ARTICLE

Facilitating Birth for Women Who Have Experienced Genital Cutting

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ABSTRACT

Female genital cutting (FGC) is a traditional practice in parts of Africa, the Middle East, and Asia. Due to increasing migration from these areas to Canada and elsewhere, the care of women who have undergone FGC has become both a national and a global concern. It is widely regarded as a public health and human rights issue affecting at least 140 million women worldwide. In Canada, pregnant women who experienced FGC may face more physical and emotional challenges than their nonpregnant counterparts. Their need to access optimal perinatal care is critical, as FGC, particularly that with more extensive cutting (infibulation), is widely considered to be an indirect cause of maternal/newborn morbidity. The purposes of this article are (1) to provide a deeper insight into challenges confronting affected women seeking maternity care in Canada and their providers and (2) to recommend the appropriateness of the Canadian midwifery model in providing optimal care for women who have experienced FGC. The goal is to support Canadian health care providers in gaining a greater understanding of the historical, cultural, and physical realities of FGC so that they are able to provide maternity care that meets Canadian standards while being sensitive to cultural values and beliefs.

KEYWORDS

female genital cutting, mutilation, pregnancy care, perinatal care, midwifery

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ARTICLE

Faciliter l'accouchement chez les femmes ayant subi des mutilations génitales

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RÉSUMÉ

Les mutilations génitales féminines (MGF) constituent une pratique traditionnelle qui se perpétue dans certaines régions de l'Afrique, du Moyen Orient et de l'Asie. Compte tenu de l'accroissement de la migration entre ces régions et le Canada et d'autres pays, les soins aux femmes ayant subi des mutilations génitales sont devenus une préoccupation d'ordre national et international. Les MGF sont largement considérées comme un enjeu de santé publique et de droits de la personne; elles touchent au moins 140 millions de femmes dans le monde entier. Au Canada, les femmes enceintes qui ont subi des mutilations génitales pourraient faire face à davantage de difficultés physiques et affectives que leurs homologues n'étant pas enceintes. Il est essentiel qu'elles aient accès à des soins périnataux de qualité optimale. En effet, les MGF, en particulier si elles sont plus étendues (infibulation), sont largement considérées comme une cause indirecte de morbidité maternelle et néonatale. Le présent article a été rédigé aux fins suivantes : (1) fournir un aperçu approfondi des difficultés que doivent affronter les femmes qui ont subi des mutilations génitales et qui cherchent à obtenir des soins de maternité au Canada, et des difficultés que doivent relever leurs fournisseurs de soins; et (2) confirmer la pertinence du modèle canadien de pratique sage femme dans la prestation de soins optimaux aux femmes ayant subi des mutilations génitales. Le but de cet article est d'aider les professionnels canadiens de la santé à approfondir leur compréhension des réalités historiques, culturelles et physiques des MGF, de façon à leur permettre de fournir des soins de maternité conformes aux normes canadiennes, tout en demeurant sensibles aux valeurs et aux croyances culturelles.

MOTS CLÉS

Mutilations génitales féminines, mutilation, soins pendant la grossesse, soins périnataux, pratique sage-femme

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INTRODUCTION

Female genital cutting (FGC), sometimes referred to as female genital mutilation or female circumcision, is a millennia-old cultural and traditional practice in parts of Africa, the Middle East, and Asia.[1] Female genital cutting is defined as "all procedures involving partial or total removal of the external female genitalia or other injury to the organs whether for cultural or other non-medical reasons."[1] Clinical practice guidelines developed by the Society of Gynaecologists and Obstetricians of Canada (SOGC) acknowledge that although the term "female genital mutilation" highlights the gravity of the procedure, it can also be considered stigmatizing. "Female circumcision" is a misnomer in that the procedure can be equated with male circumcision. Consistent with SOGC guidelines, the term "female genital cutting" (FGC) will be used in this article.

Female genital cutting is categorized as types I to IV. Types I to III are categorized according to the amount of cutting and tissue removal that take place. The severest cutting, associated with greater morbidity, is categorized as type III and involves infibulation; it is also referred to as pharaonic circumcision. In this case, partial or total excision of the clitoris and the labia minora and majora is done to reconstruct the vulvovaginal opening; suturing is required.[1] It must also be noted that in some cases the clitoris is not excised. The final category of FGC, type IV, includes all other wounding of the female genitalia for nontherapeutic reasons (for example, piercing, hymen repair, and cauterization of the genital area).[1]

Defibulation (also called deinfibulation) is "an incision of the vulva to open the vagina of a woman who has undergone infibulation."[2] This may be done during birth, to enlarge an occluded or partially occluded vaginal opening; it may also, if a pregnant woman who has undergone FGC approves, be performed prior to pregnancy or the onset of labour.[2]

Reinfibulation is the stitching of the vulvovaginal opening to close it after defibulation and birth.[2] The World Health Organization opposes any medicalization of FGC, including reinfibulation. Although reinfibulation is not specified in the Criminal Code of Canada, SOGC regards it as contributing to increased scar tissue and therefore recommends that requests to health care providers for this procedure "be declined on medical grounds."[2] Failure to comply with this recommendation can be considered medical malpractice.

Widely regarded as a public health and human rights issue, FGC affects at least 140 million women worldwide.[1] Its highest reported prevalence is in Africa, although it is also practiced in 28 countries, and in parts of the Arabian peninsula and Asia.[1,3] Because of increasing migration from these areas to Canada and elsewhere, the care of women who have undergone FGC has become both a national and a global concern.[1]

An integrated literature review documenting the perceptions of women in seven countries who were subjected to FGC reported that health care providers in those countries lacked knowledge and behaved in discriminatory ways, without respect for the affected women's language needs or privacy.[4,5] These perceptions were similar to those reported in an earlier national descriptive Canadian survey that examined the perinatal experiences of 432 affected Somali women.[6] Of these women, 74% reported that they had been afraid to seek perinatal care during their first pregnancy. They attributed their fear to their belief that Canadian health care providers lacked clinical, social, and cultural knowledge regarding FGC. Thus, they believed that these providers would have difficulty providing culturally sensitive and appropriate perinatal care; this was a particular concern in regard to anticipated care during labour and birth. For example, in Canada, cesarean sections are very often performed to prevent potential intrapartum complications associated with more-severe FGC, and this may have contributed to the concerns of affected women regarding care. Further, feeling upset by care providers' comments was reported by more than 87% of women, 74% of whom perceived verbal expressions of surprise with respect to the appearance of their genitalia, and 78% of whom saw what they perceived to be negative nonverbal gestures because of the shape of their perineum. Fifty-two percent believed that their providers were unable to care for them during the entire perinatal period.[6]

The Canadian Advisory Council on the Status of Women reports that approximately 40,000 women arriving in Canada between 1986 and 1991 were subjected to some form of FGC prior to their arrival.[7] Between 2005 and 2009, Canada received women from all 28 countries where FGC is practiced.[2] Thus, while the actual numbers of women who have undergone FGC and are currently living in Canada are unknown, it is probable that these numbers have increased substantially. Because FGC is an indirect cause of perinatal morbidity and mortality,[8,9] pregnant women who previously underwent FGC may face more physical and emotional challenges than those who did not experience

this procedure, thus heightening the need for access to appropriate perinatal care.[10,11]

PURPOSE

Greater insight into sociocultural meanings and the clinical management needed to support vaginal birth would do much to alleviate the concerns that women who have undergone FGC have about accessing maternity care in Canada. Midwives and other maternity care providers have an obligation to provide perinatal care that, while consistent with Canadian health care standards, respects the cultural values and beliefs of the women they serve. Our purpose is to provide deeper insight into the cultural and physical challenges confronting pregnant women who have undergone FGC and are seeking maternity while living in Canada. To achieve this purpose, this article (1) outlines the historical, cultural, and religious origins of FGC; (2) addresses Canadian FGC policy and legislation; (3) describes the physical, psychological, and obstetrical complications associated with FGC; and (4) provides recommendations to support health care providers, particularly registered midwives, when providing optimal perinatal care is challenging.

A BRIEF HISTORY OF FEMALE GENITAL CUTTING

The origin of FGC is unclear; FGC may have originated in one area and later spread to other regions, or it may have started in several regions concurrently and independently.[1,12,13] On the basis of existing evidence, it is reasonable to suggest that FGC arose from equatorial sub-Saharan Africa during the Middle Stone Age and spread to the old kingdom of Egypt.[14] The practice appears to have emerged from a social ideology that had various subcultural justifications. For example, some historians theorize that FGC originated in ancient Rome (10th century) mainly to prevent pregnancy among female slaves and to distinguish their social identity;[13,15,16] infibulation, the most extensive type of FGC, originally was the Roman practice of piercing the outer labia of their female slaves with a fibula or brooch.[13,15–17] Another theory is attributed to ancient Egyptians because of their belief that the soul has a sexual duality.[12,18] More specifically, they believed that if men retained the foreskin and women retained the clitoris, their ability to reach sexual maturation would be compromised, thus affecting their ability to reproduce. Upper-class and noble families practiced clitoridectomy as a gender ritual to confirm a girl's readiness for marriage.[12,13,18] Infibulation was a form of authoritative control to limit the sexual desires of female slaves, particularly among inhabitants of the Nile River and Red Sea areas.[12,17–19] There is some evidence that infibulated women were considered virgins and were for this reason highly valued in Egyptian slave markets.[12,19]

A SOCIAL AND CULTURAL REVIEW OF FEMALE GENITAL CUTTING

In some parts of the world, FGC is still a complex socially constructed ideology based on the belief that it enhances well-being—sociocultural, hygienic and aesthetic, spiritual and religious, and psychosexual.[1,3,20,31] Some view FGC as a required procedure that maintains chastity and virginity before marriage, fidelity during marriage, and genital cleanness and moral fertility during reproductive life.[1,3,21] Others see FGC as an ideology that confirms the ritual passage of females into adulthood and maintains the cultural or religious identity of a specific community.[3,19,21]

Gender control and the social construction of women's roles are major factors that force women to continue practicing and undergoing FGC.[1,3] In many communities where FGC is common, men control almost all aspects of women's lives, including those related to sexuality and reproduction.[22–24] Some men view FGC as a required procedure that sustains the traditional concept of marriage and maintains family or tribal honour.[25–27]

Typically a "silent" practice passed down through generations, FGC is discussed only among women within the family.[28,29] A key reason for this silence is sensitivity in regard to discussion of the genitals, which in many cultures are considered to be private or even shameful.[29,30,31] For health care providers in Canada, this secrecy outside of the immediate family complicates their ability to understand the FGC phenomenon.

RELIGION AND FEMALE GENITAL CUTTING

While FGC is or has been practiced in some Muslim, Christian, and Jewish communities, there are no scriptural or doctrinal references to FGC in the Qur'an, the Bible, or the Torah.[12,14,17] The practice was recorded as early as 163 BC, and there is evidence that it was practiced in some regions of Africa for more than 2,000 years.[12] Current religious justifications for FGC appear to be socially constructed.[20] For example, although male circumcision is a religious obligation in Muslim and Jewish communities, there is no such obligation to perform FGC.

Islam and Female Genital Cutting

As noted earlier, although there is no direct reference to it in the Qur'an, FGC is practiced in some Muslim communities of Egypt, Sudan, Yemen, Turkey, Iraq, Indonesia, and Malaysia,[1,17,32] but not in India, Pakistan, and Afghanistan. Muslim women who practice FGC, particularly type I (sunna, or clitoridectomy) and type II (tahara, or excision), justify their practice on the basis of a Hadith (one of a collection of descriptions of incidents attributed to something Muhammad, the Prophet, said or did).[27] The Hadith in question, the authenticity of which has been challenged, asserts that Muhammad said to a woman who performed a female circumcision in Medina, "Do not cut severely, as that is better for a woman and more desirable for a husband."[27,33,34] Female genital cutting is debated in Islamic communities, but the Hadith continues to be interpreted by some as recommending FGC.

A fatwa is a juristic ruling concerning Islamic law and issued by an Islamic scholar known as a mufti. There is no consensus on or fatwa concerned with whether FGC is a forbidden or an obligatory practice in Islam. In 1949 and 1951, Al-Azhar University in Cairo issued fatwas endorsing FGC as an obligatory religious practice. In 1981, a fatwa that completely banned the practice was issued.[17] In January 2010, 34 Islamic scholars in Mauritania signed a fatwa banning FGC, to prevent religion from being cited as a justification for FGC.[17,35,36] Despite these fatwas, the practice continues to be debated in parts of the Islamic world.[17]

Christianity and Female Genital Cutting

Female genital cutting is practiced by some Egyptian Coptic Christians and sub-Saharan Africans but not by Christians in Europe, the Americas, or Asia.[17] In the 13th century, Athanasius, Bishop of Qus, Egypt, clearly denounced the practice, saying that "female circumcision is a mistake and a sin; it is forbidden by religion, humanity and health."[17] The rationale for the Christian condemnation of FGC is that FGC constitutes a change in God's creation. Despite these views in Christianity, some Egyptian Coptic Christians still continue the practice, possibly more as a social than a religious tradition.[17]

Judaism and Female Genital Cutting

Evidence of FGC is found in an Ethiopian Jewish tribe known as the Falasha; there is no evidence of it among Jews elsewhere.[17] The origins of FGC in the Falasha are not clear, but FGC may have been an obligatory practice adopted by the family of Ishmael, a historical figure in the Torah, the Bible, and the Qur'an.[37–39] Thus, the practice of FGC among Jews has no religious source but may have been implemented in some conservative Jewish communities to maintain control over female sexuality.[38,40]

DEVELOPMENT OF CANADIAN POLICY AND LEGISLATION ON FEMALE GENITAL CUTTING

In 1993, the Women's Health Bureau and the Horn of Africa Resource and Research Group developed workshops to inform health care providers and the general public of issues associated with FGC. They also proposed preventative measures to be considered when policy and legislation are being developed.[41]

In 1994, the Ontario Female Genital Mutilation Prevention Task Force, in collaboration with the Ontario Women's Directorate, highlighted the importance of caring for increasing numbers of pregnant women who had undergone FGC.[42] In 1995, consultations with newcomer women (e.g., immigrants, refugees, transient workers, and students) from countries where FGC is practiced were held in Ottawa and Montreal. Recommendations included implementing clinical strategies such as planned cesarean sections to prevent and manage perinatal complications.[43]

In 1997, Bill C-119 amended the Criminal Code of Canada so that performing FGC or procuring the services of another to do so was deemed to be aggravated assault punishable by up to five years in prison.[42,44] Educational sessions were held to increase awareness, both in the general public and among health care providers, of Bill C-119 and the complications of FGC. In 1998, the Federal Interdepartmental Working Group on Female Genital Mutilation highlighted the impact Bill C-119 had on decreasing the prevalence of FGC in Canada.[43]

In 2000, the Ontario Department of Public Health developed educational materials to address the physical complications observed among immigrant Somali women, for whom the incidence of FGC is currently estimated to be 97.9%.[2,42] The Colleges of Physicians and Surgeons in Ontario, British Columbia, Alberta, Manitoba, Quebec, and Nova Scotia take positions that regard performing FGC or making a referral for FGC to be professional misconduct. It must be noted that the Colleges emphasized the importance of communication and cultural sensitivity in caring for affected women.[41,45]

In 2009, the Sexuality Education Resources Centre provided informational tools to assist Canadian health care

policy makers in regard to the current national and global status of FGC.[46] In a 2012 policy statement, the SOGC reiterated that "performing or assisting with the practice of FGC in Canada is a criminal offence" and that any request for reinfibulation must be declined.[47] Public awareness of complications is increasing in Canada, and progress has been made in eradicating FGC both in Canada and globally.[48] Current Canadian policy emphasizes primary prevention to eradicate the practice.[48] The real sociocultural reasons for FGC—including male authority and sexual satisfaction within a male-dominated culture—may be underestimated and may still need to be addressed.[49,50]

COMPLICATIONS AND CHALLENGES FACING MATERNITY CARE PROVIDERS IN CANADA

Medical and obstetrical complications of FGC are well documented and can be categorized according to both short- and long-term risks. These include an overall increased incidence of mortality and morbidity for birthing women, which is attributable to amplified rates of postpartum hemorrhage and cesarean section and to a higher incidence of stillbirth.[2,9,51]

The FGC procedure undergone by maternity patients presenting to health care providers in Canada may have been performed when they were between 5 and 12 years of age, without medical supervision and conducted without benefit of anaesthesia.[2] Severe pain, hemorrhage, and/or infection can be immediate consequences, as can bacterial infection or blood-borne viral infections such as human immunodeficiency virus infection and hepatitis. Pregnant and nonpregnant women who have undergone FGC can have serious and often chronic urogynecological complications, including voiding problems, urinary tract infections, and vesicovaginal fistulas.[52] Other long-term problems can include sexual dysfunction caused by dyspareunia or an inability to have intercourse because of a constricted vulvovaginal opening.

Pregnant women who have undergone any type of FGC may be susceptible to vulvovaginal bleeding associated with overvascularization of the external genitals. With respect to intrapartum complications, it is reported that pelvic-floor trauma may lead to more severe perineal tears (e.g., third and fourth degree) and urethral tears during birth in infibulated women.[10,53] In a Swedish retrospective review, the odds of anal sphincter tears were more than two times higher (n = 250,491; OR 2.08 [95% CI, 2.08–3.524]) for Somali-born women than for Swedish-born women. Further, decreased perineal elasticity, keloid formation, and dermoid cysts can increase the incidence of hemorrhage and obstructed labour.[52,54] With obstructed labour, the risk of hypoxia in newborns is also increased.[2]

Aggressive vaginal examination or urinary catheterization in an infibulated pregnant woman may elicit excessive pain or even prove impossible. It has been suggested that many pregnant women who have been subjected to FGC are unwilling to share their values and beliefs with care providers from other cultures because of concerns about sensitivity, privacy, and the many implications of FGC; their resistance may create a cultural distance between themselves and their health care providers.[55] Women who have undergone FGC may even be unwilling to access maternity care in Canada. Differing cultural perceptions may lead women to believe that because they have undergone FGC, Canadian Society views them as aberrant.[6] Their concern about being identified as minorities in Canada may also diminish their willingness to utilize appropriate perinatal care.[11,56]

RECOMMENDATIONS

Clinical practice guidelines developed by the SOGC provide useful recommendations for autonomous maternity care providers.[2] The guidelines highlight the need for all caregivers to deepen their understanding of FGC and to show an accepting and nonjudgmental attitude toward all affected women who present for maternity care; the guidelines also emphasize the need for all providers to be competent in managing any complications that may occur. These needs have important implications for those responsible for clinical practice, education, and research related to FGC. An important clinical option that could enhance care for women who have experienced FGC types I, II, or III is midwifery care throughout their pregnancy, labour, birthing, and postpartum period. In fact, midwives are ideal primary care providers in that the cornerstones of their practice model are continuity of care, partnership with the families of birthing women, and informed maternal choice.[57] Thus, Canadian midwives are well positioned to engage in and promote effective communication, safe and appropriate interventions, and referral relationships that are acceptable to their clients.

In comparison with their counterparts, midwives typically allocate a much longer time frame for prenatal visits, thus allowing for more time in which to establish a genuine and trusting relationship that will encourage women who have undergone FGC to elaborate on needed care and concerns. Because most women who have experienced

FGC are concerned about the ability of Canadian providers to offer appropriate care, it is essential that the midwife make a longer initial visit, one in which her focus is on understanding the expectations and apprehensions of her client.

Further, care must be based on effective communication and cultural sensitivity in order to create a delicate balance that puts the woman's best interest in the forefront. A trusting relationship in which the pregnant woman and the midwife discuss the risks and benefits of available maternal choices and engage in mutual problem solving through partnership is ideal. To achieve this, all caregivers need to use FGC terminology that is nonstigmatizing and that is acceptable to and understood by their clients. To achieve partnership, midwives and other caregivers need to have an in-depth understanding of FGC and its potential or existing medical, obstetrical, or psychological consequences. As well, the perspectives of women who have undergone FGC need to be understood and respected, particularly those perspectives related to privacy and confidentiality. Each woman also needs to be confident that her maternity caregivers will respect her values. It is recommended that women from areas where FGC is prevalent be respectfully asked about their status at their initial interview or appointment. Those who have experienced FGC should also be consulted about what FGC terminology they find appropriate and inoffensive, and this should be recorded.[2] Moreover, it is critical for the midwife to be direct and clear from the outset about what is possible within the Canadian health care system. For example, legal and malpractice issues around reinfibulation and the disclosure of female children at risk for FGC need to be included in the dialogue.

Since almost all midwives are females, midwifery may be viewed as a more acceptable choice for women from cultures in which discomfort or even shame results from exposing their genitals in the presence of any male other than their husband. Ideally, the initial assessment needs to be complete and well documented to minimize the need for repeat examinations that embarrass or distress women who have experienced FGC. Midwives need to be prepared for how the perineum of an affected woman looks, so that they do not reveal a shocked, inappropriate, or judgmental response. Reviewing graphic materials related to FGC in anticipation of the appointment can help to ameliorate this type of response. If deemed appropriate, the physical examination may need to be deferred until the second visit.

It is possible that many of the women will be newcomers to Canada and may have little or no experience with the language spoken by their health care providers, so it may be necessary to insure that an interpreter with whom the woman is comfortable is present. Ideally, the interpreter will be a woman who is a "well trained, trusted and neutral interpreter who can insure confidentiality and who will not exert undue influence."[2] Providers also need to be aware that cesarean section is not mandatory for women who have undergone FGC. To support a higher level of understanding, midwives and other caregivers will ideally use language or terminology with which their clients are familiar and that will further communicate information, potential complications, and birth options visually with models and with graphic and audiovisual materials.

Because midwives are committed to continuity of care, they typically practice individually or in small groups; thus, the birthing women they serve become familiar with the midwives who will be their birth attendants. Also, for a woman who has undergone FGC, only the minimum number of health care providers who are needed to safely attend her during labour and the birth should be present; this can further enhance her privacy and promote psychological comfort.

Practice guidelines for most Canadian provinces and territories require an obstetrical consultation during pregnancy as part of the care plan, thus appropriately providing an opportunity for interprofessional planning that also includes the input of affected women. This is so that anticipated complications and the availability of obstetrical care during the intrapartum period—especially if defibulation and repair are deemed necessary—are discussed in advance and can be addressed. It is important to note that if defibulation is recommended, the procedure is optimally performed prior to pregnancy or before 20 weeks' gestation if the birthing woman consents. However, it also can be performed during labour if necessary or if it is the woman's preference.[58,59]

Regarding serving the community, partnering with communities to which women who have undergone FGC belong may help decrease the social distance between the women and the maternity care providers; it can serve to promote a holistic approach and enhance egalitarian relationships. For instance, participating in or organizing community initiatives that emphasize different sociocultural aspects of FGC are relevant to providing culturally sensitive maternity care. Arranging public consultation sessions that include the views of Islamic and other religious leaders about FGC may ameliorate women's religious dilemmas about the practice of FGC. Further, public group discussion

workshops that include community leaders, health care providers, and the women themselves may create effective discussions about different social aspects such as gender roles, male authority, and other sociocultural factors relating to FGC.

With respect to education, it is important that health care educators insure that the study of FGC—including its potential complications during pregnancy and birth, and the appropriate clinical and interpersonal skills that are needed to support affected women—is integrated into the undergraduate curricula of all potential maternity care providers (i.e., midwives, nurses, and physicians). Educational and training sessions as well as guidelines for those who are required to perform the defibulation procedure need to be developed. Further, there is a need for concise and consistent material, such as the educational resource developed by the Royal College of Nursing as a manual that provides background and covers definitions, policy, legal responsibilities, and clinical interventions for midwives and nurses providing care to women who have undergone FGC.[59]

In addressing recommendations to facilitate care, it is critical to acknowledge that the quality of evidence for establishing care provider guidelines as outlined by the SOGC is based on opinions, clinical experience, and expert committees rather than on more-rigorous trials, cohort studies, or meticulous qualitative explorations.[2] This concern is supported by the recent publication of a Cochrane Collaboration Review that reported that not a single randomized controlled trial of interventions to improve outcomes for pregnant women who have undergone FGC was found.[60] This highlights the need for a greater focus on conducting well-designed studies that utilize both quantitative and qualitative methodologies to provide clinical guidance so that optimal care for women who have experienced this complex phenomenon can be realized.

CONCLUSION

Female genital cutting (FGC) is a long-standing practice that has generated social, cultural, and medical controversy. In Canada, pregnant women who have undergone FGC are part of a group of women who need consideration and respect if they are to be willing to access appropriate prenatal and intrapartum care. This approach is critical to reducing the high incidence of perinatal morbidity both in affected women and in their newborns. There is a knowledge gap in regard to the physical and psychological challenges that confront these women when they are seeking perinatal care. This article has summarized (1) the historical, religious, and sociocultural aspects of FGC as well as its complications and (2) recommendations that may help midwives and other maternity care providers develop deeper insight into circumstances that may prevent women who have undergone FGC from accessing the highest levels of care. Care that is both supported by best evidence and acceptable to the population being served is advocated. To accomplish this, in this paper we presented summaries of health policies and legislation on the practice of FGC, its major perinatal complications, and current medical and social challenges, along with recommendations for care.

REFERENCES

1. World Health Organization [Internet]. Geneva: World Health Organization; 2014 [cited 2015 Jan 27]. Available from: http://www.who.int/mediacentre/factsheets/fs241/en/
2. Perron L, Senikas V, Burnett M, Davis V. Female genital cutting. Clinical practice guidelines No. 299 [Internet]. Ottawa: Society of Gynaecologists and Obstetricians of Canada; Nov 2013 [cited 2015 Jan 27]. Available from: http://sogc.org/wp-content/uploads/2013/10/gui299CPG1311E.pdf
3. Skine RA. Traditional practice. In: Skine RA, editor. Female genital mutilation: legal, cultural, and medical issues. Jefferson (NC): McFarland & Company Inc; 2005. p. 7–34.
4. Alcaraz RM, González SJ, Ruiz SC. Attitudes towards female genital mutilation: an integrative review. Int Nurs Rev. 2014 Mar;61(1):25–34.
5. International Council of Nurses. Elimination of female genital mutilation [Internet]. Geneva: International Council of Nurses; 2010 [cited 2015 Jan 27]. Available from: http://www.icn.ch/images/stories/documents/publications/position_statements/A04_Elimination_Female_Genital_Mutilation.pdf
6. Chalmers B, Hashi K. 432 Somali women's birth experiences in Canada after earlier female genital mutilation. Birth. 2000;27(4):227–34.
7. Lalonde A. Clinical management of female genital mutilation must be handled with understanding, compassion. Can Med Assoc J. 1995;152:949–50.
8. Essen B, Bodker B, Sjoberg NO, Gudmundsson S, Ostergren PO, Langhoff-Roos J. Is there an association between female circumcision and perinatal death? Bull World Health Organ. 2002;80(8):629–32.
9. United Nations Population Fund. Toolkit. Engaging midwives in the global campaign to end female genital mutilation [Internet]. New York: United Nations Population Fund; 2014 [cited 2015 Jan 27]. Available from: http://www.unfpa.org/sites/default/files/resource-pdf/TOOLKIT.pdf

10. Banks E, Meirik O, Farley T, Akamde O, Bathija H, Ali M. Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries. Lancet. 2006;367:1835–41.
11. Sword W, Watt S, Krueger P. Postpartum health, service needs, and access to care experiences of immigrant and Canadian-born women. J Obstet Gynecol Neonatal Nurs. 2006;35:717–27.
12. Boyle E. Female genital cutting: cultural conflict in the global community. Baltimore and London: John Hopkins University Press; 2002.
13. Wasunna A. Towards redirecting the female circumcision debate: legal, ethical, and cultural considerations. McGill Journal of Medicine. 2000;5:104–10.
14. Slack A. Female circumcision: a critical appraisal. Hum Rights Q. 1988;10:437–86.
15. Chipembere N. Carving the body: female circumcision in African women's memories (unpublished manuscript). University of South Africa; Identity and Marginality Journal Volume: II, issue 6.2 Spring 2006.
16. Stanlie J. Female genital mutilation. In: Smith BG, editor. The Oxford encyclopaedia of women in world history. Oxford: Oxford University Press; 2008. p. 259–62.
17. Abu-Sahlieh S. Male and female circumcision: religious, medical, social and legal debate. 2nd ed. [Pennsylvania]: Center of Arab and Islamic Law; 2012.
18. Nielson P. Female circumcision in Egypt [Internet]. [Place unknown]: Paula Nielson; 2010– [cited 2011 Oct 13]. Available from: http://suite101.com/article/female-circumcision-in-egypt-a194378
19. Shell-Duncan B, Hernlund Y, editors. Female circumcision in Africa; culture, controversy, and change. Boulder (CO): Lynne Rienner Publishers; 2000.
20. Almaghrabi J, Kanaan H, Bondaji N. Postcircumcision epidermoid inclusion cyst of the vulva containing multiple stones. Int J Gynaecol Obstet. 2005;90(2):155–6.
21. Toubia N, Rahman A. Female genital mutilation: a guide to worldwide laws and policies. London: Zed Press; 2000.
22. Almroth-Beggren V, Hassanein OM, El-Hadi N, Al-Said SSE, Hasan SSA, Lithell UB, Bergstrom S. A community based study on the change of practice of female genital mutilation in a Sudanese village. Int J Gynaecol Obstet. 2001;74:179–85.
23. Davis G, Ellis J, Hibbert M, Perez RP, Zimbelman E. Female circumcision: the prevalence and nature of the ritual in Eritrea. Mil Med. 1999;164(1):11–6.
24. United Nations Population Fund. The state of the world population. The right to choose reproductive rights and reproductive health. New York: United Nations Program Fund; 1997.
25. Missailidis K, Gebre-Medhin M. Female genital mutilation in eastern Ethiopia. Lancet. 2000 Jul 8;356(9224):137–8.
26. Goldstein I, Meston C, Davis S, Traish A. Women's sexual function and dysfunction: study diagnosis and treatment. Abingdon (UK): Taylor & Francis; 2006.
27. Toubia N, Izett S. Female genital mutilation: an overview. Geneva: World Health Organization; 1998.
28. Lane S, Rubinstein R. Judging the other: responding to traditional genital surgeries. Hastings Cent Rep. 1996;26(3):31–40.
29. Nour NM. Urinary calculus associated with female genital cutting. Obstet Gynecol. 2006;107(2 Pt 2):521–3.
30. Ronge R. General gynaecology: circumcised women have an increased risk for primary infertility. Geburtshilfe Frauenheilkd. 2006;66(2):104.
31. Althaus F. Female circumcision: rite of passage or violation of rights. Int Fam Plan Perspect. 1997;23(3):130–3.
32. Sami IR. Female circumcision with special reference to Sudan. Ann Trop Paediatr. 1986;6(2):99–115.
33. Al-Awwa MS. Female circumcision neither a Sunna, nor a sign of respect [Internet]. [Place unknown]: [Publisher unknown]; [Date unknown] [cited 2013 Jan 12]. Available from: http://islamset.net/hip/health5/female.html
34. El Ahl A. Theologians battle female circumcision [Internet]. [Place unknown]: [Publisher unknown]; [Date unknown] [cited 2013 Jan 12]. Available from: http://yaleglobal.yale.edu/content/theologians-battle-female-circumcision
35. Abdel-Wedoud MY. Mauritanian Islamic leaders ban genital mutilation [Internet]. Nouakchott (Mauritania): Magharebia in Nouakchott; 2010 [cited 2013 Jan 12]. Available from: http://en.islamtoday.net/artshow-233-3484.htm
36. Trevelyan B. Mauritania fatwa bans female genital mutilation [Internet]. [London]: BBC News; 2010 [cited 2011 Oct 30]. Available from: http://news.bbc.co.uk/2/hi/africa/8464671.stm
37. Philo. Questions and answers on Exodus. Marcus R, translator. Cambridge: Harvard University Press; 1970.
38. Cohen S. Why aren't Jewish women circumcised? Gender and covenant in Judaism. Berkeley: University of California Press; 2005.
39. Bruce J. Travels to discover the source of the Nile in the year 1768–1773. London: Paternoster-Row; 1970.
40. Grisaru N, Lezer S, Belmaker RH. Ritual female genital surgery among Ethiopian jews. Arch Sex Behav 1997;26:211–5.
41. Ferguson I, Ellis P. Female genital mutilation: a review of the current literature [Internet]. Ottawa: Dept. of Justice Canada; 1995. Available from: http://publications.gc.ca/collections/collection_2011/jus/J3-8-1995-15-eng.pdf
42. Ontario Human Rights Commission. Policy on female

genital mutilation, 1–20 [Internet]. Toronto: Ontario Human Rights Commission; 2000 [cited 2013 Jan 12]. Available from: http://www.ohrc.on.ca/en/policy-female-genital-mutilation-fgm
43. Hussein LJ, Marian A, Shermarke A. Female genital mutilation: report on consultations held in Ottawa and Montreal (WD1995-8e/8f). Ottawa: Department of Justice; 1995.
44. Bill C-119: an act to amend the Criminal Code (child prostitution, criminal harassment and female genital mutilation) [Internet].1st Session, 35th Parliament, 42-43-44 Elizabeth II, 1994–95. Ottawa: Public Works and Government Services Canada; 1998 [cited 2015 Jan 12]. Available from: http://www.parl.gc.ca/HousePublications/Publication.aspx?DocId=2328247&Language=e&Mode=1&File=16
45. College of Physicians and Surgeons of Ontario. Female genital cutting (mutilation) [Internet]. Toronto: College of Physicians and Surgeons of Ontario; 2011. Available from: http://www.cpso.on.ca/Policies-Publications/Policy/Female-Genital-Cutting-(Mutilation)
46. Center for Reproductive Rights. Female genital mutilation (FGM): legal prohibitions worldwide [Internet]. New York: Center for Reproductive Rights; 2009 [cited 2013 Jan 12]. Available from: http://reproductiverights.org/en/document/female-genital-mutilation-fgm-legal-prohibitions-worldwide
47. Perron L, Senikas V. Female genital cutting/mutilation. No. 272, Feb 2012 policy statement. J Obstet Gynaecol Can [Internet]. 2012;34(2):197–200. Available from: http://sogc.org/wp-content/uploads/2013/01/gui272PS1202E.pdf
48. Craven RF, Himle CJ. Fundamentals of nursing human health and function. 5th ed. Philadelphia: Lippincott; 2007.
49. Shell-Duncan B. From health to human rights: female genital cutting and politics of intervention. Am Anthropol. 2008;110(2):225–36.
50. Daly K, Stubbs J. Feminist theory, feminist and anti-racist politics, and restorative justice. In: Johnstone G, Van Ness DW, editors. Handbook of restorative justice. Cullompton (UK): Willan Publishing; 2007. p. 149–70.
51. World Health Organization [Internet]. Geneva: World Health Organization; 2011. An update on WHO's work on female genital mutilation (FGM) progress report; 2011. Available from: http://whqlibdoc.who.int/hq/2011/who_rhr_11.18_eng.pdf
52. Teufel K, Dörfler DM. Female genital circumcision/mutilation: implications for female urogynaecological health. Int Urogynecol J. 2013 Dec;24(12):2021–7.
53. Rouzi AA, Sindi O, Radhan B, Ba'aqeel H. Epidermal clitoral inclusion cyst after type I female genital mutilation. Am J Obstet Gynecol. 2001;185(3):569–71.
54. Berggren V, Gottvall K, Isman E, Bergström S, Ekéus C. Infibulated women have an increased risk of anal sphincter tears at delivery: a population-based Swedish register study of 250,000 births. Acta Obstet Gynecol Scand; 2013 Jan;92(1):101–8.
55. Shweder R. What about female genital mutilation? and why understanding culture matters in the first place. In: Engaging cultural differences: the multicultural challenge in liberal democracies. Shweder RA, Minow M, Markkus HR, editors. New York: Russell Sage Foundation; 2002. p. 216–51.
56. Leduce N, Proulx M. Patterns of health services by recent immigrants. J Immigrant Health. 2004;6(1):15–27.
57. Canadian Association of Midwives [Internet]. Ottawa: Canadian Association of Midwives; 2009 [cited 2015 Jan 27]. Available from: http://www.canadianmidwives.org/vision-and-mission.html
58. Simpson J, Robinson K, Creighton SM, Hodes D. Female genital mutilation: the role of health professionals in prevention, assessment, and management. BMJ [Internet]. 2012;344:e1361. Available from: http://dx.doi.org/10.1136/bmj.e1361
59. Royal College of Nursing [Internet]. London: Royal College of Nursing; Female genital mutilation: an RCN education resource for nursing and midwifery; [2015] [cited 2015 Jan 12]. Available from: https://www.rcn.org.uk/_data/assets/pdf_file/0012/78699/003037.pdf
60. Balogun O, Hirayama F, Wariki W, Koyanagi R. Interventions for improving outcomes for pregnant women who have experienced genital cutting (review). Cochrane Database Syst Rev. 2013;(2).