

OB/GYN Resident Global Health Education Module

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Case 2: Genital Cutting



Case of Raha



Effects of female genital cutting on physical health outcomes: a systematic review and meta-analysis, *BMJ* (2014)

185 studies (from 4,989 screened) were included as per eligibility criteria. A clear association with a number of health issues from procedure throughout life was supported. The most common direct complication was hemorrhage. Several long-term consequences are discussed including: UTI, bacterial vaginosis, dyspareunia, and obstetric complications.



Female genital cutting (FGC) and the ethics of care: community engagement and cultural sensitivity at the interface of migration experiences, *BMC* (2014)

This resource entails the criminalization and condemnation of female genital cutting, with specific focus on the Canadian perspective. Culturally and ethically sensitive care is discussed and framed in the context of the CMA Code of Ethics in order to address the normalcy of FGC in practicing cultures. Considerations of ethnicity, migration, sex, and gender are argued to be integral to the social construct of FGC.



Female Genital Cutting (Clinical Guidelines), *JOGC* (2013)

A comprehensive report and practice recommendations regarding female genital cutting (FGC). Entails the WHO type classifications, recognized complications and risks, and the traditional and cultural beliefs upholding FGC. Providing competent care to affected women is discussed in the context of gynecological, obstetric, and sexual health.



The Cutting Tradition (2009)

This 47-minute documentary explores the cultural, social, religious, and economical factors contributing to the practice of female genital cutting. The film was produced by SafeHands for Mothers and FIGO.

<https://www.youtube.com/watch?v=pUpToERm0q0>

Case 2: Genital Cutting

Raha is a four-year-old daughter of a medical fellow from Oman, currently enrolled in a fellowship at your university. Raha presents with a slow growing clitoral lesion, which developed after a traditional genital cutting procedure on day 40 of life. The mass is soft and fleshy. Her parents beg to have the mass removed, as they will be returning to Oman soon and are concerned no one there will address their concern about her anatomy.

The patient undergoes an uncomplicated removal of a large epidermal inclusion cyst. Her parents are thrilled with the results. You discuss your concerns about the original female genital mutilation/cutting procedure with the father. He reveals how deeply upset he was about it, as his wife's family did it without his knowledge while he was out of town. He assures you that he will try to address the issue within his family, and his wife agrees to never let another family member undergo such a procedure. He understands and agrees with its illegal status in Canada.

Questions for Discussion:

1. What are the healthcare problems in this case?
 - Issues of female genital mutilation/cutting
2. Using the *Integrated Human Rights and Women's Health Checklist*, identify the human rights that were infringed in this case.
 - *Right to autonomy and decision-making*
 - *Right to information*
3. How should a health care provider reconcile his or her beliefs with the health care needs of the patient?
4. What are the local regulations governing female genital mutilation/cutting?
5. How can the healthcare system be improved to respect human rights and ensure health care?

BMJ Open Effects of female genital cutting on physical health outcomes: a systematic review and meta-analysis

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ABSTRACT

Objective: Worldwide, an estimated 125 million girls and women live with female genital mutilation/cutting (FGM/C). We aimed to systematically review the evidence for physical health risks associated with FGM/C.

Design: We searched 15 databases to identify studies (up to January 2012). Selection criteria were empirical studies reporting physical health outcomes from FGM/C, affecting females with any type of FGM/C, irrespective of ethnicity, nationality and age. Two review authors independently screened titles and abstracts, applied eligibility criteria, assessed methodological study quality and extracted full-text data. To derive overall risk estimates, we combined data from included studies using the Mantel-Haenszel method for unadjusted dichotomous data and the generic inverse-variance method for adjusted data. Outcomes that were sufficiently similar across studies and reasonably resistant to biases were aggregated in meta-analyses. We applied the instrument Grading of Recommendations Assessment, Development and Evaluation to assess the extent to which we have confidence in the effect estimates.

Results: Our search returned 5109 results, of which 185 studies (3.17 million women) satisfied the inclusion criteria. The risks of systematic and random errors were variable and we focused on key outcomes from the 57 studies with the best available evidence. The most common immediate complications were excessive bleeding, urine retention and genital tissue swelling. The most valid and statistically significant associations for the physical health sequelae of FGM/C were seen on urinary tract infections (unadjusted RR=3.01), bacterial vaginosis (adjusted OR (AOR)=1.68), dyspareunia (RR=1.53), prolonged labour (AOR=1.49), caesarean section (AOR=1.60), and difficult delivery (AOR=1.88).

Conclusions: While the precise estimation of the frequency and risk of immediate, gynaecological, sexual and obstetric complications is not possible, the results weigh against the continuation of FGM/C and support the diagnosis and management of girls and women suffering the physical risks of FGM/C.

Trial registration number: This study is registered with PROSPERO, number CRD42012003321.

Strengths and limitations of this study

- Based on the studies in this systematic review, there is clear evidence that female genital mutilation/cutting (FGM/C) entails harms to women's physical health throughout their life, from the moment of cutting as an infant or child, to sexuality and childbirth in adulthood.
- The precise estimation of the frequency and risk of complications was not feasible because of the small sample sizes and varying methods of the studies.
- However, the consistency of results with increased risk of several physical harms in women with genital modification is robust.
- Therefore, efforts should be expended in safeguarding girls and women against the physical risks of FGM/C and caring for those who suffer from its consequences.

INTRODUCTION

The centuries-old practice of female genital mutilation/cutting (FGM/C), also known as female circumcision, is a culturally sanctioned practice^{1 2} that consists of “all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons.”¹ According to the WHO typology, there are three main types: type I (clitoridectomy), type II (excision), type III (infibulation or pharaonic circumcision), and type IV, which is used to describe all other harmful procedures to the female genitalia in the absence of medical necessity.¹ Types I–III and unaltered external female genitalia are depicted in [figure 1](#). The nomenclature for the practice varies across regions, ideological perspectives and research frames, and we use the expression preferred by UNICEF and UNFPA, two central policymakers in the global effort to end the practice, ‘female genital mutilation/cutting’ (FGM/C).² Wade explains that Western efforts to end FGM/C since the early 1970s has relied primarily on



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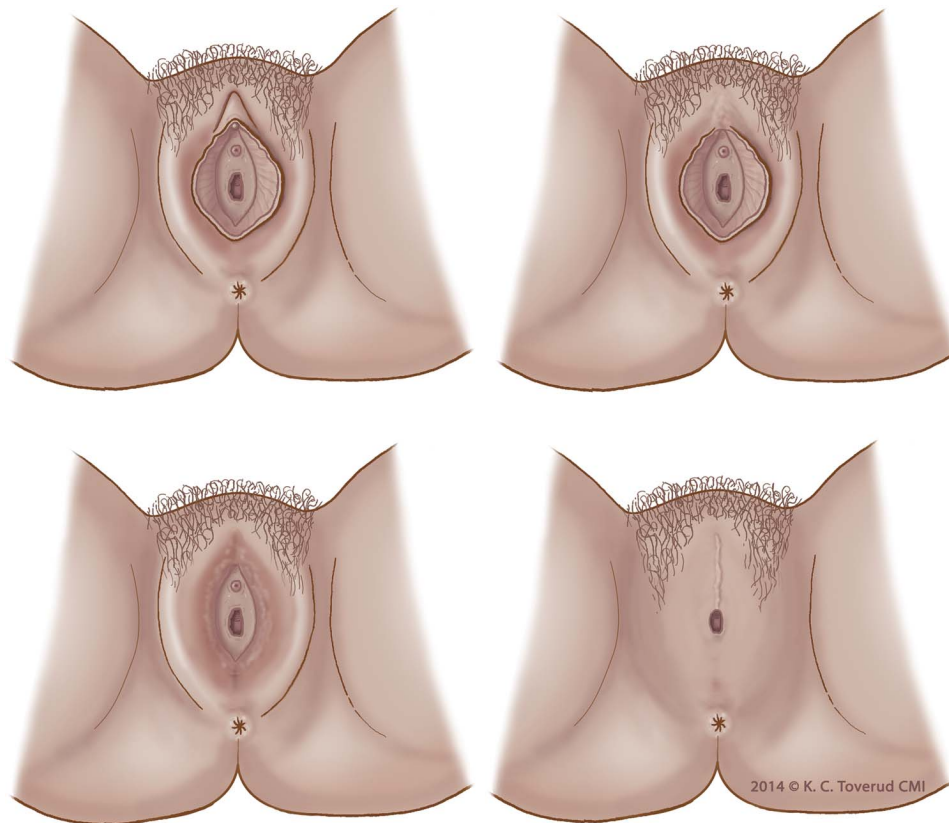


Figure 1 Illustration of unaltered external female genitalia and female genital mutilation/cutting (FGM/C) types I–III. From top left: unaltered external female genitalia, type I (clitoridectomy), type II (excision) and type III (infibulation).

two frames that have influenced the discourse of FGM/C and, in turn, the ideological contestation over the practice.³ In addition to the women's right frame, a dominant frame has been that the practice involves physical and mental harm.

Indeed, for close to a century, observational studies, supported by biological theories, have suggested a negative association between FGM/C and various health outcomes. Such studies have been summarised in a handful of reviews. Epidemiologist and medical anthropologist Obermeyer first reviewed and critiqued the available literature on FGM/C until 1996, and next summarised the subsequent literature from 1997 to 2002.^{4 5} Another early review examined primary data on health complications after FGM/C with particular emphasis on sequelae in childbirth.⁶ Recently, Iavazzo *et al's*⁷ review explored the clinical evidence for an association between FGM/C and infections. The first systematic review in this field—addressing the social, psychological and sexual consequences of FGM/C—critically reviewed and extracted data and analysed 17 comparative studies.^{8 9} While much of this research suggests a harmful effect of FGM/C on women's health, the findings from observational studies and non-systematic reviews are equivocal. Additionally, some commentators have questioned the evidence for many of the claimed short-term and long-term medical consequences of FGM/C, such as quality of sex life, obstetric complications and infections.¹⁰

We aimed to systematically review the evidence for the range of physical health risks associated with FGM/C by summarising the findings from three technical systematic review reports detailing the association.^{11–13}

METHODS

We conducted a systematic review of the physical health risks and consequences of female genital modification in accordance with the Cochrane Handbook for Systematic Reviews of Interventions and PRISMA (Preferred Reporting Items for Systematic reviews and meta-Analyses) guidelines,^{14 15} using a predetermined protocol (PROSPERO, number CRD42012001915). The full details of the systematic review including the search strategies, risk of bias assessment and analysis are found in three technical reports.^{11–13}

Search strategy

The search strategy was developed and undertaken by an experienced search specialist. Fifteen international electronic literature databases were searched to identify research published between inception and January 2012, with Medical Subject Headings descriptors and keywords such as infibulation, applying neither methodology search filters nor language or other search restrictions. The search strategy for MEDLINE (Ovid MEDLINE In-Process & Other Non-Indexed Citations 1946 to 20 January 2012) is shown:

1. Circumcision, Female/
2. ((female\$ or wom#n or girl\$1) adj3 (mutilation\$ or circumcis\$ or cutting\$)).tw.
3. "fgm/c".tw.
4. ((removal\$ or alteration\$ or excision\$) adj6 female genital\$).tw.
5. pharaonic circumcision\$.tw.
6. sunna.tw.
7. (clitoridectom\$ or clitorectom\$).tw.
8. (infibulat\$ or reinfibulat\$ or deinfibulat\$).tw.
9. or/1–8

One reviewer (RCB) manually screened the bibliographies of published reviews on FGM/C and all included studies for additional qualifying studies. RCB did additional searches for the relevant grey literature and unpublished studies in OpenGrey, OpenSigle, OAIster, browsed websites of six international organisations that are engaged in projects regarding FGM/C, and communicated with experts in the field.

Selection of studies and extraction of data

Studies retrieved were eligible for inclusion if they satisfied all our criteria: Be an empirical quantitative study with or without a comparison group published in any language that presented original quantitative data for physical health outcomes in women who had undergone any type of FGM/C as defined by the WHO.¹ All physical health outcomes were eligible, including but not limited to death, infections, infertility, fistula, pain, urinary complications, shock (primary outcomes), and bleeding/haemorrhage, menstrual complications, obstetric complications, vaginal calculus formation, cysts, tissue injury, fractured/displaced bones, urethral meatal stenosis/ urethral stricture, abscesses, keloid and other scarring (secondary outcomes). We applied the following exclusion criteria: Qualitative studies, studies without a quantitative measure of a physical consequence of FGM/C, and all genital modifications not captured by the WHO stated FGM/C definition.

Screening, quality appraisal and data extraction were independently undertaken by two investigators (RCB and VU), with discrepancies resolved by consensus. The two investigators confirmed the eligibility of first titles and abstracts and then full texts. Quality assessment of the identified studies was undertaken as recommended in the Cochrane Handbook, using design specific checklists based on the User's Guide framework.¹⁶ This was done at the study level. The investigators extracted study information and data onto a standardised data collection form, which had been piloted. Data extracted included publication details, study design, sample characteristics, FGM/C characteristics, methods of outcome measurement and health consequences. We contacted authors for additional data or clarification where needed.

Statistical analysis

We grouped the data according to outcomes across the studies, keeping the outcome categories or labels as

reported in each individual study. We estimated associations for dichotomous unadjusted variables in terms of relative risks (RR) with 95% CIs. ORs and 95% CIs were used for case-control studies and adjusted analyses. Outcomes that were sufficiently similar across studies, and reasonable resistant to biases and relatively homogeneous in this respect, were aggregated in meta-analyses. When available, we pooled adjusted estimates; otherwise, we pooled the unadjusted estimates based on crude data from the individual studies. ORs and RRs greater than one indicate an increased risk of complications with FGM/C; if less than one, they indicate a decreased risk.

We anticipated heterogeneity between studies due to different study methodologies and geographical and population differences. Heterogeneity was examined using the χ^2 test and I^2 statistic. We used a random-effects model to account for within-study and between-study heterogeneity.

In random-effects meta-analysis, the weight assigned to each included study is adjusted to include a measure of variation (τ^2) in the effects reported between studies. We used the Mantel-Haenszel method for unadjusted dichotomous data, and for adjusted data we used the generic inverse-variance method, in which weight is given to each study according to the inverse of the variance of the effect, to minimise uncertainty about the pooled effect estimates. Analyses were done with Review Manager (V.5.2.8).

We applied the instrument Grading of Recommendations Assessment, Development and Evaluation (GRADE) to assess the extent to which we have confidence in the effect estimates.¹⁷ GRADE is a transparent and systematic approach to grading our confidence in the evidence. For resource reasons, we used GRADE only for outcomes eligible for meta-analysis.

Those of us who did the systematic review were not masked to the authors, institution or journal of publication. The use of non-masked reviewers is accepted practice in meta-analyses and has been shown not to bias results.¹⁸ In line with recommendations,¹⁴ results from the studies deemed to have the highest internal validity were given preference. In this communication, we present all studies that reported outcomes for differentially FGM/C exposed groups of women, that is, studies with a comparison group.

Role of the funding source

Norad and the WHO commissioned the study and the latter contributed some funding (\$10 000). The commissioners of the systematic review had no role in the study design, data collection, data analysis, data interpretation or writing of the report. RCB had final responsibility for the decision to submit for publication.

RESULTS

Our search strategy identified 5109 unique publications, the titles and abstracts of which were screened for

inclusion. The full text of 12 publications could not be located, while 431 articles were retrieved, of which 185 met the inclusion criteria (figure 2).

The 185 included studies were of varying publication types, published between 1927 and 2011, and from 42 different countries (see online supplementary appendix 1). There were 13 studies from the Middle East, 43 from a Western country, and 129 from Africa. Twenty different African countries were represented. The FGM/C participants in studies from a Western country originated in the majority of cases from Somalia, and in the remaining cases they originated from another African country where FGM/C is commonly practised. Overall, the 185 studies involved 3.17 million female participants, from infants to women in their 70s, with a mean age of approximately 30. With respect to the FGM/C characteristics, the majority of women had genital alteration that involved the cutting and removal of portions of the external female genitalia, without stitching, corresponding to either type I or type II. The procedure had in the absolute majority of cases been undertaken in early childhood, usually before the age of 10, by a traditional circumciser. A total of 75 different outcomes were extracted.

In this overview, we present key physical health complications of FGM/C in a life course perspective. Except for some immediate outcomes, these key outcomes derive from comparative studies, that is, women with FGM/C are compared to women without FGM/C with respect to an outcome in a cohort, case-control or cross-sectional study (table 1). We prioritise the presentation of studies with clinically measured and adjusted outcome data, but note also the best available evidence for additional key outcomes, largely immediate complications. Table 1 shows the 57 studies with the best

available evidence regarding the physical health sequelae of FGM/C (comparative cohort, case-control, cross-sectional studies).^{19–72} About 40% of the outcomes were self-reported primarily by adult women, although the great majority of the obstetric and some genitourinary outcomes were clinically measured. The meta-analytical results that are based on unadjusted estimates are presented in figure 3, and those based on adjusted estimates are shown in figure 4.

Immediate complications

In most cases of FGM/C, a girl's clitoris and labia are cut away, often with a crude unsterile instrument and without anaesthetics by a traditional practitioner who has little knowledge of female anatomy.² Thus, it is reasonable to assume that physiological harms such as bleeding ensue during the cutting process and the short-term postprocedure period. We identified no studies that analysed the potential statistical differences in the risk of direct, procedure-related complications between types of FGM/C. However, 56 observational studies reported on eight main types of immediate medical harms (bleeding, shock, genital tissue swelling, fever, infections and problems with urination and wound healing) on 133 515 females of various ages and types of FGM/C. The rate of immediate complications varied greatly across the studies. There were strong indications of under-reporting of immediate complications from the procedure, with some studies reporting that 90% of the girls undergoing FGM/C experienced no bleeding at all.^{30 64} However, representative studies (ie, where the participants can be assumed to represent the larger population) of moderate and high methodological quality indicated that the most common immediate

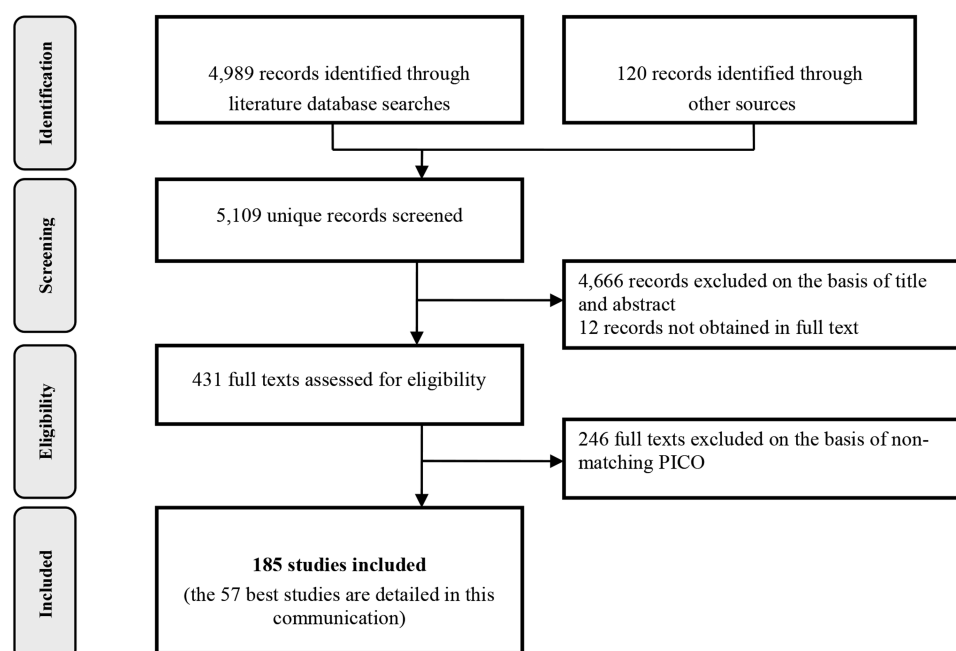


Figure 2 PRISMA flow diagram for selection of literature.

**Table 1** Summary of included comparative studies (N=57)

Author, year	Study design	Quality	N	Country	Outcomes (assessment type)
Adinma, 1997 ¹⁹	Cross-sectional	Low	256	Nigeria	Obstetric (self-report)
Almroth, 2005a ²⁰	Case-control	High	279	Sudan	Infertility (clinical)
Almroth, 2005b ²¹	Cross-sectional	High	255	Sudan	Genitourinary (clinical)
Alsibiani, 2010 ²²	Cross-sectional	Moderate	260	Saudi Arabia	Sexual (self-report)
Balk, 2000 ²³	Based on the Sudan DHS 1990	Moderate	5856	Sudan	Infertility (self-report)
Berardi, 1985 ²⁴	Prospective	Low	852	France	Obstetric (clinical)
Bohoussou, 1986 ²⁵	Cross-sectional	Low	4935	Ivory Coast	Obstetric (unclear)
Brewer, 2007 ²⁶	Based on the Kenya DHS 2003	High	539	Kenya	HIV/STIs (clinical)
Browning, 2010 ²⁷	Retrospective cohort	Moderate	492	Ethiopia	Genitourinary, obstetric (clinical)
Chibber, 2011 ²⁸	Prospective	Low	4800	Unclear	Obstetric (clinical)
De Silva, 1989 ²⁹	Prospective	Low	2157	Saudi Arabia	Genitourinary, obstetric (clinical)
El Dareer, 1983 ³⁰	Cross-sectional	Low	3210	Sudan	Immediate, genitourinary (self-report)
el Defrawi, 2001 ³¹	Cross-sectional	Moderate	250	Egypt	Genitourinary, sexual (self-report)
Elmusharaf, 2006 ³²	Case-control	High	222	Sudan	HIV/STIs (clinical)
Elnashar, 2007 ³³	Cross-sectional	Low	264	Egypt	Genitourinary, sexual, obstetric, (self-report)
Essén, 2005 ³⁶	Registry study	Moderate	2554	Sweden	Obstetric (clinical)
Fillo, 2007 ³⁷	Based on the Burkina Faso DHS 2003	Moderate	12 477	Burkina Faso	Genitourinary (unclear)
Hakim, 2001 ³⁸	Unclear if prospective or retrospective	Low	1481	Ethiopia	Obstetric (clinical)
Holmgren, 2003 ³⁹	Cross-sectional	Moderate	857	Guinea-Bissau	HIV/STIs (clinical)
Inhorn, 1993 ⁴⁰	Case-control	High	190	Egypt	Infertility (clinical)
Jackson, 2005 ⁴¹	Cross-sectional	Low	?	Ghana	Infertility (self-report)
Johnson 2005 ⁴²	Registry study	Low	5416	USA	Obstetric (clinical)
Jones, 1999-I ⁴³	Cross-sectional	Low	1920	Burkina Faso	Genitourinary (clinical), obstetric (self-report)
Jones, 1999-II ⁴³	Prospective	Moderate	5337	Mali	Genitourinary, obstetric (clinical)
Kanki, 1992 ⁴⁴	Cross-sectional	Moderate	1710	Senegal	HIV/STIs (clinical)
Kaplan, 2011 ⁴⁵	Cross-sectional	Moderate	871	Gambia	Immediate (self-report), genitourinary (clinical)
Klouman, 2005 ⁴⁶	Cross-sectional	Moderate	396	Tanzania	Genitourinary, HIV/STIs, infertility (clinical)
Larsen, 2002 ⁴⁷	Based on the Sudan DHS 1990	Moderate	5849	Sudan	Infertility (self-report)
Larsen 2002 ⁴⁸	Cross-sectional	Low	1836	Nigeria	Obstetric (self-report)
Larsen, 2000-I ⁴⁹	Based on the CAR DHS 1995	Moderate	4388	Central African Republic	Infertility (self-report)
Larsen, 2000-II ⁴⁹	Based on the Ivory Coast DHS 1995	Moderate	5930	Ivory Coast	Infertility (self-report)
Larsen, 2000-III ⁴⁹	Based on the Tanzania DHS 1997	Moderate	6043	Tanzania	Infertility (self-report)
Larsen, 1989 ⁵⁰	Cross-sectional	Low	2183	Sudan	Infertility (self-report)
Lupo, 1999 ⁵¹	Registry study	Low	114	USA	Obstetric (unclear)
Maslovskaya, 2009 ⁵²	Based on the Kenya DHS 2003	High	3114	Kenya	HIV/STIs (clinical)
Millogo-Traore, 2007 ⁵³	Prospective	Low	454	Burkina Faso	Obstetric (clinical)
Morison, 2001 ⁵⁴	Cross-sectional	High	1157	Gambia	Genitourinary, sexual, HIV/STIs, infertility (clinical)
Msuya, 2002 ⁵⁵	Cross-sectional	High	379	Tanzania	Genitourinary, HIV/STIs (clinical)
Ndiaye, 2010 ⁵⁶	Cross-sectional	Low	354	Burkina Faso	Obstetric (clinical)
NSEO, 2002 ³⁴	Cross-sectional	Low	7765	Eritrea	Sexual, obstetric (self-report)
NSO, 1995 ³⁵	Cross-sectional	Low	4775	Eritrea	Sexual, obstetric (self-report)

Continued

Table 1 Continued

Author, year	Study design	Quality	N	Country	Outcomes (assessment type)
Nwajei, 2003 ⁵⁷	Cross-sectional	Low	400	Nigeria	Genitourinary (self-report)
Odoi, 1997 ⁵⁸	Cross-sectional	Low	195	Ghana	Sexual (self-report)
Oduro, 2006 ⁵⁹	Registry study	High	5071	Ghana	Obstetric (clinical)
Okonofua, 2002 ⁶⁰	Cross-sectional	Moderate	1836	Nigeria	Genitourinary, sexual (clinical/self-report)
Orji, 2006 ⁶¹	Cross-sectional	Low	500	Nigeria	Obstetric (self-report)
Pépin, 2006 ⁶²	Cross-sectional	Moderate	1026	Guinea-Bissau	HIV (clinical)
Pépin, 1991 ⁶³	Cross-sectional	Low	345	Gambia	HIV (clinical)
Rushwan, 1983 ⁶⁴	Cross-sectional	Low	2502	Sudan	Immediate, genitourinary, sexual, infertility (self-report)
Shandall, 1967 ⁶⁵	Cross-sectional	Low	4487	Sudan	Immediate, genitourinary (clinical/self-report)
Slanger, 2002 ⁶⁶	Cross-sectional	Moderate	1107	Nigeria	Obstetric (self-report)
Small, 2008 ⁶⁷	Registry study	Low	2 179 322	Multiple	Obstetric (clinical)
Vangen, 2002 ⁶⁸	Registry study	Low	703 925	Norway	Obstetric (clinical)
WHO study group, 2006 ⁶⁹	Prospective	High	28 393	Multiple	Obstetric (clinical)
Wuest, 2009 ⁷⁰	Prospective	Low	232	Switzerland	Obstetric (clinical)
Yount, 2007 ⁷¹	Based on the Kenya DHS 2003	Moderate	3167	Kenya	HIV/STIs (clinical), obstetric (self-report)
Yount, 2006 ⁷²	Cross-sectional	Low	1700	Egypt	Infertility, obstetric (self-report)

Two studies are presented in Jones 1999⁴³ (Jones 1999-I is from Mali, and Jones 1999-II is from Burkina Faso); three studies are presented in Larsen 2000⁴⁹ (Larsen 2000-I is from the Central African Republic, Larsen 2000-II is from the Ivory Coast, and Larsen 2000-III is from Tanzania).

CAR, Central African Republic; DHS, Demographic and Health Survey; Quality, Methodological study quality at study level; STIs, sexually transmitted infections.

complications were: excessive bleeding (median 32%, range 5–62%), urine retention (median 31%, range 8–53%), genital tissue swelling (median 15%, range 2–27%), problems with wound healing (13%) and pain (11%).^{30 73 74} Girls generally suffered more than one immediate complication. We identified three clinical reports on deaths directly attributed to FGM/C.^{75–77} Fourteen studies reported the number of events for different types of FGM/C separately, allowing us to estimate differences in risk across exposure groups.^{30 45 64 65 78–87} Our results indicated that there might be a greater risk of immediate harms with FGM/C type III relative to types I–II. We found few, and small, differences in risk of immediate complications with FGM/C types I–II compared to type IV (generally ‘nick’).

Genitourinary problems

With respect to the genitourinary sequelae of FGM/C, reported years and sometimes decades following the procedure, we identified 17 comparative studies.^{21 27 29–33 37 43 45 46 54 55 57 60 64 65} In total, the studies included 38 390 women. The most frequently measured outcomes were genital tissue damage, vaginal discharge and itching, urological complications and infections. Many sequelae were examined in only one or a few studies and/or they were relatively rare events, such as keloids and abscesses. Analyses were thus often unable to establish whether there were statistically significant differences between the groups being compared and the CIs were wide. As a result, there was insufficient

information available from the studies to assess difference in risk relative to FGM/C exposure. The results were inconclusive with respect to: scarring, keloids, abscesses, fistulae, damaged tissue (perineum, anal sphincter), disfigurement, vaginal obstruction and cysts.

According to four cross-sectional studies (n=3657), there was a trend for a greater risk of vaginal discharge and itching with FGM/C (adjusted ORs (AOR) from 0.94 to 2.81).^{33 54 57 60} Urological long-term complications were reported in four comparative studies (n=3611), none of which could establish a statistically significant difference, either in unadjusted analyses (RRs from 0.85 to 1.78) or in adjusted analyses (AORs from 0.80 to 1.29), between women with FGM/C and women with no FGM/C.^{27 33 54 60} However, results from two studies of moderate to high methodological study quality indicated a trend for a greater risk of burning or painful urination with FGM/C (RR=2.56, 95% CI 0.80 to 8.22; RR=1.66, 95% CI 0.96 to 2.85).^{33 60} Menstrual problems were reported in five studies (n=6564).^{30 31 33 54 64} They showed a trend towards a greater risk of menstrual problems with FGM/C: dysmenorrhoea (RR=1.44, 95% CI 1.11 to 1.86), difficulty in menstruation (RR=1.02, 95% CI 0.06 to 16.28), menstrual problems (RR=0.77, 95% CI 0.61 to 0.97), irregular menses (RR=2.56, 95% CI 1.48 to 3.45) and difficulty in passing menstrual blood (RR=1.75, 95% CI 0.78 to 3.93).

Ten comparative studies (n=28 940) reported results concerning long-term genitourinary infections.^{21 29 30 37 43 46 54 55 64 65} Owing to few studies and

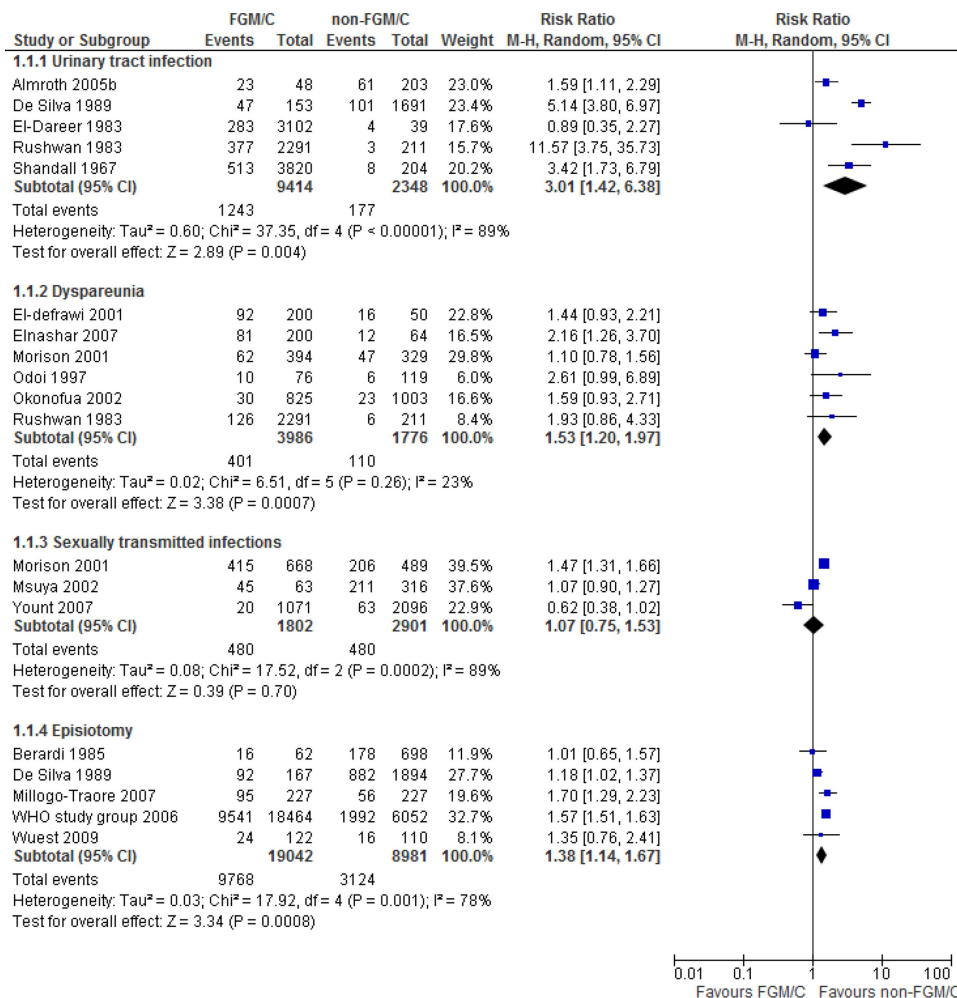


Figure 3 Meta-analyses of urinary tract infection, dyspareunia, sexually transmitted infections, episiotomy (unadjusted effect estimates).

the low number of events, the findings were inconclusive for the following outcomes: chronic pelvic infections, reproductive tract infections, genital infections and vaginitis. However, in adjusted analyses, two studies of low to moderate methodological quality found a statistically higher risk of reproductive tract infections (AOR=1.54, 95% CI 1.08 to 2.21) and genital infections (AOR=1.72, 95% CI 1.02 to 2.92) with FGM/C.^{37–43} Meta-analyses showed a greater risk of urinary tract infections (RR=3.01, 95% CI 1.42 to 6.38; GRADE: very low; figure 3)^{21–29–30–64–65} and bacterial vaginosis (AOR=1.68, 95% CI 1.28 to 2.22; GRADE: very low) with FGM/C (figure 4).^{46–54}

Painful sexual intercourse

Dyspareunia (painful sexual intercourse) was reported in six studies (n=6204).^{31–33–54–58–60–64} The meta-analysis, presented in figure 3, showed an increased risk of dyspareunia with FGM/C (RR=1.53, 95% CI 1.20 to 1.97; GRADE: very low). Correspondingly, results from two nationally representative studies from Eritrea (n=12 540) indicated a 'dose-response' relationship, with a lower risk of problems during sexual relations with FGM/C

types I–II relative to type III (RR=0.19, 95% CI 0.16 to 0.24; RR=0.44, 95% CI 0.27 to 0.72).^{34–35}

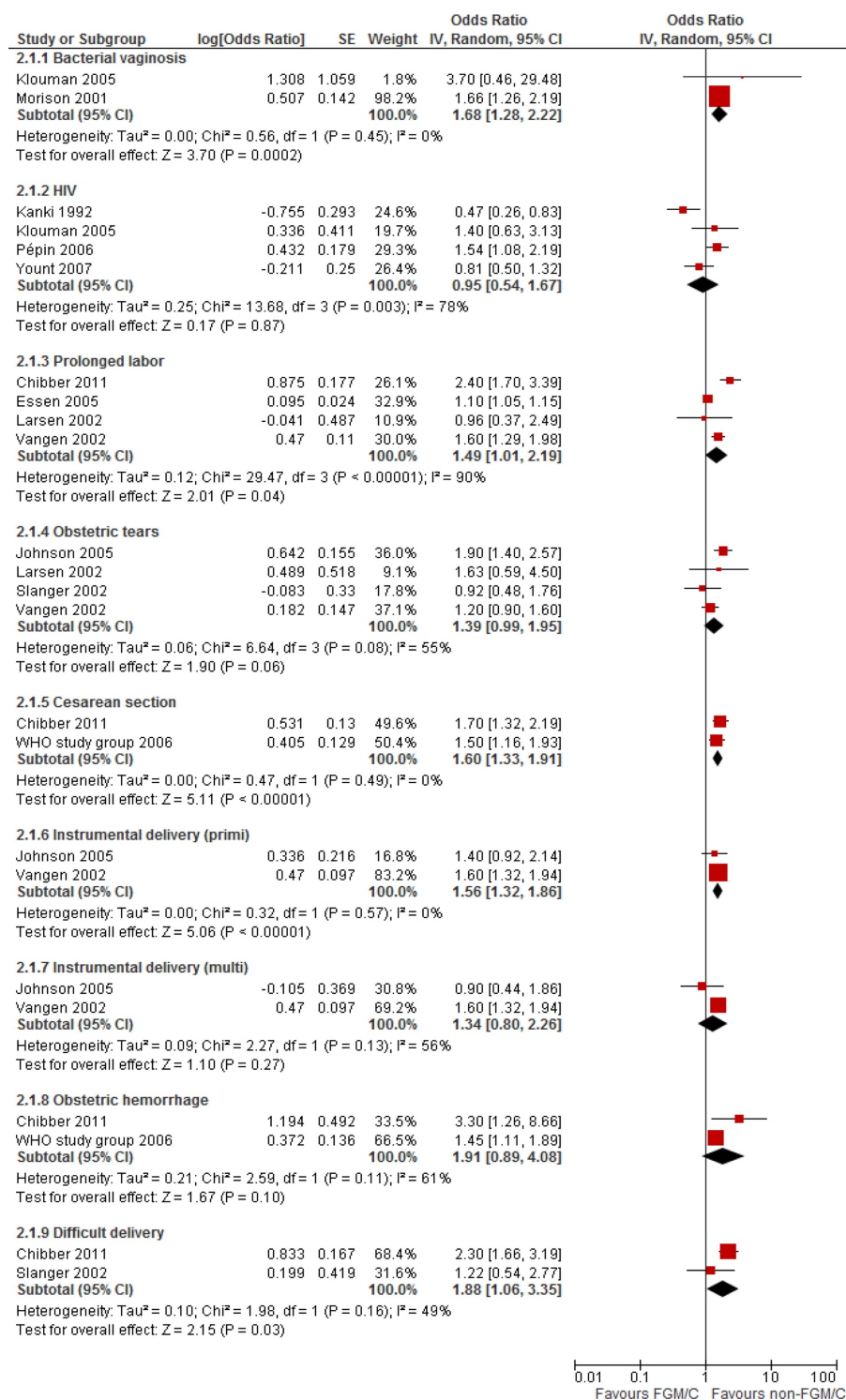
HIV and sexually transmitted infections

HIV and sexually transmitted infections (STIs) were clinically examined in one case-control study and 10 cross-sectional studies (n=12 912).^{26–32–39–44–46–52–54–55–62–63–71} The case-control study could not establish a difference between FGM/C and no FGM/C regarding STIs (AOR=1.13, 95% CI 0.73 to 1.77).³² Similarly, the meta-analysis of cross-sectional studies failed to establish a difference (RR=1.07, 95% CI 0.75 to 1.53; GRADE: very low; figure 3).^{54–55–71} As shown in figure 4, also the meta-analysis for HIV, based on four studies which presented adjusted data, failed to establish a difference relative to FGM/C (AOR=0.95, 95% CI=0.54 to 1.67; GRADE: very low).^{44–46–62–71}

Infertility

Twelve studies presented data on infertility (n=36 473).^{20–23–40–41–46–47–48–50–54–64} Two case-control studies of high methodological quality examined whether FGM/C was a predictor for infertility. The

Figure 4 Meta-analyses of bacterial vaginosis, HIV, prolonged labour, obstetric tears, caesarean section, instrumental delivery, obstetric haemorrhage, difficult delivery (adjusted effect estimates).



case-control study from Sudan could not establish an association between infertility and FGM/C (AOR=1.77, 95% CI 0.52 to 7.10).²⁰ Similarly, the case-control study from Egypt could not establish a difference between FGM/C type II and type I with respect to tubal factor infertility (AOR=1.9, 95% CI 0.8 to 4.2).⁴⁰ The available evidence did not allow us to conclude whether women were more likely to be infertile if they were cut by a traditional than a medical circumciser (AOR=2.1, 95% CI 0.8 to 5.7).⁴⁰ Ten cross-sectional studies examined infertility in women with

and without FGM/C. The association between FGM/C and infertility varied, both in unadjusted analyses (effect estimates ranged from 0.34 to 3.67) and adjusted analyses (AORs from 0.99 to 2.76). Specifically, the results of the two clinical studies of moderate to high methodological quality did not establish a greater risk with FGM/C (OR=1.3, 95% CI 0.7, 2.7; OR=1.05, 95% CI 0.65 to 1.67. Of eight adjusted estimates, two reached significance. These are not shown here because the CIs were not provided in the publications).^{46 54}

Obstetric outcomes

Obstetric events (prolonged labour, tears/lacerations, caesarean section, episiotomy, instrumental delivery, haemorrhage, difficult labour) were reported in 26 comparative studies (2.97 million women).^{19 24–29 33–36 38 42 43 48 51 53 56 59 61 66–69 71 72} Seven of these were prospective.^{24 28 29 43 53 69 70} Eight studies reported adjusted data, with the number and types of confounders varying greatly across studies (detailed in the study under review).^{28 36 42 43 48 66 68 69}

Data on prolonged labour were reported in six studies.^{28 29 36 48 53 68} The meta-analysis of adjusted estimates from four studies showed a significantly greater risk of prolonged labour with FGM/C (AOR=1.49, 95% CI 1.01 to 2.19; GRADE: low; figure 4).^{28 36 48 68} There was one prospective study, of low to moderate methodological quality, that reported an adjusted estimate for prolonged labour, the result of which was concordant with the meta-analysis (AOR=2.40, 95% CI 1.40 to 2.80).²⁸ Regarding obstetric tears/lacerations, the meta-analysis of four studies which presented adjusted data showed an AOR of 1.39 (95% CI 0.99 to 1.95; GRADE: very low; figure 4).^{42 48 66 68} No prospective studies presented adjusted estimates for obstetric tears.

There were 15 studies with data on caesarean section.^{24 25 28 29 33 42 48 56 59 66–71} Five studies reported adjusted estimates, the pooled estimate of which resulted in an AOR of 1.32 (95% CI 0.97 to 1.80; GRADE: very low). Restricting the meta-analysis to the two prospective studies established a significant difference between groups (AOR=1.60, 95% CI 1.33 to 1.91; GRADE: low), indicating a greater risk of caesarean section among women with FGM/C (figure 4).^{28 69} As with the other obstetric outcomes, the study-level results were inconsistent regarding episiotomy. Eleven studies reported on episiotomy,^{19 24 29 33 38 48 53 56 66 69 70} but there was only one (retrospective) study with adjusted data.⁴⁸ The result from the most comprehensive model in this study (ie, adjusting for the highest number of confounders) showed an AOR of 1.18 (95% CI 0.76 to 1.84). No prospective studies presented adjusted estimates for episiotomy, but we aggregated the unadjusted results from five prospective studies (n=32 088 women), finding an increased risk with FGM/C (RR=1.38; 95% CI 1.14 to 1.67; GRADE: very low; figure 3).^{24 29 53 69 70}

There were nine studies with data on instrumental delivery.^{24 25 29 42 53 66–68 70} Two (registry based) studies reported adjusted data.^{42 68} The meta-analysis for primiparous women suggested a greater risk of instrumental delivery with FGM/C (AOR=1.56, 95% CI 1.32 to 1.86; GRADE: very low), which could not be firmly established for multiparous women (AOR=1.34, 95% CI 0.80 to 2.26; GRADE: very low; figure 4). We also included nine studies with data on obstetric or postpartum haemorrhage.^{28 29 38 42 56 66 68–70} Five studies reported adjusted results, which we combined in a meta-analysis. The result indicated a greater risk with FGM/C (AOR=1.50,

95% CI 1.22 to 1.84; GRADE: very low). However, the pooled adjusted estimate based on the two prospective studies that reported adjusted data for haemorrhage failed to establish a convincing difference relative to FGM/C (AOR=1.91, 95% CI 0.89 to 4.08; GRADE: very low; figure 4).^{28 69} Lastly, we included six comparative studies with data on difficult delivery.^{28 42 43 56 66} The pooled result based on adjusted estimates from the two studies that could be combined resulted in an AOR of 1.88 (95% CI 1.06 to 3.35; GRADE: low; figure 4).^{28 66} A third study compared women without FGM/C with women who had FGM/C type I. The AORs were 0.17 (95% CI=0.06 to 0.52) and 0.32 (95% CI=0.19 to 0.54), which favoured not having FGM/C.⁴³ There was one prospective study with data on difficult delivery.²⁸ The estimate showed a greater risk with FGM/C (AOR=2.30, 95% CI 1.3 to 2.5).

DISCUSSION

This systematic review provides clear evidence that FGM/C entails harms to women's physical health throughout their life, from the moment of cutting as an infant or child, to sexuality and childbirth in adulthood. Predictably, the most common direct, procedure-related complication includes haemorrhage, most likely resulting from laceration of the internal pudendal artery or the clitoral artery. It is difficult to determine the number of females who die from procedure-related complications. Only a few studies reported death, but highly publicised fatalities from FGM/C heighten the awareness of the possible harms posed by the procedure, such as three recent cases in Egypt and Kenya.^{88–90}

We found several long-term consequences of FGM/C, including increased risks of urinary tract infections, bacterial vaginosis, dyspareunia and obstetric complications. Studies have been published since we conducted our search, and they corroborate our findings.^{91–98} The identified risks from FGM/C are also supported by biological rationales for the associations. As explained by experts,^{21 54 92} any alteration of the natural anatomy of the vulva, such as removal of the protective labia minora, can lead to structural and physiological changes, including trauma to the urethra, adjacent tissues and nerves at the time of the procedure as well as formation of scars and flaps of skin during the healing process.

FGM/C is a non-therapeutic procedure, which by definition does not treat an underlying pathological process, but rather forms an actionable risk factor for several morbidities. As public policy discussions gain momentum on how to prevent FGM/C, our findings about the health complications could be communicated to practising communities, health practitioners, government bodies, international health organisations and other stakeholders. Global policy efforts should be expended in safeguarding females against the physical risks of FGM/C and, as emphasised by the United Nations agencies,¹ in upholding their bodily integrity

and furthering their human rights. Worldwide, about 125 million girls and women alive today live with FGM/C, and every year another three million girls in the countries where the practice is concentrated are at risk of undergoing the practice.^{2 99} Caring for girls and women who suffer from its consequences and research into the best and most acceptable treatment and care are important.

This systematic review offers the most comprehensive and scientific evidence presently available on the range of physical health complications from FGM/C—other reviews are non-systematic and limited in scope^{4–7}—but a complete understanding is hindered by data gaps. The search was executed in 2012 and it is possible that our systematic review is subject to publication bias. The discrepancy between the large number of records identified in our search and the 185 studies included attest to the literature on FGM/C being longer on opinion and polemic and considerably shorter on data. We identified only three case-control studies and seven prospective studies. Many included studies had low methodological study quality; many outcomes were reported in just a few studies, and event rates in several studies were low. Thus, most data are of low quality, which partly results from the nature of the study question, which is difficult to answer by means of rigorous research methods. Additionally, the measurement and reporting of exposure, outcome and confounders were done with varying precision in the included studies, and although we did subgroup and random-effects analyses, these could not fully account for the observed heterogeneity across studies. Thus, the summary estimates for all outcomes should be interpreted cautiously. Some of the above possible sources of biases would tend to bias our summary estimates towards the null, and are likely to lead to too conservative estimates of the true harmful association of FGM/C with physical health. For example, research on male circumcision has found that adverse events are recorded less frequently in retrospective than prospective studies.¹⁰⁰ Owing to gaps in the evidence base, precise estimation of frequency and risk of complications is not possible. However, irrespective of the exact size of the greater risk from FGM/C, the consistency of results with increased risk of several physical harms in women with genital modification is robust, and even the lowest increase in risk of complications is undesirable from a woman's health perspective.

CONCLUSION

The evidence base on the physical health complications of FGM/C, which covers over half a century of research from more than 20 countries in Africa and beyond, shows that FGM/C is associated with an increased risk of health complications, especially urinary tract infections, bacterial vaginosis, painful sexual intercourse and obstetric difficulties. Further research into this question is unlikely to produce practical value. Rather, efforts

should be expended in safeguarding girls and women against the physical risks of FGM/C and caring for those who suffer from its consequences.

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DEBATE

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Female genital cutting (FGC) and the ethics of care: community engagement and cultural sensitivity at the interface of migration experiences

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Abstract

Background: Female Genital Cutting (FGC) anchored in a complex socio-cultural context becomes significant at the interface of access of health and social services in host countries. The practice of FGC at times, understood as a form of gender-based violence, may result in unjustifiable consequences among girls and women; yet, these practices are culturally engrained traditions with complex meanings calling for ethically and culturally sensitive health and social service provision. Intents and meanings of FGC practice need to be well understood before any policies that criminalize and condemn are derived and implemented.

FGC is addressed as a global public health issue with complex legal and ethical dimensions which impacts ability to access services, far beyond gender sensitivity. The ethics of terminology are addressed, building on the sustained controversial debate in regards to the delicate issue of conceptualization. An overview of international policies is provided, identifying the current trend of condemnation of FGC practices. Socio-cultural and ethical challenges are discussed in light of selected findings from a community-based research project. The illustrative examples provided focus on Western countries, with a specific emphasis on Canada.

Discussion: The examples provided converge with the literature confirming the utmost necessity to engage with the FGC practicing communities allowing for ethically sensitive strategies, reduction of harm in relation to systems of care, and prevention of the risk of systematic gendered stigmatization. A culturally competent, gender and ethically sensitive approach is argued for to ensure the provision of quality ethical care for migrant families in host countries. We argue that socio-cultural determinants such as ethnicity, migration, sex and gender need to be accounted for as integral to the social construction of FGC.

Summary: Working partnerships between the public health sector and community based organisations with a true involvement of women and men from practicing communities will allow for more sensitive and congruent clinical guidelines. In order to honour the fundamental principles and values of medical ethics, such as compassion, beneficence, non-maleficence, respect, and justice and accountability, socio-cultural interactions at the interface of health and migration will continue to require proper attention. It entails a commitment to recognise the intrinsic value and dignity of girls' and women's context.

Keywords: Female genital cutting, Female genital mutilation, Traditional practices, Migration, Public health, Ethics, Harm reduction, Community engagement, Cultural sensitivity

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'... Once the girl is cut, she is cut off ...'

Peter Kamuron, Human Rights Activist

Background

In recent years, increased international migration from a wide variety of countries has exposed social and public health care professionals in host countries such as Canada to a diversity of issues associated with traditional practices adopted by selected migrant families as they progressively integrate into a new society. When it comes to such traditional practices, providing quality, ethical and safe health care highlights the responsibilities at different levels of the health care system of the host society. The objective of this paper is to examine the ethical and legal complexities raised by traditional practices such as female genital cutting (FGC) in multicultural health and social services practice settings. We argue that socio-cultural determinants such as ethnicity, migration, sex and gender need to be accounted for as integral to the social construction of FGC. The practice of FGC is often understood as a form of gender-based violence that often results in unjustifiable consequences among girls and women; yet, these practices are culturally engrained traditions with complex socio-cultural meanings calling for ethically and culturally sensitive health and social service provision. These meanings are often strongly juxtaposed alongside positive and less positive demonstrating that the intent/meaning of FGC in cultures needs to be well understood before any criminalization and condemnation policies are implemented.

The socio-cultural context must be addressed to ensure the reduction of harm in relation to systems of care, particularly to prevent gendered stigmatization of affected individuals. Social and health care professionals will need to strengthen their practice to reach the right balance in regards to their legal obligations along with their fundamental responsibility to provide equitable and compassionate care to all. Further to a general background on FGC practices, the cultural significance of FGC for practising communities will be illustrated with a case study discussion from the Sexuality Education Resource Centre Manitoba (SERC); these arguments will ground the analysis of the ethical complexity of FGC care and health service.

Ritual alteration of the genitalia of female infants, children, adolescents and adults has been a traditional practice in numerous cultures since antiquity. These practices have been documented in at least 26 countries in and around Sub-Saharan Africa. Practiced since the time of the pharaohs, FGC has been documented in a diversity of community groups from numerous religions, including but not limited to Animists, Catholics, Jews, Muslims, Protestants, and those without religious beliefs [1-3]. Having stated that, it is important to note

that, contrary to popular belief, the primary motivations for these practices are often more anchored in cultural values than dictated by religious precepts.

The type of FGC procedures varies not only across countries, but also within countries, across ethnic groups and within cultural communities [4]. The World Health Organization (WHO) classifies the alteration of the genitalia of female infants, children, adolescents and adults into four types: type one refers to the partial or total removal of the clitoris and, in very rare cases, only the prepuce; type two refers to the partial or total removal of the clitoris and the labia *minora*, with or without excision of the labia *majora*; type three refers to the stitching/narrowing of the vaginal opening through the creation of a covering seal; and finally, type four refers to all other procedures used to alter the female genitalia for non-medical purposes, e.g., pricking, piercing, incising, scraping and cauterizing the genital area [5].

Within many patriarchal societies, the tradition of FGC is intended to ensure control of female sexuality, chastity and the honour of the community. However, FGC practices hold many additional cultural meanings, including but not limited to the preservation of group identity; a rite of passage ensuring social transition from one status level to another; preservation of virginity and family honour; and the furthering of marriage goals, including the enhancement of sexual pleasure for men. Though cultural meanings associated with the practice are diverse, it is clear that FGC practices are often viewed as a social good, essential in the socialisation of girls [1,2,6,7].

Given the evidence of physical harm caused by FGC, selected reactions from practicing communities point to the potential of social exclusion and marginalization of women (among other socio-cultural consequences) that may result when girls or women are not excised or infibulated, potentially bringing greater harm [7-10]. Though the medico-physical consequences of FGC are increasingly documented in international literature, the complex nature of the socio-cultural effects associated with these practices or lack thereof require further discussion, especially when anchored within the intricate trajectory of integration into a new society.

The ethics of terminology

The language used to describe these practices remains controversial and requires careful ethical consideration. The term 'Female Genital Mutilation,' formerly adopted by the United Nations (UN) calls attention to the gravity of the harm caused by FGC practices. 'Female Genital Mutilation (FGM)' is the terminology used within campaigns to end these practices by anti-FGC advocates from practicing countries of origin and the western

world. FGM terminology positions the practice of FGC as an extreme human rights violation. This term is often perceived as inflammatory, judgemental and stigmatising, particularly for women previously exposed to the practice who do not view their bodies, or the bodies of their daughters, as mutilated [3]. The implication within this terminology is that FGC is practiced as an act of intentional violence against female children, adolescents and women. Those who do not understand FGC as such an act, but as a valued cultural tradition, may experience the language of “mutilation” as alienating [7,9-11]. The delicate challenge of reconciling respect for cultural values associated with these practices and addressing their perceived harmful effects on health is evident in this discrepancy between the intent and impact of language.

‘Traditional women’s practices,’ ‘Traditional health practices,’ and ‘Initiation,’ are some of the preferred terms identified by individuals who subscribe to the socio-cultural benefits from these practices. Chalmers & Omer Hashi [10] as well as Vissandjée et al. [7] conducted focus groups with overall 600 women from different practising countries living in Canada which revealed “circumcision” to often be the preferred terminology. Several other authors have also identified “circumcision” as an alternative term, yet this term has been argued to trivialise the procedure, falsely attributing to FGC the legitimacy afforded to male circumcision within the West [12,13]. “Female Genital Cutting (FGC)” and “excision and infibulation” have been identified as more neutral, ethically sensitive terminology [4,6]. For the purpose of this chapter, we will use FGC as a term comprising procedures which alter the female genital organs for cultural or non-therapeutic reasons.

Discussion

Criminalization and condemnation: an overview of international policies

In multi-ethnic societies across the western world, professionals in the field of health and social services are faced with an increasing number of women, men, and families originating from countries where practices such as FGC are common [14-18]. International trends of migration contribute to the growing controversy regarding traditional practices as they meet up with host society’s cross-cultural imperatives in the health care system. As such, health care professionals are required to deal with the ethical complexity of navigating through their own personal identity and culture, most often in opposition with the identity and cultural processes of the women and men migrants they are meant to serve while bound by their legal and professional guidelines [19].

Criminalization and condemnation: an overview of Canadian policies

In 1997, the Canadian Criminal Code was amended through bill C-27 to declare acts of FGC a criminal offence. Those caught performing these acts are subject to prosecution. If health and social service providers believe a female child is at risk of the practice, or has already undergone the practice, they are required to report to relevant statutory bodies under provincial child welfare legislation [4,20]. Canada’s legal position is consistent with the WHO, World Medical Association and the International Federation of Gynaecology and Obstetrics and Society of Obstetricians and Gynaecologists of Canada which have all condemned the practice. FGC practices are becoming increasingly prohibited by law, both in countries where it is traditionally practised and in countries of immigration [8,15,18].

Legal condemnation has had notable socio-cultural consequences in host countries such as Canada. Macklin documented the experience of a Sudanese family in St. Catharines, Ontario who were charged with having the procedure performed on their daughter in Canada, by an unidentified practitioner at the age of 11 [20]. Though the charges were eventually withdrawn by the prosecution due to lack of evidence, the state intervention in this case resulted in the detention of the parents in custody and the apprehension of their two children by child welfare authorities. Macklin notes that police, child welfare authorities, and lawyers acted with cultural insensitivity. It is additionally highlighted that long term emotional and social damage to the complainant, the accused and the family was incalculable.

Under the Canadian Medical Association’s (CMA) Code of Ethics section ‘Responsibilities to Society,’ article 41 states that health professionals “must recognise that community, society and the environment are important actors in the health of individual patients” [19], p. 3. In instances where health care professionals are faced with the legal obligation to notify statutory bodies of the occurrence or risk within the host society of FGC, ethical considerations of article 41 need to be carefully weighed with their legal requirement to report. Furthermore, the CMA Code of Ethics section ‘General Responsibilities’ article 14 states that health professionals must “take all reasonable steps to prevent harm to patients” [19], p. 2. This is where the relative nature of the definition attributed to harm becomes of concern. Selected communities do not necessarily view the practice of FGC (more often, re-infibulation post-delivery) as potentially harmful; rather the lack thereof may lead to psychosocial harm experienced by girls and women at risk of being ostracised by members of their community.

Indeed, many authors converge by highlighting the fact that criminalising practices of FGC may have unintended adverse effects, such as the risk of clandestine practice of FGC within host countries, alternate practices

such as a ritual nick or that parents send their girl child to the home country to undergo these practices in unsafe conditions [6,9,15].

Issues associated with the practices of FGC in the West have notable gray areas, including but not limited to the requests for re-infibulation of the vaginal canal after childbirth or notification of the courts about previously performed practices. Re-infibulation within medical settings has been a common occurrence across the western world, often brought forward as a potential harm-reduction strategy in order to minimise health hazards associated with potentially risky behaviours. Such practice is argued to offer safer and culturally acceptable alternatives that bear the least amount of psychosocial harm [17]. Such clinical requests call for an increased awareness of health care professionals' ethics and responsibilities to give the best care possible while being sensitive to one's life context; such clinical requests may be considered by many to be contrary to professional medical ethics, yet the extent to which re-infibulation constitutes a breach of law remains unclear in many Western countries. It should be noted that legislation condemning FGC may not resolve the ethical difficulty faced by health care professionals even if increasingly anchored as a human rights abuse with the responsibility to "refuse to participate in or support practices that violate human rights" [19], p. 1.

Having stated that, a recent policy statement and guidelines from the SOGC clearly states that requests of re-infibulation must be denied [4]; on the other hand, one needs to remember to trust a medical judgment call whether or not to perform re-infibulation, beyond the ethical and legal controversy surrounding the practice if it is assessed to be for the 'patient's good' and that 'harm' will be prevented [11,14].

Criminalization and condemnation: an international controversy

In Italy, the United States and the Netherlands, proposed policy developed in partnership with selected practising communities has provoked great controversy. In an historic case in Seattle in 1996, physicians at the Harborview Medical Centre suggested a symbolic procedure of pricking the clitoral hood be performed in order to appease traditional Somali families. It was argued that such a procedure would be less invasive than circumcision (as performed on male babies) and would minimise the risk of individuals seeking FGC services illegally within the host country or sending the child abroad to the home country. Though this proposal was approved by a committee of health professionals and medical ethicists it was met with public outcry which prevented it from moving forward.

Equality Now (US based) highlighted that, in 2010, further to their policy statement in reference to paediatricians' 'nicking' of girls genitalia, 'encouraging paediatricians to

perform this practice with the umbrella of 'cultural sensitivity' is simply a shocking lack of understanding of girls' fundamental right to bodily integrity and equality. Equality Now suggested to members of the American Academy of Paediatricians, an awareness-raising discussion in collaboration with practising immigrant communities about these highly sensitive and ethical practices leading to potentially harmful consequences including tampering with a recognised human rights violation against girls and women [21,22].

A similar proposal was put forward in Florence, Italy in 2003 by the Reference Centre for Preventing and Curing FGM of the Department of Gynaecology, Perinatology and Reproduction Physiology. The suggested alternative ritual was a prick of the clitoral hood with a small needle, done under local anaesthesia on children old enough to provide consent. An Italian bioethics committee judged this proposal to be ethical, yet international public protest prevented its adoption [1].

Selected analyses of a human rights framework juxtapose western acceptance of male circumcision and female genital constructive surgery in European and North American countries with clear condemnation of FGC practices among immigrants from practising countries [23]. Very recently, a German court in Cologne ruled against circumcising young boys for religious reasons [24,25]. The Court found that the 'child's fundamental right to bodily integrity' was more important than his parents' fundamental rights to religious freedom. It should be noted that Germany does not carry a law against male circumcision, as opposed to the one against FGC, creating additional uncertainties about procedures related to both sexes. After months of debate, in December 2012, German lawmakers overturned this law granting parents the right to authorize male circumcision by a trained practitioner. Similarly, in the US, non-therapeutic circumcision of male children is part of basic health care; in regards to FGC, a number of US states have adopted laws against FGC [22,26]. In the same vein as the arguments made throughout this paper, Equality Now reinforces the fact that it is critically important for relevant local and community groups to be involved at all levels to address this sensitive issue within the diversity of relevant communities. Culturally sensitive awareness-raising, education and outreach programs need to be strengthened in order to protect a new generation of american girls. To be effective, approaches addressing FGC need to be holistic and include education and outreach components as well as measures for legal protection and accountability [22].

While getting better informed and trained about the consequences of these practices and the premises underlying them, health care professionals need to reflect upon the intricate ethical complexity of the contribution of determinants such as ethnicity, migration, sex and

gender in the social construction of FGC practices among migrants in western countries where there is, in parallel, a rise in female genital reconstruction surgeries. Just as Johnsdotter & Essén [27] stated: “... *procedures involving genital modifications are intertwined with political considerations. They are never purely about anatomy and physiology but are intrinsically entangled with cultural norms, identity and ideology. The pricking of the clitoral hood among women from countries of Africa is condemned, while reduction of clitoral tissue among women across countries of Europe is legal and accepted ...*” [27], p. 35.

In 2011 in Indonesia, though FGC was banned in 2006, guidelines to physicians on how to perform FGC were issued by the Indonesian Ministry of Health. Public statements of strong concern followed this release by a number of medical experts and rights groups who argued that release of the guidelines was responsible for an increase of FGC practice in medical settings. Of concern was also the issue that guidelines could well be misinterpreted as an endorsement of the procedure, combined with an enticement for doctors to encourage the practice [28].

At the interface of care: culturally and ethically sensitive quality of care for all

The fear of stigmatisation within the host society cultural norms in regards to the integrity and rights of girls’ and women’s bodies as well as the overt perceptions that FGC is a deviant practice that requires criminalisation has been documented as inadvertently limit women and men from accessing needed quality health services [7-9]. In addition, intercultural communication difficulties stemming from linguistic and other cultural barriers have been identified as key deterrents for many immigrant women and men in accessing health services [29-32]. Establishing proper and quality communication as the basis of an ethical clinical situation has been highlighted in ample empirical evidence as well as selected codes of ethics for health care professionals such as nurses and physicians in the context of linguistic barriers [33].

A number of women emigrating from practising countries may have already undergone FGC upon arrival [34]. At some point, many of these women will be required to use the social and health care system, particularly during pregnancy and childbirth. While studies have demonstrated the immediate harmful health effects of FGC practices, in terms of uncontrolled bleeding and infection, selected long-term effects are not well understood and may vary. Some of the outcomes include vaginal infections, difficult second stage delivery, as well as ill-sustained menstrual and sexual pain. Ill-health outcomes may affect not only those new to Canada but also those who have been in Canada for a long time but are slowly getting to know the health care system due to lack of knowledge in regards to access and general discomfort with health care providers [7,35].

It has also been documented that women having experienced these traditional practices tend to not avail themselves of other services such as sexual health clinics or pain management, not recognising that the pain may not be a “normal” condition, whether it be provoked during sexual activities or a chronic sensation. When Einstein [36] asked women about pain during any of their daily experiences, they considered them negligible - just what is ‘normal’ and what every woman has. However, when women were actually tested for pain in the vulvar region, Einstein found that all of her participants had at least one area of the vulva in which the pressure-pain threshold was lower than that for Canadian women with vulvar vestibulitis, a chronic vulvar pain condition. Einstein concludes by suggesting that her participants had chronic pain but to them it was just part of normal life [36].

European and North American studies of health care professionals’ knowledge, perception and management of birth for women who have experienced FGC have found significant gaps in knowledge and clinical practice related to the delicate and complex nature of care required [17,33,37,38]. Unfamiliarity, subtle discomfort and lack of guidelines or uptake of the latter may induce serious mismanagement of infibulation during delivery associated with the risk of psychological harm [37]. In addition, unnecessary caesarean sections have been reported among women from practicing countries due to the lack of familiarity and overall discomfort of Canadian health care professionals with the practice of infibulation [7,10]. Similar findings have been noted in Germany and other Western European countries [11]. Chalmers & Omer Hashi [10] have reported that 87.5% of the 432 Somali women interviewed in Ontario birth experiences in Canada have disclosed unpleasant and hurtful comments made by caregivers during delivery. The women interviewed reported verbal expressions of negative shock and a sense of disgust by selected caregivers, perceived to a certain extent as a lack of respect and privacy, especially when in some instances, colleagues are called upon to ‘take a look’ without prior request or permission [10].

Under the section ‘Initiating and Dissolving a Patient-Physician Relationship’ of the CMA Code of Ethics [19], article 17 states that health professionals are ethically bound not to discriminate: ‘... *in providing medical service, do not discriminate against any patient on such grounds as age, gender, marital status, medical condition, national or ethnic origin, physical or mental disability, political affiliation, race, religion, sexual orientation, or socioeconomic status...*’ However subtle, the sense of perceived disrespect towards a girl or a woman on grounds of her having experienced FGC, is a violation of article 17.

In order to softly navigate through delicate subjects such as FGC at the interface of sex, gender and migration experiences while seeking care in host countries such as Canada,

it is necessary to strengthen competence, congruency and compassion, along with the uptake of sensitive guidelines in partnership between medical and community organisations. The Sexuality Education Resource Centre (SERC), based in Winnipeg Manitoba, is among selected organisations in Canada that aims to provide sensitive and culturally competent care to girls, women and families when needed. A case study illustrating the interactions between SERC and women they attend to will allow the reader to anchor the discussion provided above as SERC strives to give voice to those living experiences associated with FGC practices. The aim of this section is to enhance the importance of a deeply sensitive and reflexive practice with an illustration of the complexity of socio-cultural issues raised via a dialogic process between a diversity of women and men and members of a community organization.

Our Selves, Our Daughters: an illustration

Despite the fact that immigration is a notable reality in places like Toronto, Vancouver and Montreal, Winnipeg is increasingly receiving its fair share of immigrants. In Manitoba, immigration has increased exponentially in the past decade due to highly successful provincial programs and policies, most notably the Provincial Nominee Program along with the long standing commitment to assist in the relocation of refugees in Canada. Over the years, a number of families from select countries in Africa have sought refuge in Manitoba [39]. In the past decade, at least seven out of the top ten source countries of refugees have been African countries, namely Ethiopia, Sudan, Eritrea, Somalia, Egypt and Sierra Leone, where prevalence levels of FGC range from 74.3% to 97.9% [40].

SERC with centres in Winnipeg and Brandon has been attending to the needs of immigrants and refugees, primarily newcomers, for 25 years. SERC's main mission is to promote sexual health through education. Central to SERC's work in education and prevention is an analysis of sexuality in its broadest sense that takes into account the intersections of sexuality and culture, values, gender, identity and migration. Since 2009, SERC has been working closely with specific migrant communities in Winnipeg to tackle this complex, rich and deeply culturally entrenched tradition. SERC seeks to work closely with women and their families, community members as well as service providers in order to reduce any risks associated with the practice of FGC as the families integrate into a new society with its specific cultural and at times contrasting values in regards to FGC. Addressing such a controversial issue has required a process-oriented, iterative approach to build community trust and successful partnerships, prerequisites for successful engagement on this sensitive and potentially stigmatizing issue.

Additional context is provided by the fact that SERC subscribes to harm reduction, health promotion and illness prevention when it comes to sexual and reproductive

issues. The following definition of harm reduction has been adopted by SERC as it applies to a range of sexual and reproductive health issues including FGC: a set of strategies and tactics that encourages people to reduce harm to themselves and their communities, through the sharing of relevant information, facts and practical material tools that will allow them to make informed and educated decisions. It recognises the competency of their efforts to protect themselves, their loved ones and their communities [41].

Applying these approaches to this community-based project meant first learning more about the practice through a community lens and through that process engaging community. To this end, the "Our Selves, Our Daughters" project began with a community-based research process. Community members were hired to conduct different phases of the research. Community views were elicited through gender-segregated focus groups (7 with 48 women, 1 with 9 young men, 1 with 7 young women, 2 with 19 men) and individual interviews with eight community members in leadership positions (5 men and 3 women), and professed religious leaders (6 men and 1 woman). Core members of the team conducted thematic analysis of the data, which were presented to participants invited to a feedback session. Further analysis was conducted with their feedback to refine our themes.

Addressing this taboo and culturally sensitive issue has enabled SERC to uncover assumptions and help readjust the world-views of those coming from non-FGC practicing communities, steeped in Western feminist thought. While delivering service provider training, SERC facilitators tended to wrongly assume that women affected by FGC were knowledgeable of harms associated with the practice. Discourses are discordant.

"-It can cause problems to the health of the woman. The sexual desire also can be reduced. Even it can also affect the fertility. She can become infertile.

- I didn't get your point. Do you mean if some organs are injured as a consequence of female circumcision?

- No, I think she can't become infertile because of circumcision. The fertility part of the woman's body is not on the place where circumcision is done.

- She may experience problems during labour.

-Maybe.

- I don't think it brings problems to labour. Labour is a natural process. So this labour problem happens naturally. There is no link between circumcision and labour. It might have other problems.

- [Circumcision] is normal in [my country], Does it have side effects?

- I remember there was something they say 'fistula,' fistula for urine and fistula for stool. That is because of circumcision.

- What is fistula?" [42], p. 21.

Converging with previous studies, a large number of women did not realize that the long-term health impacts that some were experiencing may have been linked to FGC, such as recurrent UTIs, painful menstruation/blood retention, constantly sensitive perineum, and complications during childbirth. It was accepted that if a woman experienced pain and illness, they were as likely to be caused by a curse or evil spirits. Many women attending SERC's workshops shared their belief in the role of supernatural forces regulating cause and effect in many aspects of their lives.

Given that many participants were misinformed about the practices themselves, about rights and access to quality health care in Canada as well as about interpretation services, SERC facilitators built specific training material for women and men including the function and configuration of women's internal organs, maturation of the body through menstruation, conception, pregnancy, childbirth and menopause. Women's reactions were varied, upon receipt of this new information. The strongest reaction was illustrated by women expressing regrets, stating that if they had known then what they were learning now, they would have made different decisions about their bodies. Other women were exposed many times to anti - FGC campaigns and to changing laws in their country of origin or during migration; they knew; but, they could not act much in this regard. For other women, FGC practices were not viewed as harmful practices; they were perceived to be simply a necessary step to ensure personal, social, legal and economic standing for a woman in her community and society at large:

-“A mother was doing FGC because she loves her child and wants to protect her child. We are not ashamed of our culture, we are proud” [43], p. 27.

-“Acknowledge that she loves her children. Don't victimise women” [42], p. 28.

-“Here the culture is different from back home. At home – if a child is not circumcised there is stigma. There is less chance that she will get married. When men sees she is not circumcised she will have an unpeaceful life” [43], p. 28.

-“The reason for female circumcision is to make her polite, to prevent her from becoming hyper, to prevent her from looking [for] extramarital sex, to prevent her from misbehaving” [42], p. 11.

-“I know they were doing it to protect their daughters; they had a strong belief that their daughter won't be raped easily” [42], p. 29.

Many women and men shared these viewpoints. As one religious leader shared on the issue of change:

-“We have to weigh...Who we listen to? The oral culture that has been passed down from our elders for thousands of years ... or this more recent information?” [44], p. 28.

Understanding 'harm' related to FGC may seem self-evident to a Western audience. In most FGC practicing communities, 'harm' is deeply anchored in cultural norms described by many women, particularly elders, that a woman's life is inextricably linked to suffering. In societies where childbirth and practices such as FGC occur without anaesthetics, enduring pain and suffering is expected. Women were described as the “root” or “heart” of the family and community by male participants in group discussions at SERC. As such, women are expected to put the needs of others before their own in addition to downplaying pain:

-“Even if we are hurt, as a woman we don't open our mouth and say it” [42], p. 12.

-“I heard many divorce are resulted because of sexual issues. In our country if you ask a woman what was the cause of the divorce she says [word in own language], ‘...I don't want to keep living there...’She doesn't open her mouth and say. When we don't talk, the trauma may not be expressed” [42], p. 12.

Such perceptions represent a fair challenge for organisations like SERC to create and maintain a space in which women can safely disclose experiences both positive and adverse without breaching this valued silence seen by some cultures as intrinsic to a women's identity.

Summary

Ethically sensitive approach: reframing the concept of 'harm'

Few topics elicit such a strong, visceral reaction among women and men from non-practicing countries, as do FGC practices. The fact that many women are the keepers of this tradition, that the practice is so widespread among some groups, given the sub-optimal conditions under

which the practice occurs, and the fact that it mostly affects girls creates challenges for health care and community-based providers to give ethically, gender sensitive, non-judgmental care; this is key to the success of SERC's community-based work as change is progressively and carefully promoted. The issues raised above are key 'ingredients' in the training sessions that SERC is engaged in with a diversity of providers along with women themselves, while core information about FGC, diverse cultural meanings and social constructions are shared.

In order to be non-judgmental and ethical, to avoid further marginalization of newcomer women, SERC's providers had to reflect upon their own feelings and reactions as well as beliefs and values, recognise them and suspend judgement. The presence of an in-community facilitator was essential in these teachings, as she modelled how to reflect the normalcy of FGC in practicing cultures. In addition to this most valued presence, the briefings that were held allowed providers to move away from error-inducing dichotomies such as 'freedom' vs. 'oppression', and 'them' vs. 'us' as well as 'sensitive' vs. 'insensitive' towards quality of service and care for everyone within an environment that would be as bias free as possible [45]. As providers become progressively aware of the continuum of beliefs and thoughts about the traditional practices, group discussions about a possible shift in these thoughts are held as information is shared with a diversity of women and men.

Similarly, a partnership in Switzerland, between community providers, professional actresses and amateur actors with a migration background have devised a play in English, French and Somali to increase public awareness, without accusing or judging, thereby building trust for the rounds of discussions that follow the performance [46].

In its mission to establish trust and freedom of conduct while sharing information and training women and providers, one of the challenges SERC faced was to carefully manage potential backlashes within and between members of community groups. SERC has begun to integrate issues associated with sexuality in general while increasing the time allocated to the training in order to allow for sharing and building constructively on potential emotional reactions. As discussed above, the involvement of statutory agencies such as child protection services and the police during selected training sessions have been perceived as an added value anchored in the principles of ethical collaborative strategies. Several initiatives are underway in Winnipeg to build a proper understanding of the role these agencies play in prevention, protection and support as newcomers are simultaneously encouraged to express their views about these institutions. Of interest, no such institutions have yet participated in SERCs' group discussions so as to not affect the trusting relationships.

Working partnerships between the public health sector and community based organisations with a true

involvement of women and men from practicing communities will allow for more sensitive and congruent clinical guidelines. In order to honour the fundamental principles and values of Canadian medical ethics, such as compassion, beneficence, non-maleficence, respect, and justice and accountability, the complex nature of socio-cultural interactions at the interface of health and migration will continue to require proper attention.

One of the most telling prescriptions from the Canadian Medical Association (CMA) Code of Ethics, article 12, states: "to practice the profession of medicine in a manner that treats the patient with dignity and as a person worthy of respect" [19], p. 1. It entails a commitment to recognise the intrinsic value and dignity of women's context. It has been argued earlier that selected, at times unintended, reactions from health care professionals may lead to perceptions of stigmatization by some women from practicing communities.

As a final note, it is therefore not superfluous to reiterate the importance of the obligation of health care professionals to provide compassionate and ethical care, especially when clinical situations are complex involving personal, community and legal consequences of a single clinical decision.

' ... It is unacceptable that the international community remains passive in the name of a distorted vision of multiculturalism. Human behaviour and cultural values, however senseless or destructive they may appear from the personal and cultural standpoints of others, have meaning and fulfil a function for those who practice them. However, culture is not static but is in constant flux, adapting and reforming. People will change their behaviour when they understand the hazards and indignity of harmful practices and when they realize that it is possible to give up harmful practices without giving up meaningful aspects of their culture...'

Joint Statement (August 2007)

UNFPA, UNICEF and WHO at the Global Technical Consultation in Addis Ababa, Ethiopia

' ... Culture is a matrix of infinite possibilities and choices. From within the same culture matrix we can extract arguments and strategies for the degradation and ennoblement of our species, for its enslavement or liberation, for the suppression of its productive potential or its enhancement...'

Wole Soyinka, Nigerian Nobel Laureate

Abbreviations

CMA: Canadian Medical Association; FGC: Female genital cutting; FGM: Female genital mutilation; SERC: Sexual Education Resource Centre Manitoba; UNICEF: The United Nations Children's Fund; SOGC: Society of Obstetricians and Gynaecologists of Canada; UNFPA: The United Nations Population Fund (UNFPA), formerly the United Nations Fund for Population Activities; WHO: World Health Organization.

Competing interests

The authors declare that they have no competing interests.

Authors' contributions

The four authors participated equally in the development of the outline for this paper. BV and JP (under BV's supervision) held primary responsibility in the gathering of all relevant literature in the actual writing of the 'background' and 'discussion' sections of the paper; SD and PM held primary responsibility for carrying out and describing the case study, including gathering and inclusion of relevant literature. All authors read and approved the final manuscript.

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Female Genital Cutting

This clinical practice guideline has been prepared by the Social Sexual Issues Committee and the Ethics Committee, and reviewed by the Clinical Practice Gynaecology Committee, the Canadian Paediatric and Adolescent Gynaecology and Obstetricians Committee, and the Family Physicians Advisory Committee, and approved by the Executive and Council of the Society of Obstetricians and Gynaecologists of Canada.

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Abstract

Objective: To strengthen the national framework for care of adolescents and women affected by female genital cutting (FGC) in Canada by providing health care professionals with: (1) information intended to strengthen their knowledge and understanding of the practice; (2) directions with regard to the legal issues related to the practice; (3) clinical guidelines for the management of obstetric and gynaecological care, including FGC related complications; and (4) guidance on the provision of culturally competent care to adolescents and women with FGC.

Evidence: Published literature was retrieved through searches of PubMed, CINAHL, and The Cochrane Library in September 2010 using appropriate controlled vocabulary (e.g., Circumcision, Female) and keywords (e.g., female genital mutilation, clitoridectomy, infibulation). We also searched Social Science Abstracts, Sociological Abstracts, Gender Studies Database, and ProQuest Dissertations and Theses in 2010 and 2011. There were no date or language restrictions. Searches were updated on a regular basis and incorporated in the guideline to December 2011. Grey (unpublished) literature was identified through searching the websites of health technology assessment and health technology-related agencies, clinical practice guideline collections, clinical trial registries, and national and international medical specialty societies.

Values: The quality of evidence in this document was rated using the criteria described in the Report of the Canadian Task Force on Preventive Health Care (Table 1).

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This document reflects emerging clinical and scientific advances on the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed. Local institutions can dictate amendments to these opinions. They should be well documented if modified at the local level. None of these contents may be reproduced in any form without prior written permission of the SOGC.

Table 1. Key to evidence statements and grading of recommendations, using the ranking of the Canadian Task Force on Preventive Health Care

Quality of evidence assessment*	Classification of recommendations†
I: Evidence obtained from at least one properly randomized controlled trial	A. There is good evidence to recommend the clinical preventive action
II-1: Evidence from well-designed controlled trials without randomization	B. There is fair evidence to recommend the clinical preventive action
II-2: Evidence from well-designed cohort (prospective or retrospective) or case-control studies, preferably from more than one centre or research group	C. The existing evidence is conflicting and does not allow to make a recommendation for or against use of the clinical preventive action; however, other factors may influence decision-making
II-3: Evidence obtained from comparisons between times or places with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of treatment with penicillin in the 1940s) could also be included in this category	D. There is fair evidence to recommend against the clinical preventive action
III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees	E. There is good evidence to recommend against the clinical preventive action
	L. There is insufficient evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision-making

*The quality of evidence reported in these guidelines has been adapted from The Evaluation of Evidence criteria described in the Canadian Task Force on Preventive Health Care.⁵⁹

†Recommendations included in these guidelines have been adapted from the Classification of Recommendations criteria described in the Canadian Task Force on Preventive Health Care.⁵⁹

Summary Statements

1. Female genital cutting is internationally recognized as a harmful practice and a violation of girls' and women's rights to life, physical integrity, and health. (II-3)
2. The immediate and long-term health risks and complications of female genital cutting can be serious and life threatening. (II-3)
3. Female genital cutting continues to be practised in many countries, particularly in sub-Saharan Africa, Egypt, and Sudan. (II-3)
4. Global migration patterns have brought female genital cutting to Europe, Australia, New Zealand, and North America, including Canada. (II-3)
5. Performing or assisting in female genital cutting is a criminal offense in Canada. (III)
6. Reporting to appropriate child welfare protection services is mandatory when a child has recently been subjected to female genital cutting or is at risk of being subjected to the procedure. (III)
7. There is concern that female genital cutting continues to be perpetuated in receiving countries, mainly through the act of re-infibulation. (III)

8. There is a perception that the care of women with female genital cutting is not optimal in receiving countries. (III)
9. Female genital cutting is not considered an indication for Caesarean section. (III)

Recommendations

1. Health care professionals must be careful not to stigmatize women who have undergone female genital cutting. (III-A)
2. Requests for re-infibulation should be declined. (III-B)
3. Health care professionals should strengthen their understanding and knowledge of female genital cutting and develop greater skills for the management of its complications and the provision of culturally competent care to adolescents and women who have undergone genital cutting. (III-A)
4. Health care professionals should use their knowledge and influence to educate and counsel families against having female genital cutting performed on their daughters and other family members. (III-A)
5. Health care professionals should advocate for the availability of and access to appropriate support and counselling services. (III-A)
6. Health care professionals should lend their voices to community-based initiatives seeking to promote the elimination of female genital cutting. (III-A)
7. Health care professionals should use interactions with patients as opportunities to educate women and their families about female genital cutting and other aspects of women's health and reproductive rights. (III-A)
8. Research into female genital cutting should be undertaken to explore women's perceptions and experiences of accessing sexual and reproductive health care in Canada. (III-A) The perspectives, knowledge, and clinical practice of health care professionals with respect to female genital cutting should also be studied. (III-A).
9. Information and guidance on female genital cutting should be integrated into the curricula for nursing students, medical

ABBREVIATIONS

BMA	British Medical Association
FGC	female genital cutting
FGM	female genital mutilation
FIWG	Federal Interdepartmental Working Group (on Female Genital Mutilation)
HIV	human immunodeficiency virus
IUD	intrauterine device
SERC	Sexuality Education Resource Centre (Manitoba)

students, residents, midwifery students, and students of other health care professions. (III-A)

10. Key practices in providing optimal care to women with female genital cutting include:
 - a. determining how the woman refers to the practice of female genital cutting and using this terminology throughout care; (III-C)
 - b. determining the female genital cutting status of the woman and clearly documenting this information in her medical file; (III-C)
 - c. ensuring the availability of a well-trained, trusted, and neutral interpreter who can ensure confidentiality and who will not exert undue influence on the patient–physician interaction when providing care to a woman who faces language challenges; (III-C)
 - d. ensuring the proper documentation of the woman's medical history in her file to minimize the need for repeated medical histories and/or examinations and to facilitate the sharing of information; (III-C)
 - e. providing the woman with appropriate and well-timed information, including information about her reproductive system and her sexual and reproductive health; (III-C)
 - f. ensuring the woman's privacy and confidentiality by limiting attendants in the room to those who are part of the health care team; (III-C)
 - g. providing woman-centred care focused on ensuring that the woman's views and wishes are solicited and respected, including a discussion of why some requests cannot be granted for legal or ethical reasons; (III-C)
 - h. helping the woman to understand and navigate the health system, including access to preventative care practices; (III-C)
 - i. using prenatal visits to prepare the woman and her family for delivery; (III-C)
 - j. when referring, ensuring that the services and/or practitioners who will be receiving the referral can provide culturally competent and sensitive care, paying special attention to concerns related to confidentiality and privacy. (III-C)

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INTRODUCTION

There is no international consensus on what to call the practice of physically altering girls' and women's genitals. The current most commonly used terms in the literature are "female circumcision," "female genital mutilation," and "female genital cutting." Although "female circumcision" is used in many communities where FGC is prevalent, it is problematic because it tends to equate the practice with male circumcision. "Female genital mutilation," formally adopted and used in advocacy documents by the UN and WHO, calls attention to the gravity and harm of the act, but some consider the term judgemental and stigmatizing, especially

of the communities that practice FGC. In French, FGC is often referred to as "excision"—a general term covering all types of the practice. The term "female genital cutting" was chosen for this document because it is considered medically correct, neutral, and culturally sensitive. When reference material or direct quotations from other authors are used, their original terminology is retained.

Definition of Female Genital Cutting

WHO defines female genital mutilation as "all procedures involving partial or total removal of the external female genitalia or injury to the female genital organs for non-medical reasons."¹ Genital tattooing, piercing, hair removal, and labiaplasty could technically be included in the WHO definition of Type IV FGM, but for the purpose of this document, we define FGC as WHO Types I, II, and III.

Glossary

Cultural competence: "A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables the system or professionals to work effectively in cross-cultural situations."²

Defibulation: Incision of the vulva to open the vagina of a woman who has undergone infibulation.

Infibulation: Excision of part of the external genitalia and stitching of the vulvovaginal opening to partially cover the vaginal opening.

Medicalization: The "situations in which FGM is practiced by any category of trained healthcare provider, whether in a public or a private clinic, at home or elsewhere. It also includes the surgical procedure of re-infibulation at any time in a woman's life." (WHO, 2010).³

Re-infibulation: The re-suturing of the vulvar opening that has been opened with defibulation.

Classification

WHO classifies FGM procedures into 4 types (Table 2).¹ The types of procedure vary considerably across countries, within countries, and between ethnic groups. It is estimated that most women with FGC are subjected to clitorrectomy (Type I), excision (Type II), or "nicking," in which no flesh is removed (Type IV).¹ Approximately 10% of women are subjected to infibulation (Type III), the most severe form of the procedure, practiced in Djibouti, Eritrea, Ethiopia, Somalia, and Sudan.⁴

WHO recognizes that the definition of Type IV raises a number of unresolved issues because some of the

Table 2. WHO modified typology, 2007

Type I	Partial or total removal of the clitoris and/or the prepuce (clitoridectomy). When it is important to distinguish between the major variations of Type 1 mutilation, the following subdivisions are proposed: Type Ia , removal of the clitoral hood or prepuce only; Type Ib , removal of the clitoris with the prepuce.
Type II	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision). When it is important to distinguish between the major variations of Type II that have been documented, the following subdivision are proposed: Type IIa , removal of the labia minora only; Type IIb , partial or total removal of the clitoris and labia minora; Type IIc , partial or total removal of the clitoris, the labia minora, and the labia majora.
Type III	Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulations). When it is important to distinguish between variations in infibulations, the following subdivisions are proposed: Type IIIa , removal and apposition of the labia minora; Type IIIb , removal and apposition of the labia majora.
Type IV	Unclassified: all other harmful procedures to the female genitalia for non-medical purposes (e.g., pricking, piercing, incising, scraping, and cauterization).

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practices listed are legally accepted and not generally considered FGM in many countries (e.g., genital cosmetic surgery, hymen repair, piercing). WHO recommends that in determining whether genital practices should be categorized as FGM, human rights principles should be applied, including the right of health, the rights of children, and the right to non-discrimination on the basis of sex.¹

Prevalence in Canada

Although the magnitude of the practice of FGC in Canada remains unknown, literature from as early as the 1990s confirms that FGC has been found among certain immigrant communities.^{5–11} Table 3 brings together two sets of data:

1. a list of countries in which FGC of Types I, II, III, and IV has been documented as a traditional practice,¹ and
2. Canadian immigration data related to the number of permanent and temporary residents received in Canada from 2005 to 2009 from countries in which FGC has been documented.¹²

Although the Canadian immigration data should be considered with caution, it provides insight into the continual arrival in Canada of newcomers from countries where the practice is prevalent, including adolescents and women who may have undergone FGC and girls who may be at risk.

While there is no evidence that any type of FGC is practiced in Canada, there is concern that girls from practising communities may still be at risk. In their exploratory study of the perceptions of Somali women of their earlier experience of FGC, Chalmers and Omer-Hashi¹³ found that only one third of respondents supported the Canadian law prohibiting the practice, while two thirds reported ambivalent feelings. Furthermore, when asked “whether or not they would (hypothetically) wish to have [their daughters] circumcised,” almost half said they would. In their study exploring FGC as it relates to gender identity and the acculturation process in Canada, Vissandjée et al. were unable to determine whether these practices had been abandoned by new arrivals to Canada; their findings suggested that “the need to maintain a status equal to that of the country of origin potentially increased the risk of the practices being performed [on girls].”¹¹ Finally, SERC Manitoba, in their work with immigrants affected by FGC, reported that women were split in their opinions of the issue; although some women strongly supported discontinuation of the practice, others either supported it or remained conflicted about what should be done about it.¹⁴ These findings are supported by a number of European studies that show the practice is not necessarily abandoned with migration and that girl children remain at risk.^{15–17}

Summary Statement

1. Female genital cutting is internationally recognized as a harmful practice and a violation of girls’ and women’s rights to life, physical integrity, and health. (II-3)

Table 3. Countries in which female genital mutilation of Types I, II, III, and IV has been documented as a traditional practice, and number of permanent and temporary residents (both sexes) received in Canada from those countries in the years 2005 to 2009

Country	Year*	Estimated prevalence of FGM in girls and women 15 to 49 years %	Residents received in Canada (2005 to 2009) ¹²
Benin	2001	16.8	815
Burkina Faso	2005	72.5	632
Cameroon	2004	1.4	3790
Central African	2005	25.7	88
Chad	2004	44.9	481
Cote d'Ivoire	2005	41.7	2766
Djibouti	2006	93.1	313
Egypt	2005	95.8	10 482
Eritrea	2002	88.7	2391
Ethiopia	2005	74.3	7126
Gambia	2005	78.3	178
Ghana	2005	3.8	4071
Guinea	2005	95.6	1643
Guinea-Bissau	2005	44.5	N/A
Kenya	2003	32.2	3389
Liberia†		45.0	424
Mali	2001	91.6	629
Mauritania	2001	71.3	272
Niger	2006	2.2	298
Nigeria	2003	19.0	11 259
Senegal	2005	28.2	1878
Sierra Leone	2005	94.0	406
Somalia	2005	97.9	4596
Sudan, Northern (approx. 80% of total population in survey)	2000	90.0	3752
Togo	2005	5.8	701
Tanzania	2004	14.6	1115
Uganda	2006	0.6	1113
Yemen	1997	22.6	888

*Year of national data reports from which the data were derived.

†Estimate derived from a variety of local and sub-national studies.

Columns 1, 2, and 3 reproduced with permission of the World Health Organization. (WHO. Eliminating female genital mutilation: an interagency statement. Geneva: WHO; 2008: p 29).

Table 4. Recognized complications and risks of female genital cutting¹

Immediate risks of Types I, II, and III	Long-term risks of Types I, II, and III	Additional risks associated with Type III
Pain due to the cutting of the nerves and sensitive genital tissues	Chronic pain due to trapped or unprotected nerves	Surgery to enable penetration during sexual intercourse and for childbirth, and sometimes re-infibulation
Shock caused by pain and/or hemorrhage	Epithelial inclusion cysts	Inability to have intercourse
Excessive bleeding	Infections (i.e. abscesses and genital ulcers; chronic pelvic infections; urinary tract infections)	Infertility
Difficulty in passing urine/ passing feces	Keloid formation	Dysmenorrhea due to outflow obstruction
Infections	Sexually transmitted infections, especially genital herpes	Endometriosis
Increased risk of blood borne viral infections including hepatitis and HIV due to the use of unsterilized and shared instruments	Increased risk of blood-borne viral infections including hepatitis and HIV due to genital trauma during intercourse (especially for Type III)	Difficulty voiding
Death	Sexual dysfunction (i.e. decreased sexual pleasure, pain during sex)	Difficulty using tampons, diaphragms, pessaries, etc.
Psychological consequences	Vulvar or vaginal lacerations with intercourse or childbirth	Difficulty with speculum examinations
Unintended labial fusion	Increased Caesarean section rates, obstructed labour	Difficulty accessing Pap smear screening and other gynaecological procedures requiring vaginal access (cervical cultures, endometrial biopsy, IUD placement, etc.)
Re-infibulation due to unsuccessful healing	Psychological consequences (i.e. fear of sexual intercourse, post traumatic stress disorder, anxiety, depression and memory loss)	

Immediate and Long-term Complications

FGC is usually performed on girls between the ages of 5 and 12, although infants and adult women are sometimes subjected to the procedure. Typically, the child is forcibly held while the excision is done using a razor blade, piece of broken glass, or knife. Infibulation may involve stitching or pinning the labia. The girl's legs are usually bound together to promote closure of the cut edges of the incision(s). Anaesthetic is not typically used, and the struggles of the child may aggravate the genital trauma. It should be noted that many women do not experience any long-term complications from the procedure.

The immediate health risks and consequences of FGC can, however, be serious and life-threatening to girls and women. Complications vary according to the type of procedure conducted and the conditions under which FGC is performed (e.g., hygienic conditions, instruments used, experience of the practitioner).^{1,18} Table 4 provides a synopsis of the immediate and long-term health complications of FGC/FGM from types I, II, and III as compiled by WHO.¹ Health care professionals in receiving countries tend to address the long-term complications of FGC, especially those related to Types II and III.¹⁸

Impact on Women and Adolescents Living in Receiving Countries

While the health and psychological effects of FGC have been documented in sub-Saharan Africa, research on the impact of the practice on women's well-being and health outcomes in countries of migration is limited. Berggren et al.¹⁹ found that women who had undergone FGC and were now living in Sweden "expressed a double shame at being different": shame in their countries of origin if they had not undergone the procedure, but also shame in Sweden if they had been subjected to it. These feelings of shame contributed to their increased sense of vulnerability in their encounters with Swedish maternity care and to their further negative experiences in accessing care. In a study exploring the birthing experiences of Somali women in Ontario, Chalmers and Omer-Hashi reported a Caesarean section rate of over 50%.¹³ Vangen et al., in reviewing the Norwegian Medical Registry data, found the frequency of emergency Caesarean section among ethnic Somalis (15%) was triple that of ethnic Norwegians.²⁰ Other perinatal complications in immigrant Somali women in Norway included induction of labour, fetal distress, secondary arrest, prolonged second stage of labour, and perinatal death. Although both authors recognized difficulties in ascertaining whether the adverse birth outcomes were

caused by FGC or other factors, their findings suggested that Somali women represented a higher risk group in obstetrics.²⁰ Finally, Bragg,²¹ in reviewing the results of the 2003–2005 UK Confidential Enquiry into Maternal and Children Health noted that maternal mortality was 6 times higher in black African women than in white women in the United Kingdom. Among the new factors documented as potential contributing causes were unsatisfactory arrangements for interpretation and lack of health care provider awareness of FGC.

Little is known of how FGC affects the psychological well-being of girls and adolescents.^{22,23} Anecdotal evidence suggests that the girls and/or adolescents' concerns about the practice "are very much intertwined with other concerns common to all adolescents regarding sexuality, body image, attractiveness, identity, belonging and conforming with peers."²²

Traditional and Cultural Beliefs, Values, and Attitudes Upholding the Practice

The practice continues to be perpetuated due to an array of complex social, religious, and cultural reasons intrinsically linked to traditional beliefs, values, and attitudes related to women's sexuality and the perceived need to control their sexual and reproductive capacity.²⁴ Parents submit their daughters to FGC not as means of punishment or abuse, but as a way to protect them and give them "the best possible chance to have a future that will ensure [their] social acceptance and economic security."²⁵ FGC is performed in order to prepare girls for adulthood and marriage, to ensure their virginity until marriage, to ensure their fidelity in marriage, to make them clean, beautiful, and pure, and to maintain the family's honour. In certain communities, it is seen as a rite of passage or an initiation into a secret women's society; in others it is thought to increase fertility and to enhance the sexual pleasure of men.

FGC is often performed by "older women who carry on the tradition and make sure girls in their family undergo the practice."¹⁵ Men play a role by remaining passive and not intervening in matters related to the practice, by preferring to marry a woman who has undergone FGC, or by insisting that it is performed on their daughters.^{11,15,26}

Summary Statements

2. The immediate and long-term health risks and complications of female genital cutting can be serious and life threatening. (II-3)
3. Female genital cutting continues to be practised in many countries, particularly in sub-Saharan Africa, Egypt, and Sudan. (II-3)

4. Global migration patterns have brought female genital cutting to Europe, Australia, New Zealand, and North America, including Canada. (II-3)

Recommendations

1. Health care professionals must be careful not to stigmatize women who have undergone female genital cutting. (III-A)
2. Requests for re-infibulation should be declined. (III-B)
3. Health care professionals should strengthen their understanding and knowledge of female genital cutting and develop greater skills for the management of its complications and the provision of culturally competent care to adolescents and women who have undergone genital cutting. (III-A)

Legal Issues Related to FGC in Canada

FGC is illegal in Canada and anyone who performs or assists with the practice can be criminally charged and convicted. The Criminal Code also makes it a crime for parents or family members to take a girl out of Canada for the purpose of having FGC/FGM performed elsewhere. Appendix 1 provides the main sections of the Canadian Criminal Code that state that anyone who "wounds" or "maims" a female person by excision, infibulation, or mutilation of the labia or clitoris is committing aggravated assault. Exceptions are made for surgery conducted for legitimate medical reasons.

Although not explicitly mentioned in any Canadian provincial child welfare legislation, the Federal Interdepartmental Working Group on Female Genital Mutilation considered FGC "a form of child physical abuse and as such, any child suspected of being at risk of the practice would justify intervention by child protection authorities."⁸ Because FGC is a recognized violation of human rights, a child or woman at risk for FGC has a legitimate claim for asylum.⁸

Statements and Policies of

Provincial Medical Organizations in Canada

Appendix 2 provides information related to the position statements or directives issued by provincial medical organizations that have addressed the subject of FGC. These professional organizations have consistently condemned the practice of FGC and make it clear that a physician who engages in this practice is guilty of professional misconduct.

Challenges in Responding to the Health Needs of Women and Adolescents with FGC

In a study exploring the birthing experience of Somali women in Ontario, Chalmers and Omer-Hashi found

that although not all women had negative experiences in accessing health care, many considered the care not optimal, and further reported that “they were treated in ways that they perceived harsh and even offensive to [their] cultural values.”¹³ Women’s reported concerns were mainly with lack of services and care including assistance with baby care, especially when they were in pain due to their FGC; warm, caring, and sympathetic staff; privacy during labour and in the wards; confidence in the capacity of the clinicians to provide adequate care; and appropriate clinical care, including the ability to refuse what they considered unwarranted Caesarean sections.

A consultation process undertaken in 2000 by the FIWG with community and health care providers identified the following as key health care issues affecting women with FGC in Canada: their lack of knowledge of the health consequences of the practice and the relation of FGC to their own health symptoms; differences in their health-seeking behaviours and practices from those of other women in Canada; their reluctance to seek health care due to lack of knowledge of how the system works; their distrust of authority figures (especially if they have experienced political prosecution); past adverse experience with health care providers; preference for women physicians; financial barriers; difficult and traumatic experiences in accessing care due to language and cultural barriers; lack of confidentiality and health care providers’ lack of training of in how to deal with complications of FGC; and issues related to what affected women considered the high Caesarean section rate at childbirth.⁸ These factors deter women with FGC and their families from seeking care until absolutely necessary.^{8,10,27} Studies exploring the perceptions of women with FGC in the United States, Europe, and Australia of the perinatal care they received report similar findings.^{28–33}

Recent European studies shed light on the experiences and clinical practices of health providers providing care to women with FGC and how these contribute to the quality of care provided. Vangena et al. (2002)²⁸ found that health care providers in Norway faced difficulties initiating discussion about the practice with women; lacked clinical skills in how and when to defibulate women and in determining the extent of repair after delivery; and at times performed Caesarean sections because they lacked knowledge related to care management. Widmark et al.³⁴ and Johansen³⁵ reported that health care providers found providing care to infibulated women at childbirth especially stressful and emotionally challenging. Of particular concern were the strong emotional and sometimes contradictory feelings of health providers, which included “deep empathy, protectiveness and the desire to treat the

circumcised women with extra care”, but also anger and hatred “towards tradition, religion, men and especially the husbands.”³⁴ Significant gaps in both theoretical knowledge and practice related to FGC were found among health professionals in United Kingdom, Sweden, Spain, and the United States.^{36–39}

Summary Statements

5. Performing or assisting in female genital cutting is a criminal offense in Canada. (III)
6. Reporting to appropriate child welfare protection services is mandatory when a child has recently been subjected to female genital cutting or is at risk of being subjected to the procedure. (III)
7. There is concern that female genital cutting continues to be perpetuated in receiving countries, mainly through the act of re-infibulation. (III)
8. There is a perception that the care of women with female genital cutting is not optimal in receiving countries. (III)

CLINICAL MANAGEMENT OF WOMEN LIVING WITH FGC

Gynaecologic Care

Women experiencing distressing symptoms related to vaginal obstruction or mass effect, or those considering intercourse or pregnancy can be offered surgery, defibulation, or excision. For defibulation, under general anaesthesia, the infibulated scar is incised in the midline from the neo-introitus to the level of the urethral orifice using scissors, coagulation/cutting, or laser.⁴⁰ The labial edges may need interrupted sutures to ensure hemostasis and/or approximation of the ipsilateral labial edges. Postoperatively, topical analgesic gels can help with pain relief, as can generous application of lubricants and frequent sitz baths. Estrogen cream and topical antibiotic ointment may also be helpful. Unfortunately, because FGC is not reversible some of its complications may not be amenable to therapy. Vaginal dilators may be appropriate for some women. Vaginal calibre is best sustained, postoperatively, when the woman is willing to use gentle vaginal dilation to help prevent re-stenosis of the introitus. Additional guidance related to defibulation is available in the online WHO document entitled *Management of Pregnancy, Childbirth and the Postpartum Period in the Presence of Genital Mutilation*.⁴¹

Contraceptive measures remain the same as for other women. Infertility rates may be higher in women who have undergone FGC.⁴² The incidence of infertility appears to be related to the extent of FGC. Introital stenosis can make intercourse difficult or impossible, and there may be tubal damage from infection or endometriosis. Artificial

reproductive technologies can be more challenging in a woman with FGC because of the need for a vaginal approach (hysterosonogram, intrauterine insemination, trans-vaginal ovum retrieval).

It is important for health care professionals to avoid verbal and non-verbal reactions to women with FGC that may make the women feel stigmatized. Well-woman examinations and cervical screening need to be fully explained so the woman understands the need for the tests. A wide variety of small, narrow specula should be available to perform the exam with the least amount of discomfort. The use of a lubricant is encouraged.

Obstetrical Care

Most forms of FGC do not directly impact obstetrical care. Infibulation may cause obstructed labour and is associated with an increased risk of vaginal/vulvar lacerations. When treating pregnant and labouring women it is important to demonstrate a professional and non-judgemental approach to FGC. Many of these women originate from communities where FGC is the norm. They are used to the way their genitals feel and look. They may be fearful of the changes that may occur as a result of the delivery, particularly if the delivery is conducted by someone who is not familiar with FGC. If defibulation will be necessary to allow vaginal birth, it can be performed in advance or at the time of delivery. There may be medical indications to offer defibulation in advance to decrease the incidence of Caesarean section.⁴³ However, many women prefer to wait until delivery and have defibulation only if absolutely necessary to facilitate the birth.⁴⁴ If defibulation is performed intrapartum, an episiotomy performed at the same time facilitates delivery and minimizes vaginal tearing. Possible scenarios should be discussed in advance so the woman has ample opportunity to state her views, ask questions, and understand the reasoning behind common interventions such as analgesia in labour, defibulation, episiotomy, and Caesarean section. It is advisable to discuss hospital policies on labour companions, rooming in, and visiting hours because local practices may be at odds with the expectations of the woman and her family. Sympathetic post-delivery care, good analgesia, and assistance with care of the newborn are essential given the likelihood of vulvar pain experienced by women with FGC.¹³

It is vital that women who have had FGC are treated with respect and sensitivity. In some communities, it is customary to re-infibulate the genitals after each childbirth.⁴⁵ WHO and other international health organizations strongly oppose all medicalization of FGC including re-infibulation because it may legitimize the practice of FGC/M in general.³ Re-infibulation is not specifically prohibited

by the Canadian Criminal Code; however, requests for re-infibulation should be declined on medical grounds because repetitive cutting and suturing of the vulva is likely to increase scar tissue, thus causing or perpetuating dyspareunia or voiding difficulties. If incisions are made or tearing occurs during childbirth, it is reasonable to repair defects in a way that will promote good hemostasis, vaginal support, and normal appearance. Typically, high vaginal tears should be sought and sutured first; it is important to keep in mind that obstructed labour secondary to infibulation may be associated with “blow out” lacerations of the vagina and vulva. Episiotomy incisions and perineal tears may then be repaired in the usual manner. Infibulated tissue may be tough and relatively avascular. A small anterior tear or incision may not require suturing. In other cases, re-approximation of the cut edges may be appropriate. Alternatively, the raw edges can be over-sewn with interrupted, delayed absorbable suture in an effort to preserve the capacity of the vulvar opening. The vulvar tissues have a tendency to heal together as the raw edges sit in apposition. Gentle self-dilatation after defibulation may be required while the edges heal in the postpartum period. It is common for women to be concerned about the appearance of their genitals and to request that their appearance be preserved or restored as much as possible. Reassurance and information sharing are important. A patient-centred approach requires us to hear our patients’ requests and to be sensitive to the cultural context in which these requests are made. The health care professional should support a culturally competent approach in which the autonomy of the patient is honoured as much as possible without compromising her health or breaching the ethical principle of non-maleficence.

Caesarean section seems to be more common in women with FGC than in the general population. Caesarean section rates in low-resource countries tend to be considerably lower than in North America and cultural differences exist in women’s acceptance of Caesarean. Health care professionals should be aware that FGC is not an indication for Caesarean delivery. Frequency of Caesarean delivery may be reduced if defibulation is performed antenatally.⁴³

Population studies have suggested that women with FGC have statistically increased risks of perinatal mortality, postpartum hemorrhage, and fetal distress. Currently there is insufficient data to determine whether these findings are related to FGC or to socioeconomic factors affecting health care access and quality of care.⁴⁶

Summary Statement

9. Female genital cutting is not considered an indication for Caesarean section. (III)

Sexual Health

Sexual function may be normal in women with FGC even in the absence of the clitoris and/or labia, especially in those women with Type I or II FGC (Table 2). Currently accepted treatment for sexual dysfunction should be considered for those women with FGC. Women with Type III FGC are significantly affected in terms of sex drive, arousal, and orgasm.⁴⁷ There is some evidence that defibulation can improve sexual function in the domains of desire, arousal, satisfaction, and pain, but not lubrication and orgasm.⁴⁸ The use of lubricants, self-stimulation, and dilators may improve sexual function. The need for defibulation may be considered, by some cultural groups, an indication of male sexual dysfunction. In cultures that practice Type III FGC the husband may be instructed in how to open (cut) or stretch the introitus to facilitate intercourse. Sexual dysfunction may occur in men secondary to the association of sex causing pain in their wife and their own physical discomfort when attempting intercourse.^{19,49}

Adolescent Care

The physical complications and management of FGC in adolescents are the same as those in adult women. Some adolescents request revision of their FGC to feel more “normal” or less “different.” This should not be denied as long as there is a full discussion of the risks and benefits, both physical and psychological (the risk of alienation from her society). Young women often have no recollection of FGC performed at an early age; however, once integrated into Canadian society they may feel self-conscious when they realize that they were subjected to the practice as children. One study suggests significantly higher rates of post-traumatic stress disorder (30%) and other psychiatric syndromes (48%) in women living with FGC than in the general population.⁵⁰ As in relations with all adolescents, the health care provider should be sensitive to sexual issues that may be exacerbated by FGC. Discussion about healthy sexual choices, contraception, and avoidance of sexually transmitted infections is always important, as is attention to any self-destructive behaviours (sexual promiscuity, substance abuse, eating disorders, suicidality). Well-woman examinations should also be discussed.

Working with Families with Daughters at Risk

All health professionals providing care to families from communities that practise FGC should educate the parents about the illegality of the practice in Canada and its harmful effects. This is especially true when parents are suspected to be planning to have the procedure carried out on their daughter or are struggling with the decision. It is also important to remember that health care professionals have legal responsibilities to protect children, and thus to report their

suspicions of a child at risk of FGC to provincial child welfare agencies. Practical guidance for health care professionals can be found in the BMA's latest guideline related to FGM.⁴⁵

SERC Manitoba has developed more information for professionals on how to provide culturally sensitive counselling when working with families with young daughters.⁵¹

Recommendations

4. Health care professionals should use their knowledge and influence to educate and counsel families against having female genital cutting performed on their daughters and other family members. (III-A)
5. Health care professionals should advocate for the availability of and access to appropriate support and counselling services. (III-A)
6. Health care professionals should lend their voices to community-based initiatives seeking to promote the elimination of female genital cutting. (III-A)
7. Health care professionals should use interactions with patients as opportunities to educate women and their families about female genital cutting and other aspects of women's health and reproductive rights. (III-A)
8. Research into female genital cutting should be undertaken to explore women's perceptions and experiences of accessing sexual and reproductive health care in Canada. (III-A) The perspectives, knowledge, and clinical practice of health care professionals with respect to female genital cutting should also be studied. (III-A).
9. Information and guidance on female genital cutting should be integrated into the curricula for nursing students, medical students, residents, midwifery students, and students of other health care professions. (III-A)

PROVIDING CULTURALLY COMPETENT CARE TO WOMEN AND ADOLESCENTS WITH FEMALE GENITAL CUTTING

Preamble

The experience of FGC/FGM is only one event in a woman's life, which may or may not be affecting her currently.⁵¹

The SOGC recognizes that the experience of a woman living with FGC must be considered within her experience as an immigrant and/or a visible minority women living in Canada, and possibly a refugee or asylum seeker. FGC (with or without complication) is but one of many issues and concerns a woman faces in her attempt to establish a life for herself and her family in Canada. Her experience will vary from other women depending on a number of factors

including her race, nationality, socioeconomic background, length of time in Canada or in other Western countries, education, religion, and sexual orientation. If she is a refugee or an asylum seeker, her experience may also differ from immigrant women by the possibility that she left her home under extreme circumstances, may be separated from her family, and may have been subjected to significant personal trauma such as rape or other violence. Consequently, in their interaction with women with FGC, health care professionals' focus should be directed towards addressing the woman's health concerns as a priority and taking a holistic approach.

Key Care Practices in Providing Care to Women with FGC

The following provides a summary of 10 key care practices which may assist health care professionals in the provision of culturally competent care to women with FGC. These are not meant to be prescriptive and are presented as good practices to guide you in your work with women who have undergone the FGC. The following have been adapted from a number of sources.^{18,22,23,30,34,52–56}

Terminology when providing care

Women who have undergone the practice of FGC may not see themselves as different or mutilated, and many may be offended by the use of the term “female genital mutilation.” The term “female circumcision” is frequently used by practicing communities and may be the terminology of choice of the woman and her family.⁵⁷ The health care professional in interaction with a woman with FGC should determine how the woman refers to the practice and then, use the woman's choice of terminology throughout care.

Identification of the woman's FGC status

Identifying as early as possible the FGC status of women will ensure the delivery of effective care, especially maternity care. Determining the place of origin of women can provide insight into their potential status. When completing the medical history of a woman potentially at risk of having undergone the practice, the health care professional should sensitively enquire if she has had genital surgery or if she has been cut. Further to the pelvic examination, the health care professional should document the type of FGC clearly in the medical file, using diagrams if necessary.

Examples of simple and sensitive questions to discover whether a woman has undergone FGC and is experiencing any complications related to the practice⁵⁴

- Many women from your country have been circumcised or “closed” as children. If you do not mind telling me, were you circumcised or closed as a child?

- Do you have any problems passing your urine? Does it take you a long time to urinate? (Note that women with obstruction may take several minutes to pass urine.)
- Do you have any pain with menstruation? Does your menstrual blood get stuck?
- Do you have any itching or burning or discharge from your pelvic area?
- (If sexually active) Do you have any pain or difficulty when having relations?

Communication

Effective communication is considered paramount in the provision of culturally competent care to women with FGC and their families. Not only will it ensure that women have access to the information needed to make an informed choice about their health and the care they need, but it will also enhance their care experience and may positively influence their “perceptions of themselves, their bodies and their decision to seek future health care.”²² Communication within health care teams is also essential to ensure continuity of care and care that meets the women's needs.

In interactions with a woman with FGC, the health care professional should (if necessary, possible, and appropriate), ensure the availability of a well-trained, trusted, and neutral female interpreter who can ensure confidentiality and who will not exert undue influence on the patient–physician interaction. If interpretation services are not available, choose an adult family member (preferably a female); avoid using the women's children as interpreters. If a child is the only option possible, avoid discussing very sensitive issues at the first encounter and inquire whether she can bring an adult (preferably female) at her next visit. It is important also to remember that facial expressions, body language, and tone of voice play an important role in establishing effective communications.

When working in a health care team, the health care professional should be sure to document findings in detail to minimize the need for repeated medical histories and/or examinations and to facilitate the sharing of information. Care should also be taken to ensure that all case discussions are conducted in a professional manner and that no language is used that can be construed as insensitive or patronizing.

Providing women with appropriate and well-timed information

Women from countries where FGC is practiced may not have been exposed to reproductive care discussions and be unfamiliar with their anatomy, in particular their reproductive organs, and they may never have had a

physical, breast, or internal examination. As in all health professional–patient interactions, the way the information is shared (i.e., what is said and how it is said) will influence the outcome of the treatment. Communicating in a professional manner can contribute to creating a safe environment for women who find obstetrical and gynaecological care difficult and stressful.

To ensure adequate information is provided to the woman, the health care professional should be sure to speak slowly and clearly and to use simple but accurate terms. If the woman's knowledge of reproductive care is limited, the health care professional should make use of the interaction to share information with her. Pictures, diagrams, or anatomical models may be used to facilitate these discussions. Consideration should also be given to making longer appointments available.

Confidentiality and privacy

In many countries where FGC is practiced, sex and sexuality including issues related to FGC are considered very private matters and are not openly discussed. Some women refrain from seeking care because of their fear of being humiliated and judged when they disclose that they have undergone the practice. Finally, many women may experience embarrassment when asked to disrobe and uncover their bodies in front of a health care practitioner. In many cultures affected by FGC women prefer to be cared for by female attendants.

The health care professional should ensure the woman's privacy and confidentiality by limiting the attendants in the room (including delivery room) to those who are part of the health care team. Respect of a woman's wish for modesty can be expressed by offering her a long-sleeved gown, knocking and waiting before entering the room, and draping the woman carefully when examining her. Care should be taken to ensure that the examination is done using a gentle touch, especially when examining the woman's sensitive areas. Telling her what you are about to do, what you are doing, and what you have observed (good or bad) can be calming and reassuring for her. Finally, it is important to ensure that the woman is not part of a teaching session unless informed consent has been obtained. Trainees should be introduced and the reasons for their presence and their role in the health care of the woman should be explained.

Woman-centred care

In many cultures where FGC is practiced, women who seek care may be accompanied by their husbands and other family members such as mothers-in-law and male relatives and these may expect to be involved in the decision-

making process. In some other cultures, birth is considered women's business and consequently, men are not expected to participate in the pregnancy nor the birth, nor are they the birth companion of choice of many women.⁵⁸

The health care professional in his/her interactions with the woman should explore and assess the decision-making process of the woman and her family and be sure to solicit the woman's views and wishes. The health care professional should also enquire who the woman's choice of birth companion is, and respect it.

Health-seeking behaviours and practices and preventative care

The health-seeking behaviours and practices of many immigrant women, including women with FGC, often vary from Canadian norms. They may be unfamiliar with health services for screening and illness prevention and be more accustomed to seeking care when ill. They may also continue to use traditional medicine or health methods in their health care practices. Many may find our health care services difficult to understand and navigate, and frightening and intimidating, especially if they do not speak English or French.

The health care professional should assist the woman in understanding how the health system works and help her navigate it. Every opportunity should be taken to educate the woman about preventive care practices important for herself and potentially for her daughters. Culturally appropriate educational pamphlets should also be made available.

Preparation for delivery

In many countries where FGC is practiced, prenatal care similar to that in Canada may not be available, and many births take place without skilled attendants. Health care may only be sought when complications arise. Many women with FGC prefer natural childbirth and fear Caesarean section and other unfamiliar medical procedures. The health care professional should take advantage of the prenatal visits to properly prepare the woman and her family for the delivery. The focus should be on developing a detailed birth plan with her and her family. Attention should be given to sharing information verbally and in other formats (if available) about when to come to the hospital, admission procedures, hospital policies, what to expect in the delivery room, who will be part of the health care team, the care she can expect from hospital nurses and staff, how interpreters are used at the hospital, length of stay, etc. Providing information about when and why defibulation will take place, when and why Caesarean sections are performed,

the pain medication options available (during and after labour), other medical procedures that might be necessary, and the call schedule also help the woman prepare for delivery.

Referrals

Referrals to other health care professionals and/or services are integral to the provision of quality and comprehensive care. Many women, however, may consider referrals for counselling to be foreign, not beneficial, and a waste of their time.

When referring a woman, the health care professional should ensure that the services and/or practitioners who receive the referral can provide culturally appropriate and sensitive care to women with FGC. The professional should also explain to the woman beforehand why and where the referral has been made. A woman should be referred to counselling when she requests the referral, when the health care professional feels that counselling is necessary for a favourable outcome of treatment (e.g. when an infibulated pregnant woman shows signs of anxiety about defibulation and may be experiencing flashbacks of her FGC), or when the presenting symptoms are primarily psychological or sexual in nature.

Recommendation

10. Key practices in providing optimal care to women with female genital cutting include:
 - a. determining how the woman refers to the practice of female genital cutting and using this terminology throughout care; (III-C)
 - b. determining the female genital cutting status of the woman and clearly documenting this information in her medical file; (III-C)
 - c. ensuring the availability of a well-trained, trusted, and neutral interpreter who can ensure confidentiality and who will not exert undue influence on the patient–physician interaction when providing care to a woman who faces language challenges; (III-C)
 - d. ensuring the proper documentation of the woman's medical history in her file to minimize the need for repeated medical histories and/or examinations and to facilitate the sharing of information; (III-C)
 - e. providing the woman with appropriate and well-timed information, including information about her reproductive system and her sexual and reproductive health; (III-C)
 - f. ensuring the woman's privacy and confidentiality by limiting attendants in the room to those who are part of the health care team; (III-C)

- g. providing woman-centred care focused on ensuring that the woman's views and wishes are solicited and respected, including a discussion of why some requests cannot be granted for legal or ethical reasons; (III-C)
- h. helping the woman to understand and navigate the health system, including access to preventative care practices; (III-C)
- i. using prenatal visits to prepare the woman and her family for delivery; (III-C)
- j. when referring, ensuring that the services and/or practitioners who will be receiving the referral can provide culturally competent and sensitive care, paying special attention to concerns related to confidentiality and privacy. (III-C)

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Appendices begin on next page

APPENDIX 1. CRIMINAL CODE OF CANADA

Sections of the Criminal Code of Canada that address or could be used to address FGC (Criminal Code of Canada, December 14, 2011)¹

Aggravated assault

268. (1) Every one commits an aggravated assault who wounds, maims, disfigures or endangers the life of the complainant.

Punishment

- (2) Every one who commits an aggravated assault is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.

Excision

- (3) For greater certainty, in this section, “wounds” or “maims” includes to excise, infibulate or mutilate, in whole or in part, the labia majora, labia minora or clitoris of a person, except where
- (a) a surgical procedure is performed, by a person duly qualified by provincial law to practise medicine, for the benefit of the physical health of the person or for the purpose of that person having normal reproductive functions or normal sexual appearance or function; or
 - (b) the person is at least eighteen years of age and there is no resulting bodily harm.

Consent

- (4) For the purposes of this section and section 265, no consent to the excision, infibulation or mutilation, in whole or in part, of the labia majora, labia minora or clitoris of a person is valid, except in the cases described in paragraphs (3)(a) and (b).

Removal of child from Canada

- 273.3 (1) No person shall do anything for the purpose of removing from Canada a person who is ordinarily resident in Canada and who is
- (a) under the age of 16 years, with the intention that an act be committed outside Canada that if it were committed in Canada would be an offence against section 151 or 152 or subsection 160(3) or 173(2) in respect of that person;
 - (b) 16 years of age or more but under the age of eighteen years, with the intention that an act be committed outside Canada that if it were committed in Canada would be an offence against section 153 in respect of that person; or
 - (c) under the age of eighteen years, with the intention that an act be committed outside Canada that if it were committed in Canada would be an offence against section 155 or 159, subsection 160(2) or section 170, 171, 267, 268, 269, 271, 272 or 273 in respect of that person.

Criminal negligence

- 219.** (1) Every one is criminally negligent who
- (a) in doing anything, or
 - (b) in omitting to do anything that it is his duty to do, shows wanton or reckless disregard for the lives or safety of other persons.

Accessory after the fact

- 23.** (1) An accessory after the fact to an offence is one who, knowing that a person has been a party to the offence, receives, comforts or assists that person for the purpose of enabling that person to escape.

Duty of persons to provide necessities

- 215.** (1) Every one is under a legal duty
- (a) as a parent, foster parent, guardian or head of a family, to provide necessities of life for a child under the age of sixteen years;
 - (b) to provide necessities of life to their spouse or common-law partner; and
 - (c) to provide necessities of life to a person under his charge if that person
 - (i) is unable, by reason of detention, age, illness, mental disorder or other cause, to withdraw himself from that charge, and
 - (ii) is unable to provide himself with necessities of life

REFERENCE

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APPENDIX 2. STATEMENTS AND POLICIES PROVIDED BY PROVINCIAL MEDICAL BODIES

The Provincial Medical Board of Nova Scotia

During the past few years, attention has been drawn to the practice of female genital mutilation (FGM). There has been an increase in immigration to Canada from those areas of the world which allow this practice.

Female genital mutilation is irreversible and imposed on young girls without their consent. While this practice is entertained for cultural reasons, there are severe long-term physical and psychological complications for these young girls. Many groups, including UNICEF, WHO, and African women's groups have spoken forcefully against FGM.

In 1992, the College of Physicians and Surgeons of British Columbia and Alberta endorsed the World Health Organization position which condemns mutilating procedures.

The Provincial Medical Board of Nova Scotia (PMB) would like to add its voice to these groups. The Board considers the practice of FGM such as excision of female genitalia, female circumcision, and infibulation as unacceptable medical procedures. FGM is an inhumane practice and physicians in Nova Scotia are advised not to perform this surgery nor to attempt to reconstruct the infibulations after a vaginal delivery. The PMB considers FGM outside the acceptable standards of medical care in Nova Scotia and Canada.

In addition, the practice of FGM is illegal according to Canada's Criminal Code as advised by the Federal Minister of Justice (1994). (Statement provided by College of Physicians and Surgeons of Nova Scotia on November 30, 2010.)

Le Collège des médecins du Québec

Notice published in the BULLETIN, Vol. XXXIV, No. 3 – September 1994.

In the last few years, female genital cutting has made headlines around the world. Canada has recently welcomed immigrants and refugees originating from regions where female genital cutting is practiced.

Female genital cutting is irreversible. Some cultures may view it as an important ritual, but it nevertheless results in long-term physical and psychological traumas for young women.

It's not the first time that this topic has been debated. Such a practice is unacceptable, particularly in view of articles 2.03.01, 2.03.14, 2.03.17, and 2.03.23 of the Code of ethics of physicians. It is also proscribed by the Criminal Code.

The Corporation wishes to remind its members that they must refuse to collaborate or participate in such procedures. Physicians called upon to treat victims of such mutilations must show these patients respect and empathy.

(Statement provided by Le Collège des médecins du Québec representative on November 29, 2010.)

The College of Physicians and Surgeons of Ontario

*Female Cutting (Mutilation)*¹

PRINCIPLES

The practice of medicine is guided by the values of compassion, service, altruism and trustworthiness. These values form the basis of professionalism.

The physician–patient relationship is the foundation of the practice of medicine and a physician has the duty to always act in the patient's best interest.

Good communication is a fundamental component of a trusting physician–patient relationship. Physicians should demonstrate cultural sensitivity in their communication with patients and families. [3]

POLICY

Physicians must not perform any FGC/M procedures. Further, physicians must not refer patients to any person for the performance of FGC/M procedures.

The performance of, or referral for, FGC/M procedures by a physician will be regarded by the College as professional misconduct.

Where there is doubt if a procedure is considered to be FGC/M physicians should seek advice from the Canadian Medical Protective Association and/or legal counsel.

During the course of a vaginal delivery of a woman who has been previously subjected to an FGC/M procedure, a physician may find it necessary to surgically disrupt the scar tissue resulting from the earlier procedure. In this circumstance, at the conclusion of the delivery, the physician must confine activities to repairing the surgical incision or laceration required during the delivery, and must not, for example, endeavour to reconstruct an infibulation. Wherever possible, the physician should advise the patient of this limitation prior to delivery; ideally this conversation should be had prior to pregnancy and during the course of prenatal care.

Reporting

The performance of FGC/M procedures on a female under the age of 18 by any person may constitute child abuse. Physicians who have reasonable grounds to believe that an FGC/M procedure has been performed on, or is being contemplated for, any female under the age of 18, must notify the appropriate child protection authorities, regardless of where the procedure has been or will be undertaken. [4]

In the event that a physician has reasonable grounds to believe that another physician is performing FGC/M procedures, the matter should immediately be brought to the attention of the College. This expectation is based in professionalism and ethics, and is distinct from the legal obligation to report child abuse discussed above.

Continued

APPENDIX 2. *Continued***Care of Patients**

As appropriate, physicians should provide culturally sensitive counseling regarding the dangers related to performing FGC/M procedures.

As part of their commitment to treat patients with compassion, physicians who encounter patients subjected to FGC/M procedures should educate themselves on the appropriate management of possible complications, in order to provide appropriate counsel and care.

Endnotes

3. See the CPSO's Practice Guide at <http://www.cpso.on.ca> under Policies and Publications.
4. Pursuant to *Child and Family Services Act*, R.S.O. 1990, c.C11, s.72(1) and the *Criminal Code*, R.S.C. 1985, c. C-46, s 273(1) and the CPSO's Mandatory Reporting policy.

The College of Physicians and Surgeons of Manitoba**Female Circumcision (Revised 2001)²**

Female circumcision is not an appropriate medical practice under any circumstance and if performed by a physician, represents professional misconduct. If a physician is aware of a proposal to perform female circumcision on a child, the incident must be reported pursuant to the requirement to report child abuse set forth in The Child and Family Services Act.

The College of Physicians and Surgeons of Alberta**Directive provided by the Council to its members (1994)**

THAT physicians, as well as other providers of women's health care, be made aware of the issues involved in Female Genital Mutilation (FGM).

Specifically, physicians must not perform FGM.

Where physicians encounter medical complications of FGM, they shall manage these in a culturally sensitive and ethical manner; this may require individualized consideration of secondary reconstruction of the previous FGM.

(Statement provided by CPSA representative on December 1, 2010.)

The College of Physicians and Surgeons of British Columbia**College's Position³**

The College endorses the position of the World Health Organization (WHO), and many other medical organizations, regarding female genital mutilation, as having no health benefits, and both immediate and long-term negative health consequences.

- A physician must decline to perform female genital mutilation and must not make a referral for the purpose of female genital mutilation.
- An adult parent or guardian cannot consent to the excision, infibulation or mutilation of the labia majora, labia minora or clitoris on behalf of a child, except in the circumstances described under section 268(3) of the Criminal Code.
- Urgent action must be taken if a physician considers that a child may be at risk of female genital mutilation.

Duty to Report⁶

A physician must report to the College and the Ministry of Children and Family Development if:

- A physician learns of another physician performing female genital mutilation;
- A physician is requested to perform female genital mutilation or learns that these procedures may be performed on a child or person under 18 years of age; or
- A physician considers that a child may be at risk in relation to the practice of female genital mutilation.

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