Compiled by Patricia Huston MD, MPH
Scientific Communications International, Inc
for the Federal Interdepartmental Working Group on FGM.

Copies of this report are available from:

Women's Health Bureau
Health Canada
women_femmes@hc-sc.gc.ca

The Canadian Women's Health Network
203-419 Graham Avenue
Winnipeg, Manitoba
R3C 0M3
fax: (204)989-2355

Dedication

This report is dedicated to all the women in the world who have undergone FGM and to all the people who are helping them live with and reverse this procedure. This report is part of the ongoing commitment of Canadians and the Government of Canada to stop this practice in Canada and to improve the health and well-being of affected women and their communities.

Executive Summary

Female genital mutilation (FGM), or the ritual excision of part or all of the external female genitalia, is an ancient cultural practice that occurs around the world today, especially in Africa. With recent immigration to Canada of peoples from Somalia, Ethiopia and Eritrea, Sudan and Nigeria, women who have undergone this practice are now increasingly living in Canada.

It is firmly believed by the people who practise it, that FGM improves feminine hygiene, that it will help eliminate disease and it is thought to be the only way to preserve family honour, a girl's virginity and her marriageability. FGM has a number of important adverse health effects including risks of infection and excessive bleeding (often performed when a girl is pre-pubertal). Subsequently there can be chronic problems with urination, menstruation, sexual relations, birth control, infertility, as well as difficulties with pregnancy and childbirth. Although many women adapt to this practice, others are traumatized by it. Because of its profound effect on health, a number of medical organizations have developed policy statements condemning this practice.

In Canada, as well as in most Western countries, FGM is illegal. People conducting this practice can be charged with aggravated assault and those who participate in the commission of FGM can also be charged. There is legal precedent in Canada for women to seek refugee status who are under pressure to undergo FGM against their will. FGM is considered to be a form of child abuse, and children who are at imminent risk may be removed from their family home to prevent its occurrence.

The Federal Interdepartmental Working Group on FGM commissioned key informant* research across Canada in the late 1990s, to examine the health care issues of affected women and to identify some prevention strategies. With respect to health care issues, community providers and health care providers identified the following:

- Affected women may not realize their symptoms are FGM-related or preventable.
- Affected women tend to seek health care only when it is urgent.
- Even when affected women do want health care, they are reluctant to seek it due to a number of social factors.
- When affected women do seek health care they may find it difficult and traumatic due to cultural and language barriers.
- Health care providers may not be sensitized to certain critical FGM related issues.

---

* "Key informant" refers to those individuals who took part in the interviews and research conducted for this report.

- The high Cesarean section rate is the number one health care concern of affected women.
- Key informants were concerned that FGM may be happening in Canada.
- Health care providers rarely have the opportunity to identify girls at risk.
- Schools could play an important role in identifying girls at risk.

A number of recommendations from the key informants arose from these findings.

In September 1999, representatives from a number of national organizations interested in the issue of female genital mutilation (FGM), met with members of the Federal Interdepartmental Working Group for a National Consultation. The results of the key informant research was discussed and further recommendations were made. Recommendations from both the key informants and the National Consultation can be found in Section 6 of this document.

Table of Contents

Foreword

In 1994, the Federal Interdepartmental Working Group on Female Genital Mutilation (formally called the Ad-Hoc Working Group on FGM and hereafter referred to as the "Working Group") was established to bring government departments together to better understand and address problems related to FGM. (See Appendix 1 for a list of members.) Its mandate is to work with concerned communities and advocates to ensure people are aware of the harmful health consequences of FGM and Canadian laws regarding the practice of FGM, in order to meet the needs of affected women and prevent the practice from being performed in Canada.

A literature review on FGM was undertaken in 1994[1], and the Working Group organized consultations with affected communities in 1995. The purpose of the consultations was to identify sensitive and effective measures for ensuring that FGM is not practised in Canada by families from countries where it is known to occur. A report on the community consultations recommended the development of community workshops for women and men from countries where FGM is common[2]. A workshop manual on the health and legal issues related to the practice of FGM was developed and pilot-tested, and has since been distributed to concerned communities and others working in the area of FGM prevention.[3] Because community workshops can be given in the first language of the participants by people who are known and trusted, they are seen as effective ways of providing information.

Through this work, it became apparent that women who have undergone FGM were having difficulties obtaining appropriate health care services in Canada. The Working Group decided to commission key informant research to find out why and determine what could be done to improve this situation. To this end, community and health care providers were interviewed across Canada. Then in late 1999, a National Consultation was held with representatives from national organizations interested in FGM (see Appendix 2 for a list of participants) as well as members of the Federal Interdepartmental Working Group, to discuss the findings from this research and seek additional information and advice on further action needed. As follow-up to this National Consultation, the Working Group has supported the preparation of this Report which is intended to serve two purposes:

- To provide useful information and identify relevant resources to national organizations, community advocates, health care providers and teachers;

1 Ferguson & Ellis (1995)
2 Hussein & Shermarke (1995)
3 National Organization of Immigrant and Visible Minority Women (1998)

- To stimulate further discussion and action, at local, regional and national levels, in both governmental and non-governmental settings, to address the needs of women affected by FGM and to prevent FGM in girls from affected communities living in Canada.

1. The Current Situation

With recent immigration to Canada of peoples from a number of African countries, women who have undergone FGM are now increasingly living in Canada, thus making FGM a Canadian issue.

The practice of FGM has no health benefit; rather, as will be outlined below, it is associated with a number of health problems. In Canada, as in the United Kingdom and France, it is illegal. Generally, this procedure is conducted on prepubescent girls and this population remains at increased risk, even after immigration. Participants at the National Consultation mentioned the fact that in other host countries, persons have been brought in from abroad to perform FGM on female children, and that female children have been taken out of other host countries for the purposes of FGM.

1.1 FGM DEFINED

Female genital mutilation (FGM), or the ritual excision of part or all of the external female genitalia, is an ancient cultural practice that occurs around the world today, mainly in parts of Africa There are 3 general forms of FGM:

> **Clitoridectomy**—is the excision of the prepuce (covering of the clitoris) and the clitoris
>
> **Partial Excision**—is the excision of the prepuce, clitoris and often the labia minora
>
> **Complete Excision and Infibulation—is** the excision of all external genitalia with subsequent stitching together of the vulva, leaving only a small opening at the base of the vagina.

There are a wide variety of practices used to perform FGM, including the implements used, local customs and the environment where the procedure is carried out, etc.[4] This has led to a number of variations, or sub-types of FGM. The least invasive form of all, is multiple, small incisions in the clitoris leading to scarification. This is called "Sunna" and is practiced in African countries where FGM has been banned. There are many variations in the degree, process and extent of removing the labia. Sometimes, rather than cutting the labia, the top layer of skin of the labia is scraped off and the edges of the labia are brought together (approximated) so that they fuse on healing. Infibulation, comes from the Latin term, meaning "to buckle together". Table 1 summarizes the kinds and types of FGM, including the common terms often used to describe each procedure and the descriptive medical terms.

[4] Hosken (1993:32-33)

Table 1: Types of Female Genital Mutilation

ORGAN	PROCEDURE	COMMON TERM	MEDICAL TERM
Clitoris	Excision of the prepuce (Clitoris left intact)	Circumcision	Circumcision
Clitoris	Pricking/Scarification	Sunna	Incision
Clitoris	Excision of the tip of the clitoris	Sunna or Sunna kashfi	Subtotal clitoridectomy
Clitoris	Excision of the clitoris	Sunna	Clitoridectomy
Clitoris and Labia minora	Excision of the clitoris and scraping of the labia minora, causing them to stick together	Sunna or Sunna magatia	Clitoridectomy and abrasion of the labia minora causing labial fusion
Clitoris and Labia minora	Excision of the clitoris and labia minora	Excision	Subtotal vulvectomy
Clitoris and Labia minora and/or Labia majora	Excision of the clitoris, labia minora, and may involve partial excision of the upper two thirds part of labia majora with stitching together of the edges of the wound	Intermediate infibulation	Subtotal vulvectomy and infibulation
Clitoris and Labia minora and/or Labia majora	Excision of the clitoris, labia minora and entire length of the labia majora with stitching together of the edges of the wound	Pharaonic infibulation	Vulvectomy and infibulation

1.2 THE CULTURAL CONTEXT OF FGM

Female genital mutilation (FGM) is a practice which originated in Africa and has since spread to other parts of the world, primarily Arabic and South-East Asian countries.[5]

FGM is thought to have been practised for thousands of years. Some Egyptian mummies have been found with evidence of this practice, which likely is the root of the term "Pharaonic infibulation". Originally, it marked one as nobility. To this day, it remains deeply embedded in the cultural context of the people who practise it, and is directly related to their beliefs about female health, sexuality, family honour, esthetics and marriageability.

[5] Hosken (1993:42-46)

It is firmly believed by people who practise it that FGM improves and ensures feminine hygiene. FGM is considered to be esthetically more pleasing. It is thought to help eliminate disease, protect against infertility and prevent stillbirth. Women who have not had this practice are thought to be sexually untrustworthy. This belief is so deeply embedded that many women and their families fear their daughters will not be marriageable if they have not had this practice. FGM is also thought to be an insurance against infidelity and rape. There is a lot of pressure to continue this practice, often by the mothers of young girls as well as from community elders. It is thought to be the only way to preserve family honor, a girl's virginity and her marriageability.[6]

For a long time, the term female circumcision was used. However, after much discussion, African women decided that female genital mutilation was a more accurate term. The term circumcision minimizes the disfigurement that is done. The only correlate to the male circumcision is the removal of the prepuce of the clitoris. The term circumcision ignores infibulation, from which many of the health effects arise. FGM was the term adopted by the Inter African Committee at a meeting in Addis Ababa, Ethiopia in 1990. This term was adopted by the World Health Organization in 1996. Since that time, it has increasingly become the accepted term.

1.3 DEMOGRAPHICS OF FGM

In 1995, *WIN NEWS* estimated that about 125 million women and girls in Africa had undergone FGM. The prevalence of this practice differs from one country to another. In some countries, such as Somalia, it is estimated that virtually all women have undergone FGM whereas in other countries, such as Ghana and Senegal the incidence is much lower. A summary of the type and frequency of FGM in Africa, related to indicators of population health, such as life expectancy at birth, maternal and neonatal mortality rates and female literacy rates are provided in Table 2. Specific background information is also offered on five countries from which Canada has received immigrants over the last 20-30 years: Somalia, Ethiopia, Eritrea, Sudan and Nigeria.[7]

[6] Female Genital Mutilation Workshop Manual, Unit 2: FGM and Health, NOIVMWC

[7] The following text draws upon UNDP (1991), UNICEF (1992), Hosken (1993), Dorkenoo & Elworthy (1992); El Dareer (1982), and Ungar (1985). Where specific statistics are used, a separate footnote is provided.

1.3.1 Somalia

In the years prior to the conflict in Somalia, the Somali Women's Democratic Organization had embarked on an extensive program to eradicate FGM through education at the grass-roots level. This continues to this day, although efforts have been eclipsed by the country's political conflicts. The hostilities in Somalia are long-standing, punctuated by successive waves of emigration. The first group came from the northern part of Somalia, formerly known as Somaliland (British Protectorate) during the 1970s and early 1980s because of government persecution. A second wave of immigration from Somalia came with the overthrow of the government and the ensuing civil war.

1.3.2 Ethiopia and Eritrea

Reports on the prevalence of FGM in Ethiopia and Eritrea tend to be given together since, until recently, they existed as one country. There is a definite relationship between the type of practice and ethnicity, religion, level of education and rural or urban location. Christian Amharas tend to excise early, sometimes as early as 40 days after birth or before the age of 3 or 4 years. Groups ethnically related to the Somalis and located along the border of Somalia (Ogaden) or close to the coast (Eritrea) are more likely to excise and infibulate between 6 and 9 years of age. These peoples are more likely to be rural, nomad and Muslim. While FGM is on the decline, its prevalence is still in the range of 50 to 70 percent, predominantly excision or clitoridectomy. During the civil war with the province of Eritrea in the late 1970's, Canada received a steady influx of immigrants from this area. Numbers also increased when crops failed in the mid-1980s, resulting in widespread famine.

1.3.3 Sudan

Infibulation is by far the most common type of FGM practised in the northern part of Sudan, predominantly in Muslim groups. There has been a long-standing campaign to eradicate FGM with specific laws banning Pharaonic infibulation as far back as 1947. A new form of circumcision known as Intermediate (see Table 1) was introduced, possibly as a result of the introduction of these laws. Ironically, the school for training midwives may have had an adverse effect on stemming the spread of FGM in the Sudan. Even though trained midwives are forbidden to "circumcise," it is a thriving trade which is hard to check. The country is large and mostly rural (population: 23.8 million) and health care is grossly underserviced and underfunded,[8] contributing to the persistence of this practice. Some health care providers in the Sudan have taken a gradual approach to eradication by encouraging educated parents to opt for clitoridectomy (Sunna) rather than infibulation.

[8] UNDP (1991) Table 12, p.143 shows that in Sudan public expenditure of health was 0.2% of GDP in 1986.

1.3.4 Nigeria

FGM is not practised in all areas of Nigeria and the predominant type of FGM is clitoridectomy. Since this is much less extensive than the other types described, it may not be observed or reported as often as infibulation. The incidence of FGM is approximately 20 percent.

Table 2: Demographics and Female Genital Mutilation in Africa*

Country	Prev of FGM	Usual Type of FGM	Population in Millions	Average Life Expectancy At Birth	Maternal Mortality (per 100,000)	Neonatal Mortality (per 1,000 live births)	Female Literacy Rate
Benin	50%	Excision	4.6	47	160	88	16%
Burkina Faso	70%	Excision	9.0	48	810	133	9%
C. African Republic	40%	Excision	3.0	50	600	100	25%
Chad	60%	Excision	5.7	47	960	127	18%
Cote d'Ivoire	60%	Excision	12.0	53	-	92	40%
Djibouti	99%	Infibulation	0.4	48	-	119	13%
Egypt	60%	Excision/Infibulation	52.4	60	320	61	34%
Ethiopia	90%	Excision/ Infibulation	49.2	46	-	130	-
Eritrea	80%	Excision/ Infibulation	-	-	-	-	-
Gambia	80%	Excision	0.9	44		140	11%
Ghana	30%	Excision	15.0	55	1,000	86	51%
Guinea	70%	Excision	5.8	44	800	140	13%
Guinea Bissau	70%	Excision	1.0	43	700	146	24%
Kenya	60%	Excision	24.0	60	170	68	59%
Liberia	70%	Excision	2.6	54		134	29%
Mali	75%	Infibulation	9.2	45	2,000	164	24%
Mauritania	40%	Excision	2.0	47		122	21%
Nigeria	60%	Excision/Infibulation	108.5	52	800	101	40%
Senegal	20%	Excision	7.3	48	600	84	25%
Sierra Leone	90%	Excision	4.2	42	450	149	11%
Somalia	99%	Infibulation	7.5	46	1,100	127	9%
Sudan	85%	Infibulation	25.2	51	550	104	12%
Togo	50%	Excision	3.5	54	420	90	31%

* The information on FGM comes from Hosken (1995) and UNICEF (1992) with the exception of data for Djibouti and Gambia which comes from UNDF (1991).

2. Health Implications

The health implications of FGM are both immediate and profound.

2.1 IMMEDIATE EFFECTS

All forms of FGM cause heavy bleeding at the time of excision. If not controlled, this can lead to hemorrhaging and, in extreme cases, death. Because FGM is often conducted under unhygienic conditions (and the approximating of the two sides of the vulva may be done by using thorns or twigs), infection is not uncommon. If the infection is severe, it can become systemic, leading to sepsis and death. This practice is generally done without any pain control, so there is extreme pain and is often associated with acute urinary retention.

2.2 LONG-TERM EFFECTS

Women who have undergone FGM may adapt to the changes that have occurred as a result of this practice and, especially in some of the milder forms, may not have any complications that disturb them. What is summarized here are the more common complications.

2.2.1 Urinary tract dysfunction

The first problem experienced by young girls is difficulty with urination, related to the tiny opening left after infibulation. Infibulation may cause girls to take an excessively long time to urinate or to urinate frequently. If they rush, they may not empty the bladder properly. It is not always possible to empty the bladder because of the infibulation and a residual of stale urine increases the chance for infection. An infection can cause irritation and pain in the external genitals or may spread to the kidneys, causing a pyelonephritis that can permanently damage the kidney. Other voiding dysfunctions secondary to obstruction caused by infibulation and scarring are retrograde voiding (urine flowing backwards into the vagina), incontinence (involuntary loss of urine) from overflow, and inability to pass a urinary catheter.

2.2.2 Genital tract dysfunction

When a girl who has undergone FGM reaches menarche, she is unlikely to realize that many of her menstrual difficulties are related to this practice. The small opening which allowed for the passage of urine may not permit adequate drainage of menstrual fluid. This can result in dysmenorrhoea (painful menses), oligomenorrhoea (scanty and prolonged menses), hematocolpos or hematocolpometra (retention of menses causing distention of the uterus), or endometriosis (uterine lining occurring inside the abdominal cavity). Residual menstrual blood may provide an opportune site for infection to invade the urogenital tract leading to vaginitis, cervicitis or endometritis and pelvic inflammatory disease. With extensive scarring women are also at increased risk of perineal cysts.

2.2.3 Sexual-related difficulties

Unless women have undergone a procedure to reverse infibulation (called defibulation) sexual intercourse can be traumatic. Physical penetration by the male partner may take a long time to achieve. Some women are intact weeks, months or even years after becoming sexually active. Pain, bleeding and infections secondary to trauma to the genitals on penetration, are common. Traumatized tissue leaves women at increased risk for infections, including sexually transmitted diseases, such as HIV. Many women will be psychologically traumatized as well, but for cultural reasons may not express it. This may be expressed as vaginismus (or painful, involuntary spasm of the vagina often associated with an aversion to sexual activity).

2.2.4 Birth control difficulties

Family planning is more difficult for women who are affected. They have problems using intrauterine devices or diaphragms, and may be unable to insert spermicidal products. Birth control pills are one of the few viable options for them. There are additional complications for affected women who choose to terminate unplanned pregnancies. Often, they discover that the doctor is unable to perform a defibulation which is necessary prior to the termination. This may happen if the women has not explained beforehand that she has undergone FGM, the doctor is unfamiliar with the defibulation procedure or if the equipment is not available at the time of the scheduled therapeutic abortion.

2.2.5 Infertility

When women *do* want to conceive a child, it may be difficult. The two most common reasons are difficulties with physical penetration and pelvic inflammatory disease. Structural problems can be addressed by defibulation, but even after treatment, pelvic inflammatory disease may result in fertility problems.

2.2.6 Difficulties in pregnancy and childbirth

Many infibulated women have managed to become pregnant, even without complete penetration. During pregnancy it may be impossible to conduct a pelvic examination to assess pregnancy, fetal presentation and the adequacy of the pelvic outlet. Thus, many of the possible benefits of early diagnosis during pre-natal care are lost.

Labour and delivery is often prolonged. Fistulae (a hole developing between the vagina and the rectum) may occur at an unattended birth from prolonged pressure from the baby's head, either due to the inability of the head to pass through the pelvis (cephalopelvic disproportion) or if the head is unable to pass through the perineum if defibulation (or anterior episiotomy) has not been done. Prolonged labor or obstructed delivery may lead to caesarean section. Even when defibulation is done at the time of vaginal deliveries, there are often perineal tears

as the scarred tissue cannot stretch. Local trauma from the birth causes delayed healing, infection and increased morbidity. For some, it may be so traumatic as to lead to a postpartum psychosis or depression.

2.2.7 Psychological difficulties

Pain or discomfort during sexual intercourse can trigger memories of the original practice. Some continue to experience profound emotional and physical pain secondary to coitus which may lead to sexual inhibition and frigidity. They may suffer from depression, anxiety and irritability, phobias or vague somatic complaints.

3. Legal Status and Current Policies

Like many other countries, FGM is illegal in Canada. FGM *threatens* women's health in the short-term and the long-term and people who perform FGM, as well as those who assist them, can be charged with aggravated assault, as well as other criminal offences. In addition, the threat of FGM may be grounds for obtaining refugee status in Canada. Certain provincial child protection laws apply if there is a risk of young girls undergoing FGM.

3.1 LEGAL STATUS

3.1.1 The Criminal Code

Anyone who performs or assists with the performance of FGM can be criminally charged and convicted of an offence in Canada.

A person may be charged with "aggravated assault" under section 268 of the *Criminal Code* if he or she wounds or maims, in whole or in part, the labia majora, labia minora or clitoris of another person. Neither a child, nor an adult on the behalf of a child (under the age of 18 years), can consent to such a practice. This provision does not apply to legitimate medical procedures performed by duly qualified physicians for the physical health of the person. The maximum penalty for aggravated assault is fourteen years imprisonment.

Alternatively, a person may be charged with criminal negligence causing bodily harm (section 221) which carries a maximum penalty of ten years imprisonment or criminal negligence causing death (section 220)which carries a maximum punishment of life imprisonment.

Persons who aid another to commit the offence (section 23) or who do anything for the purpose of removing a child under the age of 18 who is ordinarily resident in Canada with the intention of having FGM performed upon the girl (section 273.3) can also be charged. Section 273.3 carries a maximum penalty of five years imprisonment.

Parents may also be charged for failing to provide necessaries of life to a child under the age of sixteen years (section 215). This offence carries a maximum penalty of two years imprisonment.

3.1.2 Immigration and Refugee Law

There have been cases in Canada where refugee status was granted on the grounds of threatened FGM.[9] It is considered to be gender-related persecution.

3.1.3 Provincial child protection services

FGM is considered a form of abuse and as such, any child suspected of being at risk of FGM would justify intervention by child protection authorities. This system makes it *mandatory* for anyone who has any reason to believe that someone is abused, or is at risk of being abused, to report it. Provincial legislation varies from province to province, but the goal of legislation is generally to protect children in need of protection, including to allow authorities to intervene to prevent harm to children at risk. This may include removing a child from her family if there are reasonable grounds to believe this is necessary for protection.

3.2 MEDICAL POLICY

Both national and provincial medical organizations have developed clear policies against FGM in Canada. In 1992, the Society of Obstetricians and Gynaecologists of Canada (SOGC) issued a formal policy statement on FGM that stated:

> "Female genital mutilation is never medically indicated. Its practice in Canada, by a physician, is inexcusable. The SOGC condemns this procedure as being a violation of the female body. The SOGC recommends that physicians performing this procedure should be reported to provincial licensing bodies..."[10]

Since that time, many provincial medical organizations have issued similar statements. (See Appendix 3) It is considered malpractice for physicians to conduct infibulation or reinfibulation in Canada.

---

9 Immigration and Refugee Board decisions May 10, 1994 and March 13, 1997.

10 SOGC Policy Statement No. 12, September 1992. Available on the website: www.sogc.medical.org

4. Key Informant Research

4.1 METHODS

The main focus of the key informant research was on two groups: community providers working with affected communities, and those in the health care field who were knowledgeable about FGM. The Working Group created a list of key informants in each group. Five communities were identified that had immigrants from countries where FGM is traditionally practised: Ethiopia, Nigeria, Somalia, Sudan and Eritrea.

A list of interview questions was developed and the prepared questionnaire covered such topics as:

- typical behaviours of women and girls from affected communities in seeking health care services.
- common health concerns of affected women.
- problems that have affected women have encountered when seeking health in Canada.
- resources currently available to address these issues.
- information needed by community and health care providers so that they can better serve affected girls and women in their communities.

A researcher conducted the interviews, collected the information and then analysed the findings.

4.2 FINDINGS WITH RESPECT TO HEALTH CARE

Twenty two key contact people representing 15 community organizations in Montreal, Ottawa, Toronto, Edmonton and Vancouver were contacted and twelve agreed to respond to an in-depth questionnaire by either telephone interview or fax (55% response rate). Then 75 health care providers, including physicians, nurses, educators, psychologists, and social workers were contacted in Montreal, Ottawa, Toronto, Winnipeg, Edmonton and Vancouver. Of the 75 people contacted, 31 agreed to respond to an in-depth questionnaire by either telephone interview or fax (41% response rate). The findings were combined since there was, in general, a consensus between community and health care providers on the major health care issues and preventative measures in regard to the practice of FGM. Differences in opinions between community and health care providers on key issues were identified. The findings on the key health care issues are summarized as follows:

4.2.1 Women may not realize their symptoms are FGM-related and preventable.

Women who are affected may not realize that their urinary, menstrual and psychological problems are FGM-related. Although acute problems may have occurred after the original procedure, in the intervening period these problems most likely have either been resolved or become chronic. It has been observed that often women who are affected have an increased tolerance for physical discomfort associated with FGM. Some affected women do not appear to be disturbed by FGM. Especially for menstrual difficulties, most women have had their symptoms since menarche, so have accepted it as the norm.

4.2.2 Affected women who have recently immigrated generally have different health-care seeking behaviors from the Canadian norm.

One of the biggest differences between affected women and most Canadians is that women from affected communities rarely seek, or expect, preventive or routine care. This difference is likely linked with the fact that in Africa, health care dollars are often scarce and preventive medical care is often unknown. Thus women who are affected tend not to look for health care in Canada unless they are sick or there is a perceived need for care. A suggestion that a pelvic examination is needed in order to take a routine pap smear may seem totally inappropriate to an affected woman, as is the suggestion for a breast examination to screen for breast cancer (which is often unfamiliar to them). Many pregnant women do not seek pre-natal care. Many mothers of young children do not seek well-child care. Counseling as an integral part of health care services, is not familiar to many cultures. For example, psychological or family problems are normally discussed among family members or clan elders; they would not be a cause for seeking professional counseling.

In addition to not being aware (or comfortable) with many preventive procedures, affected women who have recently immigrated may not be familiar with the routine system of booking appointments in advance when seeking medical care. They may wait until they need medical care urgently or book an appointment and then miss it. This may set up misunderstandings and tensions between affected women and health care providers.

4.2.3 Even when affected women do want health care, they are reluctant to seek it.

It is fairly well-known that affected women are often reluctant to seek health care. Although most community providers thought this was a major barrier to health care, many health care providers felt that women and girls who are affected will overcome their reluctance when the need for care arises, and will seek care in an appropriate manner. Community and health care providers offered a number of reasons for the reluctance.

a. Many are not familiar with the Canadian health care system.

Upon arrival in Canada, affected women have little knowledge of the health care system, which they feel is bureaucratic. They are dependent to a great extent on members of their communities or workers in immigration and settlement, to help them access health care. It may be difficult for women to find out about the health care system in order to access it.

b. If affected women have experienced political persecution, they may distrust authority figures.

Many affected women may have experienced political persecution before coming to Canada; thus, they may distrust, avoid contact or are covert in their dealings with authority. Since physicians are viewed as authority figures, going to see a physician may be dreaded and therefore delayed.

c. Affected women may have had an adverse experience with a health care provider in the past.

Respondents noted that women who are affected perceived some Canadian doctors as unapproachable and condescending in their initial dealings with them. It was not uncommon to hear of health providers who were not informed about FGM and when affected women went to see them, appeared shocked, asked inappropriate questions such as demanding to know what happened, or acted inappropriately by calling other nurses or doctors to view the woman's genitals.

d. Affected women generally do not want to see a male physician.

Although the primary concerns of women who have undergone FGM are to find a doctor who is knowledgeable about the medical management of FGM and who is respectful of affected women and their cultures, most affected women would prefer to see women doctors. This may be difficult in some communities.

e. There may be a financial barrier.

Affected women may have heard that they may have to pay for health care because they do not yet have permanent resident status in Canada or do not possess a health card. Even if they are covered by a provincial health insurance plan, recent immigrants still may find it difficult to seek health care due to a lack of funds for child care or transportation.

4.2.4 When affected women do seek health care they may find it difficult and at times traumatic.

a. There may be a language barrier that can only be addressed by compromising confidentiality.

If affected women are not fluent in English or French, they may be obliged to use translators from their communities. This often provokes additional anxiety as these communities are small and there is often a concern that the translator may breach confidentiality. Cases were reported where a reputation was destroyed or a marriage prospect was negatively affected.

b. There are often cultural barriers

Cultural pressures are strong and influence affected women as well as Canadian health care providers. Women are reluctant to express themselves about sensitive and private matters such as sexuality or FGM. They tend to minimize the problems associated with FGM and tolerate a great deal of discomfort before seeking help. Health care providers may not understand the cultural context of FGM and may be abrupt or judgmental.

c. Many health care providers are not adequately trained to care for affected women.

As noted previously, many physicians, nurses and other health care providers know very little about FGM, its complications, or the treatment options such as defibulation, to effectively and sensitively address the needs of affected women. Respondents recounted situations when women requested defibulation, and were told to wait until they got married or until they got pregnant. In pregnancy, they were told to wait until the birth of the baby. Even when there was a willingness to consider defibulation, it was difficult, at times, to find someone who was trained to do it. In addition, health care providers need to be aware of certain cultural sensitivities. For example, female reproductive organs and sexuality are generally considered culturally taboo as topics of conversation. In affected women's countries of origin, sexual issues related to FGM are implicitly understood by health care providers in the cultural context and much remains unsaid.

4.2.5 The high Caesarean section rate is the most common health care complaint of affected women

Although all key informants agreed that the most common health care complaint of affected women was the high Caesarean section rate, there was a difference of opinion among community and health care providers as to why that was. In general, community providers questioned the high Caesarean section rates and tended to agree with the belief of affected women that this was due to physicians' lack of knowledge regarding the management of infibulation.

Health care providers, however, noted the high Caesarean section rates in Canada and the United States for *all* women, not just those who have undergone FGM. For example, the Canadian health care system has helped to reduce the maternal mortality rate to 3 per 100,000 live births.[11] This is very low when compared with the countries of origin of the women who are affected.(see Table 2). Maternal or fetal mortality or morbidity which could have been prevented by Caesarean section is unacceptable by Canadian standards of practice. However, there tends to be a greater prevalence of perinatal mortality and morbidity in developing nations where often the conditions do not allow for similar medical standards of practice.

Many women who are affected are concerned that providers move too quickly to intervene. For them, the preservation of the uterus and the ability to bear children in the future is of paramount importance in their culture. Several incidents of affected women refusing Caesarean sections were reported; in at least one case, it resulted in a stillbirth and a ruptured uterus leading to emergency hysterectomy.

4.3 FINDINGS WITH RESPECT TO PREVENTION

4.3.1 FGM may be practiced in Canada

A number of key informants expressed concern about the possibility of the practice happening underground in Canada. Although no one has reported FGM happening in Canada, key informants thought it was not an unrealistic possibility.

[11] UNDP (1991:180)

4.3.2 Health care providers rarely have the opportunity to identify girls at risk.

It seems to be very rare for a health care provider in Canada to identify a young girl at risk of having the practice of FGM performed on her. When young girls from affected communities seek health care, it is usually for an acute problem and there is no expectation or desire for preventive care. With a cultural taboo for discussing private matters, it is difficult to even broach the topic.

4.3.3 Schools could play an important role in identifying girls at risk.

Teachers may be in a better position than health care providers to identify girls whose health is at risk as a result of FGM having been performed on them. An observant elementary school teacher may notice, for example, when a girl from an affected community may take an inordinate length of time to use the washroom, or a high school teacher may note when a teenager from an affected community tends to miss school on a monthly basis (to deal with her menstrual problems). Recognizing girls from affected communities who may be at risk of having FGM performed on them is not a simple task.
For example, the school should take note of any family who plans to take their child out of the country for a prolonged period of time given that the purpose may be to have FGM performed. However, this may not always be the case and schools should be careful not to jump to conclusions.

5. The National Consultation

5.1 GOALS

In the fall of 1999, representatives from a number of national organizations interested in the issue of female genital mutilation (FGM), as well as members of the Federal Interdepartmental Working Group on FGM, were invited to a National Consultation. The purpose of this National Consultation was to develop recommendations for a dissemination strategy for the FGM Report, to initiate and continue to build collaborative relationships among people committed to the FGM issue, and to identify the next steps that should be taken at the national level regarding FGM in Canada. In the final preparation of this report, follow-up interviews were held with some participants for clarification and to receive updated information.

5.2 FEEDBACK

The initial feedback from the National Consultation on the literature review and key informant research was that it was positive and constructive suggestions were given which were incorporated into the final report. However, it was noted that there are significant barriers to school-based intervention in preventing FGM and specific suggestions were offered to address this new avenue. This is the focus of the feedback for this Report.

5.2.1 Barriers to teacher-based interventions

a. Teachers cannot assure their students of confidentiality.

Teachers do not have the right to withhold information. If a child indicates that she may have to undergo FGM, provincial child abuse laws make it mandatory for teachers to report any suspicion of child abuse, including the risk for FGM. Knowledge of this may actually prevent children from confiding in their teachers.

b. There are no resources available to teachers regarding FGM.

A brief fax-back survey conducted in the fall of 1999 to the provincial teachers unions, inquired whether the union representatives had ever seen any materials for teachers on the topic of FGM; none had. There was an identified need for the development of such material.

Not only would teachers benefit from educational opportunities in this regard, (both at the teacher training level and as an in-service, professional

development forum), but it would also be critical for teachers to be able to network with others in the community for support. Participants felt that it would be invaluable to develop local brochures containing the name and phone number of a contact person for support.

5.2.2 Suggestions for teacher-based interventions

a. Leadership within the education system to address this issue, should come from the school boards.

Teachers who do identify girls who are at risk for FGM, or who have undergone this procedure, need to know who they can turn to within the education system for support and assistance. School boards are the most logical place for this. The school boards could also arrange for in-servicing in the form of training videos or sponsoring speakers.

b. The Canadian Association of School Health (CASH) may also have a role to play.

CASH is a umbrella organization consisting of 25 national organizations concerned with school health. It has developed educational materials for teachers in such areas as youth suicide, AIDS awareness and sexuality. CASH would be an appropriate organization to develop a proposal to create educational materials appropriate for elementary and high school teachers.

6. Recommendations

6.1 Recommendations arising out of the Key Informant Research

To all involved:

1. ***To ensure that the practice of FGM does not occur in Canada, it will be critical to continue to promote and provide ongoing respect for the cultures of affected communities.***

   Respect for the culture has to be shown for the affected community as a whole if there is to be any impact on preventing FGM. Ongoing dialogue is needed with the women who are affected as well as their male partners and extended family about their concerns. Establishing long-term relationships with those in affected communities are particularly helpful as it will support them while they integrate into Canadian society.

To the Government of Canada:

2. ***Citizenship and Immigration Canada could provide early, effective intervention by developing information packages that are given directly to families upon arrival in Canada.***

   Education about the Canadian health care system should begin as early as possible in the immigration process and should be ongoing during the resettlement period. All immigrants have to see a doctor recommended by Citizenship and Immigration Canada and this makes for an ideal initial education strategy. Information packages might include such things as a list of appropriate community organizations where more specific health information and translation services can be obtained.

To community providers:

3. ***Community providers need to increase their efforts to educate affected communities regarding the health effects and legal status of FGM.***

   The use and utility of the workshop module (Female Genital Mutilation: Workshop Manual) for communities should be monitored to determine whether or not it is effective in providing information and education about the medical and legal aspects of FGM.

4. Community providers should promote defibulation among women who are adversely affected.

Defibulation should be freely available to women who are affected and it should be their choice whether, and when, to have the procedure. This needs to be done fully cognizant of the fact that some affected women may be very comfortable with their bodies the way they are, and this should be respected as well.

5. Community providers need to develop educational initiatives for affected communities on the Canadian health care system.

Affected communities are currently lacking information on how the Canadian health care system works, how best to access it, the role of the family physician and the need to make and keep medical appointments. Women from affected communities need to be encouraged to utilize preventive health care services for the prevention of illness and promotion of health. There is a great need for affected women to understand Canadian standards of care during pregnancy and in childbirth.

6. Community providers should continue and increase their lobbying efforts to improve available services to affected communities especially:

a. Health care services and professional translators

Health care educators and health care providers, ideally from affected communities are needed to meet the health care needs of affected women. Professional translators are sorely needed to provide confidential and culturally sensitive services to affected women.

b. Program development

While current initiatives have been largely successful, additional programs are needed. There needs to be concerted and effective outreach program to improve access to the health care system for women who are affected and encourage a preventive approach. There need to be culturally-sensitive health and wellness programs for these communities, including pre-natal programs, men's health programs and women's empowerment initiatives.

c. Culturally conducive environments

It is important that health care and health promotion services are given in environments where people from affected communities will feel comfortable.

7. Community providers are best placed to coordinate local efforts to improve the health care needs of affected women and prevent FGM in young girls.

a. Development of local referral list of health care providers

This was one of the most common recommendations that came out of the Key Informant research. There is a need to have information on local resources available to affected communities, health care providers and schools.

b. Identification of children at risk

This is an ongoing challenge that may need increased coordination with local schools to be successful.

To Health Care Providers:

8. Health care providers need to continue and increase efforts to address the gaps in knowledge needed to care for affected women.

This includes undergraduate, post-graduate and continuing medical education on the:

- immediate and long-term complications associated with FGM
- psychological implications of FGM
- legal implications of FGM
- awareness of the serious concerns expressed about Cesarean section by affected women and their communities

9. Health care providers need to obtain training in the skills needed to care for affected women.

This includes:

- interviewing skills to obtain information in a culturally sensitive way
- culturally sensitive communication skills
- surgical technique of deinfibulation
- screening skills to identify children at risk
- intervention skills to link with the necessary social and legal services to prevent FGM

10. Health care providers need to promote the optimal attitudes required to care for affected women.

- Physicians in areas where there are affected communities need to have increased:
- sensitivity regarding the cultural backgrounds associated with FGM to avoid concerns about perceived prejudice and discrimination
- understanding of the social implications of immigration, family disruption, loss of identity, etc.
- respect for preference of most affected women to be treated by women health care providers
- appreciation of the need for ample discussion of appropriate expectations during childbirth and delivery

6.2 RECOMMENDATIONS ARISING FROM THE NATIONAL CONSULTATION

To all involved:

1. Networking with others involved with FGM is more important than ever, in order to coordinate efforts, increase momentum and provide mutual support.

Government, community providers, health care providers, teachers and community activists all need to work in concert.

To the Government of Canada:

The Federal Government has a critical role to play in facilitating national and inter-disciplinary networking.

2. A National FGM Network should be created.

The Government of Canada has a critical role to play in facilitating national and inter-disciplinary networking. This would be greatly facilitated by a National FGM Network that would include affected women, community workers, health care providers, and other providers involved with FGM. The purpose of the FGM Network would be to move the FGM issue forward and to provide opportunities for collaboration and support.

3. There is a need for a National Database of FGM-related activities.

To assist networking and provide momentum for this issue a national database would be invaluable in allowing people to access information on programs and initiatives quickly and easily.

4. There is a need for a Resource Centre for disseminating information on FGM.

Closely linked with the idea of a compilation of community activities would be a centralized place for written and other resources on FGM. This would include reports, books, pamphlets, videos, and anything else that may pertain to information on FGM.

To Provincial School Boards

5. School boards need to take on a leadership role in providing educational opportunities and support for teachers to address this issue.

While there is a high level of interest in this area, to date little has been done formally. The school board is ideally placed to move forward on this issue, in collaboration with government , community and health care providers involved in this issue.

6. Educational materials need to be developed for educational in-servicing.

Teachers need knowledge and resources in order to tackle their potential key role in preventing FGM in Canada.

7. Conclusion

Education and mutual understanding are the keys to eradicating FGM. FGM has profound health effects that have traditionally been accepted as part of being a woman in affected communities.

In Canada, many women from affected communities have difficulty accessing appropriate health care. This is due to both their own lack of knowledge and reluctance because of social, cultural, financial and psychological barriers. Even when they do seek health care, it can be difficult and at times traumatic because of incomplete training of health care providers and incomplete services (such as a lack of appropriate translators). Due to cultural reasons and insufficient communication affected women are often unprepared for, and traumatized by, cesarean section.

Progress has been made. Initiatives both at the community level and among obstetricians and gynaecologists have been successful in addressing some of these health care issues. But there is much more that needs to be done.

In Canada, there have been several initiatives concerning FGM, both community and government based. The National Consultation was the first time in Canada that affected women, community groups, health care providers and government representatives came to the same table to discuss what could be done at a national level to improve the health of affected women and to ensure that the practice of FGM not occur in Canada. What is needed now are more resources, networking support, and program development to enable a continuation of the collaborative efforts which have been undertaken by individuals and groups in Canada.

Bibliography

Canadian Advisory Council on the Status of Women.
1994 *Recommendations to the Government of Canada on Female Genital Mutilation.* Ottawa: CACSW.

El Dareer, Asthma.
1982 *Woman, Why Do You Weep?* London: Zed Press.

Dorkenoo, Efua., & Scilla Elworthy.
1992 *Female Genital Mutilation: Proposals for Change.* England: Minority Rights Group.

Ferguson, Ian., & Pamela Ellis.
1995 *Female Genital Mutilation: A Review of Current Literature.* / *La mutilation des organes geniteaux féminins: Étude de la documentation existante*. Ottawa: Department of Justice (WD1995-15e/15f).

Hosken, Fran P.
1993 *The Hosken Report: Genital and Sexual Mutilation of Females* (4th Revised Ed.). Lexington, Massachusetts: Women's International Network News.

Hosken, Fran P.
1995 *Stop Female Genital Mutilation: Women Speak Facts & Actions*. Lexington, Massachusetts: Women's Internationals Network News.

Hussein, Lula J., & Marian A. A. Shermarke.
1995 *Female Genital Mutilation: Report on Consultations held in Ottawa and Montreal./ La mutilation des organes génitaux feminins: Rapport sur les consultations tenues à Ottawa et Montréal*. Ottawa: Department of Justice (WD1995-8e/8f).

National Organization of Immigrant and Visible Minority Women of Canada
1998 *Female Genital Mutilation: Workshop Module*. / *Mutilations des Organes Génitaux Féminins : Manuel de travail.* Ottawa: NOIVMWC.

Omar-Hashi, Kowser H.
1993 "Female Genital Mutilation: Overview and Obstetrical Care." *Canadian Journal of Ob/Gyn & Women's Health Care* 6(5): 538-542.

Shandall, Ahmed Abu-El Futuh.
1967 "Circumcision and Infibulation of Females." *Sudan Medical Journal* 5(4).

Statistics Canada.
1997 "1996 Census: Immigration and Citizenship." *The Daily*, November 4, 1997.

UNDF (United Nations Development Fund)
1991 *Human Development Report 1991*. New York: Oxford University Press.

UNICEF (United Nations Children's Fund)
1992 *The State of the World's Children*. New York: Oxford University Press.

Ungar, Sanford J.
1985 *Africa: The People and Politics of an Emerging Continent*. New York: Simon & Schuster.

Verzin, J.A.
1976 "Sequelae of Female Circumcision." *Tropical Doctor* October 1975.

Acknowledgements

Many thanks to all the participants of the National Consultation for their insights, suggestions and expertise and to Sandra Fraser and George Kiefl, who conducted the research for the FGM Report.

Special thanks to all past and present members of the Interdepartmental Working Group on FGM for their unflagging support in creating national documents and for cultivating partnerships to bring this issue to the fore in Canada.

Finally, our deepest thanks for all those who continue to work in their own communities to increase awareness and knowledge about FGM and decrease its practice. We hope this report will assist you in your current and future efforts.

* * * * * *

This consultation was supported by a financial contribution from the Family Violence Prevention Unit at the Health Issues Division of the Health Promotion and Programs Branch of Health Canada.

Appendix 1: Members of the Federal Inter-Departmental Working Group on FGM

Chaired by:	**Health Canada**
Representatives from:	**Justice**
	Privy Council Office
	Status of Women Canada
	Canadian Heritage
	Citizenship and Immigration Canada

Appendix 2: The National Consultation, October 1999

Representatives from community based and national organizations:

Canadian Medical Association

Canadian Society for International Health

Federation of Medical Women of Canada

Society of Obstetricians and Gynaecologists of Canada

The College of Family Physicians of Canada

Amnesty International

National Organization of Immigrant & Visible Minority - Women of Canada (NOIVMWC)

Save the Children Canada

Centre d'excellence pour la santé des femmes - Consortium Université de Montréal

QUEST

Women's Health in Women's Hands

Planned Parenthood Federation of Canada

Association national des femmes et du droit

Canadian Teacher's Federation

The Midlife and PMS Centre

Representatives from the Federal Government:

Department of Justice

Status of Women Canada

Canadian Heritage

Health Canada

Appendix 3: Statements on FGM from Provincial Medical Organizations

College of Physicians and Surgeons of British Columbia

Policy Manual C-2 June 1995
CIRCUMCISION (Female)

The Council of the College endorses the position of the World Health Organization and many medical organizations regarding female circumcision.

Mutilating procedures, such as excision of female genitalia, female circumcision, and infibulation are unacceptable medical procedures. A physician who is requested to perform any of these procedures must decline and must refuse to refer the surgery to anyone. If a previously performed infibulation is disrupted, for instance during vaginal delivery, it must not be reconstructed.

The College of Physicians and Surgeons of Ontario

March 1, 1993
Policy News for Members
FEMALE CIRCUMCISION, EXCISION and INFIBULATION

Physicians were advised in College Notice No.25 published in March 1992 that the performance of any of the above procedures by a physician licenced in Ontario would be regarded as professional misconduct. Some physicians will be providing obstetrical care to women who have previously been subjected to infibulation. At the time of vaginal delivery, physicians are reminded that they must not attempt to reconstruct a state of infibulation but should confine their activities to repairing the episiotomy or the disrupted scar tissue.

The performance of female circumcision, excision, or infibulation, may violate several *criminal code* provisions and any physician who becomes aware of a procedure of this nature being performed by another physician should, in accordance with the Code of Ethics, bring this information to the attention of the College at the earliest opportunity. Since the performance of circumcision, excision or infibulation on a female child by any person may constitute child abuse, the Children's Aid Society and appropriate police agencies must also be notified.

The College of Physicians and Surgeons of Alberta

Policy Subject: Female Genital Mutilation
Reference: C-118-94

Motion reads:

THAT

a) Physicians, as well as other providers of women's health care, be made aware of the issues involved in Female Genital Mutilation (FGM).
b) Specifically, physicians must not perform FGM.
c) 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..

The College of Physicians and Surgeons of Manitoba

Statement 111
FEMALE CIRCUMCISION

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 such a procedure on a child, then the incident must be reported as required by the Child Welfare Act regarding child abuse.

A statement is a formal position of the College with which members shall comply.

Collège des Médecins du Québec

Bulletin, Vol XXXIV, no.5 - Septembre 1994
Female Genital Mutilation

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

Female genital mutilation is irreversible and practised on young girls with or without their consent. While mutilation is accepted in some cultures, there are severe long-term physical and psychological complications for young girls who are forced to undergo it.

This is not the first time the issue has surfaced. The practice is inadmissible, and this is especially clear if one consults sections 2.03.01, 2.03.14, 2.03.17, and 2.03.23 of the *Code of Ethics of Physicians*. It is also contrary to the *Criminal Code*.

The Corporation wishes to remind all members that they must refuse to cooperate with or participate in such procedures. Physicians called upon to treat the victims of such mutilations must be respectful and show sympathy for these patients.

Collège des Médecins du Québec

Avis du Secrétaire général
Bulletin, Vol. XXXIV, no.5 - Septembre 1994.
La mutilation des organes génitaux des femmes.

Au cours des dernières années, l'attention internationale s'est portée sur la mutilation des organes génitaux féminins. Il y a eu un afflux récent au Canada d'immigrants et de réfugiés originaires de régions où cette practique a cours.

La mutilation des organes génitaux des femmes est irréversible. Même si elle constitue un rite important dans certaines cultures, il en résulte des séquelles physiques et psychologiques à long terme pour ces jeunes filles.

Ce n'est past la première fois que ce sujet fait l'objet de discussions. Une telle practique est inacceptable si l'on se réfère particulièrement aux articles 2.03.01, 2.03.14, 2.03.17, et 2.03.23 du Code de déontologie médical. Elle va aussi à l'encontre du Code criminel.

La Corporation désire rappeler à tous ses membres qu'ils doivent refuser leur collaboration ou leur participation à de telles procédures. Les médecins appelés à traiter des victimes de telles mutilations doivent faire preuve de déférence et d'empathie envers ces patientes.

College of Physicians and Surgeons of Nova Scotia

Article from the newsletter of the Provincial Medical Board of Nova Scotia (which became the College of Physicians and Surgeons of Nova Scotia in 1996).

Female Genital Mutilation

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

Female genital mutilation is irreversible and imposed on young girls with or 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 out 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 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 infibulation after a vaginal delivery. The PMB considers FGM outside the acceptable standards of medical care in Nova Scotia and Canada.

Appendix 4: Resources on FGM

The FGM Workshop Manual

A workshop module was completed and distributed across Canada in 1998 to provide community-based information and education concerning the medical and legal aspects of FGM. The workshops provide a valuable means for providing community education and information on FGM. However, it does not address the wider issue of access to health care services.

For more information about this Community workshop manual contact:

National Organization of Immigrant & Visible Minority Women of Canada (NOIVMWC)
219 Argyle Avenue, Suite 225,
Ottawa, Ontario, K2P 2H4
Tel:(613) 232-0689 Fax:(613) 232-0988

Healthy Women's Counseling Guide

This resource kit, developed by Canadian International Development Agency (CIDA) to encourage the use of preventive health care services, has been used successfully in West, East and South Africa as well as South America and India.

For more information, contact:

Carol Vlassoff
Canadian International Development Agency (CIDA).
Email address: carol_vlassoff@acdi-cida.gc.ca

Female Circumcision/Female Genital Mutilation: Clinical Management of Circumcized Women

The American College of Obstetricians and Gynaecologists (ACOG) and the Society of Obstetricians and Gynaecologists of Canada (SOGC) produced this slide/lecture kit and manual, with illustrations and photographs of the results of different FC/FGM procedures. It identifies how to treat FC/FGM complications, counsel women from non-western cultures, and handle sensitive issues such as requests for deinfibulation (reversal of the procedure) or reinfibulation (reclosing areas following incisions made during vaginal delivery). It provides recommendations that will assist physicians care for FC/FGM patients and manage the complications that can arise.

To order this slide-lecture kit contact:

Liette Perron, Coordinator International Health Programs
Society of Obstetricians and Gynaecologists of Canada
744 Echo Drive, Ottawa, Ontario K1S 5N8
Tel: (800) 561-2416 Fax: (613) 730-4314

Modern Rites of Passage *

Since 1993, Maendeleo Ya Wanawake Organization (MYWO) and PATH (Program for Appropriate Technology in Health) have been implementing an innovative communication project in four districts of Kenya. The major goal of the project is to provide community members with accurate information about the effects of Female Genital Mutilation, or FGM, and to end this harmful traditional practice.

Staff have used various methods to reach this goal, including peer-to-peer outreach (girls, women, boys, and men), family life education through the schools, and media. Over time, it became clear that alternative ways to usher girls to maturity without circumcision were needed. Project staff developed a framework for an alternative ritual activity and investigated the feasibility of alternative rituals in the community.

The first alternative ceremony took place in Tharaka Nithi in Meru District in August 1996. Thirty girls were secluded and participated in a week-long training on reproductive health issues including pregnancy and HIV/AIDS prevention, the harmful effects of FGM, and personal hygiene. A community celebration and "gift-giving" by family, friends, and godmothers followed the training. Girls were also given a booklet that contained the community's traditional wisdom and expected code of conduct – information that is typically provided to girls during the traditional ceremonies. Since the Tharaka Nithi experience, 49 other girls have graduated to adulthood in Meru without circumcision.

A second district has also developed an alternative ritual approach. Single families organized ceremonies for their own daughters. The home of each initiate was decorated with wild flowers, girls were dressed in their best clothes, food was prepared, and family and friends visited and brought gifts for both the girl and her family. These recent successful experiences have encouraged other communities to request assistance in conducting alternative ceremonies

for their daughters. By being flexible and building on each community's traditional practices, the project has been successful in providing a way for families to welcome their daughters into adulthood without circumcision.

*Verbatim from the website: : http://www.path.org/resources/r-look/f_modern_rites_of_passage.htm

Appendix 5: Information on Defibulation

It is extremely important that the woman who is affected be counselled to prepare her for the changes that will occur after surgery. It may be wise to use a colposcope with attached camera and monitor to explain the procedure in detail. It is important to illustrate the extent of the opening that will be made and explain that if the clitoris or remnant thereof remains it will be exposed to facilitate sensation.

An adolescent may request defibulation without consulting her family. Permission to perform such surgery is contingent on the accepted legal age of consent to medical treatment according to provincial law. Confidentiality and cultural sensitivity should be observed at all times.

The limitations of the procedure must be made clear; it is not plastic surgery and, since most of the erectile tissue was excised at the time of infibulation, sexual sensation will not likely be increased by defibulation. It is helpful to explain that after defibulation there will be an increased urinary flow. It will be reassuring for the affected female to know in advance that this will happen, otherwise they may think that they have become incontinent.

Defibulation is best done under general anesthetic; just touching the external genitals can cause significant pain. The pain is both physical and psychological, and it can often evoke memories of the original operation. Under general anesthetic, the perineum can be prepped with Betadine® and then the edge of the infibulation scar can be lifted with tissue forceps. The structures underlying the anterior flap are protected with the surgeon's index finger or other forceps to avoid trauma while the infibulation scar is opened with scissors or scalpel. Afterwards, the edges of the wound are repaired with dissolvable sutures. Some surgeons may elect to use electocautery or laser equipment to carry out the procedure.

Since the surgical wound is raw, adequate analgesic coverage should be provided post-operatively, to reduce the pain associated with initial urination and during healing. A sitz bath can be used after each urination to cleanse the area, or alternately, the patient should be encouraged to take at least one daily bath.

In terms of billing, although there is no specific billing code for FGM, it is appropriate to bill deinfibulation as a vulvopasty (Personal communication: A.Lalonde April, 2000).

See also:

Lalonde A. Clinical Management of female genital mutilation must be handled with understanding, compassion. Can Med Assoc J. 1995; 52:949-950.

Plasticized hand-out on infibulation and defibulation put out by the:
Research Action and Information Network for Bodily Integrity of Women
915 Broadway, Suite 1109, NY, NY 10010
Tel: 212 477-3318 Fax: 212 477-4154