

**TTSTA Tuesday**  
**Week #7**

Good Morning!

Gina Thompson developed an Islam Primer and Health Considerations as a wonderful follow up to the TTSTA Tuesday from last week. Please review this Newsletter to familiarize yourself how we may be sensitive to the beliefs and practices of Islamic clients.

Please let me know what additional topics you would like to learn about. I appreciate your willingness to serve a new population at our nursing centers.

Thank you!

# A Brief Primer on the Islam Religion and Considerations for Health Care Providers

Gina Thompson, RN  
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November 2, 2015

## Population and Projected Growth

An estimated 1.57 billion people in the world practice Islam, a religion second in size only to Christianity. According to the Pew Research Center (2015), Islam is the fastest growing religion and will equal the number of Christians in the world by 2050, totaling approximately 2.76 billion, or one-third the world's population. There are two components that attribute to the projected growth. First, Muslims have the highest average fertility rate at 3.1 per woman, and according to The Pew, 2.1 children per woman is the minimum number needed to maintain a population (2015). Second, 34% of Muslims are under the age of fifteen, the largest of any other religion (2015).

## The Islamic Calendar and Important Holidays

The Islamic calendar is based off the lunar cycle, meaning each month begins with a new moon, and lasts between 29-30 days (the US calendar is based off the solar Gregorian cycle) (Christian Broadcasting Network [CBN], n.d.). There are 354 days in the Islamic calendar, and a new day begins at sunset (CBN, n.d.).

### Ramadan

Ramadan is celebrated in the ninth month of the Islamic calendar. Ramadan (*Eid-ul-Fitr*) is a period of fasting, prayer, charity and self-reflection (Council of Islamic Organizations of Greater Chicago [CIOGC], 2013; Timeanddate.com, 2015, emphasis added). It is believed the Prophet Mohammad discovered the initial verses of the Koran

during Ramadan (Timeanddate, 2015). One of the Five Pillars of Islam, fasting is required during the periods of dawn to dusk during the ninth month (PBS.org, n.d.). Ramadan is considered “one of the most significant holidays in the Muslim religious year” (Pathy, Mills, Gazeley, Ridgley & Kiran, 2011).

**Health Considerations.** There are fasting concerns for people with special health conditions such as those with diabetes, strict medication treatment regimens and those pregnant or are breastfeeding. Populations exempt from fasting include those who are pregnant or diabetic, plus the mentally ill, children or the elderly (2011). It should be noted that those who miss the fast must “make up the work” (or their family members do the work) through charitable work in the future (2011, p. 49). Although afore mentioned conditions are exempt from participating in fasting, many choose to do so to remain spiritually close to Allah (the Arabic word for God) (2011; PBS, n.d.). Islamic law allows during emergency medical situations for the ingestion of pills, glucose or fluids (2011). *(Writer’s note: there is controversy whether inhaled powders such as MDI bronchodilators count as an allowable substance during dawn to dusk (2011), so I would add asthma to the list of special health concerns).* According to Pathy et al., Muslims are more likely to receive fasting advice from other Muslims rather than their non-Muslim health care provider (2011). This opinion is echoed by Carter & Rashidi (2004), saying the family is a system and decisions are made together, including those regarding health care. Providers should inquire if clients fast, what has worked for them in the past as far as managing their medications in a way that’s devoid of judgment (2011). One suggestion by Pathy et al. (2011) was to create a patient education pamphlet, encouraging clients with certain health conditions to discuss options with their provider during the fast (for example, checking blood sugars more often, drink fluids

frequently during sundown to rehydrate). Ramadan is estimated to start June 7, 2016 (timeanddate, 2015).

## **Hajj**

Pilgrimage is one of the Five Pillars of Islam (PBS, n.d.). Each devout Muslim is to make the pilgrimage to Mecca at least once in their life, except for the frail, elderly or those who can't afford to (PBS, n.d.). The Hajj occurs during the last month of the Islamic calendar, estimated to occur around September 8 to 13<sup>th</sup> in 2016 (Hajjbound.com, 2015). The Hajj is a more solemn celebration than Ramadan, recognizing Abraham's willingness to sacrifice his son Ishmael (PBS, n.d.). The Hajj ends with the Feast of Sacrifices (*Eid-ul-Adha*), where pilgrims donate their favored domestic livestock (CIOGC, 2013, emphasis added). The meat is cooked and served to the poor (2013).

## **Ashura**

The first month of the Islamic calendar is called "*Muharram*" (CBN, 2015, emphasis added). Some Muslims recognize days nine and ten, (the *Ashura*), by fasting in memory of the day God saved Moses and the Israelites fleeing Egypt (CIOGC, 2013, emphasis added). Shia and Sunni Muslims recognize the tenth day of Muharram as a day of mourning in memory of Hussein ibn Ali, grandson of the Prophet Mohammad killed in the Battle of Karbala (2013).

## **Considerations for Health Care Providers**

### **Clothing**

Muslim women may only expose certain parts of their body, the "awrah," in the presence of "Mahram" males, or those who are related to the woman by marriage or blood (Rabin, 2010, p. 2). Because of this, female Muslims are not allowed to be alone in a room with men who are not her family or spouse (2010). Muslim women prefer and request

female providers, and often times have other family members in attendance (2010). Islamic law allows examination by a male provider in periods of medical emergency, and gloves should be used to avoid direct skin contact (2010). Providers can ease concerns by inquiring about client's values, offer for women to wear their own clothing, only exposing areas needed for examination and allow women to keep on their headpieces (2010).

### **Eye Contact**

Direct eye contact is avoided, especially between a Muslim woman and a male provider (Carter & Rashidi, 2004). The avoidance of eye contact, even by Muslim males, may be misinterpreted as low self-esteem or evasive behavior (2004).

### **Spirituality**

A small study by Tirodkar, Baker, Makoul, Khurana, Paracha & Kandula (2011) interviewed South Asian immigrants in Chicago. Among the Muslim immigrants, spirituality and a higher power are cited as the drivers of health and/or disease (2011). Practicing *Namaaz* (regular daily prayer) was viewed as preventative, with Allah bestowing health in return for regular devotion (2011, emphasis added). Study participants listed stress, tension, poor diet and lack of exercise as contributors to poor health, and within the control of the individual (2011).

### **Holistic Viewpoint**

According to Tirodkar et al., Muslim's concept of health is very holistic, guided by the ritual of daily prayer and following of the Koran (2011). The Koran echoes this holistic belief, teaching a balance between the soul (*Nafs*), mind (*Aghl*), body (*Badan/Jesm*), emotion (*Atefah*) and spirit (*Rouh*) (Carter & Rashidi, 2004, emphasis added). All aspects of health are interconnected, and it is believed health care providers can't treat one component without consideration of the impact on the balance between systems (2004). Alluded to

above, the family is a unit and decisions are made together (2004). Providers should understand Muslims are likely to discuss treatment recommendations with their family before agreeing to initiate treatment (2004).

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**TTSTA Tuesday**  
**Week #8**

Good Morning,

This TTSTA Tuesday is compliments of a resource Bev shared with me from the policy organization [Migration Policy Institute](#). Its [mission](#) is to: The Migration Policy Institute is an independent, nonpartisan, nonprofit think tank in Washington, DC dedicated to analysis of the movement of people worldwide.

In light of the recent terrorist attacks in Paris and other countries, and reactions to those attacks, I wanted to share 10 facts about refugee resettlement. One question and response is pasted below. Please review the full response for this question and the other 9 to better understand the journey of refugees.

Question: Is the U.S. Refugee Resettlement Program a Conduit for Terrorists?

Fact: Refugees are intensively vetted for security threats before being resettled in the United States...It take 18 to 24 months for the checks for proposed refugees to the United States to be conducted. Of the 784,000 refugees resettled in the United States since 9-11-01, three have been arrested for planning terrorist activities-two of who were planning attacks outside the country.

Feedback and topics to review welcomed!

All the Best,

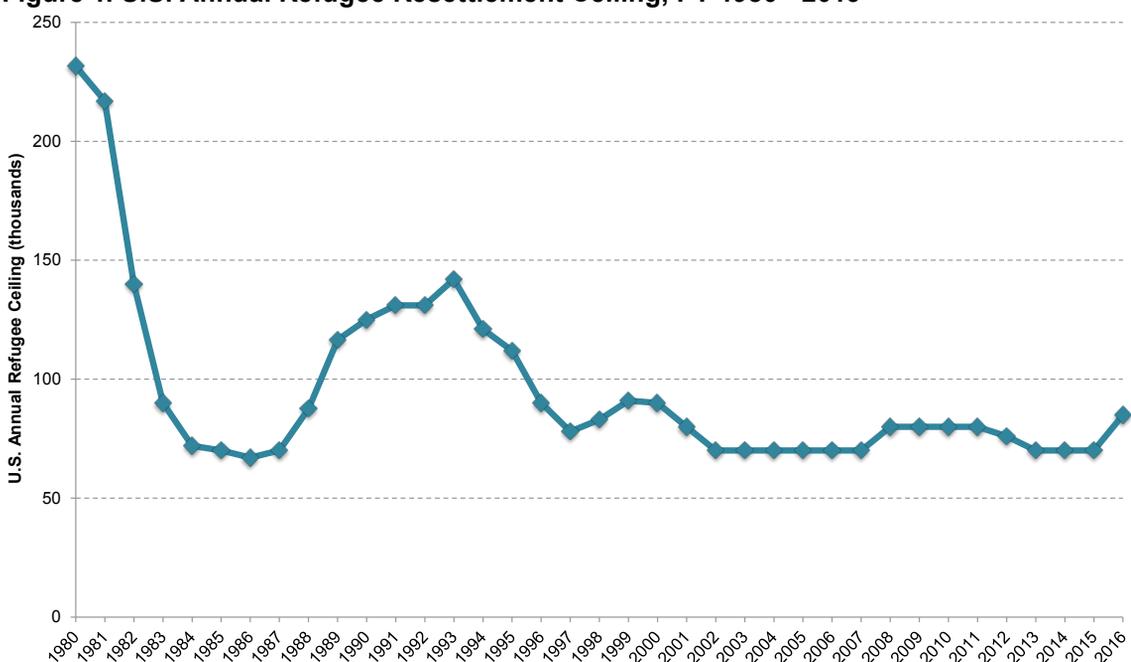
## Ten Facts about U.S. Refugee Resettlement

By Randy Capps and Michael Fix

As Europe struggles to absorb huge flows of asylum seekers and migrants from Syria, Iraq, Eritrea, and elsewhere, there are calls for the United States, which runs the largest official resettlement program in the world, to welcome more Syrian refugees. Responding to these calls, the Obama administration has announced its intention to raise the annual ceiling on U.S. refugee admissions to 85,000 for the fiscal year that began October 1 and to 100,000 the following year, up from 70,000 for the year that ended September 30. Within that 85,000 cap, the administration has committed to resettle at least 10,000 Syrian refugees this fiscal year<sup>1</sup>—a substantial increase from the approximately 2,000 Syrian refugees resettled in the United States since civil war broke out in 2011.<sup>2</sup>

The proposed U.S. refugee ceiling of 85,000 is quite modest when compared to up to 800,000 migrants projected to seek asylum in Germany by the end of 2015.<sup>3</sup> And the number of refugees worldwide is at a record high, with millions from Syria alone now housed in makeshift camps and other, often tenuous arrangements in neighboring Turkey, Jordan, and Lebanon. The U.S. refugee ceiling has at times been much higher, for instance 231,700 in 1980 and 142,000 in 1993.<sup>4</sup>

**Figure 1. U.S. Annual Refugee Resettlement Ceiling, FY 1980 - 2016**



Source: U.S. Department of State, Bureau of Population, Refugees and Migration.

How many refugees should the United States take? How many can the country afford to resettle? How well will new groups of refugees—particularly from Syria—integrate? What are the risks—security or otherwise—of taking in more refugees from unstable regions such as the Middle East? These questions touch off intense policy discussions about the future of U.S. refugee resettlement policy and the capacity of the United States to help respond to Europe’s refugee crisis.

As policymakers address these questions, it is worth reviewing some basic facts about refugee resettlement in the United States that have often been overlooked in current debates. These facts are drawn from recent Migration Policy Institute (MPI) research, analysis of U.S. government policies, and other sources.

***Question: Are Refugees Mostly Working or Unemployed?***

**Fact: The U.S. refugee resettlement system emphasizes self-sufficiency through employment, and most refugees are employed.** In fact, refugee men are employed at a higher rate than their U.S.-born peers, with two-thirds of refugee men employed during the 2009-11 period, compared to 60 percent of U.S.-born men. More than half of refugee women were employed during the same period—the same rate as U.S.-born women.<sup>5</sup> The high employment of refugees increases their tax payments and other economic contributions, while decreasing their dependency on public assistance and services over the long run.

***Question: Do Refugees Depend on Public Benefits?***

**Fact: Although many refugees initially depend on public benefits, most quickly become self-sufficient.** Unlike most other groups of immigrants, refugees are immediately eligible for public benefits such as cash welfare, food assistance, and health insur-

ance coverage. During their first five years in the United States, refugees are more likely than other immigrants and the U.S. born to receive public benefits. But benefits usage declines with length of residence, and after ten years, most of this gap closes. During the 2009-11 period, less than one-quarter of refugee households with at least a decade of U.S. experience received food stamps, compared to 11 percent for the U.S. born; and only 3 percent of refugee households received cash welfare benefits, compared to 2 percent for the U.S. born.<sup>6</sup> Fewer than 15 percent of refugee adults had public health insurance coverage after a decade in the United States, compared to 11 percent of U.S.-born adults.<sup>7</sup>

***Question: Do Refugees Improve Their Economic Position After They Are Resettled?***

**Fact: Refugees’ incomes rise over time, almost reaching parity with the U.S. born.** Refugees generally arrive with very limited resources; many arrive penniless. Over time, however, they find jobs, advance economically, and become self-sufficient. The median household income for recent refugees—those arriving within the past five years—was just 42 percent of the median for U.S.-born population in the 2009-11 period.<sup>8</sup> But for those who had arrived 10-20 years earlier, their median income was 87 percent of that for the U.S. born. Rising income and falling public benefit dependency demonstrate the increasing self-sufficiency of refugees and their increasingly positive fiscal contributions over time.

***Question: Is the U.S. Refugee Resettlement Program a Conduit for Terrorists?***

**Fact: Refugees are intensively vetted for security threats before being resettled in the United States.** The U.S. government thoroughly screens refugees’ backgrounds—an intensive process involving the Departments of Homeland Security and State, the Federal Bureau of Investigation, and national intelligence agencies. It takes 18 to 24

months for the checks for proposed refugees to the United States to be conducted (compared to four months in Canada).<sup>9</sup> Of the 784,000 refugees resettled in the United States since September 11, 2001, three have been arrested for planning terrorist activities—two of whom were planning attacks outside the country.<sup>10</sup>

### *Question: Does the Federal Government Absorb the Full Costs of Settling Refugees? Are Costs Rising Rapidly?*

**Fact: Although the federal government funds refugee resettlement assistance, funding has been limited, and the program is a public-private partnership by design.**

As a result, private agencies, NGOs, and community organizations offer substantial support for refugees. Aside from the costs of public benefits, the Office of Refugee Resettlement spends approximately \$600 million annually on refugees, and another \$350 million is spent by the State Department Reception and Placement (R&P) program.<sup>11</sup> These budgets have not increased sufficiently in recent years to account for inflation or for increased resettlement needs. Private resettlement agencies and other community institutions step up to fill gaps in assistance. One study by a resettlement agency suggested that federal funding under the R&P program covered just 39 percent of initial resettlement costs, with the rest borne by the agency and its community partners in the form of other funding, volunteer labor, and in-kind contributions.<sup>12</sup>

### *Question: Do Refugees Come to the United States with Low Levels of Education?*

**Fact: Refugees are more likely to have a high school degree than other immigrants, and just as likely as the U.S. born to have graduated from college.** Seventy-five percent of refugee adults in the 2009-11 period had at least a high school education—above the 68 percent rate for other immigrants but below the 89 percent rate for U.S.-born adults.<sup>13</sup> Twenty-eight percent of refugee adults had at least a four-year college degree, roughly equivalent to the 29 percent of U.S.-born adults and 27 percent

of other immigrants with degrees.

### *Question: Do Refugees Embrace Their New Country?*

**Fact: Refugees are on a fast track for permanent residency and citizenship, and a large majority becomes citizens.** One year after arrival, refugees are required to apply for legal permanent residence; five years later, they become eligible to naturalize. As a result, a relatively high share of legal permanent residents entering as refugees were naturalized citizens during the 2009-13 period: 59 percent versus 44 percent for all other immigrants.<sup>14</sup> Vietnamese refugees who came as refugees were more likely to naturalize than those who did not come as refugees (88 percent versus 63 percent), a pattern that holds after controlling for length of U.S. residence.<sup>15</sup>

### *Question: Do All Refugee Populations Fare Well in the United States?*

**Fact: Outcomes vary substantially among refugees depending on their origins and other characteristics.** While the process for refugee resettlement is largely standardized, self-sufficiency outcomes for both recent and longer-term refugees vary. Some longer-term groups such as Iranians, Russians, and Vietnamese have educational attainment and incomes on a par with or even exceeding the U.S. average. Other long-term refugee groups such as Cubans lag somewhat on these indicators. Fewer than 60 percent of Afghani, Bhutanese, Burmese, Hmong, Liberian, and Somali refugees arriving during 2004-13 were literate in their native languages at arrival.<sup>16</sup> More than 60 percent of all refugees from Bhutan, Burma, Iraq, Liberia, and Somalia residing in the United States during 2009-11 had incomes below twice the federal poverty level.<sup>17</sup> Whether or not their incomes rise and benefits use will fall over time remains to be seen.

### *Question: What Is the Likely Integration Picture for Syrian Refugees?*

**Fact: Syrian immigrants already in the**

**United States are relatively well educated and prosperous.** In 2014, 39 percent of Syrian immigrants (ages 25 and older) were college graduates, compared to 29 percent and 30 percent of the overall foreign- and U.S.-born populations.<sup>18</sup> The median income of households headed by a Syrian immigrant was \$52,000, slightly higher than all foreign-born households (\$49,000) but lower than U.S.-born households (\$55,000).<sup>19</sup> Recent Syrian immigrants—those arriving in the United States since 2012—had even higher educational attainment.<sup>20</sup> Of course, the socioeconomic status of Syrian refugees may differ from the larger Syrian immigrant population, but data specific to Syrian refugees are not yet available.

*Question: Is the United States Likely to Experience Flows of Would-Be Asylum Seekers Similar to Europe?*

**Fact: Due to its geographic location, the United States is unlikely to experience large flows of asylum seekers or other migrants from Syria or elsewhere in Africa or the Middle East.** Because asylum seekers from these regions have no easy land or sea route to the United States, they must generally seek admission through official resettlement channels. Only those from Latin America and the Caribbean can reach the United States by land or over a short distance by sea. The recent wave of Central American adults, unaccompanied children, and intact families seeking asylum amounts to a fraction of the population arriving in Europe.

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In sum, the evidence suggests that the U.S. resettlement program, despite its funding limitations and reduced intake from earlier periods, successfully resettles substantial numbers of refugees every year.

During their initial resettlement period, refugees depend on federal assistance and equal, if not larger, private community support. Though they start out by and large poor and dependent on public assistance, within five to ten years most refugees achieve self-sufficiency and near economic parity with the U.S.-born population. Still, some refugee groups are more successful than others, and several of the most recently resettled groups begin with substantial income and education disadvantages.

Where will the new refugee flows proposed by the Obama administration fit into this picture? Syrian refugees, if they fit the pattern for Syrian immigrants already in the United States, are likely to have relatively high educational attainment that will promote their integration and self-sufficiency. The U.S. labor market is currently strong, with an unemployment rate near 5 percent—which bodes well for initial employment of new refugees. At the same time, federal resources for refugee resettlement are limited, and any significant additions must be appropriated by Congress. Thus, there are limits as to how many refugees can be successfully resettled in the United States under current conditions. These limits may be tested by proposed increases in ceilings on annual admissions. But the tests facing the United States pale in comparison with those faced by European countries such as Germany that must resettle hundreds of thousands of asylum seekers in the coming months.

***In sum, the evidence suggests that the U.S. resettlement program, despite its funding limitations and reduced intake from earlier periods, successfully resettles substantial numbers of refugees every year.***

## Endnotes

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- 7 Ibid, 28.
- 8 Ibid, 21-22.
- 9 U.S. Department of State, "U.S. Refugee Admissions Program, Application and Case Processing," accessed October 16, 2015, [www.state.gov/j/prm/ra/admissions/](http://www.state.gov/j/prm/ra/admissions/).
- 10 Kathleen Newland, "The U.S Record Shows Refugees Are Not a Threat" (commentary, Migration Policy Institute, Washington, DC, October 2015), [www.migrationpolicy.org/news/us-record-shows-refugees-are-not-threat](http://www.migrationpolicy.org/news/us-record-shows-refugees-are-not-threat).
- 11 Andorra Bruno, *Refugee Admissions and Resettlement Policy* (Washington, DC: Congressional Research Service, 2015), <http://fas.org/sgp/crs/misc/RL31269.pdf>; U.S. Department of State, "Congressional Presentation Document, Bureau of Population, Refugees, and Migration (PRM) FY 2016, Refugee Admissions," 34, accessed October 16, 2015, [www.state.gov/documents/organization/239718.pdf](http://www.state.gov/documents/organization/239718.pdf). See prior reports for budget figures for prior years.
- 12 Lutheran Immigration and Refugee Service (LIRS), *The Real Cost of Welcome: A Financial Analysis of Local Refugee Reception* (Baltimore: LIRS, 2008), 9, <http://lirs.org/wp-content/uploads/2012/05/RP-TREALCOSTWELCOME.pdf>.
- 13 Capps, Newland, Fratzke, Groves, Fix, McHugh, and Auclair, *The Integration Outcomes of U.S. Refugees*, 19-20.
- 14 Migration Policy Institute (MPI) analysis of data from the American Community Survey (ACS), 2009-13 pooled.
- 15 Ibid.
- 16 Capps, Newland, Fratzke, Groves, Fix, McHugh, and Auclair, *The Integration Outcomes of U.S. Refugees*, 13-14.
- 17 Ibid, 22-23.
- 18 U.S. Census Bureau, "S0201: Selected Population Profile in the United States, 2014 American Commu-

nity Survey 1-Year Estimates,” American Factfinder, accessed October 15, 2015, <http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml>.

19 Ibid.

20 MPI analysis of ACS data, 2009-13 pooled.

## About the Authors



**Randy Capps** is Director of Research for U.S. Programs at the Migration Policy Institute. His areas of expertise include immigration trends, the unauthorized population, immigrants in the U.S. labor force, the children of immigrants and their well-being, and immigrant health-care and public benefits access and use.

Dr. Capps, a demographer, has published widely on immigrant integration at the state and local level. He also has examined the impact of the detention and deportation of immigrant parents on children.



**Michael Fix** is President of the Migration Policy Institute, a position he assumed in July 2014 after serving as CEO and Director of Studies. He joined MPI in 2005, and was previously Senior Vice President and Co-Director of MPI’s National Center on Immigrant Integration Policy.

Mr. Fix’s research focus is on immigrant integration and the education of immigrant children in the United States and Europe, as well as citizenship policy, immigrant children and families, the effect of welfare reform on immigrants, and the impact of immigrants on the U.S. labor force.

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The Migration Policy Institute (MPI) is an independent, nonpartisan, nonprofit think tank dedicated to the study of the movement of people worldwide. The Institute provides analysis, development, and evaluation of migration and refugee policies at the local, national, and international levels. It aims to meet the rising demand for pragmatic responses to the challenges and opportunities that migration presents in an ever more integrated world.

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**TTSTA Tuesday**  
**Week #9**

TTSTA Tuesday #9 covers a challenging topic, female genital mutilation. The practice is most common in Western and Eastern African countries, but prevalence varies within countries depending on age of the woman, socioeconomic and educational level, and religious beliefs. In some areas, the most women who were in support of FGM were young or old, of a lower socioeconomic and educational level, and Muslim, but these demographics were not consistent across countries or cultures.

Another point is this practice is not seen as a punishment, but as cultural beliefs that include enhancing fertility, promoting purity, increasing marriage prospects, and preventing stillbirths. None of these reasons are scientifically based. Young girls undergo this procedure without anesthesia or under sterile conditions. The procedure may happen at birth, or from the ages of 4-12, depending on the cultural practices. There are different types of FGM, which are described in detail in the WHO fact sheet and attached resources.

A summary of the attachments and link to the WHO fact sheet are below.

The [World Health Organization Fact Sheet on Female Genital Mutilation](#) provides an overview of the prevalence, practice, risks, and their response.

Gina Thompson also conducted a literature review on this topic, and found 4 articles to inform us as health care providers.

FGC\_2008 Nour includes a map of counties in Africa where the practice is most common with an additional study of prevalence from the WHO in WHO\_FGC 2012.

The FGMC Nour 2015 article compels health care providers to advocate for changing the practice while 2013 FGC Guidelines for Clinical Practice provides a detailed guideline for health care professionals from Canada.

I welcome further discussion on this topic. Thank you Michele for suggesting we learn more about these practices.

Warmly,

## Female Genital Cutting: A Persisting Practice

Nawal M. Nour, MD, MPH

Department of Maternal-Fetal Medicine, Brigham and Women's Hospital, Harvard Medical School, Boston, MA

*More than 130 million women worldwide have undergone female genital cutting (FGC). FGC occurs in parts of Africa and Asia, in societies with various cultures and religions. Reasons for the continuing practice of FGC include rite of passage, preserving chastity, ensuring marriageability, religion, hygiene, improving fertility, and enhancing sexual pleasure for men. The World Health Organization has classified FGC into 4 types depending on the extent of tissue removed. Immediate complications include hemorrhage, infection, sepsis, and death. Long-term complications include pain, scarring, urinary issues, and poor obstetric and neonatal outcomes. Efforts are being made nationally and internationally to eradicate this practice.*

[Rev Obstet Gynecol. 2008;1(3):135-139]

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**Key words:** Female genital cutting • Female circumcision • Female genital mutilation

**F**emale genital cutting (FGC), also known as female circumcision or female genital mutilation, is an ancient practice that predates the Abrahamic religions. Fraught with medical, legal, and bioethical debates, FGC is practiced in 28 African countries and some countries in Asia. In 1997, the World Health Organization (WHO), United Nations Children's Fund, and United Nations Population Fund issued a joint statement that defined FGC as "all procedures involving partial or total removal of the external female genitalia

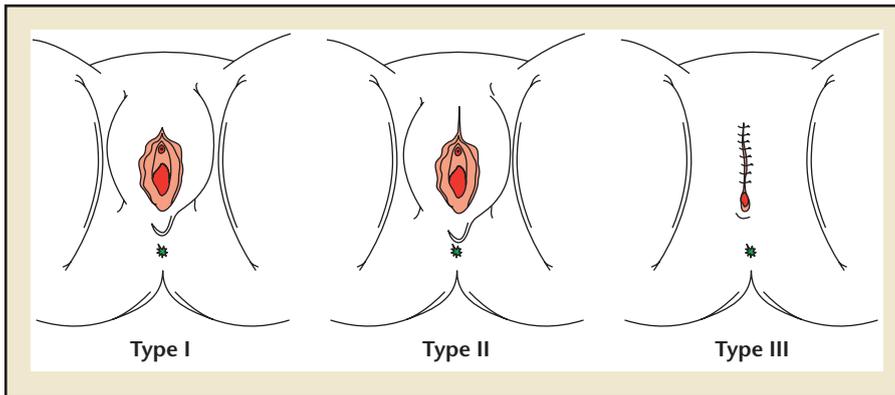


Figure 1. World Health Organization classification of female genital cutting. Type I, also known as clitoridectomy or sunna, involves removing part or all of the clitoris and/or the prepuce. Type II, also known as excision, involves removing part or all of the clitoris and labia minora, with or without excision of the labia majora. Type III, the most severe form, is also called infibulation or pharaonic. It entails removing part or all of the external genitalia and narrowing the vaginal orifice by reapproximating the labia minora and/or labia majora. Reprinted with permission from Nour N.<sup>3</sup>

or other injury to the female genital organs whether for cultural or other non-therapeutic reasons.”<sup>1</sup>

Approximately 3 million girls every year are at risk of undergoing FGC.<sup>2</sup> The health, psychological, and sexual complications of FGC depend on the type of procedure that is performed, sterility during the procedure, the experience of the operator, and the social atmosphere at the time the cutting is performed.

### Classification of FGC

WHO and other United Nations organizations have recently issued a new joint statement and have broadened the FGC classification (Figure 1).<sup>3</sup> Type I, also known as clitoridectomy or *sunna*, involves removing part or all of the clitoris and/or the prepuce. Type II, also known as excision, involves removing part or all of the clitoris and labia minora, with or without excision of the labia majora. Type III, the most severe form, is also called infibulation or *pharaonic*. It entails removing part or all of the external genitalia and narrowing the vaginal orifice by reapproximating the labia minora and/or labia majora. This infibulated scar covers the urethra

and most of the introitus, leaving a small hole for urination and menses. Type IV is the mildest form and includes any form of other harm done to the genitalia by pricking, piercing, cutting, scraping, or burning.

The prevalence of FGC varies from nation to nation, and even within a nation some areas may have never heard of FGC, whereas in other areas FGC is performed on 90% of girls (Figure 2). Type I is practiced mostly in Ethiopia, Eritrea, and Kenya. Type II is performed in parts of West Africa, such as Benin, Sierra Leone, Gambia, and Guinea. Somali, Northern Sudanese, and Djibouti women undergo type III FGC.<sup>4</sup> The Northern Nigerians perform type IV by introducing corrosive ma-

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*The international medical community strongly opposes medicalizing FGC on ethical grounds.*

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terial in the vagina (known as *gishiri*) or scraping the vaginal orifice (known as *angurya*).<sup>5</sup>

### History

The origins of FGC are a mystery. It is thought to have existed in ancient Egypt, Ethiopia, and Greece.<sup>6</sup> The prac-

tice transcends religion, geography, and socioeconomic status. Although FGC predates Islam, a small number of Muslims have adopted the practice as a religious requirement. As late as the 1960s, American obstetricians performed clitoridectomies to treat erotomania, lesbianism, hysteria, and clitoral enlargement.<sup>7</sup>

Girls typically undergo FGC between the ages of 6 and 12 years. It is performed on newborns, at menarche, and prior to marriage. Usually girls are aware that they will be cut some day, and some eagerly anticipate it. Villagers gather girls and celebrate the rite of passage with food, song, and gifts.<sup>6</sup>

Generally, midwives or trained circumcisers go from village to village and perform the cutting with no anesthesia, antibiotics, or sterile technique. Their instruments are knives, razors, scissors, or hot objects that are reused. After the tissue has been excised, sutures, thread, and local concoctions such as oil, honey, dough, or tree sap are used to ease bleeding. Postoperatively, wound care depends on the extent of damage. Girls who have undergone type I usually heal within a few days, whereas girls who have undergone type III require bed rest for approximately 1 week. Their thighs and legs are bound together to ensure proper healing of the infibulated scar.

Some girls are unaware they will be cut. FGC is performed on these girls

suddenly, without mental preparation, celebration, or fanfare. In this situation, girls can be emotionally traumatized. In other cases, nurses and physicians perform FGC in their offices under anesthesia in order “to protect” girls from complications. The international medical community strongly opposes

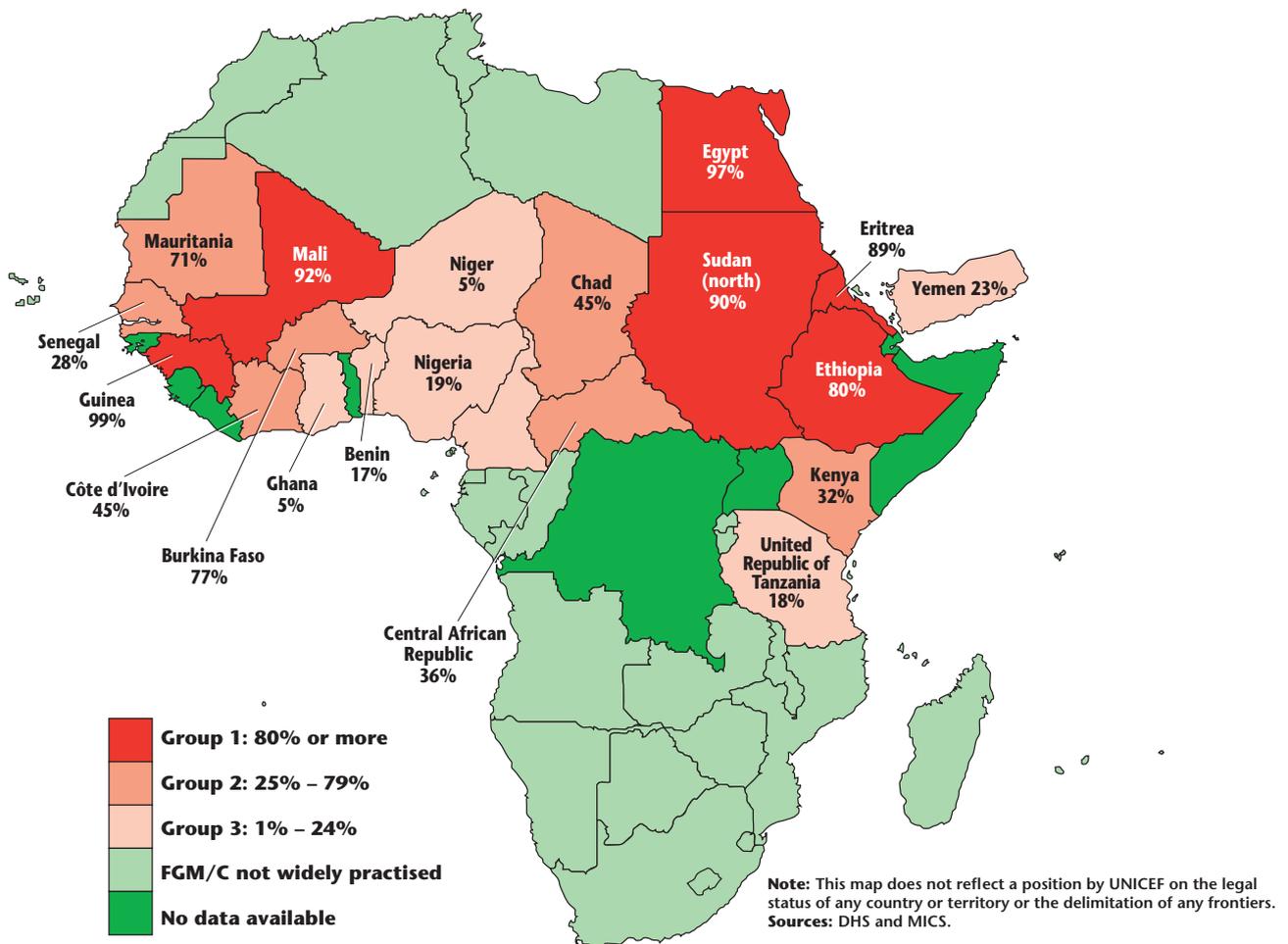


Figure 2. Female genital cutting prevalence among women aged 15-49 years. Sources: Demographic and Health Surveys and Multiple Indicator Cluster Surveys. Reprinted with permission from United Nations Children's Fund (UNICEF). Female Genital Mutilation/Cutting: A Statistical Exploration. New York: UNICEF; 2005:4.

medicalizing FGC on ethical grounds. Medical involvement is also seen as justifying and perpetuating a practice that should instead be eradicated.<sup>8</sup>

### A Persisting Practice

Parents who continue this practice are compassionate and loving. They believe that they are protecting their daughters from harm. Reasons that parents and practitioners give for the procedure include rite of passage, preserving chastity, ensuring marriageability, improving fertility, religious requirement, hygiene, and enhancing sexual pleasure for men. Parents who insist

that their daughters undergo FGC are driven by a fear that their daughters may never marry. An unmarried daughter is ostracized and shunned in these societies, and may be seen as unclean, unhygienic, and perhaps even labeled as a prostitute. Some societies believe that the clitoris is toxic, and if during child birth the clitoris touches the baby's head, the baby will die. Some societies believe that if unchecked, the clitoris will grow until it touches the ground. Thus, removing the clitoris improves survival, ensures beauty, and preserves their daughter's reputation.

### Complications and Treatment

Women with types I and II FGC who survive the procedure rarely have long-term complications given that they do not have an infibulated scar covering their external genitalia. Women who undergo type III FGC are at the highest risk for immediate and long-term complications. The most common immediate complications are uncontrolled bleeding, fever, wound infection, sepsis, and death.<sup>4</sup> The most common long-term complications are dysmenorrhea, dyspareunia, recurrent vaginal and urinary tract infections, infertility, cysts, abscesses, keloid for-

mation, difficult labor and delivery, and sexual dysfunction.<sup>4,9-13</sup>

Infertility is a devastating psychosocial complication to the infibulated woman. Her infertility rate can be as high as 30%.<sup>12,13</sup> This infertility rate is secondary to both anatomic and psychologic barriers. The infibulated scar that supposedly protects girls from pregnancy out of wedlock becomes the obstacle that prevents them from getting pregnant within marriage. With multiple coital attempts over several months and using ample lubricants, the scar can stretch, but coitus is still very painful. This creates an unhealthy and distressing sexual relationship between husband and wife. Women fear that they may never become mothers, and husbands question their masculinity.<sup>14</sup> Although some studies have demonstrated that men prefer to marry uncircumcised women,<sup>15</sup> other studies have found the opposite to be true.<sup>16</sup>

Once pregnant, infibulated women face another daunting challenge: labor and delivery. In a large study, women with FGC were found to be at an increased risk of having adverse obstetric outcomes, including postpartum hemorrhage, episiotomies, cesarean deliveries, extended maternal hospital

stay, infant resuscitation, stillbirth, or neonatal death. These risks increased with the severity of FGC.<sup>17</sup>

### How Can FGC Be Stopped?

Over the past 30 years, grassroots, national, and international organiza-

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*In a large study, women with FGC were found to be at an increased risk of having adverse obstetric outcomes, including postpartum hemorrhage, episiotomies, cesarean deliveries, extended maternal hospital stay, infant resuscitation, stillbirth, or neonatal death. These risks increased with the severity of FGC.*

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Given the degree of damage and the multiple complications from the infibulation scar, women with type III FGC can be offered a defibulation procedure to treat long-term complications. Defibulation, a surgical procedure performed under regional or general anesthesia, opens the infibulated scar and exposes the urethra and introitus. In parts of Somalia and Djibouti, defibulations are performed by midwives, traditional birth attendants, or the circumcisers themselves. Opening the scar enables women to become fertile, eases dyspareunia, and improves labor and delivery experiences. One study found that defibulation not only resolved long-term complications, but that almost 50% of the women who were defibulated had an intact clitoris (Figure 3).<sup>18</sup>

tions have actively worked on eradicating this practice. FGC has been outlawed in most countries, but because governments rarely enforce these laws they are essentially ineffective. FGC is recognized as a violation of human and child rights. But when eradication efforts are made from Western nations, the issue becomes emotionally charged. Grassroots programs organized by local and national groups that focus on increasing human rights awareness and knowledge have had great success in reducing the incidence of FGC. Communities are voicing their desire to abandon the practice, religious institutions are indicating that FGC is not a requirement, and governments are approving programs that educate the nation about the harms of FGC.<sup>2</sup> Along

### Main Points

- Female genital cutting (FGC), also known as female circumcision or female genital mutilation, is an ancient practice that predates the Abrahamic religions. FGC is practiced in 28 African countries and some countries in Asia.
- Girls typically undergo FGC between the ages of 6 and 12 years. Midwives or trained circumcisers go from village to village and perform the cutting with no anesthesia, antibiotics, or sterile technique.
- Reasons that parents and practitioners give for the procedure include rite of passage, preserving chastity, ensuring marriageability, improving fertility, religious requirement, and enhancing sexual pleasure for men.
- Women who undergo type III FGC are at the highest risk for immediate and long-term complications. The most common immediate complications are uncontrolled bleeding, fever, wound infection, sepsis, and death. The most common long-term complications are dysmenorrhea, dyspareunia, recurrent vaginal and urinary tract infections, infertility, cysts, abscesses, keloid formation, difficult labor and delivery, and sexual dysfunction.
- Given the degree of damage and the multiple complications from the infibulation scar, women with type III FGC can be offered a defibulation procedure to treat long-term complications. Defibulation, a surgical procedure performed under regional or general anesthesia, opens the infibulated scar and exposes the urethra and introitus.

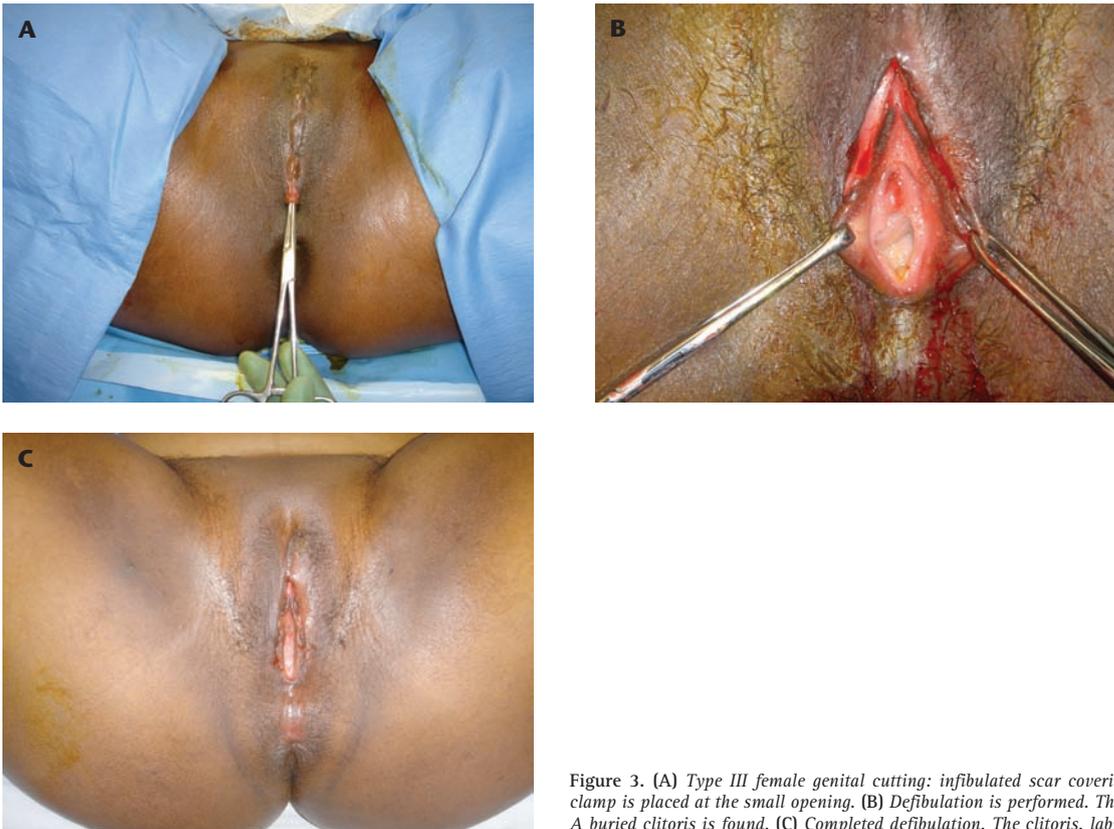


Figure 3. (A) Type III female genital cutting: infibulated scar covering urethra and introitus. A Kelly clamp is placed at the small opening. (B) Defibulation is performed. The urethra and introitus is exposed. A buried clitoris is found. (C) Completed defibulation. The clitoris, labia minora, and labia majora are visible.

with prevention, focus must be made on assisting those who have already undergone FGC and are living with long-term complications. Medical institutions must participate in promoting defibulation procedures and helping women live pain-free lives. ■

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FEBRUARY 2015

BY NAWAL NOUR, M.D.,  
M.P.H

## FEMALE GENITAL MUTILATION/ CUTTING: HEALTH PROVIDERS SHOULD BE ADVOCATES FOR CHANGE

About  
**3**  
**MILLION**  
girls globally undergo  
cutting every year.

**507,000**  
girls and women  
in the United States  
have undergone  
or are at risk of FGM/C.

More than 125 million girls and women globally are living with female genital mutilation/cutting (FGM/C) and an estimated 3 million undergo such procedures every year. The World Health Organization defines FGM/C as “all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs, whether for cultural or other nontherapeutic reasons.” It is a tradition that transcends socioeconomic status and geography; it is performed in some Islamic communities, but has no religious basis. From unknown origins, the practice survives today, often reinforced by customs and beliefs regarding marriageability, rites of passage, maintaining girls’ chastity, hygiene, preserving fertility, and enhancing sexual pleasure for men. Girls usually undergo FGM/C between the ages of four and 12, although it is performed at birth and immediately before marriage in some regions. Minimal or no anesthesia is used and antiseptics are rare.

The immediate and long-term health complications of FGM/C mean a lifetime of suffering for these girls and women. The health risks depend on the severity of the procedure, the practitioner’s skill, the instruments used, and postoperative care. Immediate complications include infection, sepsis, urinary retention, hemorrhage, shock, and even death. Long-term complications, seen predominantly in women who have undergone Type III (removal of all external genitalia and suturing of remnant tissue), include cysts, abscesses, recurrent infections, pain, labor complications, and post-traumatic stress disorders (PTSD). Curative measures include medical treatment as well as surgical excision of infections and reconstructive surgery of the scar. Accurate and effective defibulation, the surgical reconstruction of the infibulated scar, has been proven to relieve and even resolve women’s long-term complications and ensure them safer labor and delivery. However, it requires specialized

**Dr. Nawal Nour** is the director of the Ambulatory Obstetrics Practice at the Harvard-affiliated Brigham and Women’s Hospital in Boston, founder of the African Women’s Health Center, and an associate professor at Harvard Medical School. A board-certified obstetrician/gynecologist, Dr. Nour actively researches the health and policy issues regarding FGM/C and has spoken in numerous academic and national conferences regarding the medical management of women who have undergone this practice.

Committed to the eradication of FGM/C, she travels throughout the country conducting workshops to educate African refugees and immigrants on the medical complications and legal issues of this practice. She served on an FGM/C task force for the American College of Obstetrics and Gynecology (ACOG) and was the primary author of *Female Genital Cutting, Clinical Management of Circumcised Women*, published by ACOG.

Dr. Nour was honored as a 2003 MacArthur Foundation Fellow for creating the country’s only center of its kind that focuses on both physical and emotional needs of women who have undergone FGM/C.

Born in the Sudan and raised in Egypt and England, Dr. Nour received her medical degree from Harvard Medical School in 1994 and completed a chief residency in obstetrics and gynecology at the Brigham and Women’s Hospital in 1998. She obtained her M.P.H. at Harvard School of Public Health in 1999.

training. This paper will make a case for the critical role of health care providers in treating girls and women who have undergone FGM/C and in protecting others from this harmful tradition.

## The Scope of the Problem

When the African Women's Health Center (AWHC) first commissioned a study based on the 2000 U.S. Census, they found that approximately 228,000 women and girls living in the United States have either undergone or are at risk of FGM/C. The "at-risk" number reflected a staggering increase of approximately 35 percent from the 1990 census estimate. New numbers being released by the Population Reference Bureau on Feb. 6th, 2015, reveal that 507,000 girls and women in the United States today have either undergone or are at risk of FGM/C. These growing numbers demonstrate that U.S. health providers will be examining more patients with FGM/C. Though some hospitals and health centers in the United States have created a culturally and linguistically competent environment for women with FGM/C, these still do not meet the needs of this population. More often, women with FGM/C have received poor-quality care, which understandably creates an environment of distrust towards our health care system. Women with FGM/C are not only likely to experience inappropriate encounters with health providers, but they are also subject to disparities in care, with lower rates of mammograms, pap smears, vaccinations, and family planning services. If medical interpreters are used, evidence-based preventive medicine is more consistently applied.

To highlight these issues, consider the stories of several patients who eventually sought care at the AWHC. These women's names have been changed to protect their privacy.

Najat was a 26-year-old woman who came to the emergency room with abdominal pain. During the physical examination, health providers discovered that she had undergone FGM/C. They were not sure what type or whether this was the cause of her abdominal pain, but because it was a teaching hospital, medical students, residents, and nurses were brought in to "evaluate" her genitalia and learn about FGM/C. Not only was Najat humiliated and left the hospital vowing never to return, she was not treated for her abdominal pain. Had the providers spent time talking with her, they would have learned that she was gang-raped as a teenager in Somalia; her exposure to a group of strangers horribly revived that experience. Her case demonstrates not only a lack of medical knowledge in identifying the type of FGM/C, but a failure to collect a complete history that might have helped them reach an accurate diagnosis: PTSD after sexual violence. The health providers inadvertently succeeded in discouraging her from seeking access to future health care.

Layla visited an obstetrician in her first trimester excited about her first pregnancy. During the examination, providers found infibulation—a scar that covers most of her external genitalia,

with a small hole allowing the passage of menses and urine—evidence that she had undergone Type III FGM/C. At the end of the visit, the obstetrician informed Layla that giving birth would be risky and that she needed an abortion. Though abortion was against Layla's religion, given the grave concerns of the obstetrician, she was convinced to undergo the procedure. Layla regretted this decision, as she discovered later that her scar could have been operated on during her second trimester or at the time of her delivery. Lacking the medical and surgical knowledge to care for Layla, this health care provider's only advice was an unnecessary abortion.

Samia was pregnant and, like Layla, had undergone infibulation. This condition was a great concern to her obstetrician, who told her that delivery would require a caesarean section. It is not uncommon for infibulated women to undergo unnecessary caesarean sections in the United States. Most health providers lack the awareness, knowledge, and understanding of the medical, surgical, and cultural management of women with FGM/C. Studies throughout the Western world have consistently demonstrated that unless providers take the initiative to learn about FGM/C themselves, their knowledge is lacking. Health providers need extensive training on the immediate and long-term complications, and the medical and surgical management of the various types of FGM/C.

## United States Law

In 1996, the United States passed 18 U.S. Code § 116 on female genital mutilation, which states in part, "whoever knowingly circumcises, excises, or infibulates the whole or any part of the labia majora or labia minora or clitoris of another person who has not attained the age of 18 years shall be fined under this title or imprisoned not more than 5 years, or both." It also required the Department of Health and Human Services (HHS) to both compile data on FGM/C and to engage in education and outreach to relevant communities. The law directs the Immigration and Naturalization Service to provide information to all nonresidents issued U.S. visas on the health and psychological effects of FGM/C, as well as its legal consequences under criminal and child-protection statutes. At the time the law was enacted, we at AWHC actively participated in outreach and community building, as well as education regarding the law and its consequences. Communities were both surprised and relieved that HHS had made a concerted effort to inform them. To date, there has only been one conviction of FGM/C in the United States.

Numerous attempts have been made to introduce the Girl Protection Act, which would add an extra-territorial component to the law. In January 2013, the federal criminal code was amended "to impose a fine, up to a five-year prison term, or both for knowingly transporting a girl under the age of 18 from the United States and its territories in foreign commerce for purposes of female genital mutilation."

The AWHC conducted outreach in Boston and found that this amendment was seriously misunderstood. Some people mistakenly believed that the original law already incorporated an extra-territorial component, while others were confused about why an amendment was even necessary. But it is thought that some girls are still being taken to their home countries in order to undergo FGM/C and then returned to the United States—a phenomenon known as “vacation cutting.” If this practice is indeed happening, outreach is just as vital as it was two decades ago to educate and engage communities regarding the new amendment and its ramifications. The media and nongovernmental organizations have become more aware of this possibility, but no cases have yet been reported to the authorities.

Significant challenges lie ahead. We must determine whether, how, and to what extent FGM/C and vacation cutting are still happening in the United States. Collection of data will be difficult, given its clandestine nature. In addition, the law is not clear on who should be reporting these cases. Some suggest that reporting should be mandatory among pediatricians, social workers, emergency medical technicians, school nurses, school counselors, police, and immigration officers. As a health provider who has been working hard to maintain access to care for this population, I believe strongly that it would be difficult to make the health system primarily responsible.

In addition, although the data on how many girls and women have undergone and are at risk of FGM/C have been updated, these numbers are still estimates—based on the prevalence of the practice in the country of origin. FGM/C is not done uniformly in a particular country; it depends on the region, ethnicity, and how quickly this practice is being abandoned. The data do not take into account from which region of a country a woman comes. In addition, census data collected every 10 years may not reflect changes in beliefs regarding this practice among immigrant populations. Achieving better data will require improved recordkeeping and coding by health providers, better surveys that capture the countries and regions of birth and the girl’s length of stay in the United States, and sensitive evaluation of changes in attitudes that influence this population. With such detailed data, health providers can tailor clinical treatment to the patient as an individual.

## The Role of Medical Societies

In the 1990s, medical associations such as the American Medical Association, the American Academy of Pediatrics (AAP), the American College of Obstetricians and Gynecologists (ACOG), and the Institutes of Medicine published policy statements against FGM/C. ACOG developed and distributed a slide-lecture kit (and subsequently a DVD) on the clinical management of FGM/C to U.S. medical schools and residency programs. Some medical schools, midwifery schools, nursing schools, and residency programs have incorporated FGM/C into their curricula. But these efforts are sporadic and not always consistent from year to year. In an attempt at cultural sensitivity, in 2010 the AAP updated its policy statement

but emphasized that, “It might be more effective if federal and state laws enabled pediatricians to reach out to families by offering a ritual nick as a possible compromise to avoid greater harm.” This policy statement came as quite a shock to the health providers, activists, UN organizations, and policymakers who had been working toward the abandonment of the practice. AAP’s board of directors voted to retire the new policy, stating that it “does not endorse the practice of offering a ‘clitoral nick,’ ” and agreeing that it was “forbidden under federal law and AAP does not recommend it to its members.”

Medical societies must be held responsible for upholding the highest ethical standards through working closely with communities who have undergone FGM/C in order to help improve their medical care. The dictum “First, do no harm” must be applied in the broadest possible humanitarian and cultural sense, as well as clinically and surgically. Thus, health providers need training not just in school but also during their continuing medical education. Providers must understand the fundamental reasons why FGM/C still occurs, where it occurs, why parents choose to cut their daughters, and ultimately how to provide patients with excellent care that is imbued with compassion but free of judgment. Creating educational handbooks, a website, and even laminated pocket cards are some simple solutions; however, training with culturally competent providers allows for in-depth understanding and discussion. Otherwise, our health care delivery will continue to enforce our ethnocentric cultural values, stigmatizing our patients, and relegating them to substandard care.

## Conclusion

As a threat to the health and basic human rights of girls and women, FGM/C violates all bioethics principles and must be stopped. However, girls and women in the United States who already suffer the long-term complications of FGM/C deserve both respect and the highest quality of health care possible. Our providers need the skills, knowledge, support, and tools to enable them to provide such care. Better adherence to evidence-based medicine ensures consistency of care for this population, regardless of ethnicity, language, or insurance coverage. Gaps in research remain that need to be remedied to further improve the care we give women with FGM/C.

The AWHC plays two important roles: providing both holistic care and a haven for women who suffer the health consequences of this practice; and offering state-of-the-art academic training for health providers in culturally and linguistically competent care for this vulnerable population. Health providers must play a larger role in advocating to stop FGM/C, informing patients about the health and legal consequences of FGM/C, and finally, understanding the long-term complications and best practices to resolve them. Until our success is reflected in future generations of healthy girls free of FGM/C, we must continue to support and care for those who are still suffering its consequences.

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**The African Women's Health Center (AWHC)** provides appropriate health and outreach programs to the African community in Boston. Founded in 1999, AWHC, located at Brigham and Women's Hospital, ensures access, understanding, and community to women who have long-term complications from FGM/C. It provides culturally and linguistically appropriate obstetric, gynecologic, and reproductive health care via a collaborative team-based approach that includes obstetricians, gynecologists, nurses, midwives, medical interpreters, nutritionists, social workers, and when needed, psychiatrists. The overall mission is to holistically improve the health of refugee and immigrant women who have undergone FGM/C and inform them of best practices, the importance of well-visits, and clear, accurate information about their anatomy.

Contact the AWHC at: [africanwomen@partners.org](mailto:africanwomen@partners.org).

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## Resources

Charlotte Feldman-Jacobs, *Ending Female Genital Mutilation/Cutting: Lessons From a Decade of Progress* (Washington, DC: Population Reference Bureau, 2014).

Charlotte Feldman-Jacobs and Donna Clifton, *Female Genital Mutilation/Cutting: Data and Trends Update 2014—DataSheet* (Washington, DC: Population Reference Bureau, 2014).

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# Female genital cutting: current practices and beliefs in western Africa

Heather L Sipsma,<sup>a</sup> Peggy G Chen,<sup>a</sup> Angela Ofori-Atta,<sup>b</sup> Ukwuoma O Ilozumba,<sup>c</sup> Kapouné Karfo<sup>d</sup> & Elizabeth H Bradley<sup>a</sup>

**Objective** To conduct a cross-national comparative study of the prevalence and correlates of female genital cutting (FGC) practices and beliefs in western Africa.

**Methods** Data from women who responded to the Multiple Indicator Cluster Surveys between 2005 and 2007 were used to estimate the frequencies of ever having been circumcised, having had a daughter circumcised, and believing that FGC practices should continue. Weighted logistic regression using data for each country was performed to determine the independent correlates of each outcome.

**Findings** The prevalence of FGC was high overall but varied substantially across countries in western Africa. In Sierra Leone, Gambia, Burkina Faso and Mauritania, the prevalence of FGC was 94%, 79%, 74% and 72%, respectively, whereas in Ghana, Niger and Togo prevalence was less than 6%. Older age and being Muslim were generally associated with increased odds of FGC, and higher education was associated with lower odds of FGC. The association between FGC and wealth varied considerably. Burkina Faso was the only country in our study that experienced a dramatic reduction in FGC prevalence from women (74%) to their daughters (25%); only 14.2% of the women surveyed in that country said that they believe the practice should continue.

**Conclusion** The prevalence of FGC in western Africa remains high overall but varies substantially across countries. Given the broad range of experiences, successful strategies from countries where FGC is declining may provide useful examples for high-prevalence countries seeking to reduce their own FGC practices.

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## Introduction

More than 100 million girls and women have undergone female genital cutting (FGC, also known as “female circumcision”), and more than 3 million female infants and children are at risk for this procedure annually.<sup>1–3</sup> FGC is seen as a rite of passage for young girls in some communities and is most often performed between the ages of 4 and 10.<sup>1,4</sup> Reasons for this practice include beliefs that it enhances fertility, promotes purity, increases marriage opportunities and prevents stillbirths. These beliefs are strongly rooted in tradition, culture and religion, but none carries a scientific basis.<sup>5–8</sup> Young girls and women who undergo FGC are subjected to extreme pain, since the procedure is often conducted without anaesthesia and under non-sterile conditions. When accompanied by excessive bleeding, it can even lead to death.<sup>9,10</sup> Additional complications can include localized infection and abscess formation, pelvic infection, sepsis, tetanus, urinary retention and chronic urinary tract infection, hepatitis and human immunodeficiency virus (HIV) infection.<sup>11</sup> Other reproductive health complications can include obstructed menstruation, difficulty conceiving, prolonged labour, tearing of tissues during delivery and neonatal death.<sup>8,11–16</sup> Psychiatric sequelae such as flashbacks to the event, affective disorders and post-traumatic stress disorders can also affect women throughout their lives.<sup>8,12,13</sup>

Despite the risks associated with FGC, the peer-reviewed literature on the prevalence and predictors of FGC is sparse. Studies from Egypt and Ethiopia give FGC prevalences of approximately 85% and 70%, respectively,<sup>17,18</sup> and several qualitative and anthropological studies have examined the underlying context for FGC.<sup>6,19–22</sup> No studies, however, have

reported cross-national comparisons of the prevalence of FGC and of the factors with which it is associated. Such data would be helpful for understanding the variation in the frequency of FGC, particularly in western Africa, where the practice is known to be common despite legislation and other efforts to curb its prevalence. Western Africa is also particularly well suited for cross-national comparisons because substantial differences exist between countries in prevalence rates and in the approaches used to eliminate this practice. These differences can bring to light potential strategies that may be useful in similar settings.

Accordingly, we sought to estimate the prevalence of FGC practices and beliefs across all western African countries for which national data were available from the most recent round of the Multiple Indicator Cluster Surveys (MICS). We also aimed to identify correlates of these practices and beliefs to identify high-risk subpopulations. This evidence may be useful to help better understand country-level variation in this persistent but widely criticized practice<sup>1,23,24</sup> and to target efforts to rid future generations of the practice of FGC in western Africa.

## Methods

### Study design and sample

We conducted a cross-sectional study of 10 countries in western Africa using self-reported data collected between the years 2005 and 2007 during the third round of the Multiple Indicator Cluster Surveys (MICS). Data were available for Burkina Faso, Côte d'Ivoire, Gambia, Ghana, Guinea-Bissau,

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Mauritania, Niger, Nigeria, Sierra Leone and Togo. Surveys were conducted in French in all countries except Gambia, Ghana, Nigeria and Sierra Leone, where they were conducted in English.

The MICS is a household survey developed by the United Nations Children's Fund (UNICEF) to provide national estimates of health indicators for women, men and children. The third round of the MICS used a two-stage stratified sample design in which enumeration areas were selected first, stratified by administrative region and area type (urban/rural). Households were systematically sampled from each enumeration area. Total sample size varied by country. The MICS used three sets of questionnaires, including a women's self-reporting questionnaire administered face to face to all women in each household between the ages of 15 and 49 years.<sup>25</sup>

## Measures

We examined three primary outcome measures. First, participants were asked "Have you yourself ever been circumcised?" (*yes/no*). Second, participants with at least one living daughter were asked "Have any of your daughters been circumcised? If yes, how many?" Responses indicated the number of daughters circumcised. For analysis, this variable was dichotomized into *yes* (at least 1 daughter circumcised) versus *no* (no daughters circumcised). Participants who had not heard of FGC or female circumcision (women who responded *no* to both "Have you ever heard of female circumcision?" and "In a number of countries, there is a practice in which a girl may have part of her genitals cut. Have you ever heard about this practice?") were assumed to have not been circumcised and to have not had their daughters circumcised and were coded accordingly. Third, participants were asked "Do you think this practice should be continued?" (*yes/depends/no*). For analysis, this third variable was collapsed into two categories: *yes/depends* versus *no*. Participants who had not heard of FGC were coded as missing for this outcome.

Our independent variables included basic sociodemographic characteristics that were available across all countries, including age (5-year age groups), educational level (none, primary, above primary), marital status (currently married, formerly married, never married),

wealth quintile and religion (Muslim versus non-Muslim). Subgroups of non-Muslims were examined for differential effects. Wealth quintiles were derived by the MICS using a combination of reported household assets and utility services.<sup>26</sup>

## Statistical analysis

Analyses were performed separately for each country. We first generated weighted frequencies to determine the prevalence of the three outcomes and to describe the characteristics of the sample populations. We then examined the potential for multicollinearity among the independent variables by using an average threshold correlation coefficient of 0.50. We constructed logistic regression models for each outcome, including all sociodemographic characteristics, whether or not they significantly contributed to the model. This approach was used to ensure the comparability of the models across countries. Because not all circumcised women are aware of having undergone circumcision, particularly if they have smaller incisions or were circumcised in infancy, we conducted a sensitivity analysis by repeating all analyses without including those respondents who reported never having heard of FGC, and we compared these results with our other findings. In all models we accounted for sample weighting and complex survey designs by adjusting for strata and cluster membership. Cases with missing data (<5%) were excluded from the analyses, which were completed with SAS version 9.2 (SAS Institute, Cary, United States of America).

## Results

### Sample characteristics

On average, slightly more than half of the women in each sample were between the ages 15 and 29 (Table 1). More than half of the women in Burkina Faso, Côte d'Ivoire, Gambia, Guinea-Bissau, Niger and Sierra Leone had had no formal education. In most countries, the majority of women were currently married, and the proportion of Muslims per country ranged from 14% to 99%.

### Country prevalence

The prevalence of FGC was high overall but varied substantially between countries. In Sierra Leone, Gambia, Burkina

Faso and Mauritania, prevalence rates for FGC were 94%, 79%, 74% and 72%, respectively (Table 2). In contrast, fewer than 6% of women had been circumcised in Ghana, Niger and Togo. Gambia and Mauritania had the highest percentage of daughters circumcised (64%) and Togo, Ghana and Niger had the lowest (1%). In three countries, more than half of the women believed that the practice of FGC should continue (Sierra Leone, 88%, Gambia, 77% and Mauritania, 59%). The lowest percentages of women believing the practice should continue were found in countries with the lowest reported rates of FGC: Ghana (4%) and Niger (7%). Prevalence estimates after excluding women who had never heard of FGC remained largely unchanged.

### Associated sociodemographic characteristics

In general, being older, having less education, and being currently or formerly married as opposed to never married were all associated with increased odds of having been circumcised (Table 3, available at: <http://www.who.int/bulletin/volumes/90/2/11-090886>). However, the opposite effects were seen in Gambia, where being older was associated with lower odds of having been circumcised and no association was noted between having been circumcised and educational level. Furthermore, being Muslim was generally associated with increased odds of having been circumcised. Effects across non-Muslim subgroups were largely similar, and the non-Muslim reference category was therefore maintained for analysis. The association between wealth and FGC varied across samples. In five countries greater wealth was associated with increased odds of having been circumcised; in the other five, less wealth was associated with increased odds of having been circumcised.

Being older, having less education and being Muslim were associated with higher odds of having had a daughter circumcised (Table 4, available at: <http://www.who.int/bulletin/volumes/90/2/11-090886>). Wealth was inconsistently associated with having had a daughter circumcised; these associations were similar to those seen for having been circumcised. Finally, in most countries believing that the practice of FGC should continue was associated with being younger, having less education, being currently married

Table 1. Sociodemographic characteristics (weighted data) of women surveyed<sup>a</sup> in 10 western African countries, 2005–2007

Characteristic	Sierra Leone (n = 9 381) (%)	Gambia (n = 9 982) (%)	Burkina Faso (n = 7 316) (%)	Mauritania (n = 12 549) (%)	Guinea-Bissau (n = 8 010) (%)	Côte d'Ivoire (n = 12 888) (%)	Nigeria (n = 24 566) (%)	Togo (n = 6 211) (%)	Ghana (n = 5 890) (%)	Niger (n = 9 223) (%)
<b>Age (years)</b>										
15–19	14.4	22.9	20.3	21.7	21.8	22.5	17.2	18.2	20.7	18.6
20–24	15.3	20.3	16.8	20.8	20.8	20.0	17.5	16.8	18.3	17.9
25–29	23.3	19.2	18.3	15.1	18.9	17.9	20.2	19.4	16.8	19.4
30–34	15.4	13.5	14.4	13.9	13.0	12.8	16.2	14.8	13.2	14.7
35–39	16.4	10.5	12.2	12.0	11.4	10.9	12.8	14.5	12.7	12.6
40–44	9.3	8.2	10.1	9.1	7.8	9.9	9.2	9.2	9.8	9.6
45–49	5.9	5.4	7.9	7.3	6.3	6.0	6.8	7.2	8.6	7.1
<b>Educational level</b>										
None	73.9	54.0	75.4	23.5	57.7	53.0	40.7	38.6	26.3	83.5
Primary	11.0	11.8	13.6	32.7	26.5	27.1	19.0	34.2	19.7	10.4
Beyond primary	15.1	27.3	11.0	20.4	15.9	19.9	40.3	26.9	53.9	6.1
Non-standard/Madrasa <sup>b</sup>	–	7.0	–	23.4	–	–	–	–	–	–
<b>Marital status</b>										
Never married	14.7	26.8	20.6	28.4	29.0	38.5	25.9	25.4	30.2	9.9
Currently married	79.5	68.6	75.3	58.6	65.0	40.1	70.2	66.1	58.8	86.1
Formerly married	5.8	4.6	4.1	13.0	6.1	21.4	3.9	8.5	11.0	4.0
<b>Wealth quintile</b>										
Lowest	19.4	17.1	17.7	17.8	18.7	17.6	18.1	15.7	16.2	19.0
Second	20.3	19.0	19.0	17.5	17.9	17.3	18.6	17.0	17.6	19.3
Middle	19.8	20.2	19.3	18.8	18.6	18.7	18.8	17.9	19.5	19.0
Fourth	19.7	21.4	19.7	22.0	20.3	21.2	20.8	23.6	22.0	20.7
Highest	20.7	22.3	24.4	23.9	24.6	25.2	23.7	25.8	24.6	22.0
<b>Religion</b>										
Non-Muslim	21.1	3.8	37.7	NA	56.1	64.4	53.0	86.5	84.7	2.4
Muslim	77.9	96.2	62.3	NA	43.9	35.6	47.0	13.5	15.3	98.6

NA, not available.

<sup>a</sup> In third round of Multiple Indicator Cluster Surveys.

<sup>b</sup> Non-standard education in Gambia and Madrasa education/Koranic school in Mauritania were included in the analysis because of the high percentages of women who selected these categories.

and being poorer (Table 5, available at: <http://www.who.int/bulletin/volumes/90/2/11-090886>). The associations between sociodemographic characteristics and outcomes were largely unaffected by excluding from the analysis those women who had never heard of FGC.

### Comparisons across outcomes

Recognizing that the frequencies of our outcomes could represent changes in the prevalence of FGC over time, we plotted the data sequentially by country (Fig. 1). In all countries, the percentage of women who had their daughters circumcised was lower than the percentage who had themselves been circumcised. The relationship between believing that

FGC should continue and having had a daughter circumcised was not consistent across countries. Burkina Faso and Mauritania were the only two countries where the percentage of women who believed that FGC should continue was lower than the percentage that had had their daughters circumcised.

### Discussion

The estimated prevalence of FGC varied widely across countries, despite their geographic proximity, and this variation probably reflects the differences in political, social and historical contexts in countries where FGC is practiced. In Burkina Faso, Gambia, Mauritania

and Sierra Leone more than 70% of women had been circumcised, whereas in Ghana, Niger and Togo less than 6% had been circumcised. Additionally, in four countries at least one third of the women reported having had their daughters circumcised, and in six countries more than 20% believed that FGC practices should continue despite recent public criticism of FGC. These findings are concerning, given the potential for causing a girl severe physical and psychological harm.

We also recognize that the prevalence of FGC can vary substantially within the same country. Our findings show that certain women belonging to certain subgroups based on educational

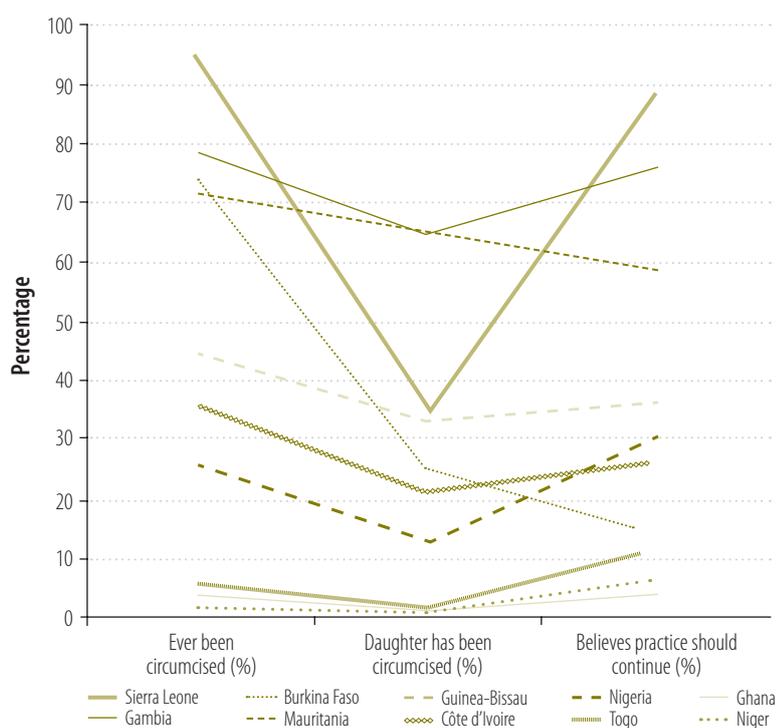
Table 2. **Female genital cutting (circumcision) practices (weighted data) as reported by women surveyed<sup>a</sup> in 10 western African countries, 2005–2007**

Country	Had been circumcised (%)	Had had one or more daughters circumcised (%)	Believed practice should continue <sup>b</sup> (%)
Sierra Leone	94.0	34.9	88.1
Gambia	78.5	64.4	76.7
Burkina Faso	73.7	24.8	14.2
Mauritania	72.2	64.2	59.0
Guinea-Bissau	44.6	33.3	36.7
Côte d'Ivoire	36.5	20.9	26.7
Nigeria	26.0	13.3	31.0
Togo	5.8	1.0	11.4
Ghana	3.8	1.3	3.7
Niger	2.2	0.9	6.6

<sup>a</sup> In third round of Multiple Indicator Cluster Surveys.

<sup>b</sup> Percentages include both *yes* and *depends* responses.

Fig.1 Graphical depiction of prevalence for each outcome by country<sup>a,b</sup>



FGC, female genital cutting; MICS, multiple indicator cluster surveys.

<sup>a</sup> Due to the proxy measure used to assess FGC in Sierra Leone, the MICS recommends not interpreting the estimate for believing that this practice should continue.<sup>27</sup>

<sup>b</sup> Percentages include both *yes* and *depends* responses.

level, wealth and religion have significantly increased rates of FGC. Such rates can also vary within countries depending on ethnicity and geographic region. Although these variables could have enhanced our analysis, they were excluded to maintain comparability across country models. For instance, reports of FGC are common in the southern

regions of Nigeria but are substantially less frequent in its northern regions. Recognizing the diversity within countries in western Africa is particularly important for developing interventions and targeting efforts to reduce FGC.

Two countries – Burkina Faso and Mauritania – stand out for having succeeded in reducing FGC and support

for this practice. This is evidenced by the fact that the percentages of women who have been circumcised, who report that their daughters have been circumcised, and who believe that FGC should continue have shown steady declines. Burkina Faso, for instance, has established the National Committee to Fight against the Practice of Excision, a government-led entity that seeks to make citizens aware of the dangers of FGC and to ensure that proper law enforcement is in place to convict people who continue the practice. Although several countries have passed legislation banning FGC, Burkina Faso is the only country in which people who break this law are commonly prosecuted.<sup>28,29</sup> Mauritania has also experienced consistent declines in FGC and in support for the practice, although less dramatically than Burkina Faso. The government of Mauritania has established the Ministry of Women's Affairs (MCPFEF), which works with governmental groups as well as community and religious leaders to promote FGC awareness campaigns.<sup>30</sup> Mauritania also has a law against "harm[ing] the genital organs of a female child". However, prosecution is rare.<sup>31</sup> Diligence in prosecution could contribute to the differing rates of decline between Burkina Faso and Mauritania.

Based on the efforts and outcomes in both Burkina Faso and Mauritania, we postulate that four components are necessary for effectively reducing FGC practice and support. These include: (i) community education and awareness, (ii) the use of prominent groups to champion the cause, (iii) the support of FGC practitioners such as nurses, midwives, and traditional healers, and (iv) enforced legislation. First, community education and awareness can enable and facilitate affected communities to promote positive attitudes towards discontinuing the practice.<sup>5,32,33</sup> Successful community strategies have been documented, including circumcision-free rite-of-passage ceremonies and collective declarations in which villages pledge not to circumcise their daughters.<sup>8</sup> Second, strategies in Burkina Faso and Mauritania have used high-ranking women and a broad array of professionals and other influential people, such as government representatives and religious leaders to champion reform efforts.<sup>29,34</sup> Third, the participation of FGC practitioners within each country are central to meaningful implementation

of reform strategies by limiting access to FGC services and educating their patients.<sup>35,36</sup> Last, enforced legislation is particularly critical; legislation alone, without broad-based political support and enforcement, is likely to be ineffective.<sup>37</sup> Such concerted and multifaceted commitments allow for the preservation of a community's cultural heritage and social values while sustaining attitude shifts away from FGC for the benefit of future generations of women and girls.

Our results suggest subpopulations in each country where efforts could be targeted. For instance, older ages were consistently associated with the practice of FGC. The FGC practices of older women may be a result of past societal norms, including pressure from family members or spouses, even if they did not support the practice. Conversely, younger ages were more likely to believe the practice should continue, possibly because many may not yet have had to consider circumcising their own daughter. When women are faced with the decision to circumcise their own daughters or have already done so, their support of FGC may diminish. Furthermore, these younger women may not have been circumcised themselves and are therefore able to support the practice more easily without having experienced the medical and psychological complications that many of the older women had. Being less educated and Muslim were also generally associated with all three of our outcomes, suggesting that these subpopulations may be important groups for intervention approaches in some countries. Correlates, however, were not always consistent across countries. FGC in Niger and Nigeria, for instance, was not associated with Muslim religion. Additionally, in some countries wealth was associated with higher odds of engaging in the practice, and in others it was associated with lower odds of engaging in the practice. These variations reiterate contextual differences and the importance of having country-specific data to effectively tailor approaches for reducing and eliminating the practice of FGC.

Strengths of this study include its role in filling a large and significant gap in the peer-reviewed literature. Given the risks to both the physical and mental health of girls and women who undergo FGC and the desperate need for more effective strategies to eliminate this practice, our research calls attention to the substantial prevalence in several countries and provides information for affected governments and communities. Furthermore, medical and public health professionals in western Africa can use these results to identify patient subpopulations with whom they may need to address FGC practices and beliefs. Through this cross-country comparison, we were also able to highlight potential approaches for effectively reducing and eliminating this complex and deeply rooted practice. We also generated the data needed to identify subgroups of women at high risk for FGC to ensure that these strategies may be effectively implemented.

Our results should be interpreted in light of some limitations. First, we used only sample characteristics that were available in all countries and those that were largely consistent across countries, limiting our ability to describe practicing communities further. Second, it is possible that FGC-related practices and attitudes may have changed since the time of data collection (2005–2007); however, we used the most recent round of data made available by the MICS for this region. Third, the data collected from Sierra Leone may not be as comparable to other data as we may have wished. Questions for Sierra Leone did not refer to female circumcision or genital cutting, but to initiation into the Bondo Society. This alternative phrasing was deemed most relevant to the practicing culture in Sierra Leone,<sup>27</sup> although this measurement was markedly different from that used in other countries. Fourth, responses may be subject to social desirability or recall bias, depending on the cultural context and strategies in place to eliminate FGC. Women may have been motivated to

underreport circumcision and their support for the practice, particularly in countries in which legislation exists against such behaviour. Although other approaches, such as medical record reviews or examinations,<sup>38</sup> may have been more valid for measuring the prevalence of FGC, they were not feasible in these settings due to additional cost and time. As a result, these self-reported data across several countries were best for meeting our research objectives. Last, our analysis did not consider the type of FGC that had been experienced by the women in our samples. The type generally performed in each country, however, was not markedly different. Most of the countries in our sample perform a combination of Type I (clitoridectomy) and Type II (excision) or Type II only. It has been estimated that approximately 90% of all FGC includes these types where the flesh is either nicked or removed. Three countries in our sample (Gambia, Ghana, and Nigeria), however, perform the most severe form of FGC (Type III, infibulation) in at least some parts of the country. Infibulation, or being sewn shut, may describe up to 10% of all FGC.<sup>5,34,39</sup> The countries where this type occurs, and these affected women, may warrant additional and increased efforts.

Although action against FGC must be tempered with an understanding of the deeply rooted traditions that have allowed this practice to continue for so many generations, effective approaches for reducing FGC are critical. Despite widespread efforts, prevalence remains high in many countries, putting millions of girls at risk every year. Successful strategies for eliminating FGC are likely to require multi-pronged approaches in which political, legal and cultural elements are choreographed to effect large-scale change. Such concerted societal commitments are necessary for the benefit of future generations of women and girls. ■

**Competing interests:** None declared.

## ملخص

تشويه الأعضاء التناسلية للإناث: الممارسات والمعتقدات الحالية في غرب أفريقيا  
الغرض إجراء دراسة مقارنة شاملة لعدة بلدان حول انتشار الممارسات ومعتقدات تشويه الأعضاء التناسلية للإناث وارتباطاتها في غرب أفريقيا.  
الطريقة تم استخدام البيانات المستقاة من السيدات اللاتي استجبن للمسوح العنقودية متعددة المؤشرات التي أجريت فيما بين عامي 2005 و2007 لتقييم معدلات تواتر إجراء الختان، وإجبار

والثروة بشكل ملحوظ. وكانت بوركينا فاسو البلد الوحيدة في دراستنا التي شهدت انخفاضاً هائلاً في انتشار تشويه الأعضاء التناسلية للإناث من السيدات (74%) إلى بناتهن (25%)؛ وذكرت نسبة 14.2% فقط من السيدات اللاتي أجري عليهن المسح في هذا البلد أنهن يؤمن بضرورة الاستمرار في هذه الممارسة. الاستنتاج يظل انتشار تشويه الأعضاء التناسلية للإناث في غرب أفريقيا مرتفعاً بشكل عام، ولكنه يتنوع بشكل كبير فيما بين البلدان. وفي ضوء النطاق الشاسع من التجارب والاستراتيجيات الناجحة المستقاة من البلدان التي ينخفض بها تشويه الأعضاء التناسلية للإناث، يمكن تقديم نماذج مفيدة للبلدان ذات نسبة الانتشار المرتفعة التي تسعى لخفض ممارسات تشويه الأعضاء التناسلية للإناث بها.

البنات على الختان، والاعتقاد في ضرورة مواصلة ممارسات تشويه الأعضاء التناسلية للإناث. تم إجراء الارتداد اللوجستي المرجح باستخدام البيانات الخاصة بكل بلد لتحديد الارتباطات المستقلة لكل نتيجة.

التائج كان معدل انتشار تشويه الأعضاء التناسلية للإناث مرتفعاً بشكل عام ولكنه كان متنوعاً بشكل كبير فيما بين بلدان غرب أفريقيا. ففي سيراليون وغامبيا وبوركينا فاسو وموريتانيا، كانت نسبة انتشار تشويه الأعضاء التناسلية للإناث 94%، و79%، و74%، و72% على التوالي، بينما كانت نسبة الانتشار في غانا والنيجر وتوغو أقل من 6%. وارتبطت زيادة احتمالات تشويه الأعضاء التناسلية للإناث بالفئات العمرية الأكبر والمسلمة، وارتبط انخفاض احتمالات تشويه الأعضاء التناسلية للإناث بالتعليم العالي. وتنوع الارتباط بين تشويه الأعضاء التناسلية

## 摘要

### 女性生殖器割礼:西非当前的习俗和信仰

**目的** 开展西非女性生殖器割礼 (FGC) 习俗和信仰的普及率和相关性的跨国比较研究。

**方法** 使用参与 2005 至 2007 年多指标群体调查的女性的回答数据评估女性曾经被割除阴蒂的频率、曾经有一个女儿被割除阴蒂的频率以及认为应延续 FGC 习俗的频率。通过执行使用每个国家数据的加权逻辑回归方法确定每个结果的非依赖关系。

**结果** 西非整体 FGC 普及率高,但各个国家差别显著。在塞拉利昂、冈比亚、布基纳法索和毛里塔尼亚,FGC 的普及率分别为 94%、79%、74% 和 72%,而在加纳、尼日尔和多

哥,普及率不到 6%。年纪更大且信奉穆斯林的群体一般会有更高的 FGC 比率,而接受高等教育的群体则表现为更低的 FGC 比率。FGC 和财富之间的关联差异很大。在我们的研究中,布基纳法索是唯一出现从女性 (74%) 到其女儿一辈 (25%) FGC 普及率显著降低的国家;该国家接受调查的女性仅 14.2% 认为应延续此习俗。

**结论** 西非国家整体上依然普遍施行 FGC,但各个国家差别很大。就大范围经验而言,FGC 比率降低的国家的成功战略可以作为高 FGC 普及率国家降低其本国 FGC 习俗普及率的有用范例。

## Résumé

### Mutilations génitales féminines: pratiques et croyances actuelles en Afrique de l'Ouest

**Objectif** Réaliser une étude comparative transnationale de la prévalence et des indicateurs des pratiques et croyances en matière de mutilations génitales féminines (MGF) en Afrique de l'Ouest.

**Méthodes** Les données fournies par des femmes ayant répondu aux enquêtes en grappes à indicateurs multiples entre 2005 et 2007 ont servi à estimer la fréquence avec laquelle elles avaient été excisées, avaient fait exciser une ou plusieurs de leurs filles et pensaient que les pratiques de MGF devaient se poursuivre. Une régression logistique pondérée a été réalisée afin de déterminer les indicateurs autonomes de chaque résultat.

**Résultats** La prévalence des MGF était généralement élevée mais variait de manière significative d'un pays d'Afrique de l'Ouest à l'autre. En Sierra Leone, Gambie, Burkina Faso et Mauritanie, la prévalence des MGF était de 94%, 79%, 74% et 72%, respectivement, alors qu'au Ghana, Niger et Togo, cette prévalence était inférieure à 6%. Un âge plus avancé et le

fait d'être musulmane constituaient des facteurs généralement associés à des risques accrus de MGF et un degré d'éducation plus élevé était associé à des risques plus faibles. L'association entre MGF et aisance financière variait considérablement. Le Burkina Faso était le seul pays de notre étude à avoir noté une diminution spectaculaire des MGF des femmes (74%) à leurs filles (25%); seules 14,2% des femmes interrogées dans ce pays ont déclaré penser que cette pratique devait se poursuivre.

**Conclusion** La prévalence des MGF en Afrique de l'Ouest reste généralement élevée mais varie de manière significative d'un pays à l'autre. Compte tenu du large éventail d'expériences, des stratégies réussies dans des pays où les MGF sont en baisse peuvent fournir des exemples utiles à des pays à forte prévalence désireux de diminuer leurs propres pratiques de MGF.

## Резюме

### Женское обрезание: существующая практика и связанные с ней верования в Западной Африке

**Цель** Провести межгосударственное сравнительное исследование распространенности и соотношения практики женского обрезания и связанных с данной практикой верований в Западной Африке.

**Методы** Данные о женщинах, принявших участие в кластерных исследованиях с множественными показателями в период с 2005 по 2007 гг., были использованы для оценки частоты проведения

обрезания среди самих женщин, среди их дочерей, и полагающих, что практика женского обрезания должна быть продолжена. Для определения независимых соотношений по каждому результату была применена средневзвешенная логистическая регрессия с использованием данных по каждой стране.

**Результаты** Распространенность женского обрезания, в целом и целом, была высокой, но существенно варьировалась по странам

en la región de África Occidental. En Sierra Leona, Gambia, Burkina Faso y Mauritania la prevalencia de la MGF fue alta en general, si bien variaba de manera sustancial en los diversos países de África Occidental. En Sierra Leona, Gambia, Burkina Faso y Mauritania, la prevalencia de la MGF fue de un 94%, 79%, 74% y 72%, respectivamente, mientras que en Ghana,

en el oeste de África Occidental la prevalencia fue inferior al 6%. Una edad más avanzada y la condición de musulmana se asociaron generalmente a una mayor probabilidad de haber sufrido una MGF, mientras que se asoció una educación superior a una menor probabilidad de MGF. La asociación entre MGF y riqueza variaba ostensiblemente. Burkina Faso fue el único país dentro del estudio que experimentó una reducción drástica en la prevalencia de la MGF entre las madres (74%) y las hijas (25%). Solo el 14,2% de las mujeres encuestadas en dicho país afirmaron considerar que debía continuarse con dicha práctica.

**Conclusión** La prevalencia de la MGF en África Occidental sigue siendo elevada en general, si bien varía sustancialmente entre los diversos países. Teniendo en consideración la amplia variedad de experiencias, las estrategias fructíferas en países donde la MGF está descendiendo podrían servir de ejemplo útil a los países con una mayor prevalencia que deseen reducir sus prácticas de MGF.

## Resumen

### Mutilación genital femenina: prácticas actuales y creencias en África occidental

**Objetivo** Llevar a cabo un estudio comparativo entre países de África Occidental sobre la prevalencia y correlación de las prácticas de mutilación genital femenina (MGF) y las creencias relacionadas.

**Métodos** Se emplearon los datos procedentes de las mujeres que respondieron a las Encuestas de Indicadores Múltiples por Conglomerados entre 2005 y 2007 para calcular el porcentaje de mujeres que habían sido sometidas a una ablación, el de hijas de dichas mujeres que habían sido sometidas a una ablación y la creencia de que las prácticas de MGF deberían mantenerse. Se realizó una regresión logística ponderada empleando los datos procedentes de cada país para determinar las correlaciones independientes de cada resultado.

**Resultados** La prevalencia de la MGF fue alta en general, si bien variaba de manera sustancial en los diversos países de África Occidental. En Sierra Leona, Gambia, Burkina Faso y Mauritania, la prevalencia de la MGF fue de un 94%, 79%, 74% y 72%, respectivamente, mientras que en Ghana,

Níger y Togo la prevalencia fue inferior al 6%. Una edad más avanzada y la condición de musulmana se asociaron generalmente a una mayor probabilidad de haber sufrido una MGF, mientras que se asoció una educación superior a una menor probabilidad de MGF. La asociación entre MGF y riqueza variaba ostensiblemente. Burkina Faso fue el único país dentro del estudio que experimentó una reducción drástica en la prevalencia de la MGF entre las madres (74%) y las hijas (25%). Solo el 14,2% de las mujeres encuestadas en dicho país afirmaron considerar que debía continuarse con dicha práctica.

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Table 3. Odds ratios (ORs) for having undergone female genital cutting (circumcision), by sociodemographic characteristics, for women surveyed<sup>a</sup> in 10 western African countries, 2005–2007

Characteristic	Sierra Leone (n = 7 631) OR (95% CI)	Gambia (n = 9 926) OR (95% CI)	Burkina Faso (n = 7 199) OR (95% CI)	Mauritania (n = 12 498) OR (95% CI)	Guinea-Bissau (n = 7 882) OR (95% CI)	Côte d'Ivoire (n = 12 707) OR (95% CI)	Nigeria (n = 24 207) OR (95% CI)	Togo (n = 6 189) OR (95% CI)	Ghana (n = 5 881) OR (95% CI)	Niger (n = 9 164) OR (95% CI)
<b>Age (years)</b>										
15–19	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
20–24	2.06** (1.50–2.83)	0.83* (0.70–0.98)	1.20 (0.93–1.54)	1.08 (0.93–1.25)	1.14 (0.83–1.57)	1.11 (0.92–1.33)	1.27** (1.07–1.51)	1.47 (0.82–2.64)	1.25 (0.64–2.48)	1.03 (0.65–1.64)
25–29	2.15** (1.52–3.05)	0.74** (0.60–0.92)	1.30* (1.03–1.63)	1.17 (0.97–1.41)	1.25 (0.82–1.90)	1.13 (0.91–1.40)	1.59** (1.33–1.91)	2.66** (1.44–4.91)	0.97 (0.48–1.96)	1.81* (1.04–3.15)
30–34	2.29** (1.57–3.32)	0.75* (0.60–0.94)	1.73** (1.40–2.14)	1.17 (0.94–1.44)	0.95 (0.64–1.42)	1.25* (1.00–1.55)	1.90** (1.56–2.33)	3.37** (1.90–6.00)	2.01 (0.89–4.54)	1.83* (1.03–3.26)
35–39	2.89** (1.83–4.57)	0.80 (0.63–1.01)	2.05** (1.61–2.62)	1.24 (0.97–1.59)	1.46 (0.95–2.23)	1.25 (0.97–1.62)	2.20** (1.82–2.67)	4.33** (2.43–7.70)	2.05 (0.95–4.45)	2.61** (1.41–4.82)
40–44	2.40** (1.37–4.22)	0.65** (0.50–0.83)	2.54** (1.96–3.29)	1.35* (1.06–1.71)	1.01 (0.63–1.63)	1.09 (0.83–1.42)	2.90** (2.34–3.61)	5.20** (2.76–9.77)	1.78 (0.78–4.03)	2.79** (1.47–5.30)
45–49	2.15* (1.18–3.92)	0.58** (0.42–0.78)	2.34** (1.75–3.12)	1.36* (1.05–1.77)	1.17 (0.74–1.86)	1.07 (0.80–1.43)	4.41** (3.48–5.58)	5.24** (2.59–10.57)	2.70* (1.16–6.28)	2.33* (1.18–4.60)
<b>Educational level</b>										
None	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Primary	0.52** (0.38–0.71)	1.02 (0.75–1.38)	1.13 (0.93–1.37)	0.68** (0.56–0.82)	0.52** (0.39–0.71)	0.46** (0.38–0.57)	3.75** (3.17–4.45)	0.44** (0.31–0.63)	0.56** (0.39–0.81)	0.76 (0.40–1.45)
Beyond primary	0.44** (0.33–0.60)	0.88 (0.72–1.07)	0.97 (0.62–1.53)	0.56** (0.45–0.71)	0.20** (0.11–0.34)	0.38** (0.31–0.48)	3.85** (3.19–4.64)	0.46** (0.28–0.77)	0.21** (0.12–0.35)	0.21** (0.07–0.66)
Non-standard/ Madrasa <sup>b</sup>	–	1.17 (0.53–2.58)	–	0.57** (0.45, 0.72)	–	–	–	–	–	–
<b>Marital status</b>										
Never married	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Currently married	3.53** (2.63–4.73)	1.28* (1.05–1.56)	1.55** (1.26–1.92)	1.35** (1.15–1.57)	0.86 (0.59–1.24)	2.04** (1.68–2.47)	1.18* (1.02–1.37)	2.35* (1.24–4.47)	1.37 (0.69–2.72)	0.47* (0.26–0.88)
Formerly married	3.49** (2.14–5.69)	1.35 (0.99–1.84)	1.74** (1.21–2.51)	1.25* (1.03–1.52)	1.06 (0.64–1.77)	1.01 (0.82–1.25)	1.26 (0.99–1.61)	2.00 (0.98–4.08)	0.78 (0.34–1.80)	0.54 (0.19–1.50)

Characteristic	Sierra Leone (n = 7 631) OR (95% CI)	Gambia (n = 9 926) OR (95% CI)	Burkina Faso (n = 7 199) OR (95% CI)	Mauritania (n = 12 498) OR (95% CI)	Guinea-Bissau (n = 7 882) OR (95% CI)	Côte d'Ivoire (n = 12 707) OR (95% CI)	Nigeria (n = 24 207) OR (95% CI)	Togo (n = 6 189) OR (95% CI)	Ghana (n = 5 881) OR (95% CI)	Niger (n = 9 164) OR (95% CI)
<b>Wealth quintile</b>										
Lowest	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Second	0.44** (0.27–0.73)	2.20** (1.53–3.18)	1.35* (1.06–1.71)	0.34** (0.25–0.47)	1.55** (1.20–2.01)	0.44** (0.31–0.63)	2.03** (1.58–2.62)	1.12 (0.71–1.75)	1.12 (0.69–1.82)	1.93* (1.00–3.69)
Middle	0.54* (0.32–0.94)	2.22** (1.42–3.47)	0.96 (0.77–1.20)	0.13** (0.10–0.19)	2.36** (1.67–3.55)	0.41** (0.27–0.62)	2.65** (1.96–3.59)	0.89 (0.54–1.45)	0.47* (0.25–0.87)	1.86 (0.75–4.59)
Fourth	0.34** (0.20–0.59)	1.68* (1.08–2.64)	1.60** (1.22–2.08)	0.06** (0.04–0.09)	2.31** (1.61–3.31)	0.36** (0.23–0.55)	4.11** (3.08–5.49)	0.81 (0.47–1.40)	0.27** (0.13–0.55)	5.87** (3.15–10.94)
Highest	0.22** (0.13–0.38)	0.74 (0.48–1.13)	1.66** (1.22–2.25)	0.04** (0.03–0.06)	1.11 (0.73–1.70)	0.26** (0.17–0.41)	2.83** (2.10–3.80)	0.40** (0.22–0.72)	0.40* (0.18–0.89)	3.04** (1.42–6.51)
<b>Religion</b>										
Non-Muslim	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Muslim	2.01** (1.55–2.60)	16.56** (11.09–24.73)	1.87** (1.45–2.41)	NA	218.97** <sup>c</sup> (158.69–302.15)	7.22** (5.49–9.50)	0.56** (0.46–0.68)	26.90** (18.01–40.18)	4.38** (2.52–7.63)	0.03** (0.01–0.12)

CI, confidence interval; NA, not available; \*P < 0.05; \*\*P < 0.01.

<sup>a</sup> In third round of Multiple Indicator Cluster Surveys.

<sup>b</sup> Non-standard education in Gambia and Madrasa education/Koranic school in Mauritania were included in the analysis due to the high percentages of women who selected these categories; as a result, education for Gambia and Mauritania was modelled as dummy variables instead of the ordinal sequence used for other countries.

<sup>c</sup> OR estimate is large due to low frequencies of non-Muslims having ever been circumcised and low frequencies of Muslims not having ever been circumcised.

Table 4. Odds ratios (ORs) for having had at least one daughter undergo female genital cutting (circumcision), by sociodemographic characteristics, for women surveyed with at least one daughter<sup>a</sup> in 10 western African countries, 2005–2007

Characteristic	Sierra Leone (n = 4 970) OR (95% CI)	Gambia (n = 5 321) OR (95% CI)	Burkina Faso (n = 4 518) OR (95% CI)	Mauritania (n = 6 598) OR (95% CI)	Guinea-Bissau (n = 4 706) OR (95% CI)	Côte d'Ivoire (n = 5 791) OR (95% CI)	Nigeria (n = 12 880) OR (95% CI)	Togo (n = 3 431) OR (95% CI)	Ghana (n = 3 099) OR (95% CI)	Niger (n = 6 148) OR (95% CI)
<b>Age (years)</b>										
15–19	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
20–24	0.90 (0.45–1.78)	1.25 (0.91–1.71)	1.86 (0.52–6.63)	1.55* (1.11–2.17)	2.09** (1.28–3.42)	1.16 (0.58–2.29)	0.72 (0.37–1.39)	Excluded <sup>b</sup>	0.78 (0.06–9.80)	Excluded <sup>c</sup>
25–29	2.21* (1.19–4.10)	2.37** (1.74–3.23)	4.54* (1.38–14.90)	2.02** (1.45–2.80)	4.66** (2.90–7.49)	1.47 (0.78–2.80)	0.94 (0.52–1.71)	–	0.60 (0.06–6.06)	–
30–34	6.27** (3.40–11.56)	3.86** (2.74–5.43)	8.04** (2.38–27.18)	2.00** (1.41–2.83)	6.60** (3.99–10.93)	2.67** (1.47–4.83)	1.41 (0.76–2.61)	–	0.66 (0.09–5.10)	–
35–39	10.33** (5.67–18.82)	4.84** (3.37–6.93)	19.95** (6.07–65.52)	2.54** (1.80–3.57)	9.95** (5.86–16.89)	4.60** (2.30–9.20)	1.75 (0.95–3.23)	–	1.42 (0.17–11.66)	–
40–44	23.14** (12.39–43.23)	4.89** (3.44–6.94)	38.66** (11.48–130.18)	2.67** (1.84–3.88)	11.26** (6.51–19.48)	6.59** (3.43–12.63)	2.63** (1.44–4.79)	–	1.22 (0.17–8.69)	–
45–49	29.78** (15.90–55.78)	4.41** (2.97–6.54)	45.51** (13.72–150.90)	3.13** (2.18–4.49)	12.23** (6.92–21.62)	6.43** (3.28–12.62)	3.38** (1.85–6.16)	–	2.54 (0.36–18.10)	–
<b>Educational level</b>										
None	1.00	1.00	1.00	1.00	1.00	1.00	1.00	Excluded <sup>b</sup>	1.00	1.00
Primary	0.80 (0.63–1.03)	0.79 (0.61–1.02)	1.06 (0.79–1.43)	0.60** (0.49–0.72)	0.71* (0.52–0.97)	0.44** (0.32–0.61)	2.60** (2.05–3.29)	–	0.47 (0.17–1.34)	0.51 (0.12–2.14)
Beyond primary	0.60** (0.46–0.79)	0.48** (0.39–0.59)	0.42** (0.22–0.79)	0.39** (0.30–0.51)	0.21** (0.12–0.34)	0.34** (0.15–0.77)	2.10** (1.55–2.83)	–	0.18** (0.05–0.67)	0.97 (0.26–3.71)
Non-standard/ Madrasa <sup>d</sup>	– (0.73–2.49)	1.35 (0.73–2.49)	–	0.63** (0.50–0.78)	–	–	–	–	–	–
<b>Marital status</b>										
Never married	1.00	1.00	1.00	1.00	1.00	1.00	1.00	Excluded <sup>b</sup>	Excluded <sup>d</sup>	Excluded <sup>c</sup>
Currently married	93 (0.54–1.60)	1.59 (1.00–2.54)	5.61 (0.76–41.42)	7.18** (4.49–11.48)	1.97** (1.21–3.18)	2.13** (1.57–2.89)	0.92 (0.53–1.60)	–	–	–
Formerly married	1.18 (0.66–2.13)	1.39 (0.83–2.32)	4.83 (0.63–36.74)	5.66** (3.47–9.24)	1.58 (0.85–2.94)	0.98 (0.67–1.43)	0.97 (0.52–1.79)	–	–	–
<b>Wealth quintile</b>										
Lowest	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Second	0.94 (0.76–1.16)	1.74** (1.31–2.30)	1.05 (0.82–1.33)	0.37** (0.27–0.51)	1.00 (0.69–1.44)	0.57** (0.39–0.82)	2.35** (1.62–3.41)	1.18 (0.54–2.60)	1.31 (0.73–2.33)	1.57 (0.58–4.24)
Middle	1.10 (0.90–1.34)	1.77** (1.26–2.50)	0.98 (0.72–1.32)	0.15** (0.11–0.21)	0.90 (0.62–1.31)	0.55** (0.38–0.80)	2.78** (1.83–4.21)	0.44* (0.20–0.94)	0.36 (0.11–1.16)	0.72 (0.22–2.38)
Fourth	0.94 (0.76–1.16)	1.62* (1.12–2.35)	1.29 (0.96–1.73)	0.07** (0.05–0.10)	0.87 (0.60–1.27)	0.33** (0.22–0.49)	5.03** (3.38–7.47)	0.33 (0.10–1.05)	0.36 (0.10–1.34)	3.07** (1.33–7.06)
Highest	1.03 (0.80–1.34)	0.88 (0.62–1.26)	1.66** (1.19–2.31)	0.03** (0.03–0.05)	0.55** (0.37–0.80)	0.20** (0.13–0.30)	3.10** (2.05–4.68)	0.14** (0.03–0.58)	0.19 (0.03–1.31)	1.02 (0.30–3.51)

Characteristic	Sierra Leone (n = 4 970) OR (95% CI)	Gambia (n = 5 321) OR (95% CI)	Burkina Faso (n = 4 518) OR (95% CI)	Mauritania (n = 6 598) OR (95% CI)	Guinea-Bissau (n = 4 706) OR (95% CI)	Côte d'Ivoire (n = 5 791) OR (95% CI)	Nigeria (n = 12 880) OR (95% CI)	Togo (n = 3 431) OR (95% CI)	Ghana (n = 3 099) OR (95% CI)	Niger (n = 6 148) OR (95% CI)
Religion										
Non-Muslim	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Muslim	1.38** (1.16–1.65)	17.20** (9.70–30.51)	1.51** (1.18–1.93)	NA	85.93** <sup>f</sup> (57.39–128.67)	3.92** (2.83–5.42)	0.88 (0.67–1.15)	19.06** (8.24–44.10)	4.31** (2.18–8.50)	0.27** (0.10–0.72)

CI, confidence interval; NA, not available; \* $P < 0.05$ ; \*\* $P < 0.01$ .

<sup>a</sup> In third round of Multiple Indicator Cluster Surveys.

<sup>b</sup> In Togo, there were no women in the 15 to 19 age category, in the "never married" category, or in the "above primary" or "non-standard education" categories. Based on the likelihood ratio test ( $P < 0.05$ ), we chose to exclude age, marital status and education level and present the better fitting, more parsimonious model.

<sup>c</sup> In Niger, there were no women in the 15 to 19 age category or in the "never married" category who had had at least one daughter cut. Based on the likelihood ratio test ( $P < 0.05$ ), we chose to exclude both age and marital status and present the better fitting, more parsimonious model.

<sup>d</sup> Non-standard education in Gambia and Madrasa education/Koranic school in Mauritania were included in the analysis due to the high percentages of women who selected these categories; as a result, education for Gambia and Mauritania was modelled as dummy variables instead of the ordinal sequence used for other countries.

<sup>e</sup> In Ghana, there were no women in the "never married" category who had had at least one daughter cut. Based on the likelihood ratio test ( $P < 0.05$ ), we chose to exclude marital status and present the better fitting, more parsimonious model.

<sup>f</sup> OR estimate is large due to low frequencies of non-Muslims having been circumcised and low frequencies of Muslims having never been circumcised.

Table 5. Odds ratios (ORs) for believing the practice of female genital cutting (FGC) should continue, <sup>a</sup> by sociodemographic characteristics, for women who had heard of FGC in survey<sup>b</sup> in 10 western African countries, 2005–2007

Characteristic	Sierra Leone (n = 7 380) OR (95% CI)	Gambia (n = 9 770) OR (95% CI)	Burkina Faso (n = 6 644) OR (95% CI)	Mauritania (n = 11 392) OR (95% CI)	Guinea-Bissau (n = 6 990) OR (95% CI)	Côte d'Ivoire (n = 10 559) OR (95% CI)	Nigeria (n = 12 706) OR (95% CI)	Togo (n = 4 528) OR (95% CI)	Ghana (n = 4 052) OR (95% CI)	Niger (n = 2 979) OR (95% CI)
<b>Age (years)</b>										
15–19	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
20–24	0.90 (0.70–1.15)	0.78** (0.65–0.93)	0.80 (0.53–1.20)	0.86 (0.74–1.01)	0.80 (0.63–1.00)	0.75** (0.62–0.92)	0.94 (0.79–1.12)	0.80 (0.51–1.25)	0.72 (0.34–1.49)	0.80 (0.43–1.51)
25–29	0.92 (0.70–1.22)	0.70** (0.58–0.84)	0.59** (0.43–0.80)	0.93 (0.79–1.11)	0.88 (0.66–1.18)	0.62** (0.51–0.76)	0.88 (0.73–1.05)	0.97 (0.61–1.56)	1.22 (0.59–2.53)	0.88 (0.43–1.79)
30–34	1.06 (0.77–1.45)	0.67** (0.54–0.83)	0.49** (0.34–0.71)	0.78** (0.65–0.94)	0.85 (0.65–1.13)	0.73** (0.59–0.91)	0.79* (0.63–0.97)	0.87 (0.53–1.44)	0.98 (0.42–2.27)	0.77 (0.39–1.51)
35–39	1.15 (0.85–1.55)	0.65** (0.52–0.82)	0.66* (0.47–0.92)	0.78* (0.64–0.94)	1.20 (0.89–1.62)	0.73** (0.58–0.92)	0.87 (0.70–1.08)	0.93 (0.58–1.48)	0.53 (0.23–1.22)	0.97 (0.45–2.12)
40–44	1.31 (0.89–1.94)	0.56** (0.44–0.72)	0.60** (0.42–0.86)	0.77* (0.62–0.95)	1.01 (0.75–1.37)	0.71** (0.56–0.91)	0.97 (0.77–1.23)	1.02 (0.60–1.75)	0.85 (0.37–1.97)	0.78 (0.34–1.81)
45–49	1.85** (1.17–2.93)	0.56** (0.42–0.76)	0.61* (0.42–0.89)	0.77* (0.62–0.97)	0.91 (0.65–1.29)	0.81 (0.60–1.10)	1.22 (0.94–1.57)	1.27 (0.74–2.18)	0.32* (0.13–0.84)	1.44 (0.67–3.10)
<b>Educational level</b>										
None	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Primary	0.79 (0.63–1.01)	0.74* (0.58–0.95)	0.89 (0.70–1.13)	0.58** (0.50–0.68)	0.43** (0.36–0.52)	0.46** (0.39–0.56)	1.40** (1.15–1.69)	0.80 (0.59–1.09)	0.56* (0.31–0.99)	0.45** (0.25–0.80)
Above primary	0.34** (0.27–0.42)	0.50** (0.42–0.60)	0.17** (0.11–0.26)	0.36** (0.30–0.43)	0.21** (0.16–0.28)	0.22** (0.17–0.28)	1.31** (1.08–1.59)	0.50** (0.35–0.71)	0.62 (0.38–1.04)	0.25** (0.11–0.59)
Non-standard/ Madrasa <sup>b</sup>	–	0.91 (0.44–1.88)	–	0.76** (0.64–0.91)	–	–	–	–	–	–
<b>Marital status</b>										
Never married	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Currently married	1.44** (1.12–1.84)	1.31** (1.09–1.56)	1.03 (0.53–1.99)	1.23** (1.06–1.42)	1.45** (1.13–1.86)	1.93** (1.58–2.37)	1.14 (0.95–1.35)	1.62* (1.04–2.51)	1.80 (0.96–3.37)	0.62 (0.32–1.20)
Formerly married	1.12 (0.81–1.54)	0.98 (0.75–1.29)	0.76 (0.36–1.63)	1.10 (0.92–1.32)	1.18 (0.85–1.64)	1.02 (0.81–1.28)	1.14 (0.87–1.50)	1.26 (0.69–2.32)	0.96 (0.46–2.01)	0.25** (0.09–0.67)

Characteristic	Sierra Leone (n = 7 380) OR (95% CI)	Gambia (n = 9 770) OR (95% CI)	Burkina Faso (n = 6 644) OR (95% CI)	Mauritania (n = 11 392) OR (95% CI)	Guinea-Bissau (n = 6 990) OR (95% CI)	Côte d'Ivoire (n = 10 559) OR (95% CI)	Nigeria (n = 12 706) OR (95% CI)	Togo (n = 4 528) OR (95% CI)	Ghana (n = 4 052) OR (95% CI)	Niger (n = 2 979) OR (95% CI)
<b>Wealth quintile</b>										
Lowest	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Second	0.63 (0.38–1.03)	1.60** (1.13–2.26)	0.63** (0.47–0.83)	0.50** (0.38–0.65)	1.01 (0.79–1.28)	0.60** (0.46–0.78)	1.12 (0.85–1.48)	0.62** (0.44–0.87)	0.74 (0.43–1.27)	0.85 (0.50–1.44)
Middle	0.39** (0.24–0.64)	1.52 (1.00–2.32)	0.84 (0.64–1.11)	0.23** (0.18–0.30)	0.86 (0.66–1.12)	0.51** (0.38–0.69)	1.13 (0.84–1.53)	0.57* (0.37–0.88)	0.65 (0.36–1.17)	0.72 (0.42–1.21)
Fourth	0.20** (0.12–0.32)	0.93 (0.61–1.40)	0.76 (0.55–1.05)	0.12** (0.09–0.15)	0.63** (0.48–0.82)	0.40** (0.29–0.56)	1.26 (0.94–1.70)	0.45** (0.30–0.70)	0.34** (0.18–0.64)	0.63 (0.37–1.08)
Highest	0.15** (0.09–0.24)	0.38** (0.26–0.56)	0.86 (0.65–1.13)	0.06** (0.05–0.08)	0.33** (0.24–0.43)	0.24** (0.17–0.34)	0.79 (0.58–1.07)	0.47** (0.30–0.73)	0.22** (0.11–0.43)	0.53* (0.31–0.93)
<b>Religion</b>										
Non-Muslim	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Muslim	1.60** (1.29–1.97)	16.92** (10.75–26.64)	1.75** (1.39–2.20)	NA	17.42** (13.82–21.96)	3.12** (2.50–3.89)	1.33** (1.11–1.61)	0.92 (0.68–1.25)	0.99 (0.59–1.68)	0.62 (0.30–1.29)

CI, confidence interval; NA, not available; \* $p < 0.05$ ; \*\* $p < 0.01$ .

<sup>a</sup> "Believing the practice should continue" includes both yes and depends responses.

<sup>b</sup> Third round of Multiple Indicator Cluster Surveys.

<sup>c</sup> Non-standard education in Gambia and Madrasa education/Koranic school in Mauritania were included in the analysis due to the high percentages of women who selected these categories; as a result, education for Gambia and Mauritania was modelled as dummy variables instead of the ordinal sequence used for other countries.

# Female Genital Cutting

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

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Disclosure statements have been received from all members of the committees.

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## Abstract

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

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

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

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

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

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

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

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

**Summary Statements**

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

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

**Recommendations**

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

**ABBREVIATIONS**

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

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

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

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## INTRODUCTION

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

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

## Definition of Female Genital Cutting

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

## Glossary

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

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

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

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

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

## Classification

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

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

**Table 2. WHO modified typology, 2007**

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

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

### Prevalence in Canada

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

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

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

While there is no evidence that any type of FGC is practiced in Canada, there is concern that girls from practising communities may still be at risk. In their exploratory study of the perceptions of Somali women of their earlier experience of FGC, Chalmers and Omer-Hashi<sup>13</sup> found that only one third of respondents supported the Canadian law prohibiting the practice, while two thirds reported ambivalent feelings. Furthermore, when asked “whether or not they would (hypothetically) wish to have [their daughters] circumcised,” almost half said they would. In their study exploring FGC as it relates to gender identity and the acculturation process in Canada, Vissandjée et al. were unable to determine whether these practices had been abandoned by new arrivals to Canada; their findings suggested that “the need to maintain a status equal to that of the country of origin potentially increased the risk of the practices being performed [on girls].”<sup>11</sup> Finally, SERC Manitoba, in their work with immigrants affected by FGC, reported that women were split in their opinions of the issue; although some women strongly supported discontinuation of the practice, others either supported it or remained conflicted about what should be done about it.<sup>14</sup> These findings are supported by a number of European studies that show the practice is not necessarily abandoned with migration and that girl children remain at risk.<sup>15-17</sup>

### Summary Statement

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

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

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

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

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

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

**Table 4. Recognized complications and risks of female genital cutting<sup>1</sup>**

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

### Immediate and Long-term Complications

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

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

### Impact on Women and Adolescents Living in Receiving Countries

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

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

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

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

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

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

### **Summary Statements**

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

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

### **Recommendations**

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

### **Legal Issues Related to FGC in Canada**

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

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

### **Statements and Policies of**

#### **Provincial Medical Organizations in Canada**

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

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

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

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

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

Recent European studies shed light on the experiences and clinical practices of health providers providing care to women with FGC and how these contribute to the quality of care provided. Vangena et al. (2002)<sup>28</sup> found that health care providers in Norway faced difficulties initiating discussion about the practice with women; lacked clinical skills in how and when to defibulate women and in determining the extent of repair after delivery; and at times performed Caesarean sections because they lacked knowledge related to care management. Widmark et al.<sup>34</sup> and Johansen<sup>35</sup> reported that health care providers found providing care to infibulated women at childbirth especially stressful and emotionally challenging. Of particular concern were the strong emotional and sometimes contradictory feelings of health providers, which included “deep empathy, protectiveness and the desire to treat the

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

### Summary Statements

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

## CLINICAL MANAGEMENT OF WOMEN LIVING WITH FGC

### Gynaecologic Care

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

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

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

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

### Obstetrical Care

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

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

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

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

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

### Summary Statement

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

## Sexual Health

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

## Adolescent Care

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

## Working with Families with Daughters at Risk

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

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

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

## Recommendations

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

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

### Preamble

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

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

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

### **Key Care Practices in Providing Care to Women with FGC**

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

#### **Terminology when providing care**

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

#### **Identification of the woman's FGC status**

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

#### **Examples of simple and sensitive questions to discover whether a woman has undergone FGC and is experiencing any complications related to the practice<sup>54</sup>**

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

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

### **Communication**

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

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

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

#### **Providing women with appropriate and well-timed information**

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

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

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

### **Confidentiality and privacy**

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

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

### **Woman-centred care**

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

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

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

### **Health-seeking behaviours and practices and preventative care**

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

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

### **Preparation for delivery**

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

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

### Referrals

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

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

### Recommendation

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

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

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*Appendices begin on next page*

## APPENDIX 1. CRIMINAL CODE OF CANADA

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

### Aggravated assault

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

#### *Punishment*

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

#### *Excision*

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

#### *Consent*

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

### Removal of child from Canada

273.3 (1) No person shall do anything for the purpose of removing from Canada a person who is ordinarily resident in Canada and who is

- (a) under the age of 16 years, with the intention that an act be committed outside Canada that if it were committed in Canada would be an offence against section 151 or 152 or subsection 160(3) or 173(2) in respect of that person;
- (b) 16 years of age or more but under the age of eighteen years, with the intention that an act be committed outside Canada that if it were committed in Canada would be an offence against section 153 in respect of that person; or
- (c) under the age of eighteen years, with the intention that an act be committed outside Canada that if it were committed in Canada would be an offence against section 155 or 159, subsection 160(2) or section 170, 171, 267, 268, 269, 271, 272 or 273 in respect of that person.

### Criminal negligence

**219.** (1) Every one is criminally negligent who

- (a) in doing anything, or
- (b) in omitting to do anything that it is his duty to do, shows wanton or reckless disregard for the lives or safety of other persons.

### Accessory after the fact

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

### Duty of persons to provide necessities

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

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

### REFERENCE

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

## APPENDIX 2. STATEMENTS AND POLICIES PROVIDED BY PROVINCIAL MEDICAL BODIES

### The Provincial Medical Board of Nova Scotia

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

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

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

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

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

### Le Collège des médecins du Québec

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

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

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

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

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

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

### The College of Physicians and Surgeons of Ontario

#### *Female Cutting (Mutilation)*<sup>1</sup>

#### PRINCIPLES

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

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

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

#### POLICY

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

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

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

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

#### *Reporting*

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

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

*Continued*

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

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

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

**Endnotes**

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

**The College of Physicians and Surgeons of Manitoba****Female Circumcision (Revised 2001)<sup>2</sup>**

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

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

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

Specifically, physicians must not perform FGM.

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

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

**The College of Physicians and Surgeons of British Columbia****College's Position<sup>3</sup>**

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

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

**Duty to Report<sup>6</sup>**

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

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

**REFERENCES**

1. The College of Physicians and Surgeons of Ontario. Female genital cutting (mutilation). Policy #2-11. Available at: <http://www.cpso.on.ca/policies/policies/default.aspx?ID=1596>. Accessed on August 2, 2013.
2. The College of Physicians and Surgeons of Manitoba. Female circumcision (2011 rev.) Statement 111. Available at: <http://cpsm.mb.ca/cj39alckF30a/wp-content/uploads/st111.pdf>. Accessed on August 2, 2013.
3. College of Physicians and Surgeons of British Columbia. Professional standards and guidelines: female genital mutilation. Available at: <https://www.cpsbc.ca/files/u6/Female-Genital-Mutilation.pdf>. Accessed on August 2, 2013.

**TTSTA Tuesday**  
**Week #10**

Happy TTSTA Tuesday #10!

I trust that you all had a restful Thanksgiving weekend-or at least had moments of rest.

This week's TTSTA Tuesday is compliments of Jean. She shared a link to a recently released 4-minute video on the screening process of potential refugees entering the U.S., produced by the White House. Under the video text, there are links to related content that may also be of interest. Thank you Jean for being on the pulse of the current issues and information concerning refugees!

<https://www.whitehouse.gov/blog/2015/11/24/watch-heres-what-refugee-screening-process-looks>

Please continue to share your thoughts, ideas, and learning needs.

Thank you,

**TTSTA Tuesday**  
**Week #11**

Happy Tuesday Morning!

Thank you for your support as we become more familiar with this new population that we will serve. In preparation of our visit to the Pan African Community Association (PACA) <http://panafricoma.org/>

I invite you to review the PACA website. Please note click on their "About Us" tab to read their Mission, Vision, Values, Goals and Objectives. Also, review the names of their Board of Directors. Finally, familiarize yourself with their program offerings so we may support and refer when appropriate.

I know our partners at PACA are looking forward to our visit on Thursday, December, 17th from 10:30-12.

A poem was read at the Our City of Nations Conference last week. It was written by a Kenyan-born Somali poet, writer and educator based in London. Warsan Shire writes about the refugee journey. The imagery is striking and may be difficult to read. The link takes you to the blog post with more information about the poet. The poem is pasted below.

[HOME by Warsan Shire](#)

no one leaves home unless  
home is the mouth of a shark  
you only run for the border  
when you see the whole city running as well

your neighbors running faster than you  
breath bloody in their throats  
the boy you went to school with  
who kissed you dizzy behind the old tin factory  
is holding a gun bigger than his body  
you only leave home  
when home won't let you stay.

no one leaves home unless home chases you  
fire under feet  
hot blood in your belly  
it's not something you ever thought of doing  
until the blade burnt threats into  
your neck

# TEACHING TODAY'S STUDENTS FOR TOMORROW'S AMERICA



College of Nursing

and even then you carried the anthem under  
your breath  
only tearing up your passport in an airport toilets  
sobbing as each mouthful of paper  
made it clear that you wouldn't be going back.

you have to understand,  
that no one puts their children in a boat  
unless the water is safer than the land  
no one burns their palms  
under trains  
beneath carriages  
no one spends days and nights in the stomach of a truck  
feeding on newspaper unless the miles traveled  
means something more than journey.  
no one crawls under fences  
no one wants to be beaten  
pitied

no one chooses refugee camps  
or strip searches where your  
body is left aching  
or prison,  
because prison is safer  
than a city of fire  
and one prison guard  
in the night  
is better than a truckload  
of men who look like your father  
no one could take it  
no one could stomach it  
no one skin would be tough enough

the  
go home blacks  
refugees  
dirty immigrants  
asylum seekers  
sucking our country dry  
niggers with their hands out  
they smell strange  
savage  
messed up their country and now they want  
to mess ours up  
how do the words

# TEACHING TODAY'S STUDENTS FOR TOMORROW'S AMERICA



College of Nursing

the dirty looks  
roll off your backs  
maybe because the blow is softer  
than a limb torn off

or the words are more tender  
than fourteen men between  
your legs  
or the insults are easier  
to swallow  
than rubble  
than bone  
than your child body  
in pieces.  
i want to go home,  
but home is the mouth of a shark  
home is the barrel of the gun  
and no one would leave home  
unless home chased you to the shore  
unless home told you  
to quicken your legs  
leave your clothes behind  
crawl through the desert  
wade through the oceans  
drown  
save  
be hunger  
beg  
forget pride  
your survival is more important

no one leaves home until home is a sweaty voice in your ear  
saying-  
leave,  
run away from me now  
i dont know what i've become  
but i know that anywhere  
is safer than here

----Warsan Shire

**TTSTA Tuesday**  
**Week #12**

Good Tuesday Morning,

Thank you Anne for your Global Health Primer. We learned a lot in a short period of time! Thank you team for the open discussion at yesterday's cross site meeting. I appreciated the dialogue and willingness to engage in rapid-cycle improvement as we determine best practices of care. Your respective wisdom, talents, and experiences make our team strong.

Below you will find a number of websites that address information and resources concentrating on the health of Refugee populations. Please take some time to look at the resources and bookmark them for further reference. There are a lot of materials developed that we may draw upon as we begin to serve this new population.

I welcome ideas on new topics and need for further information for TTSTA Tuesdays.

Have a great week! ~Jeana

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<http://ethnomed.org/patient-education>



Patient Education —  
EthnoMed  
Browse by Language  
Amharic Listing of  
patient education  
materials in Amharic  
language. Chinese  
Listing of patient  
education materials  
in Chinese language.  
[Read more...](#)

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<http://spiral.tufts.edu/providers.shtml>



SPIRAL: About Us  
Information for  
Healthcare Providers  
. 24 Languages  
Project: Health  
Education Brochures

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in Multiple  
Languages  
(University of Utah/  
Utah Department of  
Health)  
[Read more...](#)

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<https://healthreach.nlm.nih.gov/>

HealthReach - Health Information in  
Many Languages  
HealthReach is a resource of quality  
multilingual, multicultural public  
health information for those working  
with or providing care to individuals  
with limited ...

[Read more...](#)

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<https://sis.nlm.nih.gov/outreach/multicultural.html>

<http://hmonghealth.org/>



HmongHealth.org  
Hmong Health  
Information  
provided by the  
HMong Health  
Education Network.  
[Read more...](#)

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<https://www.nlm.nih.gov/medlineplus/healthtopics.html>



Health Topics:  
MedlinePlus - US  
National Library of  
Medicine  
Read about  
symptoms, causes,  
treatment and  
prevention for over  
950 diseases,  
illnesses, health  
conditions and  
wellness issues.  
MedlinePlus health  
topics ...  
[Read more...](#)

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<http://www.cancer.org/apicem/default>

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Asian Pacific  
Islander Cancer  
Education Materials  
Tool  
Asian Pacific  
Islander Cancer  
Education Materials  
Tool. Use this search  
tool to find cancer  
information in Asian  
or Pacific Islander  
languages. These  
materials ...  
[Read more...](#)

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