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Female Genital Cutting/Mutilation

This policy statement has been reviewed by the Social Sexual Issues Committee, the Ethics Committee, and the Clinical Practice Gynaecology Committee, and approved by the Executive and Council of the Society of Obstetricians and Gynaecologists of Canada.

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INTRODUCTION

Despite important gains made internationally to eradicate the practice, it is estimated that between 100 and 140 million girls and women worldwide currently live with female genital cutting/mutilation,[1] and every year, 3 million girls in sub-Saharan Africa, Egypt, and Sudan continue to be at risk of being subjected to the practice.[2] FGC/M is most prevalent in 28 countries in Africa and in some countries of Asia and the Middle East. With post-Second World War migration, it is also found within certain immigrant, refugee, and asylum-seeker communities in Europe, Australia, and North America (including Canada).[2]

USE OF TERMINOLOGY

There is no consensus internationally on what to call the practice. The terms most commonly used in the current literature are "female circumcision," "female genital mutilation," and "female genital cutting." Although "female circumcision" is used in many communities where FGC/M is prevalent, it is problematic because it tends to equate the practice with male circumcision. "Female genital mutilation," formally adopted by the UN and used in UN and WHO advocacy documents, calls attention to the gravity of the harm of the act; however, some consider the term judgemental and stigmatizing, especially for communities that practise it. The term "female genital cutting" is considered medically correct, more neutral, and ethically sensitive. "Female genital cutting/mutilation" is used in this statement. This term was chosen because it is considered appropriate by communities that practise it but also conveys the human rights concerns associated with the practice and the need for advocacy.

FGC/M refers to "all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons."[1] The procedure is usually carried out on girls between the ages of 4 and 14 years. In certain communities it is also performed on infants and adult women.[2]

Evidence shows that the prevalence of FGC/M globally is decreasing slowly, but changes in the practice have been noted in certain countries. These include a shift from infibulations to less invasive types of FGC/M,[3] performance of the procedure at a much earlier age, reduction of the ceremonial aspect of the practice,[4] and medicalization of the practice.[5] Recent data suggest that the medicalization of the practice, mainly through the act of reinfibulation, is also a concern in countries that receive migrants from countries where FGC/M has been documented.[4]

FGC/M is considered a harmful practice internationally and a violation of the human rights of girls and women. In many countries, including Canada, FGC/M is a criminal offence and those performing it are subject to prosecution. In Canada, when a female child is believed to have undergone or to be at risk of being subjected to the practice, health care providers have a duty to report

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under provincial child welfare legislation. The practice has been condemned by a growing number of international and national organizations, including the WHO, the World Medical Association, the International Federation of Gynaecology and Obstetrics, and the Organization of African Unity. In 1992, the Society of Obstetricians and Gynaecologists of Canada was one of the first associations in Canada to issue an official policy document against the practice.[6] Provincial colleges of physicians and surgeons in Alberta, British Columbia, Nova Scotia, Manitoba, Ontario, and Quebec have endorsed the World Health Organization position on FGC/M and/or adopted official statements calling for its elimination and providing specific directions to their physicians with regard to the practice.

GLOSSARY

Infibulation: Excision of part of the external genitalia and stitching of the vulvo-vaginal opening (Type III).

Defibulation: Opening of the vulvo-vaginal opening to open the infibulated genitalia.

Reinfibulation: Stitching of the vulvo-vaginal opening to close it after defibulation and delivery.

Medicalization: Situations in which FGC/M is practised by any category of health care provider, whether in a public or private clinic, at home, or elsewhere. It also includes the surgical procedure of reinfibulation at any time in a woman's life.

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."[7]

CLASSIFICATION OF FGC/M

WHO has classified FGC/M into four types[1]:

- Type I: Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).
- Type II: Partial or total removal of the clitoris and labia minora, with or without excision of the labia majora (excision).
- 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 (infibulation).
- Type IV: All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping, and cauterization.

The type of procedure varies considerably across countries, within countries, and across ethnic groups. It is estimated that the majority of the women with FGC/M are subjected to clitoridectomy (Type I), excision (Type II), or "nicking" where no flesh is removed (Type IV)[1]; approximately 10% of women are subjected to infibulation, the most severe type of the practice (Type III).[8] WHO recognizes that this definition of Type IV includes practices that are legally accepted and not generally considered to constitute FGC/M in many countries (e.g., genital surgery and piercing). WHO recommends that in determining whether genital practices should be categorized as FGC/M, human rights principles should be applied, including the right to health, the rights of children, and the right to non-discrimination on the basis of sex.[1]

HEALTH CONSEQUENCES FOR GIRLS AND WOMEN

FGM/C has no known health benefits for girls or women. As the procedure is often done without anaesthesia by a traditional practitioner using scissors, razor blades, and/or broken glass,[2] the immediate health risks and consequences can be serious and life-threatening. They include severe pain, shock, urinary retention, ulceration of the genitals, injury to adjacent issue, and in some cases death.[2] Longer term complications include infections, keloid, reproductive tract infections and sexually transmitted infections (especially genital herpes), increased risk of HIV, birth complications, danger to the newborn, and psychological consequences, including fear of sexual intercourse and post-traumatic stress disorder. Furthermore, women who have undergone Type III FGC/M are at risk of complications because of frequent surgery to deinfibulate and possibly reinfibulate, as well as urinary and menstrual problems, painful sexual intercourse, and infertility.[1]

PERPETUATION OF THE PRACTICE OF FGC/M

The perpetuation of FGC/M is due to an array of complex social, religious, and cultural reasons intrinsically linked to traditional beliefs and values related to women's sexuality and the perceived need to control their sexual and reproductive capacity.

ABBREVIATIONS

FGC/M	female genital cutting/mutilation
UN	United Nations
WHO	World Health Organization

CARE OF GIRLS AND WOMEN WITH FGC/M IN CANADA

WHO/UNFPA/UNICEF defines female genital cutting/mutilation as "all procedures involving partial or total removal of the external female genitalia or other injury to the female organs for non-medical reasons."[9] European and American studies looking specifically at health care professionals' knowledge, perception, and management of birth for women with FGC/M found significant gaps in knowledge and clinical practice related to their care.[10–15] Of special concern were the lack of clear guidelines for the care of women with FGC/M, including how to deal with requests for reinfibulation or resuturing of the infibulations after delivery, and the extent of the perinatal repairs.[11]

POSITION

The mission of the SOGC is to promote excellence in the practice of obstetrics and gynaecology and to advance the health of women through leadership, advocacy, collaboration, outreach, and education. The mission is based on the firm belief that women should have equitable access to optimal, comprehensive health care provided with integrity, compassion, and dignity.

SOGC lends its voice to major international and national organizations that have recently reaffirmed their commitment to eliminating FGC/M within this generation[1] and to stopping the medicalization of the practice worldwide, including in countries that, because of international migration, will become home to a growing number of girls and women who have been subjected to the practice.[4]

SOGC believes that FGC/M is a violation of the rights of girls and women to life, to physical integrity, and to health. The practice has no medical benefit and is recognized as being harmful to physical and psychological well-being. The SOGC believes that health care professionals are in a privileged position to use their knowledge, influence, and authority to work towards the abandonment of the practice and to ensure that girls and women living with FGC/M receive culturally competent care.

SOGC advises members that

- Performing or assisting with the practice of FGC/M in Canada is a criminal offence.
- Reporting to appropriate child welfare protection services is mandatory when it is suspected that a female child has been subjected to FGC/M or is at risk of being subjected to the practice.
- Requests for reinfibulation must be declined.

SOGC encourages members to

- Strengthen their knowledge and understanding of FGC/M and develop greater skills related to the provision of culturally competent care for women living with FGC/M and their families.
- Educate and counsel families against having FGC/M performed on female family members.
- Advocate for the availability of and access to culturally competent support service providers (health interpreters, social workers, etc.) who are knowledgeable about FGC/M to ensure that women and families receive adequate and respectful counselling and support.
- Lend their voices to community-based initiatives seeking to promote the elimination of FGC/M.
- Use interactions with patients with FGC/M as opportunities to educate families.

SOGC supports

- Community-based activities and initiatives promoting the elimination of FGC/M, including education and support.
- Community-based support services for women and families from communities with a high prevalence of FGC/M.
- Research into FGC/M in Canada, including women's perceptions of FGC/M and their experiences accessing sexual and reproductive health care, and the perspective, knowledge, and clinical practice of health professionals with respect to FGC/M.

SOGC recommends that

- The issue of FGC/M should be integrated into the medical school curriculum for both students and residents. The curriculum should focus on
  - providing information related to the factors surrounding the practice;
  - the beliefs and values supporting its continuation;
  - the health consequences of the practice and recognition and management of the complications of FGC/M, including obstetric care;
  - how to counsel women and families on FGC/M-related issues.

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