Increasing Physician Education about and Resources for Female Genital Mutilation/Cutting

Ghazal Haddad

Hira Raheel

Type of Paper: Position Paper

Approved: Date

Revised: 2019/09/15

CFMS

Canadian Federation of Medical Students

FEMC

Fédération des étudiants et des étudiantes en médecine du Canada

CFMS Canadian Federation of Medical Students **FEMC** Fédération des étudiants et des étudiantes en médecine du Canada

Briefing Note

Increasing Physician Education about and Resources for Female Genital Mutilation/Cutting

Date 2019/09/15

POSITION PAPER

Female genital mutilation or cutting (FGM/C) is a long-standing custom and is practiced in 30 countries in Africa, the Middle East, and Asia. Even though the origin of FGM/C practices lies outside of Canada, the borders of Canada are not immune to this practice. With Canada being home to a large number of ethnic groups originating from countries in which FGM/C is regularly practiced, it is expected that a considerable proportion of women in Canada would have undergone FGM/C. This issue is especially pertinent to healthcare providers due to the medical complications associated with FGM/C. Ontario doctors perform reversal surgeries for infibulation (FGM/C type III) for the purposes of childbirth or sexual activity. Various reports have found deficits in the knowledge of healthcare workers about FGM/C and their attitude toward FGM/C patients. Although Canadian data is sparse on this matter, one report found that affected women are dissatisfied with the high Caesarean section rates among women who have undergone FGM/C and that community-providers attribute this to a lack of knowledge and education in treating FGM/C patients among healthcare workers. This paper outlines concerns with regards to FGM/C awareness in the Canadian medical system and puts forth recommendations in order address those concerns.

CONCERNS

1. There is currently little to no content in medical education on FGM/C and trauma informed care for survivors.
2. There is a lack of strong advocacy from Canadian physicians against FGM/C and bringing awareness to the issue.
3. There is huge gap in research into the prevalence of FGM/C in Canada and no official funding incentives exist to encourage it.
4. *There is a paucity of sexual health resources for FGM/C survivors in Canada.*

RECOMMENDATIONS

1. That medical schools and post-graduate medical education programs improve and increase medical student and physician education on FGM/C and trauma-informed care for FGM/C survivors.
2. That physicians serve as strong advocates in initiatives seeking to eliminate FGM/C.
3. That the Canadian Institutes of Health Research (CIHR) allocates research funding within the next 5 years to address unanswered questions about FGM/C in Canada.
4. That Health Canada and provincial and territorial ministries of health should work together with appropriate stakeholders to create specialized sexual health resources for FGM/C survivors.

Introduction/Background

Practice of female genital mutilation/cutting

Female genital mutilation or cutting (FGM/C) is a long-standing custom and is practiced in 30 countries in Africa, the Middle East, and Asia (1). It refers to procedures that alter the female genitalia for non-medical reasons (1). The World Health Organization classifies FGM/C procedures into four categories and recognizes that there is considerable variation in how these procedures are conducted across different countries, between ethnic groups, and even within a country (1). The four categories are as follows:

Type I) Partial or total removal of the clitoris and/or the prepuce.

Type II) Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora.

Type III) Narrowing of the vaginal orifice with the creation of a covering seal by cutting and juxtaposing the labia minora and/or the labia majora, with or without the excision of the clitoris.

Type IV) Any other harmful procedures to the female genitalia for non-medical purposes (1).

FGM/C is mostly performed by traditional or community cutters. This practice is recognized internationally as a violation of human rights since it has no health benefits and causes significant harm to those affected (1). The reasoning behind this practice varies depending on the region and country. In some areas, FGM/C is performed as a rite of passage to adulthood or done to preserve social acceptance (2). In other communities, the procedure could also be performed as a means of promoting marriageability, preserving virginity before marriage, ensuring loyalty after marriage, aesthetic reasons, or preventing rape. It is believed in some communities that FGM/C is required by religion; however, the practice is not found in major religious texts (3). Short-term medical complications include severe pain, excessive bleeding, infections, urinary problems, shock, and even death (1). Long-term consequences can include urinary, vaginal, menstrual, sexual, and psychological problems of various severities (1). The procedure is typically conducted between infancy and adolescence. The highest prevalence of FGM/C are in Somalia (97.9%), Guinea (96.8%), Djibouti (93.1%), and Egypt (87.2%) (3).

Relevance of FGM/C from a Canadian Perspective

Even though the origin of FGM/C practices lies outside of Canada, the borders of Canada are not immune to this practice. With Canada being home to a large number of ethnic groups originating from countries in which FGM/C is regularly practiced, it is expected that a considerable proportion of women in Canada would have undergone FGM/C. In fact, using Canada census data from 2016 and estimates from UNICEF for FGM/C prevalence by country, we estimate that nearly 129,535 women in Canada have undergone this practice, constituting more than 0.7% of all women in Canada (Table 1, see Appendix). Additionally, in 2017, a global survey of 385 women belonging to a community which is readily known to practice FGM/C, reported that 5% of women (18 out of 385) were residing in Canada and 2 of the women actually had undergone FGM/C procedure within Canada, whereas others were taken out of the country for the procedure (5). Due to the taboo nature of FGM/C, reliable statistics on its prevalence within Canada are not available, despite FGM/C having been deemed a criminal offense under aggravated assault within Canada since the 1990s. Considering the small and limited size of the aforementioned survey, it is reasonable to infer that there are likely thousands of females in Canada living with the repercussions of FGM/C or are at risk of being cut. With the continuing arrival of immigrant and refugee families into

Canada and the potential desire of some families to retain traditional practices within future generations, there are likely young girls living in Canada that are at risk of FGM/C.

This issue is especially pertinent for healthcare providers due to the medical complications associated with FGM/C. Ontario doctors perform reversal surgeries for infibulation (FGM/C type III) for the purposes of childbirth or sexual activity (6). In fact, the reversal procedure has been billed 308 times in Ontario between 2010 and 2017 (6). Still, most Ontario doctors are unfamiliar with the obstetrical management of patients with FGM/C (6). Primary care providers in Ontario often refer patients with FGM/C to experienced gynecologists for routine Pap smears, and common health problems such as stress incontinence, difficulty managing periods, pain during intercourse, or lack of pleasure during sex (6). The need to refer patients to specialist for what should be routine healthcare problems can place increased strain on the healthcare system, create bottlenecks for accessing specialized service, and keep patients waiting unnecessarily longer for routine aspects of care. All these outcomes, consequently, could lead to diminished trust in the healthcare system and decreased willingness to access healthcare services. For these reasons, it is essential that physicians and the health-care system are well-informed and equipped to identify and manage female patients who have undergone FGM/C in a sensitive and appropriate manner.

Physician education on FGM/C

Various reports have found deficits in the knowledge of healthcare workers about FGM/C and their attitude toward FGM/C patients. Although Canadian data is sparse on this matter, one report found that affected women are dissatisfied with the high Caesarean section rates among women who have undergone FGM/C and that community-providers attribute this to a lack of knowledge and education in treating FGM/C patients among healthcare workers (5). Another study reported FGM/C survivors in Canada receiving hurtful comments from their caregivers (87.5% of those surveyed) and experiencing disrespect from their caregivers (57.4%) (7). The Society of Obstetricians and Gynecologists of Canada (SOGC) has also recommended the integration of FGM/C into medical school curricula for both students and residents (8).

Principles/Stance

1. Canadian physicians must have adequate knowledge and training regarding FGM/C and the management of its complications.
2. Canadian physicians have a responsibility to advocate on behalf of their patients in order to reduce the adverse health outcomes associated with FGM/C.
3. There should be adequate Canada-specific data to support evidence-based practice regarding the care of FGM/C survivors.
4. Canadian FGM/C survivors should have access to adequate sexual health resources.

Concerns

1. *There is currently little to no content in medical education on FGM/C and trauma informed care for survivors.*
2. *There is a lack of strong advocacy from Canadian physicians against FGM/C and bringing awareness to the issue.*
3. *There is huge gap in research into the prevalence of FGM/C in Canada and no official funding incentives exist to encourage it.*
4. *There is a paucity of sexual health resources for FGM/C survivors in Canada.*

Recommendations

1. **That medical schools and post-graduate medical education programs improve and increase medical student and physician education on FGM/C and trauma-informed care for FGM/C survivors.**

In light of instances of inadequate care for women who have undergone FGM/C in Canada and the large population of women with FGM/C in Canada, it is of utmost importance that physician education on the topic of FGM/C care is increased. Specifically, it is imperative to emphasize care provision that is culturally-sensitive and trauma-informed. As an example, physicians may not be familiar with the culturally-sensitive terminology when discussing FGM/C: those who have undergone FGM/C feel unease or offended when the word "mutilation" is used, due to its negative connotation. A relevant study reported on an educational intervention in Central Maine in the United States for certified nurse-midwives to increase their knowledge on providing obstetric care for those living with FGM/C. The study found that the midwives' level of self-confidence for the management of FGM/C considerably increased following the intervention (9). This and others serve as examples of successful interventions for increasing the knowledge surrounding FGM/C for healthcare providers.

As such, we recommend the following:

a) Early introduction of FGM/C related health issues to future physicians by dedicating at least 10 minutes of lecture time during the pre-clerkship years in Canadian medical schools.

b) Dedication of one training session within Obstetrics and Gynecology (Ob/Gyn) rotations during clerkship and within Canadian Family Medicine, Ob/Gyn, and Pediatrics residency programs.

These trainings should consist of the presentation of relevant information and recommendations, discussion of cultural sensitivity, and practical demonstration of appropriate obstetrical care for women with FGM/C. Importantly in the contexts of pediatrics and family medicine, these trainings should include a discussion of appropriate strategies for approaching conversations with patients regarding the harms of having FGM/C performed on female family members. As recommended by SOGC, they should also emphasize reporting to appropriate child welfare protection service when it is suspected that a child has been subjected or is at risk of being subjected to FGM/C. These trainings can also be offered through external organizations. For example, Women's Health in Women's Hands Clinic in Toronto, ON is in the process of developing culturally-sensitive, trauma-informed, and comprehensive training modules on the care of clients with FGM/C for healthcare professionals (10). These modules can be applied for specific use in medical curricula.

2. **That physicians serve as strong advocates in initiatives seeking to eliminate FGM/C**.

Physicians are uniquely positioned to lead initiatives that work to reduce the incidence of FGM/C and to advocate for this purpose alongside community groups. However, it is critical that these initiatives do not propagate the stigma that already surrounds this important issue. As subject experts witnessing the harmful effects of FGM/C and developing relationships with those affected by FGM/C, physicians are

critical to advocating for culturally-sensitive initiatives to reduce FGM/C without alienating victims and while engaging the relevant stakeholders.

3. **That the Canadian Institutes of Health Research (CIHR) allocates research funding within the next 5 years to address unanswered questions about FGM/C in Canada.**

In order to begin to recognize the relevance of FGM/C as an issue of concern in Canada, more research and research funding must be dedicated to this issue. Research is needed to, primarily, accurately determine the number of women in the country who have undergone and are at risk of undergoing FGM/C. More research is necessary to determine the impact of FGM/C on the sexual, reproductive and mental health of survivors in order to inform the provision of trauma-informed care for this sensitive issue. Research on FGM/C should also be focused on evaluating physician training, confidence in managing FGM/C, and cultural competencies. There are also several other knowledge gaps in understanding the obstetrical and gynaecological consequences of FGM/C which need to be addressed (11). This lack of research on FGM/C is aggravated by the general under-funding of women's health research in Canada (12). FGM/C-specific research funding from the CIHR is critical in answering these questions.

4. **That Health Canada and provincial and territorial ministries of health should work together with appropriate stakeholders to create specialized sexual health resources for FGM/C survivors.**

Specific health services and resources catering to FGM/C survivors are lacking in Canada. One of these is specialized sexual health resources (7). Additionally, since immigrants likely constitute a high proportion of FGM/C survivors in Canada, survivors would face the systemic barriers that result in challenges in accessing, using, and benefiting from health services in Canada, including sexual health resources (13). These barriers are exacerbated with the lack of resources for and knowledge about the survivors' FGM/C-related concerns. As such, it is necessary to have easily-accessible resources for survivors. To achieve this, we recommend that Health Canada and provincial and territorial ministries of health commit to create and to support the creation of dedicated sexual health resources for FGM/C survivors within the next 5 years, including a list of healthcare providers who are familiar with FGM/C and its consequences. Such a resource would be invaluable to all Canadians who have undergone FGM/C.

References

1. World Health Organization. WHO guidelines on the management of health complications from female genital mutilation. World Health Organization; 2016.

2. Ali AA. Knowledge and attitudes of female genital mutilation among midwives in Eastern Sudan. 2012;9(1):23.

3. UNICEF. At least 200 million girls and women alive today living in 30 countries have undergone FGM. 2016.

4. Census Canada. Census Profile. 2016 Census. (Statistics Canada Catalogue no. 98-316-X2016001).

5. Taher M. Understanding Female Genital Cutting in the Dawoodi Bohra Community: An Exploratory Survey. Sahiyo, https://sahiyo.; 2017.

6. Henry M. Ontario doctors repairing cases of female genital mutilation done a world away. Toronto Star. 2017.

7. Chalmers B, Hashi KO. 432 Somali women's birth experiences in Canada after earlier female genital mutilation. Birth. 2000;27(4):227-34.

8. Perron L, Senikas V. Female genital cutting/mutilation. Journal of Obstetrics & Gynecology Canada. 2012;34(2):197-200.

9. Jacoby SD, Smith A. Increasing certified nurse-midwives' confidence in managing the obstetric care of women with female genital mutilation/cutting. Journal of Midwifery & Women's Health. 2013;58(4):451-6.

10. Women's Health in Women's Hands (WHIWH). FLOURISH: Communities collaborating to address female genital mutilation/cutting project. In: WHIWH, editor. 2018.

11. Abdulcadir J, Rodriguez MI, Say L. Research gaps in the care of women with female genital mutilation: an analysis. BJOG: An International Journal of Obstetrics & Gynaecology. 2015;122(3):294-303.

12. Galea L. Gender Equity in CIHR Research Funding: Implications for Women's Health Research: Women's Health Research Institute; 2017.

13. Campbell RM, Klei A, Hodges BD, Fisman D, Kitto S. A comparison of health access between permanent residents, undocumented immigrants and refugee claimants in Toronto, Canada. Journal of Immigrant & Minority Health. 2014;16(1):165-76.

Appendix

Country	*Percentage of girls/women 15-49 who have undergone FGM/C by place of residence (3)*	*Number of female residents in Canada, measured by country's demonym ethnic group (4)*	*Estimate of females who have undergone FGM/C in Canada by country's demonym ethnic group*	*Name of ethnic group in Census Canada (4)*
Benin	9.20%	2320	213	Beninese
Burkina Faso	75.80%	1485	1126	Burkinabe
Cameroon	1.40%	12230	171	Cameroonian
Central African Republic	24.20%	No data	N/A	N/A
Chad	38.40%	885	340	Chadian
Côte d'Ivoire	36.70%	5450	2000	Ivorian
Djibouti	93.10%	920	857	Djiboutian
Egypt	87.20%	47410	41342	Egyptian
Eritrea	83%	12430	10317	Eritrean
Ethiopia	65.20%	22385	14595	Ethiopian
Gambia	74.90%	475	356	Gambian

Ghana	3.80%	17770	675	Ghanaian
Guinea	96.80%	3455	3344	Guinean
Guinea-Bissau	44.90%	No data	N/A	
Iraq	8.10%	34955	2831	Iraqi
Kenya	21%	5685	1194	Kenyan
Liberia	44.40%	1360	604	Liberian
Mali	82.70%	2210	1828	Malian
Mauritania	66.60%	No data	N/A	N/A
Niger	2%	No data	N/A	N/A
Nigeria	18.40%	24805	4564	Nigerian
Senegal	23.46%	4670	1096	Senegalese
Sierra Leone	86.10%	1295	1115	Sierra Leonean
Somalia	97.90%	32330	31651	Somali
Sudan	86.60%	9645	8353	Sudanese

Togo	4.70%	2430	114	Togolese
Uganda	0.30%	2830	8	Ugandan
United Republic of Tanzania	10%	2310	231	Tanzanian
Yemen	18.50%	3305	611	Yemeni
Total	N/A	255045	129536	

Table 1: Estimate of prevalence of FGM/C in Canada, based on global FGM/C statistics and 2016 Canada census data. The first column represents the percentage of girls and women of age 15-49 who have undergone FGM/C by country of residence. The data in this column was obtained from UNICEF and spans from 2004 to 2017 for different countries (3). The second column is the number of female Canada residents from the demonym ethnic group of each country (specified in the fourth column) obtained from the 2016 Canada census (4). The third column is the estimate of females in Canada who have undergone FGM/C. It is obtained by multiplying the second column by the proportion represented by the first column. This estimate has undeniable imperfections. For example, the first column represents females from 15-49 years old but the census data in the second column encompasses females of all ages. Furthermore, the ethnic groups resident in Canada are not necessarily representative of those ethinic groups resident in each of the countries in the first column. Additionally, many countries encompass several ethnic groups; but here, one ethinic group is considered per country. However, this estimate adequately serves as a means to demonstrate that there are likely tens of thousands of females in Canada living with FGM/C.