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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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Key words: Female genital cutting, female genital mutilation, female circumcision, pregnancy, gynecological care, adolescents, Canada.

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 Grey (unpublished) literature was identified through searching the websites of health technology assessment and health technology-related agencies, clinical practice guideline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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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
	E. There is good evidence to recommend against the clinical preventive action
III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees	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)

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)

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

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 clitorectomy (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 major (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-Hashi[13] 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.

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Table 4. Recognized complications and risks of female genital cutting[1]

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 Johansen[35] 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 lubrification 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 practice[54]

- 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 necessaries

215. (1) Every one is under a legal duty

(a) as a parent, foster parent, guardian or head of a family, to provide necessaries of life for a child under the age of sixteen years;

(b) to provide necessaries of life to their spouse or common-law partner; and

(c) to provide necessaries 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 necessaries of life

REFERENCE

1. Department of Justice. Consolidation Criminal Code (R.S.C., 1985, c. C-48). Act current to 2011-12-14. Available at: http://laws-lois.justice.gc.ca/eng/acts/C-46. Accessed on August 2, 2013.

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 militating 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 than 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 Position[3]

The College endorses the position of the World Health Organizational (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 Report[3]

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

- A physicians 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.

REFERENCES

1. The College of Physicians and Surgeons of Ontario. Female genital cutting (mutilation). Policy #2-11. Available at: http://www.cpso.on.ca/policies/policies/default.aspx?ID=1596. Accessed on August 2, 2013.
2. The College of Physicians and Surgeons of Manitoba. Female circumcision (2011 rev.) Statement 111. Available at: http://cpsm.mb.ca/cjj39alckF30a/wp-content/uploads/st111.pdf. Accessed on August 2, 2013.
3. College of Physicians and Surgeons of British Columbia. Professional standards and guidelines: female genital mutilation. Available at: https://www.cpsbc.ca/files/u6/Female-Genital-Mutilation.pdf. Accessed on August 2, 2013.