that the effects of the trauma of FGM/C can be long-term and can include obstetric complications, lack of feeling or no sensation. So, there's no sexual pleasure that is experienced. Problems with the menstruation, chronic UTIs, and of course mental health concerns.

We also know that FGM/C exists on all continents, except for Antarctica. It is present in, at least, 92 countries, and there are currently 200 million women and girls. 200 million women and girls living with the effects of FGM/C in the world today. However, I am sharing this statistic with some caution that it most likely is an underrepresentation of the true figure of women and girls impacted by FGM/C. As you can see, that only those countries in dark purple have national surveys that ask about FGM/C, while those in other colors such as light purple, pink, and orange, they might have more indirect estimates or small scale surveys or anecdotal evidence. And you can see that many of those countries are not even shaded at all. Well, we just don't have any surveys or studies to confirm or disconfirm that FGM is prevalent in that country.

And at what age does FGM occur? As you can see, from this slide, among countries that have a survey, that asks about FGM/C, the age it occurs varies from country to country, ranging from, say, at birth in Nigeria, to 15 years of age

in Egypt, with an average of about five to seven years. However, we do know that, over time, the age that FGM/C occurs is lowering. And in some parts of the world, such as in Indonesia, we've been told and shown that is being offered as part of the birthing package of services being provided.

So, people ask, "Well, then, why is FGM/C done to young girls?" And as you saw in the video, FGM/C is considered a social norm within communities. This means that it has been justified in all sorts of ways, so that it can continue from generation to generation. Some reasons given for its continuation in many communities include to control sexuality, by curbing sexual desire and preventing promiscuous behavior. It's thought to increase marriageability in certain traditions and cultures, to instill a sense of cleanliness and purity to aid in religious piety, and that there is a misconception that is required by religion.

And despite the fact that FGM/C has no religion, some people incorrectly think that it only happens in Muslim communities, when in fact, FGM/C occurs in all major religions, and actually predates Islam. And while we have data from the UN on FGM/C from 32 countries, mostly, in Africa and the Middle East, FGM/C is reported in 92 countries globally, yet many people think that this is only an African practice when it has global implications.

And finally, a misconception from those living in the US and in Europe is that, this is something that just doesn't happen here. Yet, FGM/C is a problem in the United States that impacts a significant number of women and girls in this country. And it is up to all of us to avoid playing into these misconceptions, so that we can greatly improve the quality of care and support that you are able to provide.

So, now, how do we provide that care and support? We know that education is key to preventing FGM/C. And to that end, our team has been developing a virtual online living toolkit for a variety of audiences, including yourself, educators, about FGM/C. And you can find the toolkit at FGM/CToolkit.gwu.edu. And I invite you all to interact with our toolkit and help us build a virtual community that can best meet your needs.

We have built the toolkit with over 200 interviews and surveys of survivors, providers, religious leaders, law enforcement, teachers, and educators. Please do take a tour of the toolkit and you will find up-to-date and evidence-based content, fact sheets with general information, screening forums, as well as dos and don'ts, diverse content including videos, case studies, and survivor stories, and also resources.

I want to thank you all for spending the time with us today, to learn more about what you can do to prevent FGM/C.

Cindy Carraway-Wilson: Thank you so much for all of that information, Dr. McDonnell.

And I want to encourage everybody to check out your chat. The toolkit link has been posted in the chat, as well as several other resources that we've already talked about.

It's now my great pleasure to welcome Dr. Ekwutosi Okoroh, commander in the US Public Health Services and team lead for the Maternal and Child Disease Prevention and Health Promotion at the Centers for Disease Control. Dr. Okoroh?

Ekwutosi Okoroh: Thank you, Cindy.

As already shared, my name is Ekwutosi Okoroh, and I'm the team lead for the Maternal and Child Health Epidemiology Program, which is in the Division of Reproductive Health at CDC. I would like to start by acknowledging the land of the Hohokam that I currently reside. It is such a pleasure and an honor for me to speak with you today about how CDC is supporting the efforts to better understand female genital mutilation and cutting in the United States.

CDC has been engaged in FGM/C since the late 1990s. The agency's role has been, primarily, to provide estimates of women, potentially, at risk, and to measure the prevalence of FGM/C in the United States. For instance, in 1997, the CDC's collaboration with the Office of Women's Health was based in response to the 1996 passage of the US law making it illegal to perform FGM/C. In 2014, CDC began participating in a US government interagency policy committee efforts to combat FGM/C. The committee was established following the 2013 passage of the US law, making it illegal to knowingly transport a girl out of the country for the purpose of cutting, also known as vacation cutting. In 2015, CDC and the Office of Women's Health collaborated to convene FGM/C experts to discuss strategies for measuring FGM/C. And recently, with funding from the Department of Justice's National Institute of Justice Office for Victims of Crime and HHS's Office of Women's Health, CDC designed, piloted and implemented a study to understand women's health experiences and needs from selected communities in the United States, with high concentration of residents from countries where FGM/C is prevalent.

I will now discuss some of the noted activities in more detail. The 1997 study, which was carried out jointly by the Office of Women's Health and CDC, estimated that, approximately, 168,000 women and girls, living in the United States, were at risk for having had FGM/C. In 2016, CDC conducted a subsequent analysis, applying similar methods, which reactivated the number of potentially at risk, finding that, a little over half a million women and girls had experienced or were at risk of FGM/C in the future. This was a threefold increase from 1997 and was due in part to the rising number of immigrants from FGM/C practicing countries.

It's important to understand that both analysis were based on indirect measurements with at risk, defined as, potentially, having undergone FGM/C in the past or at risk for undergoing FGM/C in the future. These findings had numerous limitations, including the assumption that FGM/C prevalence in the

country of origin can be applied to US residents. As a result, we wanted to pursue a more direct way to measure the prevalence of FGM/C.

The Women's Health Needs Study or WHNS, its purpose was to identify and document the health needs and experiences of women in selected communities who are potentially affected by FGM/C. Our intentions were to document their experiences and attitudes related to FGM/C, FGM/C associate health conditions, and access to healthcare services and reproductive health characteristics. WHNS also hope to generate findings that would inform prevention efforts and public health strategies to meet identified needs from the study participants.

In regards to eligibility, women aged 18 to 49 who were born or whose mother was born in a country where FGM/C is widely practiced, we're eligible for the study. Our goal was to conduct, approximately, 1,100 interviews. We conducted the study pilot in one community, and the main study in four communities, which are listed on the slide. We used a hybrid venue-based sampling and respondent-driven sampling approach to identify and survey, potentially, eligible women. We were intentional in including women with and without FGM/C, so we could have comparisons on key outcomes.

As I mentioned previously, we conducted a pilot study in one community. The pilot was conducted in 2019, and its objectives were to test the sampling design and procedures, to determine whether the methods are feasible for the study population, to determine whether eligible women would be willing to participate in the WHNS pilot study, to test study questions, to determine whether women would understand and respond in a face-to-face interview, and determine whether women would discuss FGM/C with an interviewer.

So, what did we find? Well, we were successful in including women from multiple countries of origin and age groups. We found that our approach and recruitment strategies were feasible, that the standardized questionnaire worked and would allow for quantitative and comparative analysis for the multi-site study, and we were able to demonstrate that women were willing to answer sensitive questions. So, we were feeling good and ready to move on to the main study in 2020, but we all know what happened in 2020.

So, we had to make some changes to accommodate for the pandemic. Some of those efforts are listed below. For instance, our interviewers were trained to ask survey questions over the phone, and they learned to use web survey via tablets to record participants' responses and observations. The places women gathered were now virtual locations, and participants were asked to recruit more women from their social network.

But despite the pandemic, and the necessary changes, and the delaying start, we exceeded our expectations. We completed 1,132 interviews. And again, our goal was 1,100. And currently, we are working on data analysis and report preparations. Our plan is to disseminate the findings through peer review literature, online study reports, community workshops, healthcare provider forums, and of course, now, through educational forums. So, thank you, again,

so much for inviting us to be here today and to share on our findings. And I will provide some of our findings over the next few slides.

More than half of the women in our study, or 55%, reported that they've experienced FGM/C. Among the women who reported FGM/C, 29% were sewn closed, 57% reported they had flesh removed, 2% were cut, no flesh removed, and 12% did not know the type of FGM/C they experienced. Most women with FGM/C in our study were born or their mother was born in Somalia, followed by being born or their mother was born in a West African country, and those African countries... And those West African countries, excuse me, are listed on the slide.

Regarding health concerns, 67% reported a problem with childbirth, compared with 49% without FGM/C. These problems included postpartum bleeding, extensive vaginal tears from childbirth or emergency C-sections. 47% reported a reproductive health problem, compared to 23% without FGM/C. These problems included difficulty passing period blood, difficulty passing urine, pain with urination or having many urinary tract infections. 44% reported a sexual health problem, compared to 17% of women without FGM/C, this includes pain or bleeding during sex. And lastly, 35% reported feeling sad for many weeks at a time, compared to 24% without FGM/C. 58% reported feeling comfortable discussing their FGM/C with a healthcare provider, and 31% have discussed their FGM/C with the healthcare provider. The majority of study participants believe that FGM/C should be stopped, that it can cause health problems, especially later in life, and is not required by their religion.

Some strengths of the WHNS are that, it included women from multiple countries of origin, different immigrants generations, and length of time in United States. And as we've shown, the standardized questionnaire allowed for quantitative and comparative analysis. We, however, cannot generalize to the entire US population of affected and at-risk women and girls. Therefore, WHNS will not produce prevalent estimate. It relies on women's self-reported FGM/C status, and is restricted to women who are 18 years of age due to mandatory reporting laws for child maltreatment for anyone under 18. And lastly, WHNS does not document vacation cutting, which again has taken a girl to a foreign country to perform the procedure.

In closing, I would like to thank and acknowledge all of our partners listed on the slide, and I would like to give particular and extensive kudos to our implementing partner, NORC, who are based in Chicago and did a lot of heavy lifting to get the study completed.

Thank you, again.

Cindy Carraway-Wilson: Thank you so much for your presentation, Dr. Okoroh. I was particularly taken by the numbers that you shared from your study out of 1,132 individuals in your study, with that 55%, that's over 620 people who experienced FGM, just in that one study. We can imagine the number of people who weren't in that study, who weren't reached, and the number of adolescents who are in school, and even younger, even into elementary.

And I also appreciated some of the symptoms that you mentioned. That might be things that our school nurses, our school-based health clinics might be aware of, if students are coming in with these kinds of complaints, to maybe begin to think about and ask about. So, thank you very much for all of that.

And now, it's my pleasure to introduce Ms. Susan Masling, who is the senior trial attorney for the Human Rights and Special Prosecution Section of the Criminal Division of the US Department of Justice. Susan?

Susan Masling: Thanks, Cindy. It's a pleasure to be here, and I really appreciate all of you taking the time out to learn about this important topic. And I also want to give kudos to CDC for engaging in this important study. We are never going to be able to eradicate this practice until we know when and where it's occurring in the United States. And because it is such a secretive practice, that it's still an ongoing challenge.

I work for the Department of Justice, the Human Rights and Special Prosecution Section, and we're the office that has the jurisdiction to prosecute FGM when it occurs in the United States.

FGM is illegal in the United States, although it wasn't illegal until 1996. It only applies to girls, not to women. And as you've heard, it does cover the practice of taking a child out of the US to have her cut in another location. And that is something that, as educators, may impact you because there is a great deal of cutting that occurs. I call it the cutting season around school holiday. So, that's something to watch for and you'll hear more about later when children may come back with symptoms or emotional issues after a family holiday.

It is not, as you've heard, a defense under the law that it's required by a religion, that it's a basis in custom or ritual. This is not something that is an excuse for the practice, it is just, per se, illegal, and it is now punishable by up to 10 years in jail.

It does apply to parents, to guardians, to caretakers, anybody who even just consents to it, it doesn't have to be just the persons who perform it or those who facilitate it. And the federal law, the definition of FGM is, basically, the same as you heard from Dr. McDonnell, what the World Health Organization describes as FGM. So, it covers all the four types.

There have not been very many prosecutions under the federal statute, in part, because as I mentioned, the practice is so secretive and there is very little reporting. The first case was in Los Angeles tattoo parlor, and that was a sting operation by the FBI. They were advertising FGM, so no child was actually hurt. Then, in 2017, in Detroit, a doctor and several parents and a nurse were accused of cutting eight girls, some of whom traveled from other states to be cut in Detroit, by this clinic. And in May of this year, there will be a trial in Houston, Texas of a woman who was accused of taking a child out of the country for the purpose of FGM.

So, those are the only three cases under the federal statute. However, there have been a couple of state cases as well. And as I mentioned, the primary reason for that is a lack of reporting. This happens at an age where children are not inclined to know who to report to, and that's, again, the importance of educators. In other countries, teachers have been responsible for reporting cases that were later prosecuted in Australia and in Sweden. The tips came from alert teachers. So, your role is very important.

In addition to the federal law, there are 40 states that have passed specific laws banning FGM/C, and some of those laws also ban FGM against women, and many of them have a mandatory reporting prohibitions.

However, even if there were no state laws, and even if there was no federal law, it's the federal government's position that FGM is a form of child abuse. And so, at a minimum, FGM/C constitutes the form of battery that would be considered child abuse under any state laws. And I'm sure that all of you, as educators, are familiar with the mandatory reporting for child abuse and other issues, and FGM definitely would come under that as well.

The federal government takes this issue very seriously. As part of the effort, we know that we're not going to litigate our way out of the problem, it's not going to be ended by prosecuting a few people, and so that we get together with other agencies including Homeland Security, Health and Human Services, Department of State, and of course Department of Education to talk about what we can do, as a whole, how we can work together, and collaborate to try to end this practice.

I'm available for any questions. If you have any comments, if you are unsure what to do or who to report to, feel free to reach out to me or any of the other excellent experts that you're going to hear from today. Thank you so much.

Cindy Carraway-Wilson: Thank you for all that information, Susan. There was a comment in the Q&A that appreciated that you talked about and provided some evidence for the practice happening in the US. It's important to understand that this happens in 92 countries, including the US.

I also appreciate it that you mentioned the important role that those teachers in Australia and the other country had, resulting in prosecution and holding adults accountable for hurting children through the practice. So, thank you so much for all of that.

It's now my pleasure to introduce Ms. Kathryn Finley, who works with the US Department of Homeland Security as an associate legal advisor in the Human Rights Violator Law Division, and in the office of the principal legal advisor at the US Immigrations and Customs Enforcement. Kathryn?

Kathryn Finley: Thank you, Cindy, and thank you so much for organizing today's event. It's really a pleasure to be here today, to sit on this panel with some really amazing

colleagues doing such critical work in this space. And thanks everyone for being here.

As Cindy mentioned, I'm Kate Finley, I am an associate legal advisor from the Department of Homeland Security's Human Rights Law Division team, which is part of ICE's Office of the Principal Legal Advisor. And I work very closely with our agents at Homeland Security Investigations and inter-agency partners, like Susan, in FGM investigations for the US government.

As was mentioned, Susan mentioned that 1996 was the year that we had a federal criminal statute enacted for FGM, criminalizing the practice. In the immigration space, it was also a watershed year regarding the recognition of the persecutory and criminal nature of FGM law. Under US immigration law, excuse me. And that year, 1996, the Board of Immigration Appeals issued a very important decision in a case called Matter of Kasinga, which granted asylum to a young woman who was fleeing FGM in her native country of Togo.

And so, in this picture, you'll see Ms. Kasinga with her then student attorney, Layli Miller Muro, who went on to create the Tahirih Justice Center. So, this was a really important case in US immigration law, because it is established for the very first time ever, that FGM is considered in the eyes of US immigration law, a harm severe enough to constitute persecution. And that women threatened with or who have undergone FGM, they absolutely deserve the protection of the US government, because they are targeted on account of their particular social group.

And so, what that decision, almost 30 plus years later, we now have, under immigration law, very important recognition for FGM survivors or individuals who are fleeing a possible FGM scenario in their home country. So, we have immigration benefits available to those individuals. For example, asylum, refugee status in immigration court. There are certain protections of things called withholding of removal or cancellation of removal. Perhaps, if we have law enforcement individuals on the line today, you may have heard of something called the U visa, which is for victims of FGM here in the United States, who have cooperated, reported their victimization to law enforcement.

So, there's a number of different important immigration benefits available to individuals who have suffered this type of harm, this human rights abuse, form of gender-based violence, as well as individuals who are fleeing that practice in their home country.

On the flip side of that is, we do also have immigration consequences that apply to perpetrators of FGM. Unfortunately, throughout my time with the department, for example, we've seen some really egregious cases and a really egregious fact, patterns of individuals, human rights abusers who have perpetrated this practice against young girls, against women, and we take the position that the United States shall not be a safe haven for those who perpetrate this type of violence against women and girls. And so, there are immigration consequences, potentially, depending on the facts for those specific cases.

And then, last but not least... And I won't spend too much time on it, because this is really getting into the weeds of the very exciting Immigration and Nationality Act, which is our governing document for all things, US immigration law. But the immigration laws, specifically, do not list FGM in our specific laws. And I did want to highlight that for this audience because it goes to show that the bulk of what we're operating with in the US immigration law context is from architecture that is from 1965. That is really when a lot of the laws that we have in the Immigration and Nationality Act were written.

And as you've been hearing in 1996 and several years later, our federal criminal law was enacted and later amended. And so, really, it's an evolving situation with FGM, and that we are recognizing this is a form of human rights abuse, a form of gender-based violence, but yet the Immigration and Nationality Act doesn't specifically mention that. And so, again, as folks who are working on this issue within the department, that can sometimes create some challenges. We can go on to the next slide.

Something I did want to highlight, especially for this audience is, we often hear, from our international partners, that FGM survivors and advocacy groups in this space is really the importance on education and outreach, how critical those two pieces are in ending the practice of FGM. You heard Susan just mention, we know that prosecutions, for example, we can't prosecute our way out of this issue, out of this problem. And accountability certainly plays an important role in combating FGM worldwide, but prevention efforts through education and outreach are critical to ensure FGM doesn't happen in the first place.

And so, in 2014, I just wanted to give a quick background here before sharing with you the programming efforts that we have here at Homeland Security Investigations. Just a brief history on what the UK launched in 2014, which is an operation called Operation Limelight, focusing on protecting young girls. So, individuals under the age of 18 who are vulnerable to certain harmful cultural practices like FGM through outreach and education at airports and train stations. And the primary goal in initiating that operation in the UK was to really raise awareness about FGM and encourage public support. So, the operation, that is still in existence today, focuses on flights, specifically traveling directly or connecting to countries with very high percentages of FGM, and focuses very much so on anti-FGM outreach efforts to all passengers traveling to those countries.

And hearing wind of this in the United States, we were really excited to collaborate with our international partners in the UK, so that in January of 2017, officials from the Homeland Security Investigations team, the FBI, DOJ, traveled to the UK to learn all about how Operation Limelight works, and hoping to initiate, perhaps, something similar here in the US, to learn more about how we might be able to combat FGM in this particular way.

And since that trip to the UK in 2017, Homeland Security Investigations, along with other inter-agency partners, FGM survivors, NGO groups, congressional members, for example, Homeland Security Investigations has led the charge in implementing Operation Limelight USA, which is a public awareness campaign

at certain airports here in the United States, with the goal of preventing FGM through education and outreach.

And you heard right at the beginning of this presentation, Deka's story. And really, the goal of Operation Limelight USA is to prevent something like that from even happening in the first place. So, during school vacation season, Homeland Security Investigations, for example, there's teams of folks that go to various airports around the country, they talk to people at the jetway, and they educate passengers through our pamphlets, which I'll show you momentarily on our next slide. The pamphlets outline the dangers of FGM that you've heard about, and as well as the significant criminal immigration and child protection consequences, if any individual knowingly cuts or otherwise injures the genitals of a girl under the age of 18, or assists in doing so.

And so, at the airport are HSI agents, for example, are collaborating with other DHS personnel like CBP and TSA, local authorities, community members, NGOs, survivors to help spread the word. And so, if encountered, we... And we've had this happen several times where we are speaking with someone who is a potential FGM victim. In that moment, there are resources available that we can connect that girl or young woman, too, in the event that she is in need of services or in need of seeking help to, again, prevent that FGM happening in the first place.

Here is a screenshot of the FGM flyer we hand out during our Operation Limelight USA's, to all airport travelers in the specific flights that we are working with. And as you'll see here, there are resources to report suspected FGM, including the ICE tip line and the National Child Abuse hotline. And so, I believe they've been included in the resources slide that everyone should receive, at some point. And I just wanted to highlight that here because I wanted, especially for this audience, for folks to know that there are resources available, specifically when we're dealing with children, where there are concerns about FGM. Either that has happened or about to happen, there are resources here to turn to, to report that.

And then, also, here is a screenshot of a recently created gender-based violence pamphlet, issued by the Department of Homeland Security. This pamphlet is now publicly available in 11 different languages. This particular link to the pamphlet has been shared as a resource as well with this audience. And so, you'll receive that momentarily. But you'll find here, it's very broadly focused on gender-based violence, but there's specific language on FGM.

And what I really wanted to highlight on this slide, in particular is, a resource that is an important resource for adult survivors of FGM or adults over the age of 18 that might be at risk of FGM. And that is highlighted here, just because the resources on the previous slide are specifically geared towards minors, girls under the age of 18. And here focuses, as well, on an FGM, because unfortunately, women are also, either at risk, or potentially, we're working with individuals who have already had it done.

This particular document, I just wanted to highlight as I close here, is important because of something... This concept of intersectionality with gender-based violence and FGM. Not all individuals who face FGM are at risk of other harmful practices, but various gender-based harms can intersect with FGM in several ways. You heard Deka mentioned, for example, that her parents were concerned she may not be able to get married, unless she had FGM done. And so, FGM can be considered a prerequisite for girls getting ready to marry. And what we certainly see here at DHS, for example, is the risk or experience of FGM could also indicate risk of future forced marriage or early child marriage. And that, at times, can be a really challenging dynamic when we're talking about accessing services, we're talking about minors who are traveling internationally, FGM, force marriage, for example, often have this overseas dynamic.

And so, the resources here highlighted in this particular brochure, potentially, could be helpful. And this is a publicly facing brochure. You'll receive it in the resources at the end. Feel free to use those resources, if and when needed.

So, with that, I will turn it back over to Cindy, to introduce our next presenter. Thank you so much.

Cindy Carraway-Wilson: Kathryn, thank you so much for all of that information. Operation Limelight is an important way of be being able to get those young folks who might be experiencing that same circumstance that was related in the Deka story. I greatly appreciate that.

I also appreciate the ongoing framing that all of the speakers, so far, have been using around framing female genital mutilation as both a human rights violation and also as an act of violence against women. I think it's important for us to always keep that in mind because of the broad impacts that it has on a person's trauma and things that they might be bringing back into the school, particularly when we've heard... And again, in that Deka story, the first assignment of the school year was, what'd you learn over the summer? And to have that be the first assignment after having such an experience is pretty powerful, pretty hard, I would imagine.

Now, it's my great pleasure to introduce Ms. Angela Peabody, the founder and executive director of Global Woman's P.E.A.C.E. Foundation. Angela?

Angela Peabody: Thank you, Cindy. Thanks for inviting me to participate in this very important webinar today, and thanks everybody for attending. My name is Angela Peabody, I'm the founder and executive director of Global Woman P.E.A.C.E. Foundation.

I will be talking about something a little different from what everybody else talked about, creating a law, an education law in Virginia, mandating that the study of FGM/C be taught its schools in the Commonwealth of Virginia.

Virginia State Senator, Richard Black, contacted and solicited my organization to work with him on an Education Bill, I was elated. He said he wanted to do one

more thing before he retired that year. I called it a dream come true, because I had always wanted to see FGM/C taught in Virginia schools, so we excitedly worked with the senator to put the clauses in the Bill and made sure that what he foresaw was in there and also what we wanted to cover in the Bill. Since we had already worked with him two years before, the same senator on the criminal law, and got it passed in Virginia, it was a great opportunity to work with him again.

We settled down to work on exactly what the Senator wanted in the Bill. We were also complimented that he saw us as experts on the topic of FGM/C. So, while he provided the legal expertise to the Bill, we provided what we wanted, what we thought was appropriate for the students to learn.

Initially, we both wanted every student in Virginia to be included in the law. Therefore, the initial Bill included all students. But when we put forth the Bill, the Senate committees sent it back and said, "We needed to take out the elementary school students," we were a little disappointed because we thought that the elementary school students, it's important for them to know about FGM/C because it is at that age that it is done.

What is shown on this slide is the final clause or are the final clauses in the Bill. In summary, the Bill called for FGM/C to be included in the family life education curriculum for all middle and high school students in Virginia. We figured there was no need to create a whole separate curriculum law. Instead, we would just request that FGM/C be included in the original family life education, more commonly known as FLE curriculum.

The day we were scheduled to testify before the Senate committee, Senator Black assured us that we didn't have anything to worry about. He said he had done his work by working both sides of the aisle, and he was confident that we would have majority vote. He told us not to be too concerned, but I was nervous, even though we had been there before, in that same space, to testify on the criminal law. But I was concerned because knowing that FGM/C was not so familiar with the lawmakers and in Virginia, and I didn't know what to expect. But as a result, the revised Bill unanimously passed both the General Assembly and the Senate Committee. And once again, Senator Black had a reason to celebrate with us.

So, we had made history since no other state in the US, at the time, had passed an educational Bill against FGM/C. It was mandated that FGM/C be taught in all Virginia, middle and high schools. And the senator felt that he was ready to retire, at that time. And the picture you see there, on the slide, it's the date that we ended our testimonies and we had victory with Senator Black.

Well, after the governor signed the Bill into law on the 1st of July in 2019, we had a mandate in the Commonwealth of Virginia. We were so excited. The senator warned us that there would be some pushback by schools and educators, but we had not anticipated what was to follow. Suddenly, we started receiving inquiries from various county school boards and the Office of Curriculum Design and Instructional Services. There seemed to be confusion. A

law had been passed. And due to the lack of information, the teachers didn't really know where to find information, what was required, what they needed to teach. So, since we had played a major role in getting the law passed, people were referring people to Global Woman P.E.A.C.E Foundation for information, so I turned to our board of directors about putting together a curriculum, so that when they contacted us, we would have something to provide them.

GWPF is fortunate, I must say, to have two educators on our board of directors, one of whom is a retired Virginia high school teacher, and the other is Dr. Karen McDonnell, who is in this webinar today. So, we knew what we wanted to be taught in the schools, for whatever was prepared, needed scrutiny and approval, which was not to be simple and quick. So, just as we were working toward assisting the school administrators, then the pandemic hit, and everybody went into virtual mode, then all the schools started teaching distant learning, and so we had to put everything on pause and regroup.

Since everyone was starting to online training and education, we organized a couple of virtual workshops ourselves for the Fairfax County School administrators. We were invited to do presentations on FGM/C to the administrators. There, we established relationships with some of the school principals and school administrators. Finally, in early 2021, we did our first presentation to the Fairfax County School administrators. Although we were making some progress, a curriculum remained a work in progress. So, with our partnership with George Washington University, we began to work with them in updating their very valuable toolkit. Through students from GW at the university, we conducted interviews and did surveys, and we started slowly putting together something through the toolkit.

It was through that undertaking that brought us to where we are today in working with Fairfax County School administrators for a set curriculum. As some of you might know that, Fairfax County is the largest county in the Commonwealth of Virginia. It is a huge county, so it covers so many different school districts. But while the curriculum is under construction, there are still things that we can do, meanwhile. What you can do to help if you are thinking how you can help, since we have so many teachers in the audience, you can be a champion in your school, you can be that go-to person where people come to for answers, you can also be that champion in your school district. And remember, experts were not born experts, they learned. And after repeated execution, they became experts and champions. So, you too can be that champion and that expert in your school district.

Every school has an FLE program, and I mentioned, the Virginia law included, we requested that FGM/C be included in the FLE program. So, see how you can add to your Family Life Education class. What can you do to get to include FGM/C in your class, for study? We, in Virginia, didn't ask for a separate law to be passed for a new curriculum, we just included that in the already Family Life Education curriculum. What you can do, also, is to help. I think Karen mentioned about the myths about FGM/C. There are so many myths. You can help to dispel those myths surrounding FGM/C when you become that champion. Let them know that it's not a religious practice, it predates all three major religions. Let them

know that it does happen right here in the US, it's a myth that it only happens in Africa. I think some of my colleagues covered that earlier. Otherwise, we wouldn't be fighting for laws to be passed in the US, if it didn't happen here.

And know that parents who allow their girls to be cut, they are not barbaric, some of them believe that it is a passage to womanhood, some of them believe that it's an act of love. So, you want to help to dispel some of those myths. It's really important, especially among the students.

I'm really excited about this, what's on this slide. One of our practicum students from George Washington University working with us became so interested in FGM/C that he decided to start conducting lectures to high school students in Northern Virginia. Since we had conducted lectures to two high schools, prior to the pandemic, where we did it in person, I encouraged him to use that C model for his practicum project. As a result, we are currently working with Chantilly High School in Virginia as the pilot project for his project. And we already have a relationship with Chantilly High school through our internship program that we run there.

If all goes as planned, we will be launching the secondary lecture in mid-March of this year at Chantilly High School and other area high schools that are targeted, or Westfield High School in Arlington, Centreville High School in Centreville, and Alexandria City High School in Alexandria, all located in the Commonwealth of Virginia.

Our support group, I want to talk a little bit about that because we educate our support group. And our support group comprises of women who have experienced FGM/C, and now they're adults, but we use the support group to educate these women on various topics. Our support group used to meet in person, prior to the pandemic. But we, again, trying to virtual learning and support after the pandemic, and the first point of contact when a survivor comes to us, a survivor of FGM/C turns to us, we conduct an initial screening to find out what services, what exact services that we offer that they need. And then, we gather as much information from the individual, to determine exactly what will benefit her and what she is requiring, too. So, we recommend both group and individual counseling to all of our survivors.

Many of them are not comfortable speaking out in the group, so we offer individual counseling with a licensed psychologist, all of which is done virtually. When we turn to a virtual support group, we were... I think the support group grew because of that, because then we got people contacting us from all over the United States. Due to sensitive information exchanged in the group sessions and individual sessions, we stress confidentiality, that's why we don't record our support group sessions, because of that, because some of most of the women are not comfortable with recording them. And we never take photos or videos of our survivors, unless they agree to it. We don't expose them to the public without their permission. So, we stress that.

As I mentioned in the last slide, gaining trust and confidence is essential to our support group services. We realize that it is not easy for the women to open up,

and share their feelings, and their stories with us, so it's an honor for them to trust us. And I've had people say to me, in the past, "It's amazing how you get these women to trust you." But we teach them how to have self-confidence. We have a different educational topic each month. We select topics that will have a positive impact on them. They have already lived through negativity enough, so we don't want to teach them... I mean, we don't want them to have more burden on them.

And I will just end my presentation at this time. Thank you for your time.

Cindy Carraway-Wilson: Angela, thank you so much for all of your valuable information. We greatly appreciate it. Angela's contact information will also go into the chat, so you can reach out if you have any further questions. I really appreciated your call to action to all of our folks in the schools right now about becoming that champion and educating themselves, so that they can be the expert and help to address FGM/C in their schools.

I'd like to bring a wrap on the content delivery section of the webinar, so that we can move into the live Q&A. We have several questions in the queue that we'd like to address. Please do keep using the Q&A icon to add your questions to that list. We want to thank all of the speakers for all the valuable information that you've given us today. It's wonderful.

This is a great starting point for us to begin to think about, how we can implement education and interventions in the schools, now that we have a better understanding of the practice. We also wanted to make sure everyone was aware that we have a several upcoming webinars. March 8th, a webinar that will be focusing on nutrition. March 22nd on marijuana use and prevention. April 12th will be one of our human trafficking series webinars focused on forced criminality in human trafficking. And April 26th, we'll focus in on full service community schools. And we hope that we can see you at all of these webinars, as well.

The link for the feedback form has been put into the chat, and we hope that you all take time to complete that form. We take your feedback seriously. And indeed, your feedback has been helping us to determine content to deliver back to you. That link will be here in the chat and we will, at the end, leave the webinar up for about five minutes, so that you can get that link to make your report and give us that feedback.

Now, I'd like to invite our speakers back online, so that we can review some of the questions that are going into the Q&A. And the first one that I'd like to begin with is, thinking about... So many schools don't have organized curricula or approaches design, I'd like to see if we can have a conversation about some things that a supportive adults can do to approach this topic with a young person, or inquire about any fears that they might have about it, or if they've experienced the practice.

So, if we can all bring our webcams up, and we'll have a conversation about that question.

Would anybody like to begin the sharing ideas about how you might envision launching a conversation with the young person?

Karen McDonnell: Well, I think it's always important to have those conversations. Maybe it's not one you want to have one-on-one, but how do you teachers, how do you people support staff? How do everyone in education talk about other forms of trauma being experienced?

And I think, most importantly, it's integral that, that student know that there's a trusted individual that they can go to talk to about whatever is going on. And if it's FGM/C, that they know that somebody knows what they're talking about. I think that's the fear with the shame and the secrecy is, people not knowing who they would be able to talk to, that would understand what they're going through. And I think, first and foremost, as we know with many other public health issues today, that kids are facing, that, that's probably the most important thing.

But I know, Angela, you've worked in with Fairfax County. Any other things that people and teachers have told you, was helpful?

Angela Peabody: Yes. I think, just an adult being approachable for the students to feel that they are able to go to an adult at school, and that's why it's so important for, not only teachers, but school nurses and school counselors to be very knowledgeable about FGM/C, because it's important for those students to feel that they can approach their teachers or approach their school nurses, and talk to them about what they are feeling.

If they're feeling fear because they suspect something is going to happen, just like the girl in the video talking about how, "Oh, I'm so excited, I'm going to my parents' country, home country." Well, if she told that to a knowledgeable teacher at school, the red light might go off and think, "Oh, something is up." So, that's what makes it so important for them to know.

Cindy Carraway-Wilson: Yeah, absolutely. And maybe even taking some of the pamphlets or other literature that are in the resources, and just having those available at school, right? Maybe in the school nurse's office, or in the counselor's office, or even maybe in a school community bulletin board so folks know that it's an issue that's known, and that there's people in the school that are willing to talk about it, for sure.

This next question might-

Susan Masling: Can I just say something to that last question?

Cindy Carraway-Wilson: Please do. Yes.

Susan Masling: I think this is kind of a different situation where counselors might normally reach out to the parents or to the mother right away, to alert them. This is a situation where, frequently, the mother is responsible or is involved in the process, so care should be taken before reaching out to the parents, to notify them about this concern.

If someone was saying, "I was getting sexually abused at home." Something like that. Even though the parents are loving, it's a good home, it may have been perpetrated by the parents. So, if you are going to talk to the family, that's something to maybe carefully consider, perhaps, with your local CPS office.

Cindy Carraway-Wilson: Excellent. Thank you. Thank you for that. That's a very important piece.

Like you said, an issue of abuse going on, we always need to make sure that there's a safety plan for that student, because they do have to go home, right? I mean, they're going to likely go home, so we want them to be safe at home.

One of the questions that also has come up, and this might be going to you, Susan or Kathryn, but anyone who feels like you can respond, please do. There was a question that asked about, how can authorities assure a young victim that they will not be separated from their families after they report FGM/C after a trip? Or can they?

Susan Masling: Well, I mean, that's a very difficult question. I mean, the thing about this form of child abuse is that, in every other way, the home is usually a loving and supportive home. And this is only something that's happened already in the past and there's no danger of it recurring. So, it's a little bit different if you're reporting, "Someone's going to take me out of the country." Then, there is a risk. But I've been involved in situations where there are interventions, and NGOs, and CPS officers can maybe go to the home and talk to the family about the fact...

So, there's two things. One, has it happened already? In that case, I don't think it would be warranted to take the child out, and I would've hope that the CPS officers are knowledgeable enough to know that, because there's no ongoing risk. And the other is, if there's an imminent danger, then sometimes, you get involved with people like Angela's group or other NGOs that can intervene and talk to the family about, "Hey, reconsider." Or something like that. And that's, of course, the ideal is to stop it before it happens.

Please, other folks, if you have ideas, that's a tough question.

Cindy Carraway-Wilson: Would anybody else like to weigh in on that?

Kathryn Finley: It is a tough question. And just to piggyback off of Susan, I mean, for example, at DHS, we have our victim assistance program that we, in any type of FGM investigation, we are relying on, specifically, trained personnel, victim assistant specialists and forensic interview specialists that are trained to work with in a trauma informed, victim-centered way on these investigations and speaking

with children, speaking with parents. And it's can be a very complicated situation, sometimes, because the parents themselves may be the perpetrators.

So, just to highlight just the overall mechanics, sometimes, of these investigations. There are very, specifically, trained individuals brought in, to make sure that these conversations, investigations are led in a victim-centered way and with a victim-centered approach.

Cindy Carraway-Wilson: And there's a lot of nuance there. I go back to what Angela said that, yes, parents might be involved, but oftentimes is done out of love. And we've heard that in the Deka story as well, where she's like, "Oh, it's mother-daughter bonding." Ms. Deka's interpretation of that. And the mother approaching Deka, it sounded like, "This is important, and we love you, and we want you to have a good life." Right? So, it's also that context of why it's done in the parent's perspective and stance, in that act.

We are at 4:30. We have a few questions we didn't get to, but we will take those questions. They'll be forwarded to the department, and all our speakers will have those questions as well.

I want to thank everybody for your participation, for the icons, for the questions. If you continue to have any questions, please do reach out to us. You can connect through the Best Practices Clearinghouse if you are doing things that you might recommend to other schools or districts. And please do go back to that feedback form link, which will go back into the chat, and let us know what you thought about today's webinar.

We greatly appreciate you, and we're so grateful for all of our presenters for the valuable information shared to us today. Thank you, everyone, and have a wonderful rest of the day.