Do No Harm?

Discrepancies across Canadian Healthcare Policy and Obstetrics and Gynaecology Training for Treating Women affected by Female Genital Cutting

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Abstract

Female genital cutting (FGC) is a flashpoint feminist issue. It is a deeply stigmatized and controversial cultural practice that affects millions of women and girls internationally and is criminalized in Canada. My research set out to answer the questions: To what extent is obstetrics and gynaecology training in Canada structured to provide adequate, effective, and culturally sensitive care for women who have undergone FGC? Does this training reflect the broader framing of FGC as a "barbaric" practice? Through my research into medical education, I find that Canadian healthcare reflects norms and values of nationalism when considering whose bodies represent these standards. With the methodology of transnational feminism, these covert issues of structural violence that mark certain bodies as Other become more clearly recognizable. I challenge predominant knowledge, attitudes, and skills of healthcare practitioners to ultimately recommend four steps toward creating a new benchmark for culturally sensitive training and care.

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List of Abbreviations

CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
CRC	Convention on the Rights of the Child
FGC	Female Genital Cutting
GoC	Government of Canada
HCPs	Health Care Providers
ISGL	Integrative Small Group Learning and Application
OB-GYN	Obstetricians-Gynaecologists
SDGs	Sustainable Development Goals
SOGC	Society of Obstetricians and Gynaecologists of Canada
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Introduction

Female genital cutting (FGC) is a flashpoint feminist issue. It is a deeply stigmatized and controversial cultural practice that affects millions of women and girls internationally and is criminalized in Canada. Unfortunately, western-based media and academic scholarship tend to frame FGC as a moral issue, and outright condemn the practice as "barbaric," "tribal," and "dangerous" without a greater concern for how this stance affects women who have already experienced FGC (Smith, 2011). Through this rhetoric, biases are created and perpetuated that shape how women who have undergone FGC navigate western[1] society and the social challenges that ensue. Access to appropriate and adequate healthcare that does not further stigmatize or harm patients is just one of the potential challenges that arises.

My research examines if and how prospective obstetrician-gynaecologists (OB-GYNs) receive appropriate and culturally sensitive training for the treatment of women in Canada who have experienced female genital cutting (FGC).[2] This research aims to address what this level of training means in terms of the Government of Canada (GoC)'s commitment to gender mainstreaming and incorporating nuanced, feminist, and above all, intersectional approaches to policy development and implementation with specific concern over Canada's policies and social programming concerning treatment of marginalized women.

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[1] A note on language differentiation: Throughout this thesis, the term "western" is used to refer to an ideology, perspective, and approach that comes from this standpoint; whereas, "Global North" refers to the geopolitical area as it is conceptualized in conjunction to the "Global South." These are not interchangeable terminology.

[2] I suggest that although FGC has similar western-based legacies, the surrounding discourse frames the specific practice of FGC as that of the cultural Other and mainly exists in Canada through transnational immigration. I acknowledge that there is a difference between sex, gender, and expression and that not all people who have vaginas identify as women. Entrenched in disciplinary discourse and cultural considerations, throughout this thesis I refer to people who have undergone FGC as "women," "female," and "she/her," as this is the gendered language used to describe the people most affected by FGC. However, I must note that this gendered language is not meant to exclude people who do not identify with these terms, rather this terminology reflects that of the literature. Furthermore, the terminology of "female genital cutting" specifically refers to the non-western cultural practice and does not encompass other anatomically similar genital alteration surgeries.

My research sets out to answer the questions: to what extent is obstetrics and gynaecology training in Canada structured to provide adequate, effective, and culturally sensitive care for women who have undergone FGC? How and why are women affected by FGC still considered Other in medical education? Does this training reflect the broader framing of FGC as a "barbaric" practice? I analyze the content of undergraduate medical training curriculum on obstetrics and gynaecology to examine if and how it addresses the issue of sexually active and pregnant adolescent girls and women who have undergone FGC.

Although more recent studies have addressed similar problems of FGC care internationally (Evans et al., 2019; Higginbothan, 2015; Johansen et al., 2018; Vissandjée et al., 2014; Zurynski et al., 2015), Koukoui's (2017) article is one of the few examples from the limited scholarship based in the Canadian context. Drawing from these international studies and especially Perron et al.'s (2020) "Guideline No. 395-Female Genital Cutting" produced by the Society of Obstetricians and Gynaecologists of Canada to establish an approximate benchmark of "best practice," this research uncovers areas of disconnect between the theory of government policies and programming and the practice of training, while addressing why there is limited literature and knowledge relating to this area of study.

My work is intended to provide much needed insight into this area of treatment with the hopeful outcome of greater awareness of the information gap so that adequate training can be instituted to reduce additional trauma that affected women may experience. This thesis highlights instances of problematic gender norms and inequalities reproduced through healthcare programming and provision and adds to the growing body of evidence on this topic (Hay et al., 2019; Heise et al., 2019). Significant outcomes of this work include improving policy and practice to increase benefits to the lives of women who require these services, consequently promoting a

better life experience for immigrant women in Canada. Thus, my research is ultimately accountable to women who are affected by FGC and access the Canadian healthcare system.

I contend that culturally sensitive training is necessary for effective care and respectful treatment of women with FGC who are seeking obstetrics and gynaecological health services. The limited evidence of programming for care surrounding women affected by FGC demonstrates an alarming disconnect between Canada's institutional health policies and the reality of nearly non-existing medical education training, which reflects biases within our health system surrounding whose care is valued. This disconnect illuminates the greater issues of Canada's "official nationalism" versus the lived reality for citizens and newcomers. A lack of effective and adequate health knowledge and programming on the needs of women affected by FGC represents Canada's ignorance toward the lived realities and opinions of affected women. Through my theoretical framework that intersects nationalism and transnational feminism, this thesis explores these dynamics and argues that the framing of Canadian institutional health policy and national guidelines around treating women affected by FGC does not reflect the reality of health training for prospective OB-GYNs at the level of undergraduate medical education. I use the Society of Obstetricians and Gynaecologists of Canada (SOGC) Guideline No. 395-Female Genital Cutting (Perron et al., 2020) as a basis of institutionally established best practices for Canadian healthcare providers (HCPs). Based on this background, I analyze the Government of Canada's "Family-centred maternity and newborn care: National guidelines" (last modified 26 May 2021) policy document, in which there are multiple chapters with the section "Special Situations." Under the "Special Situations" sections, there is a further subsection "Women who have Experienced Female Genital Cutting."

This policy document situates the care of women who have experienced FGC along with other "special" cases of pregnancy and delivery, such as, "women with mental illness," "LGBTQ2 families," "women with complications of pregnancy," and "women with underlying health conditions," as examples. This grouping of special case pregnancies is salient for my analysis. It signifies that treating women affected by FGC is as relevant to specific case training as treating women with the other health concerns in this collective. Putting women affected by FGC within this category alongside common health concerns that are not tied to any one cultural identity is an indication that the GoC wants to take women affected by FGC into consideration. In other words, it seems like relegating this community to an ignored category of 'health concerns of the Other' is not the GoC's approach. As this research shows, treating women affected by FGC is not explicitly covered within most of the undergraduate medical education at the medical schools, not even the rotations with special interest in obstetrics and gynaecology, where many of these other special health concerns *are* considered. My analysis explores how women affected by FGC are still considered as a cast aside Other in medical education and not treated as a necessary case for both clinical and cultural competency especially when GoC policy frames this specific type of care as prevalent and significant enough to specifically reference these women within the national policy guidelines while considering the thoroughness of the SOGC clinical practice guideline.

To help clarify this research, I will briefly explain what undergraduate medical education entails in Canada. Through my research, there does not seem to be any synthesized information on the training breakdown for Canadian medical schools, which may be indicative that the process and curriculum are not the exact same across each institution. However, Undergraduate Medical Education generally entails four years of training. This involves two years of Foundational academic science and clinical courses (Faculty of Medicine the University of British Columbia,

n.d.; MD Program University of Toronto, n.d.). Then, students complete an additional two years of Clerkship training in clinical and experiential workplace settings. During Clerkship, medical students go through "rounds" learning specific specialities more in-depth, such as Obstetrics-Gynaecology, and have hands-on training in hospital and clinic settings under supervision and in collaboration with physicians and other healthcare members (Faculty of Medicine the University of British Columbia, n.d.; MD Program University of Toronto, n.d.). Through this education, students earn their Doctor of Medicine degree. Following this degree, prospective OB-GYNs undertake their post-graduate studies through an Obstetrics and Gynaecology residency program for an additional five years (Obstetrics and Gynaecology University of Toronto, n.d.a.). For broad healthcare needs, it is important to incorporate understandings of FGC within undergraduate medical education that includes obstetrics and gynaecology rotations and within family medicine. Incorporating training within the obstetrics and gynaecology residency program is critically important for pregnant woman affected by FGC given that most deliveries seem to be attended by specialist OB-GYNs (Aubrey-Bassler et al., 2015). Undergraduate medical education specifically has the potential for more standardized care across institutions due to most of the learning being clearly tied to documented curriculum, as opposed to residency training where information and knowledge translation is based more on experiential work than classroom settings. Due to this differentiation and how the GoC and SOGC policy documents frame the problem of training for HCPs treating women affected by FGC, I assert that undergraduate medical education must be examined for inclusion of this type of training as it is an important case for consideration of diverse populations and inclusion of cultural sensitivity approaches to training and practice. Undergraduate education is a critical foundational training for all physicians engaging with women affected by FGC.

The GoC and SOGC policy documents showcase problems with there being limited OB-GYN skill and knowledge for treating women affected by FGC, which has created significant gaps in medical provision. Both policy guides highlight the need for improved healthcare provider knowledge of FGC and how to treat and care for affected patients. This reported limited understanding of both FGC as a practice along with the life experiences of affected women is problematic. Given this official stance, medical education needs to reflect the apparent gaps in practice as stated in both policy guides. Furthermore, there are almost no studies on the healthcare experiences of women affected by FGC living in Canada. This is an additional problem of there being very limited information, especially on a nationwide meta-study scale. It is also concerning that women themselves are not necessarily being included in this research or in the formulation of medical training curriculum. Based on these issues, I explore the dynamics of healthcare pertaining to FGC to find that there needs to be an improved and clear benchmark for what constitutes appropriate, effective, and moreover, culturally sensitive care.

I develop a theoretical framework which includes an analysis of Canadian nationalism from several works, especially Benedict Anderson's (2016) "imagined community" concept and transnational feminism. My analysis identifies the rhetoric of "official nationalism" to highlight evident themes within FGC-based policy and practice. I then draw on transnational feminist practices as a method to critique the institutional racism and systemic violence that state-run healthcare can perpetuate if the needs of marginalized peoples are not considered. Transnational feminism addresses the interlinked systems of varying oppressions that marginalize women throughout cultures and beyond borders and binaries. The theory posits that these oppressions are not experienced in the same way by all women. It is necessary to acknowledge that patriarchal forces are not the sole force of oppression with which transnational feminism is concerned. Rather,

this theory understands that the network of international hegemonies, such as, colonialism, capitalism, and globalization have impacted women throughout all cultures in oppressive ways, but also have impacted individual women differently (Adams & Thomas, 2018; Conway, 2017; Falcón & Nash, 2015; Grewal & Kaplan, 1994; Mohanty, 2003; Nagar & Lock Swarr, 2010; Reilly, 2011). Transnational feminism is an especially important theory of feminism to consider in relation to FGC because it addresses the realities of discrimination and seeks to rectify them through solidarity by simultaneously accepting both the differences and similarities in the marginalization of all women. This is a necessary conceptual approach for Canadian medical practices that aim to help women affected by FGC. Policies and practices must be informed by this understanding of diversity to begin decolonizing healthcare and to dismantle assumptions about who patients are and what their life experiences entail.

Because I am not a doctor nor am I personally affected by FGC, I cannot make detailed claims as to what would entail direct and appropriate changes to medical education. However, through my research I find that there is a clear disconnect between what the GoC and SOGC state as problems and gaps in medical care versus what is being taught, or rather, not being included in medical curriculum. As a result, there needs to be a revised benchmark for healthcare training programming and the provision of care. Based on the findings of my research, I establish that a new benchmark for training would entail adequate, effective, and culturally sensitive care that seeks out knowledge, perspectives, guidance, feedback, and concerns from affected committees to determine how this new standard of care should be conceptualized. In the Conclusion chapter of this thesis, I elaborate on this finding to recommend four ways forward to create a new evidence-based benchmark for adequate and effective care.

Contextualizing Female Genital Cutting

To situate the significance of my research findings, it is important to first explore what FGC is and some of the meanings surrounding the practice. An estimated 200 million women and girls alive today have experienced female genital cutting throughout 30 different countries, mostly in Africa, Asia, and the Middle East, but also, Europe, Latin America, North America, Australia, and New Zealand (United Nations Population Fund [UNFPA], July 2020). Additionally, UNICEF (2016) claims that "44 million are girls below age 15," thus the prevalence of FGC is still at a steady rate. According to the UNFPA (July 2020) "in 2019, an estimated 4.1 million girls will be cut. This number of girls cut each year is projected to rise to 4.6 million girls in the year 2030." Furthermore, FGC is specifically condemned through Goal 5, "achieve gender equality and empower all women and girls," of the Sustainable Development Goals (SDGs) (United Nations, n.d.). Other human rights discourse, such as, The Convention on the Rights of the Child (CRC) and The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) also call for the end of such practices. As such, there are a multitude of international campaigns for the elimination and prevention of FGC (World Health Organization [WHO], 2008).

FGC is the process of deliberately altering, removing, or harming female genital organs for non-medical purposes (WHO, 3 February 2020). It is not specifically associated with any one religion, region, language, or cultural group. FGC is practiced in many different contexts and can vary immensely by community, family, and household. As such, the reasons participants claim for taking part in the ritual are highly diverse, nuanced, and complex, which creates a spectrum of adult women's views on the practice. This means that girls' experiences with FGC and women's memories of the ritual are significantly varied, and their opinions on the continuance, abandonment, or shifting the appropriate context and type of the practice may change throughout

life, especially with international immigration or into other communities that do not value FGC (Adinew & Mekete, 2017; Akinsulure-Smith & Chu, 2017; Akinsulure-Smith et al., 2018; Ali et al., 2020; Chu & Akinsulure-Smith, 2016; Bedri et al., 2019; Fedorak, 2014; Johansen, 2017; Johnson et al., 2018; Koukoui et al., 2017; Martell et al., 2020; Obiora et al., 2020; Obiora et al., 2021; Paakkanen, 2019; Shell-Duncan et al., 2021; Titilayo et al., 2018). The ritual is often universalized within literature, while in reality "female genital cutting" is an all-encompassing term that represents a vast array of practices. Female genital cutting goes by many different names, such as, "female genital mutilation," "female circumcision," "excision," and "sunna", as examples. This thesis will refer to the practice as "female genital cutting" and "FGC" because of the arguments made against the stigmatizing and limiting nature of other terms, which allude to outsider perspectives of superiority and prejudice against the ritual (UNICEF, July 2013).

FGC is further broken down into four different types based on the varying degree of alterations made to a woman or girl's genitals. Type 1, the most prevalent form of FGC, is commonly referred to as a clitoridectomy or "sunna," which means "tradition" or "duty" in Arabic (UNICEF, July 2013). This procedure involves the total or partial removal of the clitoris, and rarely, the prepuce (UNICEF, July 2013). Type 2, or excision is the total or partial removal of the clitoris and the labia minora (the inner labia) with or without excision of the labia majora (the outer labia) (UNICEF, July 2013). Type 3 is infibulation, which is the least common type of FGC, and involves the narrowing of the vaginal orifice by creating a covering seal through cutting and then sewing together both sides of the outer labia and leaving a small hole (UNICEF, July 2013). This may involve removal of the clitoris or inner labia. Type 3 results in the closure of the urethra and vaginal orifice meaning that it is increasingly difficult to urinate, pass menses, have intercourse, and give birth (UNICEF, July 2013). As a result, women who are infibulated often need to be

deinfibulated or cut back open for childbirth. Afterward, some women traditionally decide to be reinfibulated or have the process of Type 3 redone to return to their normal genital appearance (UNICEF, July 2013). Depending on the woman's choice, this cycle of deinfibulation and reinfibulation may happen several times if the woman gives birth vaginally more than once. Finally, Type 4 is the category used for all other forms of FGC, such as, piercing, pricking, scratching, incising, stretching, or burning the genital area (UNICEF, July 2013).

FGC is practiced for a multitude of reasons and carries varying symbolisms. Although some sources cite that there are no specific religious, cultural, or traditional reasons for undergoing FGC, this information is inaccurate and universalizing, as there are many specific and nuanced reasons why FGC is valued in certain communities. Although FGC is largely condemned by the international community with approximately 60 countries currently having laws against the practice (Prime Minister of Canada Justin Trudeau, 6 February 2021), the tradition has significant meaning within the contexts where it is practiced. For example, for the Kono people of north-eastern Sierra Leone, their Bundu ritual involves excision or Type 2 FGC and is performed as a symbol of rebirth into womanhood as a full member of society (Ahmadu, 2007, p. 289). There must be an understanding that the circumstances of FGC are diverse, thus the reasons for practicing it are highly nuanced. FGC is a ritual that has been practiced since ancient times, pre-dates major religions, and "as late as the 1960s, American obstetricians performed clitoridectomies to treat erotomania, lesbianism, hysteria, and clitoral enlargement" (Nour, 2008, p. 136). It has been claimed that different types of FGC, especially Types 1, 2, and 4 are comparable to procedures defined as "female genital cosmetic surgery," but anti-FGC human rights and legal discourse mainly differentiates the practices based on the setting under which they happen and age of participants (Braun, 2010; Braun & Kitzinger, 2001; Dobbeleir et al., 2011; Florquin & Richard,

2020; Smith, 2011; Krivenko, 2015; Paakkanen, 2019). This distinction between the different forms of alteration along with the context under which they are performed allows genital cosmetic surgeries to be accepted and are legalized.

Framing women affected by FGC living in Canada as victims of illegal cultural practices does not make it acceptable for the nation state and its actors to disregard their own bodily autonomy and existing needs for care. In fact, the international prevalence of FGC is increasing during the COVID-19 pandemic (Orchid Project, 2020; Lancet Public Health, 2021; UNFPA-UNICEF, April 2020; UNFPA, 6 February 2021). The problem of lack of healthcare considerations for women affected by FGC in Canada is not changing even with campaigns encouraging ethical health sector intervention to condemn, prevent, and eradicate the practice; rather, the prevalence is increasing. Thus, I suggest that there is more demand than ever before to shift focus to treating those women and girls who have already been affected by the practice and teaching HCPs how to care for patients effectively and appropriately without further stigmatizing or casting them aside as devalued members of the imagined community.

COVID-19 Considerations

This project was hindered by the drastic changes the COVID-19 pandemic demanded. Under these circumstances, I was forced to pivot my research journey. While it is clear to me that the pandemic has impacted the world beyond what I can comprehend now, it has also altered the course of this research and significantly heightened the need for answers. The pandemic's urgent need to prioritize global health meant that contacting academics and university staff from across Canada via email was incredibly challenging since they were understandably occupied with more important matters. With this new environment, after three rounds of follow-up emails and reaching out to other university representatives at the fourteen medical schools I tried to contact, I only

received useful communication from eight of those institutions. It took over two months of back and forth emailing to get the amount of medical school content that I analyze in this thesis. I understand that COVID-19 has put an increased demand on email communications and that this could have impacted the number of responses and training materials that I was able to gather. Additionally, the methods I chose to use in this work shifted with the intensity and longevity of the pandemic. Undertaking interviews with physicians and those accessing health services would be extremely sensitive and challenging during the COVID-19 pandemic. Because of increased time constraints and the fact that health care providers are clearly under an alarmingly intense demand, I decided to switch from an anticipated mixed methods approach that incorporated surveying OB-GYNs to focusing on content analysis of policy and training guidelines along with scholarly publications.

Finally, it is important to address that the COVID-19 pandemic exemplified the need for thorough and effective healthcare on all levels and highlighted the interconnectedness of health and care. There needs to be a re-examination of the value that is misplaced from marginalized bodies. When people are left out of healthcare, how are they supposed to cope with the additional complications and anxieties that this creates? This time of exponential health system stress has only made it clearer that there are gaps within the system that push marginalized people through the cracks to disregard their right of adequate, effective, and respectful care.

Doing FGC Research and Positionality

My research comes from my perspective as a white settler, western woman. Thus has the potential to reinforce the race, class, and colonial hierarchies that continue to persist transnationally. However, it is my aim to work toward dismantling these hierarchies and create new foundations for health practices. As Tuhiwai Smith (2012) argues, “what counts as Western

research draws from an 'archive' of knowledge and systems, rules and values which stretch beyond the boundaries of Western science to the system now referred to as the West" (p. 44). This issue is complicated with gender and racial tensions that are at play when knowledge is considered only to belong to and within the context of a singular vision of what is epistemologically "valid." Oakley (1998) states, "the argument about masculinist bias hiding behind the lens of 'objectivity' has been especially crucial in highlighting how mainstream definitions of valid knowledge may unintentionally reflect the partial view of men as the dominant group" (p. 724). Within health-based research, this problem is of significant concern. Power is exerted by legitimating claims to knowledge through both explicit and covert methods, of which science and academia are complicit (Tuhiwai Smith, 2012, p. 45). As a feminist researcher, I operationalize this knowledge to the effect of not reproducing these hierarchies of neocolonial power. My work aims to interrogate existing race and gender challenges at the heart of the healthcare system. By undertaking a methodology that opposes western universality and engaging in personal feminist reflexivity, I am using the privilege of access to these institutions as a method of critiquing them.

According to Haraway (1988), "feminist objectivity is about limited location and situated knowledge, not about transcendence and splitting of subject and object. It allows us to become answerable for what we learn how to see" (p. 583). I recognize the ethical limits of my positionality, and my goal is not to prescribe new specific standards of best practice, rather to illuminate systemic issues and create the potential for change. This change can only ethically and morally happen with the direct inclusion and guidance from the people who would be directly affected by this work. Smith (2011) writes:

> the alternative discourse I seek does not privilege Western normative conceptions of women's bodies, but it also is not another form of cultural relativism. It is based on dialogue

> among women and seeks to create an environment where reciprocal analysis of body-modification practices can take place. (p. 28)

Thus, in the vein of Mohanty's (2003) work and that of other post-colonial and transnational feminists, positionality must be considered in terms of solidarity and allyship. Mohanty (2003) explains that "it is the praxis-oriented, active political struggle embodied in this notion of solidarity that is important to my thinking – and the reason I prefer to focus attention on solidarity rather than on the concept of 'sisterhood'" (p. 7). Recognizing the potential for strength in difference of experience is necessary while not attempting to claim authority over the experiences of others. It is also important to consider that I am both an "outsider" in the context of women affected by FGC and an "outsider" in terms of the medical institutions from which I wish to gain information. However, my positionality becomes an asset to this work, as I can use my background of academic scholarship to investigate health policy and programming with attention to my own preconceived biases, judgements, and emotional triggers along with perhaps those of HCPs and women affected by FGC. Additionally, there is a need to separate whiteness and racial prejudice from my position in this research because critiquing and condemning the role of these concepts within health policy and practice is my exact methodology.

Furthermore, taking knowledge gained through in-depth study of academic publications written on the experiences of women and girls who have undergone FGC, I have an outsider's understanding of the nuances of the cultural practice and the potential physical, emotional, and psychological outcomes that affected women have experienced. With this diverse set of knowledge, I wish to sidestep notions of superiority over my research and aim to contribute to undoing a salient site of institutional racism. For Conway (2017), dismantling systems of hegemonic knowledge production is necessary, and:

> implies feminist scholars grappling with messy practices in situ and in their own terms; bringing their scholarly analytics to bear, while being open to revising them in light of activist knowledge; and critically re-connecting with the political needs of concrete feminist movements, recognising their inevitable complicities and contradictions. (p. 222)

My epistemological position comes from that of pre-existing feminist discourse. Specifically, sites of transnational feminism that do not aim to make judgements about FGC and affected people, rather those who see and seek out the potential for solidarity without universalizing the experiences of affected women and girls.

Chapter Outlines

In Chapter 1: Literature Review and Research Methodology, I establish my research by contextualizing health-based FGC research. Within the literature review section, I address a diverse range of perspectives and approaches to conceptualizing FGC and healthcare. I highlight critical perspectives on FGC, medical knowledge on FGC, and transnational feminist approaches to address FGC discourse. Further, I explain my methodological approach including the process of my data collection and data analysis.

Chapter 2: Nationalism and FGC Healthcare Policy Approaches, delves into Benedict Anderson's (2016) *Imagined Communities*, particularly his concepts of "official nationalism" and the "imagined community." These concepts are integral to understanding the discrepancies between Canadian healthcare policies relevant to FGC and the apparent lack of specified and appropriate training for Canadian undergraduate medical education that I found through this research. Using these concepts, I assess the Canadian policies relevant to FGC and healthcare provision: The Society of Obstetricians and Gynaecologists of Canada's Clinical Practice Guideline on FGC; and The Government of Canada's Family-Centred Maternity and Newborn Care: National Guidelines. These policies are important to contrast the official nationalism of health policy versus the reality of the problematic gaps in healthcare training and provision.

In Chapter 3: Towards Centering Immigrant Women's Healthcare through Transnational Feminist Practice, I explain transnational feminism and use this theoretical framework to analyze the undergraduate medical education training documents, specifically highlighting the Western University training module and the corresponding student response memo. I also address the Royal College of Physicians and Surgeons of Canada CanMEDS framework. In this chapter, I also assess the University of Toronto FGC training module for obstetrics-gynaecology residents. Through the lens of transnational feminism, I interrogate how official nationalism and the imagined community are represented within Canadian healthcare and how this dynamic leads to Othering of marginalized bodies, in particular, immigrant women.

Finally, I conclude with four steps toward creating a new benchmark for FGC-related healthcare training based on my research findings and the recommendations of Werunga et al. (2016). I also highlight some of the limitations of this work and suggest future research avenues for healthcare and different intersections of FGC discourse.

Chapter 1: Literature Review and Research Methodology

Contextualizing Health-Based FGC Research

While the current studies are essential for increasing knowledge and academic literature within FGC discourse, there is still a salient gap in what has been published. With an overwhelming number of publications concerned with human rights debates, elimination and prevention efforts, and changing cultural norms, there is less information focused on: how to appropriately care for women who have already experienced female genital cutting; and, what these approaches should be for healthcare practitioners, especially those outside of high prevalence communities (Abdulcadir et al., 2015; Calvert et al., 2020; Einstein, 2008; Evans et al., 2019; Joseph & Mullen, 2021; Klein et al., 2018; Little, 2015; Lussiez et al., 2020; Marea et al., 2021; Payne et al., 2019; Shahawy & Nour, 2021; Taraldsen et al., 2021). My research aims to build on these existing studies to contribute to this knowledge gap. A focus on this problem would help improve care practices, especially in terms of reducing the potential harm caused by ignorance. Improving Canadian health provision understandings of FGC can only improve the relationships between HCPs and their patients.

Altogether, this literature review represents that medical care approaches do not have to be universalized and mutually exclusive to transcultural embodiment, I argue the need to connect these two necessary approaches as equal facets of health programming to improve the quality of care. I have particularly emphasized that there is a disconnect between the abstract idea of FGC and the maintenance of the body within the western medicalization perspective, instead of listening to the voiced needs of women affected by FGC within Canada. Even when the scholars in my literature review have gone through FGC themselves, their voices are not centred within the surrounding context of medicalization and healthcare practices. Western situated research can

skew the way knowledge translates into practice, especially with what stories are being told about the experiences of marginalized peoples. The existing information on FGC for clinicians is not robust enough, thus, not as effective as it must be for taking care of patients in a personalized and culturally competent way. The main concern seemed to focus on the physical technicalities and not a genuine concern for the patient's mental and emotional wellbeing. Consequently, physicians tend to categorize FGC as a health issue which leads to barriers in accessing appropriate and culturally sensitive healthcare beyond the physical aspects.

In the literature review on health-based FGC research, I attempt to carve out key areas of knowledge and debate within the field. First, I review critical perspectives on FGC to include both the necessary contributions and shortcomings of current health perspectives and campaigns to abandon FGC. Next, I include literature on medical knowledge and FGC. This section reviews some large-scale studies that seek to determine the current state of international clinician knowledge, attitudes, and practices for treating patients affected by FGC. I also compile literature that considers the necessity of cultural competency training in this context. Finally, I end with scholarship that looks toward transnational feminist futures. In this section, the works I have included seek to analyze FGC discourse with a critical feminist lens that engages in cultural relativism and reflexivity to challenge current health-based FGC knowledge and debates within the field. These works seek out the voices and perspectives of women, girls, and communities who are affected by FGC and aim to illuminate the overlooked nuance in FGC discourse. Overall, the opinions and perspectives through this literature review represent many different facets and approaches to addressing FGC discourse, especially how the practice and affected communities are represented in health-based knowledge.

Critical Perspectives on FGC

The practice of FGC is highly contested throughout the international community as well as by individuals from communities that value the ritual. There are countless governments, international health agencies, NGOs, and grassroots organizations working toward eradicating FGC. Some key arguments and campaigns against FGC are led by local community and government initiatives that challenge FGC and fight to shift social and gender norms or end the practice altogether (Johnson et al., 2018; Mwendwa et al., 2020). There is a plethora of anti-FGC movements from western NGOs, governments, and international organizations such as the United Nations and WHO. FGC is viewed by the international community as an abuse of human rights, child abuse, and a form of sexual and gender-based violence (SGBV). This is also true of the many women who are affected by the practice and have vocalized the trauma and pain they experience as a result.

Undergoing FGC has been widely reported to be traumatic due to the circumstances surrounding it, the age of the girls who go through the experience, and the issues surrounding lacking informed consent to the procedure (Adinew & Mekete, 2017; Akinsulure-Smith et al., 2018; Chu & Akinsulure-Smith, 2016; Einstein, 2008; Klein et al., 2018; Obiora et al., 2020; Obiora et al., 2021; Payne et al., 2019). Women who have undergone FGC may experience long-term physical and mental health consequences. According to Payne et al. (2019) "there are significant immediate and long-term risks associated with FGM/C including obstetric, neonatal, urologic, gynecologic, infectious, sexual, and psychological health consequences" (p. 857). Based on the vast array of potential health consequences, there needs to be more distinction in the medical literature on the different types of FGC, and how HCPs must be able to identify the varying physical severity of the four types along with the health consequences that may result (Earp &

Johnsdotter, 2021; Ogunsiji & Ussher, 2021; Werunga et al., 2016). These long-term health consequences are especially a concern with the more physically invasive types of FGC like Type 2 (excision) and Type 3 (infibulation). To this end, Earp and Johnsdotter (2021) review current critiques of the WHO policy on FGC and particularly dissect the missed nuance across medical discourse on the practice and campaigns to abandon FGC. The authors highlight that the grouping of all four types of FGC as one monolith, as well as the separation of FGC from any other genital surgeries that are performed on female anatomy is problematic and overly simplistic (Earp & Johnsdotter, 2021).

Understandings of FGC within healthcare bridges the clinical with the cultural and works to negotiate the hierarchy of the professional and the patient. This tension is clarified when considering positions of authority and whose knowledge is considered best practice. This knowledge builds on theoretical understandings of FGC within the discourse and operationalizes these understandings in a practical manner to apply to healthcare. These publications contextualize what is being written on the macro level without necessarily narrowing in on a specific community. These texts build a body of literature that speaks to both the social science perspective and the often more scientific approach of healthcare practitioners.

There is a heightened focus on ethical health sector intervention within this literature. This includes a concern over the medicalization of FGC, where healthcare professionals perform the ritual as a harm reduction strategy (Bedri et al., 2019; Nabaneh & Muula, 2019). However, this method still suggests an "illusion of 'legitimacy'" that undermines eradication efforts (Nabaneh & Muula, 2019, p. 255). Further, the legal and human rights debates against FGC emphasize that continued criminalization, alternative rites of passage, and empowering health education are safer solutions that would ultimately lead to the end of the practice over time (Nabaneh & Muula, 2019).

Ultimately, politics and power dynamics influence this hierarchy, especially in the western context where FGC is condemned and illegal. As a result, much of the existing literature on FGC is concerned with prevention and intervention rather than treatment, especially in the context of medical professionals' roles (Bedri et al., 2019; Higginbothan, 2015; Johansen et al., 2018; Klein et al., 2018; Koukoui, 2017; Nabaneh & Muula, 2019; Ogunsiji & Ussher, 2021; Payne et al., 2019; Shell-Duncan, 2008).

One major area of the literature discusses the importance of health care providers in preventing and eliminating the practice of FGC, especially through sexual health education for women and girls (Bedri et al., 2019; Nabaneh & Muula, 2019; Ogunsiji & Ussher, 2021; Payne et al., 2019; Perron et al., 2020). HCPs are a strategic source for identifying instances of FGC in adult women along with the continued prevalence of the practice on young girls. In countries where FGC is not practiced, HCPs can assess newcomers' opinions on the practice and perceived sexual health knowledge. As a result, they may be able to educate families on the physical and psychological harm that FGC can cause long-term along with the illegality of the practice in Canada. Interactions with OB-GYNs can be used as a circumstance to work toward the goals of FGC abandonment campaigns.

However, HCPs need to learn more about the context and nuance of different types of FGC practices and experiences through speaking with affected women and studying literature devoted to cultural competency education. Salmon et al. (2020) report on negative stereotyping and homogenization of women who have been affected by FGC in UK-based health campaigns aimed at stopping the practice. They argue that there must be more effort to include affected women in creation of this messaging to better reflect the realities of their diverse identities and life experiences to reduce harm caused by inaccurate messaging (Salmon et al., 2020).

Previous research on the efficacy of medical training for OB-GYNs in the Canadian context is limited. Johansen et al. (2018) and Koukoui (2017) focus on health policy and the relationship between doctors and patients. Their work provides a necessary comparative background to situate my own research on inequalities of power. Rather than solely focusing on abandoning the practice, it is necessary to consider the effects of FGC and the potential of increasing traumas through healthcare that is not culturally sensitive or has not sufficiently understood social norms surrounding gender. Shell-Duncan (2008) and Higginbothan (2015) are more concerned with this aspect of FGC care. These works offer background to my critique of interlocking systems of stigma and discrimination, and how these concepts play into questions of Eurocentrism within the western-based medical institution.

Medical Knowledge on FGC

Furthermore, the intersection between culture and clinical care is a salient aspect of this work. Issues arise when a western-based medicalization perspective is applied to a cultural practice, which is especially the case when the cultural practice is both far removed from and not concerned with a western-based perspective. The generalized western perspective on FGC is to condemn and eradicate the practice, which deprioritizes the lived experiences of affected women as the focus is removed from the personal level to a universalizing critique that limits discourse and shapes HCP perceptions (Florquin & Richard, 2020; Paakkanen, 2019; Werunga et al., 2016).

Clinical-based medical discipline attempts to understand culture feed into the underlying tension between science and social science research on healthcare. These publications represent some of the core information that has been produced and show how HCPs research and write about FGC. These approaches do not take a social science perspective or methodology as they focus more on the medical treatment of affected women, rather than on the individual and their

personhood. Throughout these works, there is discussion of knowledge, attitudes, and training for healthcare practitioners when treating women affected by FGC. There is an important focus on what is missing from the healthcare perspective like attempts to develop nuanced understandings of FGC to fill gaps in policy and programming, especially cultural competency training (Evans et al., 2019; Vissandjée et al., 2014; Werunga et al., 2016). This is the field my research is in conversation with. Despite my lack of expertise in the field of medicine, scholars who focus on the social, cultural, and political impact of health and medical practices can legitimately contribute to this critical discussion. These publications speak to the disconnect between how OB-GYNs, nurses, and other healthcare professionals practice healthcare and the highly individualized experiences of women affected by FGC. Certainly, research and training surrounding patient care must be generalized on some level, but at the same time, there must be greater understanding of just how culturally and personally specific FGC can be. The publications reviewed in this section are concerned with the operationalization of knowledge into practice, which is increasingly challenging for a nuanced cultural ritual being considered within a health-based context.

There is significantly more globally located literature on training for HCPs treating affected women both in countries that practice FGC and other western contexts such as the UK and Scandinavia as opposed to scholarship that is Canadian-driven. Kimani et al. (2018) tested nurse-midwives at a hospital in Kenya using a quiz method before and after they attended a relevant three-day training session. The researchers found that the nurse-midwives' knowledge improved after the training, but that there is still a competency gap and recommended better integration of training at the university level (Kimani et al., 2018). Importantly, this article was concerned with management and prevention of the practice within Kenya (Kimani et al., 2018). In comparable findings, Jackson (2017) reports on a survey that was sent to all members of the British Association

for Counselling and Psychotherapy. This survey assessed counsellors' knowledge of FGC and treatment of affected patients (Jackson, 2017). Through surveying, content analysis, and quantitative data reporting, the study found that practitioners had limited training and understanding of the health, social, and emotional implications of FGC (Jackson, 2017).

On a larger scale, Abdulcadir et al. (2017) conducted a meta-analysis of literature internationally published from 1995-2016 on healthcare students' and providers knowledge, attitude, and practices regarding treatment of women affected by FGC to find that there is inadequate standardized training and clinical practice. Zurynski et al. (2015) conducted a similar study and came to the same conclusions. On a practical level, Relph et al. (2013) used questionnaires to gather data on training and knowledge of FGC treatment for medical and midwifery professionals in the identified high prevalence area of northeast London. The authors found that respondents were knowledgeable to a certain extent, but that more comprehensive training needed to be implemented (Relph et al., 2013). Likewise, Turkmani et al. (2018) surveyed Australian midwives to find that there are still educational knowledge gaps and lack of training for treatment of women affected by FGC.

Cultural competency and sensitivity training are especially necessary when treating women affected by FGC. These studies find that culturally specific knowledge and cultural intervention skills gained through training and workshops can be effective, but most training needs improving for more focus on developing culturally sensitive attitudes, as there are systemic gaps in knowledge, awareness, attitudes, and skills (Alizadeh & Chavan, 2016; Domenech Rodríguez et al., 2019; Evans et al., 2019; Govere & Govere, 2016; Ho et al., 2010; Majda et al., 2021; Vasquez Guzman, et al., 2021; Vissandjée et al., 2014; Young & Guo, 2020). There needs to be further development of training to improve the quality of information and HCPs' retention of this

approach to care. Cultural competency training is proven to be effective, but there are limitations in the breadth and depth of current programming. In my Conclusion chapter, I make recommendations for how to approach improving cultural competency on FGC for Canadian medical institutions.

As the existing studies each note, there is a lack of information on this topic in both medical school training and for healthcare professionals. Thus, there is a need to fill the gap in information and to not assume that Canadian healthcare is already operating within best practices. This problem is especially complicated when considering the history of research about FGC and whose knowledge has created the surrounding discourse as power dynamics influence what information is considered most important and useful for clinicians. With the predominant discourse surrounding FGC being on eliminating the practice altogether, the focus is taken away from women and girls who have already experienced FGC (WHO, 2008). This positioning has a strong impact on affected women and the extent of their care. With less attention paid to the experiences of affected women, there is a discrepancy between lived realities and the impersonal intellectualization of FGC as discourse. This enforces a tension between what and who is prioritized in research and can speak to the positionality of those at the forefront of discourse building. This is especially the case with the westernization and general medicalization of FGC discourse. A significant amount of the information published at this intersection is focused on eliminating FGC through health-sector involvement but does not consider as strongly the impacts of HCPs' generally limited information about the values, roles, and perceptions of FGC in practicing communities, especially how to effectively care for women in a way that reduces stigma and undue harm from improper care.

Looking to Transnational Feminist Futures

Transcultural embodiment encapsulates an anthropological standpoint on FGC and care that is not meant to be objective, which is a response to move toward understandings of FGC on the personalized level of lived experience (Johnson-Agbakwu & Manin, 2021). Transcultural embodiment of women affected by FGC refers to the binaries of physical and cultural borders that affected women exist across and within transnationally. It is the experience of living in the margins of belonging and unbelonging (Anzaldúa, 1987). Women affected by FGC who immigrate to western nations live as transcultural bodies who are marked as the cultural Other in host nations and may begin to conceptualize themselves and the appearance of their genital anatomy differently as a result (Hernlund & Shell-Duncan, 2007). These publications stress the need for non-universalizing approaches to conceptualizing and operationalizing FGC and healthcare, which is a transnational feminist approach of viewing diverse experiences and perspectives. Transcultural embodiment emphasizes looking beyond science and clinical understandings of what "care" means. Regardless of whether a woman's experience of FGC is positive or negative, viewing the practice within the scope of morality is not the point for critical transnational feminist perspectives as they work to unsettle universalizing tendencies on this topic. The perspectives presented through this area of research go beyond debates on the validity and ethics of practicing FGC. They work toward dismantling the hegemony of FGC discourse and reattach the woman to her own vagina. This viewpoint places ownership back into a woman's own body, instead of seeing women as only the sum of their parts, altered or otherwise. By reintroducing embodiment in literature that overwhelmingly focuses on disembodiment, there is power in the connection a woman has to herself.

As a prominent scholar in the field of FGC, Ahmadu (2007) discusses her own experiences of undergoing FGC and her affective response of being within this area of academia that is vehemently condemned. Ahmadu (2007) urges that the tension between perspectives of cultural insiders versus outsiders enforces a binary within knowledge production. Further, as editors of the anthology *Transcultural Bodies: Female Genital Cutting in Global Context*, Hernlund and Shell-Duncan (2007) have produced a seminal text that represents diverse perspectives and angles to approach FGC research, particularly from an over-arching anthropological perspective that does not aim to condemn nor support the practice, rather to build and disseminate knowledge on a variety of subsections of FGC-based scholarship. Similarly, Smith (2011) discusses the variety of voices that have diffused the tone of how FGC is represented internationally with specific attention to the language used to describe the practice. The tendency to condemn FGC ultimately creates a separation between the experiences of women who are affected by FGC and the literature published around it. With a focus on reattaching affected women with their own bodily experiences, this is a necessary and salient approach to FGC knowledge building that is lacking in publications focused more closely on healthcare.

Florquin and Richard (2020) "join the debate from their position as professionals working in Belgium's main 'anti-FGM organization' as well as researchers" (p. 292). They argue that an overwhelming amount of the reporting on FGC both historically and currently is overly simplistic to the nuance of the issue, especially with concern for how gender norms and racialization are internalized by both men and women and transnationally to create a spectrum of belonging and unbelonging (Florquin & Richard, 2020). Martell et al. (2020) interviewed 43 women in New York City who had experienced FGC or originated from countries that practice it to determine their perceptions of the ritual and its continuance. Overall, they found that many participants agreed that

FGC should be eradicated and concluded that social pressure and acceptance are main contributors to why it persists (Martell et al., 2020). Martell et al. (2020) state, "the ongoing global conversation often fails to acknowledge the complex interplay of individual, social, and religious perspectives surrounding this practice, even among survivors and asylum seekers," which is reflected in medical training (p. 1246). Furthermore, as Ali et al. (2020) find through their study on perceptions of FGC within second generation immigrant youth living in the UK, there needs to be more community-centred approaches to discussing the issue of FGC and campaigns need to consider an intersectional approach that focuses on empowerment of individuals to make their own informed choices about their health and well-being.

Part of the limited nuance in FGC discourse, specifically anti-FGC movements, is the contesting of FGC without simultaneous reflection and analysis of other medically unnecessary genital alteration surgeries that are more commonly practiced in western societies like male circumcision, intersex genital normalization surgeries, and aesthetic cosmetic genital surgeries (Boddy, 2007; Braun, 2010; Earp & Johnsdotter, 2021; Florquin & Richard, 2020; Joseph & Mullen, 2021; Krivenko, 2015; Paakkanen, 2019; Smith, 2011). These practices, like FGC, are persisting methods of meeting accepted gender norms by fulfilling the pressure of societal expectations that control and limit appearance. Transnational feminist futures in FGC research necessitates investigating these issues further and reflecting on the illegality and framing of FGC as SGBV while other genital surgeries, especially those also performed on children and adolescents, are overwhelmingly not considered illegal or instances of violence, which presents double standards in the regulation of genital alteration.

In their article "A Decolonizing Methodology for Health Research on Female Genital Cutting," Werunga, et al. (2016) report from their perspective as Canadian nurses. They urge that

changes must be made in what ways and how FGC is researched, and the authors "offered an alternative narrative, a decolonizing methodology, by framing the FGC issue within critical theoretical perspectives in recognition of the complexities and deeply contextual situatedness of FGC for affected women as well as for practicing communities" (Werunga et al., 2016, p. 162). Werunga et al. (2016) argue that critical theoretical approaches are the most productive approach, specifically, "postcolonial feminist framing of FGC along with an African contextual understanding . . . intersectional analysis has policy and practice implications . . . decolonizing methodology is needed to counter the often-repeated single story and to present alternate stories" (p. 162). A more holistic approach to conceptualizing what FGC really is and a nuanced approach to consider the cultural relevance it may carry for practicing communities are more effective strategies to engage with FGC discourse. Similarly for Johnson-Agbakwu and Manin (2021), to move toward culturally informed discussions, "health-care providers must first comprehend the complex political, historical, sociocultural, and societal contexts in which these discussions are taking place, and how they are embodied" (p. 1953). By looking to decolonial scholars, affected women themselves, and interrogating our own positionalities and practices, "outsider" researchers can begin to approach FGC discourse in a nuanced, critical, and useful way. Transnational feminist futures for FGC seek new conversations that better reflect the diverse realities of FGC for affected women and take into consideration the power of situated knowledge.

Methodological Approach

With consideration of the arguments made by Werunga et al. (2016) and Johnson-Agbakwu and Manin (2021), my research works toward decolonizing the Canadian perspective of practicing healthcare by using a transnational feminist lens for analysis and as a methodological approach. As a result, my research must be reflexive and involve interrogating my own positionality as a

white settler researcher. This is an effort to step away from the tendency of western approaches to studying, addressing, or condemning the cultural practices of the Other without simultaneously considering their own biases and practices. Since this research is predicated on the concepts of nationalism and transnational feminism, my methodology considers the harm caused by healthcare programs and provision that is not designed with consultation from those they aim to treat. Haraway (1988) makes "an argument for situated and embodied knowledges and an argument against various forms of unlocatable, and so irresponsible, knowledge claims. Irresponsible means unable to be called into account" (p. 583). By studying the knowledge producers, they are held accountable for unethical actions and can be challenged for upholding neocolonial power dynamics. Consistent with Bannerji (1995), "we need a social analysis whose theory and practice involve political actors who both produce this knowledge and make it organizationally actionable" (p. 89). By "studying up" with prospective OB-GYN training practices and surrounding government health policy, my research goal is to critique systems of inequality and to reduce harm. Because of these methods and potential outcomes of the research, my goal is to take ethical considerations highly, especially given the context of accessing obstetrics and gynaecological healthcare, a likely already sensitive experience for many women, but even more so for marginalized peoples who potentially experience multiple sites of discrimination based on intersecting identity factors.

This type of research must consider training issues within the context of policy, but then go further to incorporate and base this information from those affected by the healthcare practices. I chose content analysis as my method with the goal of reducing ethical, access, and time-based restrictions. Furthermore, as aforementioned in the COVID-19 Considerations section of the Introduction chapter, it became increasingly apparent that health care practitioners are in high

demand and low supply, which led me to dismiss the idea of surveying OB-GYNs on their perspective and knowledge on treating women affected with FGC. Studying documents helps to establish a basis of the existing health discourse surrounding FGC. The studies previously referenced in my literature review illustrate that there is very limited information on both an international and Canadian level regarding relevant training practices and their efficacy in clinical settings. By using content analysis, I can produce more knowledge within this understudied area. This method also has a higher chance for success given time and capacity constraints posed by graduate research conducted during a pandemic, and especially, in terms of my "outsider" positionality. As Mullings (1999) elucidates, "the 'insider/outsider' binary in reality is a boundary that is not only highly unstable but also one that ignores the dynamism of positionalities in time and through space" (p. 340). Guided by transnational feminist theory and a decolonial lens, I recognize the possible challenges my research might present and actively work to not reproduce these issues. My method of content analysis of documents, instead of interviewing women affected my FGC, which was an original approach for conducting this research, works toward this ethical consideration.

My methodology takes ethical concerns as the highest priority given the history of FGC discourse and its associated research and knowledge production. Considering that I used content analysis, there were limited ethical risks within this research. This was an intentional choice, as FGC research has historically, and often still, continues to build a discourse that is ultimately harmful to affected women as there is more often ignorance to or limited concern for interrogating the colonial legacies that remain dominant within FGC discourse (Werunga et al., 2016). Harm is caused when research is done without these methodological considerations. It is necessary to consider the potential effects of undertaking different methods and the different outcomes that

these variations would create. My research attempts to stop perpetuating a cycle of white saviourism by studying the content that creates substantial consequences instead of directly researching the people this information would affect, which was a research path I had initially considered and was encouraged to follow. By choosing content analysis as the method for this research, I focus on evaluating systems of knowledge and power without causing harm on the individual level or being exploitative, especially with consideration of my positionality as a researcher. Researching on the systemic level rather than at the individual is a method of reducing risk and identifying structural issues. This is a salient distinction of the research method, especially given the colonial legacies at play within FGC discourse and the technologies of power at play with government-controlled health policy and practice.

Boddy (2007) urges feminists "to interrogate why and how female circumcision in Africa is constructed as an issue for the West" (p. 47). Not engaging in judgements of the practice is a more ethical and transnational feminist approach to researching FGC as an "outsider" by disengaging with the area of anti-FGC and FGC-health discourse that condemns the practice and focuses on prevention and eradication, instead of wondering how this focus affects the lives of women who have already experienced the practice. This thesis builds literature to speak to this concern.

My method and methodology are relevant to transnational feminism as they aim to critique the political and social structures of Canadian society while situating the issue within an international context as a source of shared experience and comparison. These problems do not only exist within Canada but are of concern to other countries with similar colonial histories and those with higher rates of immigration of people from countries with a high prevalence of FGC, such as, the United States of America, the United Kingdom, Australia, and Scandinavia, as examples. Analyzing literature published from international perspectives gives greater insight into the scale

of these concerns and provided a basis for comparative analysis of best practices as these respective healthcare systems are not necessarily designed with consideration of the unique needs of women affected by FGC.

Data Collection

To conduct this research, I gathered a sample of texts (see Appendix B). The corpus of texts is composed of three approximate document types, and the unit of analysis is each individual text. The main type of document I wanted to assess was undergraduate medical education syllabi specializing in obstetrics and gynaecology from Canadian medical schools. Of the seventeen accredited faculties of medicine in Canada, fourteen of which are predominantly English-speaking (Royal College of Physicians and Surgeons of Canada, n.d.a). I sent out three rounds of emails to members of the administrative staff, teaching staff, professors, and undergraduate medical education coordinators in the Departments of Obstetrics and Gynaecology and the general Departments of Undergraduate Medical Education at the fourteen English-speaking medical schools across Canada (see Appendix A for my Letter of Intent). It was my hope to obtain at least one training document from each institution but unfortunately that was not possible given the time constraints, difficulties connecting with staff, and most significantly, the general lack of inclusion of content. Additionally, I have included Canadian health policy documents and guidelines within my sample. The Public Health Agency of Canada website was a key site for gathering sample texts. Moreover, academic scholarship from books and journals, especially that concerned with an international assessment of these materials was integral. This content was accessed through both the Carleton University and Dalhousie University library databases. Since I had access to both databases, I cross-referenced my searches using the same key words, and I discovered that likely because Dalhousie University has a medical school, there was more varied content and a

significant increase in medical-specific literature. However, as aforementioned, there is limited existing information in this area, especially that which is Canada-specific. The goal sample size was to be as large as possible to be adequately exhaustive, but there is a lack of information on this subject. These three different source types build the corpus to represent different facets of knowledge production. By analyzing syllabi, policy documents, and academic scholarship, I can contextualize FGC healthcare discourse and investigate the varied sources of knowledge production that could be considered when creating medical training resources.

My data collection included compiling and systematically reviewing health policy documents, medical school training documents, and academic scholarship on this topic (see Appendix B). I then used content analysis to unveil discrepancies in rhetoric, primarily government information, and reality of the training that is supposed to provide the basis of competency in treating women affected by FGC. Analyzing academic scholarship was necessary to situate these findings within the international context of healthcare provision and to determine what research has already been published around FGC-based healthcare provision in Canada. By reviewing pre-existing international scholarship, I established a contextual basis of comparison for best practices that I used to critique the quality of the Canadian model.

The specific institutional health policy and programming documents that I analyze are the Public Health Agency of Canada's "The Family-Centred Maternity and Newborn Care: National Guidelines" along with the Society of Obstetricians and Gynaecologists of Canada's Guideline No. 395-Female Genital Cutting published by Perron et al. in 2020. I also consider the Royal College of Physicians and Surgeons of Canada CanMEDS framework. These three resources work together to establish the best practices of Canadian healthcare from clinical perspectives to the role of cultural competency in health programming. These areas of knowledge dissemination inform

and influence each other to build the institutionalization of Canadian healthcare and are produced by governing bodies that impact medical education. When curriculum is created for medical schools, these types of documents are taken into consideration as the foundations of current practitioner knowledge.

Through collecting my sample, I found that undergraduate medical education for treating women affected by FGC was only reported at two medical schools, out of the eight that replied to my inquiries, from the 14 Canadian medical schools that I contacted. The two medical schools that do refer to FGC are Western University and University of Manitoba. Western University teaches this topic through a specific small group discussion on FGC titled "Integrative Small Group Learning & Application – Female Genital Cutting (Course: Principles of Medicine 2)" and sent me a student response memo that critiques the shortcomings of this training (see Appendices B & C). Conversely, at University of Manitoba it is referenced in one Women's Reproductive Health Year 2 session but not in-depth. The University of Manitoba representative would not give me access to their curriculum to assess the content that they do include. Additionally, University of Saskatchewan reported that they considered adding FGC to the curriculum in the past but have not yet done so. Memorial University of Newfoundland cited that their curriculum is under review but does not have any dedicated teaching about FGC. I did acquire syllabi from the University of Saskatchewan "Curriculum Explorer Year 4 – Course Objectives," Northern Ontario School of Medicine "2021-2022 Phase 3 Core Rotation Outcomes: Women's Health Rotations," and University of British Columbia "OB-GYN Rotation Clinical Objectives - Women and Children's Health Block Curricular Details – Sessions 2020-2021 Academic Year (From Faculty of Medicine Curriculum Management Unit)" and "Objectives for Obstetrics and Gynecology Year 3 Clerkship Formal Teachings," none of which refer to FGC or cultural competency directly. University of

Calgary stated that FGC care was sometimes taught in the past in their Global Health course but not last year or likely the next. Lastly, I received a response from Queen's University explaining that medical students do not need FGC-specific training to be effective HCPs for these patients (J. Pudwell, personal communication, 10 May 2021). The email responses I received from the medical schools were more telling of the framing of FGC and the level of value placed on the healthcare experiences of affected women than the lack of information in the training documents. Of the eight medical schools who responded to my research requests with information, only Western University has specific and detailed training pertaining to FGC, which I report on through my analysis in more detail and in conjunction with the student response memo (see Appendices B & C).

Additionally, through searching online for Canadian medical school curriculum on FGC, I located a Global Women's Health training resource from University of Toronto (Obstetrics and Gynaecology University of Toronto, n.d.c). This curriculum document "was created in response to survey findings of Canadian Obstetrics and Gynaecology residency programs" that call for a comprehensive and standardized introduction to Global Women's Health (Obstetrics and Gynaecology University of Toronto, n.d.c). Although this curriculum is in its pilot stage and seemingly based out of the University of Toronto Obstetrics and Gynaecology Residency program, the initiative includes six case study documents produced in collaboration by doctors from University of Toronto, Dalhousie University, University of British Columbia, and University of Ottawa (Obstetrics and Gynaecology University of Toronto, n.d.c). Although this initiative pertains to residency training and not undergraduate medical education, I include it in my analysis as a key example of emerging training on FGC for Canadian OB-GYN students. It is salient that this is the only Canadian medical education training document specifically on FGC that can be sourced via a Google search and is readily accessible to the public. I analyze the curriculum

document titled “Case 2: Genital Cutting” in Chapter 3 of this thesis (Obstetrics and Gynaecology University of Toronto, n.d.a).

By using content analysis as my method of data collection, I was able to systematically identify key themes that emerge across these texts (Bourgeault et al., 2010, p. 419; Krippendorff, 2019, p. 20). Content analysis is a useful method for this research because I am examining the existence of training and what that entails to contextualize the Canadian model of care. It is an effective method for examining policy and practice as represented through written documents. Once the corpus was established, I did content analysis through systematic coding. I developed and updated a running list of codes throughout the data collection process, some of which were: “knowledge,” “skills,” “attitudes,” “assumptions,” “bias,” “cultural,” “competency,” “legal,” “normal,” “respect,” and “race.” I used the list of codes within the data analysis process to establish key themes that are central to my data analysis and argument. In conjunction with this data collection, it was essential to assess the existence of a basis of best practice across the corpus. By including pre-existing scholarly sources that consider both Canadian and international implications within my data collection, it became increasingly apparent that there is a considerable lack of information in this area on top of perceived biases that stigmatize women affected by FGC. This step of collection helped to frame the narratives and allow for deeper analysis of the potential shortcomings and successes of the Canadian model.

Data Analysis

Due to the method of content analysis, data collection inherently involves data analysis. Coding already produces a degree of analysis (Bernard, 2017, p. 460). For Bourgeault et al. (2010), “the task of the health (policy) researcher in that respect is not to be beguiled by content, but to examine content as a component of a wider network of action” (p. 422). Thus, my data analysis

involved establishing themes through coding. Once the general themes were created, I used memoing as a method of linking these areas of interest and establishing commonalities (Bernard, 2017, p. 466). Memoing operationalized the data collected through coding to make it useful for creating a model of findings. Analyzing the manifest and latent content within themes across the three sample types was imperative. This was essential for extrapolating knowledge production, especially of attitudes and perceptions of FGC beyond physical care, such as, biases and prejudice that may be subliminally present in the content of the texts.

At the beginning of my research process, I started investigating the key themes of "knowledge," "attitudes," and "practices" in their various meanings as represented throughout the documents. These three areas helped to address my guiding research questions for my data analysis. What and whose knowledges are being produced and reproduced? What moral and ethical standpoints are undertaken? How does this reflect potential bias and prejudice? Does concern over FGC-based care extend beyond training measures into actual practice? Is there a clear concern over harm reduction? Is Canadian health policy really practiced with the intention of providing the "best" care possible? What are these implications? Through my analysis, I assess the degree of concern for cultural relativity in Canadian policy and training guides and examine if training is comprehensive considering cultural competency. My data analysis was led by these questions while identifying themes, but I was surprised to learn that my assumptions for the extent of FGC-specific care were overly confident compared to what I uncovered through my data collection process and my following analysis. Once major themes were generated, I condensed my initial questions along with many follow-up considerations into relevant sections that form the basis of my argument.

Chapter 2: Nationalism and FGC Healthcare Policy Approaches

Canada is often promoted as a cultural mosaic comprised of diverse identities (Public Health Agency of Canada, December 2017c) who share equal access and human rights. However, there remains a disconnect between these national policies of the "imagined community" and the lived realities of citizens of all identities and life experiences (Anderson, 2016). This disconnect is even more startling in the case of women affected by FGC since their experience is exacerbated by multiple intersectional identities that mark potential instances of discrimination. Nationalism is reflected within the Canadian healthcare system and works to reinforce values and wider social norms like the idea of whose body represents the norm for standards of care in training. Healthcare nationalism undermines abilities to see flaws and impose change. The discrepancy between the perceived superiority of the Canadian healthcare system versus the realities of insufficient breadth of care can be explained through theories of nationalism and the imagined community. Canadian healthcare nationalism suggests that the supposed excellence of our medical system must reflect adequate coverage of care for all Canadians.

Official Nationalism and Canadian Healthcare Policy

In Canada, our universal healthcare system is part of the national identity and a key instance of official nationalism. When examining government policy and healthcare institutions, it is necessary to first highlight the spirit and role of nationalism on the relationship between government, technologies of power, and citizens. To do so, I turn to Benedict Anderson's (2016) *Imagined Communities: Reflections on the Origin and Spread of Nationalism.* There are three main notions that Anderson addresses while attempting to frame nationalism. Firstly, that nationalism is "imagined" (Anderson, 2016, p. 6). Second, that it is "official" (p. 86). And lastly, that it conceals discrepancies across the asymmetry of power (p. 110). These elements of

nationalism are reflected in healthcare nationalism pertaining to FGC when considering the relationships between how the health policies are contrived compared to what is being taught in medical curriculum and whose bodies and experiences are accounted for in this knowledge. The official nationalism of healthcare framing suggests that all members of the imaged community are valued, however, marginalized peoples, especially women affected by FGC, may experience exclusion from Canadian health provision.

The concept of nationalism being *imagined* is at the core of Anderson's (2016) conceptualization of the theory. "In an anthropological spirit, then, I propose the following definition of the nation: it is an imagined political community – and imagined as both inherently limited and sovereign" (Anderson, 2016, pp. 5-6). The idea of the nation being limited can be used as an interesting critique of Canada's multicultural mosaic identity. The GoC's approach of publicized acceptance and welcoming of all peoples to create a diverse cultural understanding of our nation is potentially impossible given Anderson's (2016) note that there is limitation to the nation. How can the nation be so diverse and open when it is simultaneously limited? What does this mean for newcomers and citizens alike? Anderson (2016) continues, "it is *imagined* because the members of even the smallest nation will never know most of their fellow-members, meet them, or even hear of them, yet in the minds of each lives the image of their communion" (p. 6). In this sense, Anderson introduces the nation as a shared collective:

> [The nation] is imagined as a *community*, because, regardless of the actual inequality and exploitation that may prevail in each, the nation is always conceived as a deep, horizontal comradeship. Ultimately it is this fraternity that makes it possible, over the past two centuries, for so many millions of people, not so much to kill, as willingly to die for such limited imaginings. (Anderson, 2016, p. 7)

The significance of the collective and assumed comradeship is evident in the framing and stereotyping of Canadian official nationalism. The imagined community conceives the citizens of

the nation as equals who are, at most, genuinely concerned with the success of their neighbours and country. In the final phrase of the above quotation, Anderson highlights the power in the imagined community as citizens are willing to place their livelihoods in the hands of the nation by choosing to take part in the nation as a citizen. By living within a nation state, individuals agree to accept the rules, laws, and institutional programs that the government creates and enforces. For healthcare delivery, the Canadian medical system is an institution of the state with formal and informal agents that inform policies and practices that define standards of care and determine which bodies should be taken into consideration.

Next, the lasting power and legitimacy of nationalism comes from the characterization of nationalism as being *official*. The official nationalism of Canada is key for my argument as it exemplifies the disconnect between government-based rhetoric and the reality for citizens that fall outside of the real norm of the "average Canadian citizen" that society is designed by and for. Anderson's (2016) official nationalism formulation is drawn from Seton-Watson's *Nations and States*:

> These 'official nationalisms' can best be understood as a means for combining naturalization with retention of dynastic power, in particular over the huge polyglot domains accumulated since the Middle Ages, or, to put it another way, for stretching the short, tight, skin of the nation over the gigantic body of the empire. (p. 86)

From this definition, official nationalisms create a forced concept of wholeness. It marks a large empire and the people residing within its domain as inherently connected with a shared national identity. In Canada's official nationalism, government messaging asserts that diversity is welcomed and celebrated while maintaining that Canadians have shared values and identity (Public Health Agency of Canada, December 2017c). This supposed sameness of citizens fits within the official nationalism mold and creates a collective of united peoples. However, the official nationalism masks people's diverse realities and does not do the work we think it does,

that is, it may not protect or progress the livelihoods of all people on account of deeply ingrained systemic racism. Canadian healthcare nationalism reinforces the social binary of strong in-group and out-group categories, which deepens racism and creates additional ways for inequality to manifest. This is especially clear when considering the pride that Canadians take in our medical care as supposedly one of the top health systems globally. Superior healthcare is tightly tied up with Canadian national identity. However, the gaps in our system are indicative of wider social issues and the biases exposed in representations or lack thereof of diverse Canadians, which competes with the idea of Canada as a multicultural mosaic of diversity.

Furthermore, this process often "…represented a violent, conscious welding of two opposing political orders, one ancient, one quite new" (Anderson, 2016, p. 86). This characterization establishes that official nationalism is exerted through force and in many circumstances, would be synonymous with settler-colonialism and/or imperialism. The officiality of nationalism alludes to a need to assert power, rather, that the validity of nationalism may not exist organically putting into question its legitimacy. As Anderson (2016) states, "the key to situating 'official nationalism' – willed merger of nation and dynastic empire – is to remember that it developed *after*, and *in reaction to*, the popular national movements proliferating in Europe since the 1820s" (p. 86). Thus, the *officiality* of nationalism comes from colonial origins and is expressed out of a need to unite the nation *into* a universal or homogeneous identity. In the Canadian healthcare system, these values are exemplified through whose care needs are addressed, prioritized, and represented in programming for medical education in relation to the diversity of the population.

Finally, as Anderson (2016) claims, "in almost every case, official nationalism concealed a discrepancy between nation and dynastic realm" (p. 110). This discrepancy is referring to the asymmetry of power and the pluralism of identity across the imagined community. Enforcing

nationalistic ideals as universal, imagined, and 'official' are accomplished through a shared language, culture, history, maps, museums, and ultimately, shared memory and meaning of what the community and nation represents. Through these universalizing and naturalization technologies of power, a singular concept of the nation is created. This process was central to colonial violence. When considering nation-building in the context of imperial expansion, a shared and official nationalism is forced onto a community that is only imagined, as violence is necessary to suppress cultural diversity and Indigenous sovereignty with clear roots in racism. Anderson (2016) writes:

> In an age when it is so common for progressive, cosmopolitan intellectuals (particularly in Europe?) to insist on the near-pathological character of nationalism, its roots in fear and hatred of the Other, and its affinities with racism, it is useful to remind ourselves that nations inspire love, and often profoundly self-sacrificing love. (p. 141)

While the idea of nations inspiring love is echoed from the concept of the imagined community and the lengths that citizens will go to live and die for their nation, the national project does have its roots in creating and preying on social hierarchies such as classism, racism, sexism, and Othering. According to Anderson (2016), "the dreams of racism actually have their origin in ideologies of *class*, rather than in those of nation: above all in claims to divinity among rulers and to 'blue' or 'white' blood and 'breeding' among aristocracies" (p. 149). Still, class hierarchy was one of the central tools of imperialism and is deeply tangled up with racism. A national project for the continued success of the upper and ruling classes must be at the expense of lower classes, who are so often racialized peoples:

> official nationalism was typically a response on the part of threatened dynastic and aristocratic groups – upper *classes* – to popular vernacular nationalism. Colonial racism was a major element in that concept of 'Empire' which attempted to weld dynastic legitimacy and national community. (Anderson, 2016, p. 150)

Thus, herein lies the discrepancies in official nationalism and the asymmetry of power that it seeks to conceal. An official nationalism tightly grips onto the power and legitimacy that it claims through the imagined community narrative. By creating a universalizing ideation of what the nation is, it crafts an entity and identity to grasp onto. Specifically, something that citizens will want to protect if the imagined idea of the community is enticing and supports their own desires. With colonial projects, those that do not subscribe to the imagined community in all its officially imposed imagery would be forced to submit or face the legitimatizing power of the state with possible dire implications. The imposition of nationalism suggests that not every citizen may adhere to the legitimacy of the state or sees themselves reflected in its narratives. The suggested imagined community is purposely ignorant of the ongoing systemic violence used to uphold societal impositions of difference. I consider the roles of these processes within GoC and SOGC policies and care pertaining to those who are considered Others by way of gender, race, culture, language, class, and potential citizenship status, as some examples.

Within FGC discourse that comes out of "outsider" perspectives, there are incongruent tensions between how to frame FGC as a cultural practice along with how to view affected women and interpret the health consequences of FGC. This is also a tension within communities that practice FGC as there is both significant criticism and support from cultural insiders, but in those circumstances, there is not the added dynamic of outsiders telling affected people what should be considered right. From one side, affected women are seen as victims of human rights and child abuses at the hands of their own communities and families. Whether or not this is how some affected women view their own experiences, international criticism and western morality particularly suggests that FGC is violent and that affected women must be protected. At the same time, western-based policies, healthcare programs, and anti-FGC campaigns support the

condemnation of FGC, while having a significant problem of not simultaneously considering the current experiences of women who have already undergone the ritual. This tension suggests that affected women are not individuals with diverse lives, rather that they are a homogenous subaltern group of women who may not be considered within national-based policies and only in international development policies and programs. How can people be framed as both victims that need protection but then also not considered as people who need access to appropriate services that would provide this support? This speaks to greater issues of the colonial imposition of social hierarchy along with international protectionist policies often rooted in morality that mark certain people as victims and undermine their agency.

Colonialism created hierarchal concepts of worthiness to condemn non-white people as the "Other." In deeming groups of people as the subaltern, they are removed from any power through systemic violence. Coloniality operates as the representation of power from colonialism through the institutions of society and legacies of trauma that are still felt. Colonialism operated as violence through slavery, dispossession, displacement, and cultural genocide and impacts every aspect of modern society, especially hierarchal social organizing. These transnational and national systems of difference and oppression limit access to power for the groups that are deemed the Other and left outside of methodologies of care. The relationship between institutional power and the lives of the population is essentially what this research is investigating, especially with concern over how these tensions play out in the lived experiences of marginalized peoples within the nation. Legacies of colonial differentiation are exemplified through the structural violence of policies and practices that only cater to certain groups of peoples. Healthcare policies that seek to identify flaws within systems of knowledge and governance are a positive step toward calling out and changing implicit biases and harm deeply imbedded in these systems. The following section identifies two

Canadian health policies that are seemingly self-reflective of the current problems within healthcare provision, and how this has detrimental impacts on women affected by FGC. But, as Chapter 3 of this thesis finds, there are still discrepancies between the changes the health policies urge for and what current medical training curriculum entails.

Canadian Policies Relevant to FGC and Healthcare Provision

In this section, I expand on the policies of The Family-Centred Maternity and Newborn Care: National Guidelines, which is the main GoC policy document that informs this research along with the SOGC's Guideline No. 395-Female Genital Cutting. To contextualize the main governmental policy document, it states: "The Family-Centred Maternity and Newborn Care: National Guidelines are intended to assist health care organizations, providers, program planners, policy makers, administrators and families to propose, plan, implement and evaluate maternal and newborn health care policies and practices" (Public Health Agency of Canada, December 2017c). The National Guidelines exemplify what specific health concerns the GoC wants Canadian healthcare provision to include while producing an evaluation of the problems they identify within current care. The National Guidelines highlight issues with current Canadian health programming for treating women affected by FGC. It is important to analyze the way that the language and knowledge included in these documents frame FGC, especially considering that this document is not a clinical practice guideline and relies more on an assessment of quality of care and cultural bias issues. This is particularly significant as the illegality of FGC positions the practice as outside of and against concepts of Canadian values. Additionally, the National Guidelines make frequent reference to the SOGC Clinical Practice Guidelines on Female Genital Cutting. This document was updated in February 2020, whereas the National Guidelines were revised in 2012 and published in December 2017. They are still not fully updated and reference the preceding version

of the SOGC Guidelines from 2013. The clinical guideline on FGC by Perron et al. (2020) for the SOGC is the referential guideline that influences health education and training. I offer an analysis of the content and framing of this clinical practice guideline as it critiques and calls out HCPs' cultural bias against the communities and women affected by FGC.

Government policy and programs can operate as an element within Anderson's (2016) "official nationalism." The two following guidelines are reflective of the GoC's creation of an official nationalism with intentions of creating an equal society. Both guidelines indicate a subtle acknowledgement that there are shortcomings in the current structuring of the nation state that have created and enforced systemic inequalities. The guidelines operate within Canada's ideals of an imagined community that supports all members. They also reflect the goals of the GoC's official nationalism that reminds HCPs of "the richness of the Canadian mosaic with its culturally diverse population" that must be represented through appropriate healthcare (Public Health Agency of Canada, December 2017c). I use these policies to situate and frame how official nationalism deems how Canadian society should be structured, as dictated by the government, to support the success of all members of the community. This is especially contrasted with the reality of the imagined community where certain members are not actually included social programming and institutional support based on identity factors that place them outside of the accepted norm. In this case, support is determined through training for and experiences of OB-GYNs with treating women affected by FGC.

The SOGC Clinical Practice Guideline on FGC

The SOGC Guideline No. 395-Female Genital Cutting produced by Perron et al. (2020) is intended for "health care providers delivering obstetrical and gynaecological care" on the target population of "women from countries where FGC is commonly practised and Canadian girls and

women from groups who may practise FGC for cultural or religious reasons" (p. 205). Within this document, there is a significant amount of information on the practice of FGC, health need challenges, "clinical management of women living with FGC," and "providing culturally competent care to women and adolescents with female genital cutting" (Perron et al., 2020). Perron et al. (2020) state "in the last year, there has been a resurgence of interest in this issue in Canada and abroad. For this reason, the authors propose to conduct a comprehensive revision in the next few years" (p. 204). Overall, this guide offers a significant focus on cultural competency and stresses the importance of trying to understand a patient's individual experiences and how that affects their healthcare needs. Perron et al. (2020) emphasize that women affected by FGC must be treated with physical and emotional sensitivity to reduce further stigmatizing them or increasing trauma through inadequate healthcare. One of the most telling signifiers of the tone of this clinical practice guideline is the Objectives section. Perron et al. (2020) write:

> Objectives: To decrease the likelihood that the practice of female genital cutting (FGC) be continued in the future and to improve the care of girls and women who have been subjected to FGC or who are at risk by providing (1) information intended to strengthen knowledge and understanding of the practice, (2) information regarding the legal issues related to the practice, (3) guidance for the management of its obstetrical and gynaecological complications, and (4) guidance on the provision of culturally competent care to girls and women affected by FGC. (pp. 204-205)

Ultimately, HCPs must do no harm, so listing the Objectives as generally to move toward eradicating the practice is logical as FGC is considered medically unnecessary and potentially harmful. Healthcare intervention is widely considered a key method toward ending FGC. Then, there is a focus on knowledge dissemination and education on FGC including the legal and human rights issues from a Canadian perspective. Finally, there is engagement with clinical care along with cultural competency training. In general, Perron et al. (2020) attempt to help contextualize FGC by providing a broad overview on the practice itself, but this would be strengthened with

greater nuance into the practice and its value for affected communities. Further, by incorporating more varied perspectives on FGC, HCPs would be more aware of the diversity of people, experiences, and perspectives that are involved in the practice from cultural insiders. Perron et al. (2020) do briefly highlight that there is currently not a lot of research into the health outcomes and wellbeing of women with FGC who have immigrated. They also clarify, "it should be noted that many women do not experience any long-term complications from the procedure . . . Health care providers in receiving countries tend to address the long-term complications of FGC, especially those related to types II and III" (Perron et al., 2020, p. 209). With this information, their clinical practice guideline goes beyond discussion of specific medical and surgical care to create a more thorough and overarching guide to the varying elements of FGC related healthcare. This includes attempts to contextualize the practice, discussion of literature on patient reports of HCP shortcomings, and moves to address the need for cultural competency training.

The clinical guideline is informative and takes a perspective that admits the wrongdoings of HCPs who further stigmatize and harm patients due to inadequate knowledge of FGC and how affected women should be treated. The document still reflects certain universalizing assumptions about the identities, life experiences, and autonomy of marginalized women. The universalizing nature of medical care presents challenges when treating patients who have experienced a highly nuanced cultural practice. This clinical guideline represents assumptions about affected women's knowledge, education, and agency that echo the framing that women from the Global South are necessarily repressed and subjected to patriarchal culture that is the source of their supposed lack of autonomy (Mohanty, 1988; Perron et al., 2020, pp. 210, 212, 214). This framing is reductive and does not account for nor address how neocolonial legacies and global capitalism enforce the binary of the west versus the rest and how this Othering affects social structures transnationally. It

represents a western epistemology that marks certain bodies as the Other that is disenfranchised because it does not fit into the colonial model of belonging and power. Throughout the clinical practice guideline, there are suggestions that affected women may have limited education along with knowledge of reproductive care (Perron et al., 2020, pp. 210, 212, 214). Generally, it is part of the job for OB-GYNs to educate their patients on sexual and reproductive health. In this specific case, there are added complications related to potential racialized power dynamics that oppose the knowledge of affected women under the assumption that if she represents a culture that values FGC, she must not understand her own human rights or have bodily autonomy (Johnson-Agbakwu & Manin, 2021). This also feeds into an infantilizing narrative about women from the Global South leading to western healthcare perspectives that downplay the autonomy that patients do have.

It is significant how Perron et al. (2020) describe the practice of FGC itself. Under their heading "Immediate and Long-Term Complications" they explain that "typically, the child is forcibly held while the excision is done using a razor blade, piece of broken glass, or knife" (Perron et al., 2020, pp. 208-209). While this information is not inaccurate, it is not always the case that this is how FGC is performed but framing it as such without elaborating on the other methods and locations of the ritual adds to the narrative of FGC as solely being barbaric, dirty, and coerced (Ahmadu, 2007). As discussed in my literature review in Chapter 1, while many women who have experienced FGC may condemn the practice, there are also many who do support it considering that it is primarily elder women in communities who uphold the tradition (Ahmadu, 2007; Shell-Duncan et al., 2018). Much of the discourse surrounding FGC tends to frame the practice in a universal way as the determined four types of FGC that happen globally and mainly throughout Africa. This homogenization of the practice leads to assumptions about morals, values, and knowledge of those communities and individuals who value the tradition. With a deeper concern

over the nuance of FGC and a recognition of the ineffectiveness of universalizing such a diverse concept, outsider researchers and HCPs can develop greater knowledge and understanding that would lead to more inclusive and effective healthcare that works to reduce biases, stigma, and harm.

To this end, Perron et al. (2020) cite multiple studies where women affected by FGC report that their healthcare was overall a negative experience that was "harsh" and "offensive" to cultural values (p. 210). This should be compounded with numerous studies that Perron et al. (2020) cite:

> Widmark et al. and Johansen 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 care 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.' Significant gaps in both theoretical knowledge and practice related to FGC were found among health care providers in United Kingdom, Sweden, Spain, and the United States. (p. 211)

Health care providers seem to face a conundrum where they felt empathy for their patients on the one hand while also exhibiting a blockage against considering that FGC as a coming-of-age cultural ritual is mainly controlled by women across diverse communities and not usually directly by men (Shell-Duncan et al., 2018). Improved medical curriculum on FGC could discuss these potential contradictions, biases, perspectives, and emotional standpoints during training to reduce potential harm when the HCP is treating patients. This type of cultural sensitivity training could work toward destigmatizing FGC in Canadian healthcare and for those patients and their families who do value the practice. In this document, there are attempts to destigmatize FGC from the western perspective, but it falls short by choosing language that feeds into the perils of the single-story trope of subaltern victims, which is especially harmful as women affected by FGC are already marginalized in western settings and may not view themselves in this way. With enhanced nuance

in the way that women and FGC are framed, this clinical practice guideline would better reflect the realities of who patients are and the sensitive approach to care needed from HCPs.

Finally, within Canadian OB-GYN practices related to FGC, there are issues surrounding who is considered the "norm." Since this document emphasizes the illegality of FGC, it is important to highlight how they include this information. Perron et al. (2020) remind HCPs:

> 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. (p. 210)

The supposed legitimacy of certain medical reasons over others is a grey area where mental health reasons and achieving "normal sexual appearance" are cited as acceptable reasons to deviate from this law (Perron et al., 2020, p. 217.e1). What is considered "normal" is subjective and reflect the white, western vagina in the Canadian context. As Perron et al. (2020) state:

> 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. (p. 212)

Perron et al. (2020) highlight that while the practice may have varying anatomical long-term health consequences, there is a concern over differing social norms and potential vulnerability from difference for immigrant women in Canada. Women affected by FGC both exist within the norm of their home culture and outside of acceptability in the west. When considering obstetrical care through delivery and post-delivery, there is the added issue of the potential need for incision or resulting tearing that must be repaired to "normal appearance" while remembering that "reinfibulation should be declined on medical grounds" but that there must be sensitivity to women-centred health and cultural respect (Perron et al., 2020, p. 212). Perron et al. (2020) explain, "the health care provider should support a culturally competent approach in which the

autonomy of the woman is honoured as much as possible without compromising her health or breaching the ethical principle of non-maleficence" (p. 212). However, this process is subjective and reliant on the HCPs' notions of anatomical norms, especially in the case when a patient has experienced Type 3 FGC and requires deinfibulation for vaginal delivery. To what extent is the HCP able to meet the medical and cultural needs of their patients when the idea of the norm is reflective of specific bodies and not truly universal? This is an especially complex and nuanced area within FGC discourse.[1]

The SOGC's clinical guideline is considered the benchmark of Canadian care for clinical and cultural competency when treating women affected by FGC. Perron et al. (2020) present ten key care practices for providing culturally competent care. The themes are: "terminology when providing care;" "identification of the women's FGC status;" "communication;" "providing women with appropriate and well-timed information;" "confidentiality and privacy;" "woman-centred care;" "health-seeking behaviours and practices and preventive care;" "preparation for delivery;" and "referrals" (Perron et al., 2020, pp. 213-215). Each of these aspects emphasize respect for patients' agency, histories, and life situations while clearly communicating health processes and the illegality of FGC and reinfibulation (Perron et al., 2020, pp. 213-215). The SOGC's Guideline No. 395-Female Genital Cutting presents a variety of information and emphasizes the HCP's role in perpetuating stigma and their responsibility to aid and listen to their patients. Perron et al. (2020) state, "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

[1] The illegality of FGC within western settings contrasted with the legality of genital cosmetic surgeries like labiaplasty and the "husband stitch" is a contentious area of debate. Within these areas of research, it is more challenging to assert claims one way or the other. Importantly, there is the concern over informed consent, especially in terms of the ages of girls who undergo FGC along with under what conditions contrasted to cosmetic genital surgeries. The issue of consent to FGC more closely aligns with similar concerns over consent to "corrective surgeries" for intersex babies that parents choose on their behalf to align more closely with what are considered "normal" appearances of "unambiguous" genitalia in western contexts.

insensitive or patronizing" (p. 214). However, there are some shortcomings in the document itself regarding the language usage and the focus of the information that represents potentially harmful narratives around FGC and the life experiences of women who have been affected by the practice. The guideline provides two and a half pages of content on cultural competency, but this aspect should be further developed to promote successful integration of this care approach given that it seems to be under-taught in medical schools based on my research, the current literature in the field that I have discussed in Chapter 1, and the reports cited in Perron et al.'s (2020) guideline and the GoC's National Guidelines. A necessary improvement for this benchmark of care involves greater research into the healthcare experiences of women affected by FGC in Canada, as this information is very limited. Then, consulting with affected communities to address what they deem are appropriate and effective improvements to care. It is possible, however, that the proposed future revisions of this clinical guideline might move towards a de-centering of westernizing narratives around FGC in medical care.

The Family-Centred Maternity and Newborn Care: National Guidelines

If the nation reflects narratives of sociocultural norms and values, the state represents both the formal institution of governmentality and the informal institutions like patriarchy and neocolonialism that work to uphold and reinforce state power, practices, knowledge, and values of the hegemonic (Development Centre Studies, 2007). Healthcare itself is comprised of both formal institutions of education where information and objectives come directly from national medical societies and associations along with informal institutions of how this knowledge gets translated into educational training like in medical rounds, for instance. The state and its informal institutions of society centre western norms, attitudes, and culture. Due to the legacies of colonialism and deeply ingrained structural violence, politics, universities, healthcare, and religion are just some

of the social institutions that gatekeep to allow only certain people into positions of power for decision-making and knowledge production.

The Government of Canada's "Family-Centred Maternity and Newborn Care: National Guidelines" influences OB-GYN practice as it identifies priority action areas for informing changes in healthcare models and is a GoC analytic overview of the status of Canadian care standards with a focus on improving the quality of health provision beyond clinical ideations into a more holistic approach. The GoC states:

> overall, family-centred maternity and newborn care (FCMNC) is about increasing the participation of women and their families in the decision-making process concerning their pregnancy, birth, and early postpartum experiences, in order to promote optimal health and well-being for both mother and child. It is sustained by an environment that promotes collaboration, partnership, respect, and information-sharing between women/families and their health care providers (HCPs). (Public Health Agency of Canada, December 2017a)

This philosophy is evident throughout the chapters and the information that is highlighted throughout their subsections.

In "Chapter 1: Family-Centred Maternity and Newborn Care in Canada: Underlying Philosophy and Principles" (Public Health Agency of Canada, December 2017a), the policy outlines seventeen principles that underpin the basis of the guidelines. Those that are most pertinent to this research are principles 8, 13, 14, 15, and 17:

"8. Culturally-appropriate care is important in a multicultural society;…

13. Women and their families play an integral role in decision making;

14. The attitudes and language of health care providers have an impact on a family's experience of maternal and newborn care;

15. Family-centred maternal and newborn care respects reproductive rights;…

17. Family-centred maternal and newborn care best practices from global settings may offer valuable options for Canadian consideration." (Public Health Agency of Canada, December 2017a)

These five principles in particular highlight that Canada is a multicultural and diverse society and that there is value in looking internationally at global health practices, which are viewed as just as important as national policies. Additionally, there is suggestion that HCP biases and stigma can deeply affect the experience of women and their families, who must be respected and viewed as worthy of input in their own healthcare experience with agency over their own bodies within the bounds of the Canadian legal system and human right discourse. This framing reflects the need to better inform policy and practice to represent Canada as a multicultural society including a focus on how newcomers are treated and valued as patients.

Of the seven chapters currently published in the National Guidelines, "Women Who Have Experienced Female Genital Cutting (FGM/C)" are given their own subheading in four of the chapters with the last one instead using the subheading "Female Genital Mutilation/Cutting (FGM/C)." These four chapters are titled: Chapter 2: Preconception Care; Chapter 3: Care during Pregnancy; Chapter 4: Care during Labour and Birth; and Chapter 5: Postpartum Care. The headings that women affected by FGC are placed under include "6. Women with Specific Needs," "10. Special Situations," "6. High-Risk Pregnancies/Births and Special Circumstances," and "4. Complications Related to the Mother," respectively. Across these chapters and their own subsections, women affected by FGC are situated in the same categories as other "special" cases of pregnancy and delivery, such as, "women with mental illness," "LGBTQ2 families," "women with complications of pregnancy," and "women with underlying health conditions," as some of the wider examples. This framing situates affected women's care as just as necessary to consider

within the Canadian healthcare experience as other mothers whose conditions might be assumed to be more prevalent or common to the "Canadian" healthcare experience, such as, "Advanced Maternal Age/Delayed Child-bearing" (Public Health Agency of Canada, December 2017b). In other words, the GoC believes that women affected by FGC are to be specifically considered within health policy and practice of maternity and postpartum health. This is a significant distinction that reflects the increasing prevalence of affected women immigrating to Canada and acknowledgement of a need to focus on their care.

Across the four chapters that I have considered, there is a gap in knowledge and adequate and appropriate education for HCPs treating women affected by FGC that can lead to heightened physical and emotional harm along with distrust and fear of the Canadian medical system (Public Health Agency of Canada, December 2017b). A basic explanation of FGC is offered along with some of the common clinical complications that must be considered. Interestingly, each subsection emphasizes at least once that it is imperative to treat affected women with respect, dignity, privacy, modesty, and for the HCP to reduce their own biases and judgemental attitudes to not further stigmatize their patients. The National Guidelines disturbingly cites, "Canadian research revealed that 88% of maternity caregivers have expressed some kind of hurtful comments" about women and families affected by FGC (Public Health Agency of Canada, December 2017b). The National Guidelines highlight the importance of working with women and their families to involve them as decision-makers, especially to not make assumptions about affected women's life experiences or specific care needs, which must be personalized. Educating affected women about their own reproductive anatomy, rights, and contraceptive options is also emphasized.

There is more attention on HCPs' bedside manner than medical elements, especially since the National Guidelines cite that they are not trying to represent clinical guidelines and that those

can be found under the SOGC, such as Perron et al. (2020) as one example (Public Health Agency of Canada, December 2017c). In the policy guideline, there is discussion of the merit of cultural sensitivity, but there is also an emphasis placed on how the practice of FGC is "traditional" which is coded language for non-modern or a kind of primitive practice: "Learning about the cultural, social, psychological, and physical implications of this centuries-old traditional practice will help HCPs talk to mothers appropriately and provide care that is culturally aware and respectful" (Public Health Agency of Canada, 16 December 2020). This is coupled with repeated reminders to HCPs to explain the illegality of the practice including the need to stop women from reinfibulation along with performing FGC on their daughters. This language may be harmful to people from communities that value FGC as it positions the practice in opposition to modernity, which is a framing that is also reflected in the Western University ISGL on FGC that I analyze in Chapter 3. Also, the National Guidelines mention that deinfibulation should happen with more severe types of FGC but should be first discussed with the mother to determine the best course of action and if the surgery can happen prenatally or during labour. As stated by the GoC:

> By discussing the need for defibulation and the illegality in Canada of FGC and infibulating again with the woman before conception—preferably with her partner present—the HCP may help deter the couple from seeking traditional providers to infibulate again after a birth. (Public Health Agency of Canada, 2017b)

This language and framing of the practice of FGC and the women involved shows that health-based discourses taking a culturally sensitive approach is contentious and contrasts with the Canadian imagined landscape and community, which supposedly includes immigrant women experiences as outlined in official nationalism. The policy, overall, seems to be out of step with the ideal of a pluralistic and diverse society envisioned by official nationalism.

The more controversial element of what the GoC has included in the National Guidelines relates to Chapter 4: Care during Labour and Birth. There are two significant points I wish to address within the following quotation (emphasis my own):

> In some cases HCPs may offer caesarean birth, possibly because of discomfort with intrapartum management of FGM/C. Infibulation is not an adequate indication for caesarean birth, and deinfibulation is far less dangerous than caesarean birth. According to the SOGC guideline, after delivery, vaginal, perineal, and vulvar trauma should be *repaired in the usual way to restore normal anatomy*. While repair of torn or cut vaginal and vulvar tissue is appropriate, infibulating again is illegal in Canada and can result in criminal charges. (Public Health Agency of Canada, 20 June 2018)

The first issue is HCPs' overreliance on caesarean birth when it is not always necessary because they remain undereducated on how to appropriately treat women affected by FGC, especially when they are citing that deinfibulation is a better practice (Okusanya et al., 2017; Rodriguez et al., 2017). Why is this considered acceptable to jeopardize the health of the mother due to inadequate training, especially since the medical best practices standard of the SOGC clinical guideline also details this shortcoming in health knowledge? If restoring "normal anatomy" is accepted but not reinfibulation, then who is the definition of the norm in this case? There also needs to be a consideration of the infamous, unsolicited and usually non-consensual, yet legal "husband stitch" where torn tissue is sewn a stitch or two more than considered medically necessary under the patriarchal and highly questionable idea that this would be preferred by sexual partners of the mother, which is a practice that I contend is anatomically similar to concepts of FGC (Braun & Kitzinger, 2001; Braun & Wilkinson, 2001; Dobbeleir, 2011).

Overall, the discrepancies represented in this policy show an asymmetry of power between who controls the official nationalism and who exists within the imagined community. The Family-Centred Maternity and Newborn Care: National Guidelines are representations of Canada's official nationalism that is expressed through policy in tandem with the nationally imposed Perron et al.

(2020) SOGC Guideline No. 395-Female Genital Cutting. By establishing and analyzing the existing relevant policy, I am setting up a basis of critique to demonstrate the disconnect between the published intentions of the GoC and national medical societies and the reality of a gap in the current training standards. A main intention of the National Guidelines is to foster care that is inclusive and does not rely on assumption about patients or their lives. This approach to viewing the lives of Canadians and their health is also reflective of the social determinants of health, which have a greater impact on those who are most marginalized within society. With greater concern over how tensions in hierarchical power dynamics plays into healthcare policy and practice, there is room for improvement in medical regulation and practice. Through my analysis of these guidelines, I suggest that the policies do have good beginnings, but need deeper consideration of cultural competency that is determined by affected communities in Canada and thorough implementation through mandatory training at all levels of healthcare to be effective.

Chapter 3: Towards Centering Immigrant Women's Healthcare through Transnational Feminist Practice

My research so far assert that power operates to limit who society protects and those it ignores, determined by the biases and goals of those with power and the informal institutions that influence these decisions. In the context of institutional healthcare provision, these dynamics become more apparent as they create added tension to potentially literal life and death situations. This is an important distinction as these dynamics represent an enforcement of difference, especially one that is imbued in a hierarchy of power that is indicative of First/Third World, Global North/South, and western/Other binaries. The distinction of globalization is that these borders impose meaning and limitations to indicate narratives about geographic regions and their populations. The narratives serve to further boost the binary between the claimed superiority of the western world while positioning much of the globe into a tertiary subaltern category.

As I have highlighted in Chapter 2, colonial power was created and enforced by imposing difference and placing meaning onto those differences. As Walter Mignolo (2018) reminds us, "*borders* are everywhere and they are not only geographic; they are racial and sexual, epistemic and ontological, religious and aesthetic, linguistic and national. Borders are the interior routes of modernity/coloniality and the consequences of international law and global linear thinking" (p. 112). Borders serve to divide and ascribe meaning. Borders within the heteropatriarchal nation state are the identity factors that reduce people to sites of oppression and are accepted bases of discrimination. Borders keep people out physically but also socially and politically. Official Canadian nationalism suggests that the international border is always open. Meanwhile, the narrative of the diverse, multicultural mosaic versus the realities of the limited, imagined

community suggest that Canada's imagery is not reflective of the lived experiences of those who exist within, across, and outside of the imposed social borders.

Furthermore, Eve Tuck and K. Wayne Yang (2012) write on the impossibility of decolonizing processes due to the ubiquitous nature of colonialism and its persistence in not just every physical aspect of society, but also the enforced internalization of the legitimacy of systems of hierarchies, oppressions, and the trauma that this has created over time. When the systems of society are so deeply entrenched in processes of differentiation, it seems impossible to create change within them without dismantling the systems altogether. This is especially the case for the medical and scientific fields, as they are predicated on the demarcation of bodies by identity factors, but it is not impossible.

In this chapter, I seek to provide a critical response to the narratives around FGC in the context of Canadian healthcare. Using transnational feminist theory, I will address the realities of the health training and knowledge that does exist. Acknowledging the prominence of western-centric systems and institutions helps to identify some of the shortcomings and harm that can be caused by inadequate healthcare. Considering transnational feminism, society can move forward with inclusion of marginalized peoples through working toward decolonizing Canadian healthcare and centering immigrant women's experiences. Finally, I end this chapter by tying together my previous exploration of Anderson's (2016) nationalism concepts with transnational feminism through a discussion of marginalized bodies in the imaginary of the gendered nation state. Through these arguments, I offer a critical examination of some of the issues that persist in the current healthcare system especially for immigrant women.

Transnational Feminism, Practice, and Health

Transnational feminism highlights the interlinked system of varying oppressions that marginalize women throughout cultures and beyond borders and binaries. As Inderpal Grewal and Caren Kaplan (2006) state, we need "to rearticulate the histories of how people in different locations and circumstances are linked by the spread of and resistance to modern capitalist social formations even as their experiences of these phenomena are not at all the same or equal" (p. 5). "Women" should not be a term intended to describe a homogenous group. There must be an understanding that women are not all the same and do not have the same life perspectives, experiences, or oppressions. Thus, when cultures and societies do not support women by making universalizing assumptions, transnational feminism provides a critical approach that addresses the realities of discrimination and seeks to rectify them through solidarity by simultaneously accepting both the differences and commonalities in the marginalization of all women.

This approach necessarily incorporates intersectionality, meaning that there is acknowledgement of the multiple intersecting identity factors a person may have that impact their access to power and lead to increased sites of oppression. For instance, women affected by FGC may experience multiple levels of societal disadvantages based on their gender, race, religion, language, and class, as a few possible identity factors that together increase the level of discrimination a woman may face. As Rita Kaur Dhamoon (2015) explains, "an intersectional-type framework starts from the premise that distinctive systems of oppression such as racism, patriarchy, and heteronormativity need each other in order to function; they are co-produced and productive of unequal material realities" (p. 29). These systems create violence through grouping people based on identity factors and associating meaning that results in various degrees of privilege or disadvantage (Dhamoon, 2015, p. 29). Intersectionality highlights the ways that social structures

inform livelihoods and a person's potential to succeed based on how society enforces binaries of belonging.

Transnational feminists support the movement of feminism into the realm of anti-oppressive, anti-racist activist work that focuses on solidarity across and beyond borders. Solidarity movements do not aim to link all people as one but recognize the importance in acknowledging the imposed difference and social stratification of different groups of peoples along with the effects this has on individuals' everyday lives. This feminist ideology is reactionary to liberal and global feminisms which do not consider or value the need to consider intersectionality in power dynamics. Historically, "liberal feminism" is synonymous with "white" and "western" feminism that seeks to exclude racialized women from the movement while simultaneously projecting the idea that there is a "sisterhood" amongst all women. This idea comes out of Robin Morgan's (1984) *Sisterhood Is Global: The International Women's Movement Anthology* that features essays from a multitude of contributors specifically writing from a wide variety of countries about the status of women within those areas. Although it has a preface of including a multitude of international voices, the work still makes it seem like all women suffer from the same plight without considering difference or added intersections. This reflects Morgan's white, American, and class-privileged epistemology.

Partially in critique of this feminist ideology, Chandra Talpade Mohanty's (1988) seminal essay "Under Western Eyes: Feminist Scholarship and Colonial Discourses" continues to be one of the most influential pieces written to address the reality of past and present feminisms. Mohanty's (1988) concern over the effectiveness of post-colonial feminisms for representing the realities of a so-called subaltern, non-western womanhood is evident through what she deems the Othered interpretation of the "Third World woman." This trope, and "Third World" feminisms

rely too heavily on the concept of a homogenous, passive victim, where all non-western women are the same with shared and unvarying oppressions. Mohanty (1988) places a heavy focus on acknowledging and addressing the problematic fact that popular feminist thought and activism leading up to that moment was dominated by hegemonic western feminist views. These views did not necessarily encompass the lived realities for non-western women, nor were they especially concerned with intersectionality because white, western feminism did not need to think outside themselves to serve the loudest voices within the movement. As such, there is an overdue need to redefine power relationships between the subaltern woman of the Global South, who is viewed as necessarily oppressed and the white, western feminist, who mainly faces oppression by the heteropatriarchy. This can be achieved by recognizing the intersectional axis of oppressions that women may face regardless of where they live or where they come from.

Thus, discarding essentialist binaries like that of First/Third World women, rejecting heteronormative gender constructs, and taking an actively anti-racist approach to feminist theory is crucial. In their (1997) anthology *Feminist Genealogies, Colonial Legacies, Democratic Futures*, Mohanty and M. Jacqui Alexander explain that "to talk about feminist praxis in global contexts would involve shifting the unit of analysis from local, regional, and national culture to relations and processes across cultures" (p. xix). This shift is salient for my research as it alludes to the issue of how to approach international cultural boundaries and borders that are permeated through transnational immigration. Nations may have their own variety of regional and local cultures but begin to take on cultures of the Other through diaspora communities. The success of cultural change relies on acceptance of diversity and shifting norms and values to represent emerging population change, rather than fighting to retain a grasp on past visions of what the imagined community should be.

Instead of suggesting that all "Third World women" or all women affected by FGC are the same, we must move beyond this type of reductive categorization of people and look at specific life contexts due to the intersectional and varying nature of networks of oppressions. Likewise, there needs to be recognition of the solidarity that is formed through addressing the reality of shared, similar, but non-homogenous ideas of "woman" and the potential oppressions that result within and across cultural networks. Mohanty urges feminists to critically analyze social structures and the institutions that uphold them, especially through the lens of the most marginalized members of the imagined community (p. 231). To truly seek out feminist mobilizing requires a much-needed shift to include intersectional analysis that looks to marginalized peoples through modes of allyship to recognize life differences and support each other through resistance to structural inequality.

Similarly, Grewal and Kaplan's (1994) anthology *Scattered Hegemonies: Postmodernity and Transnational Feminist Practices* sought to criticize the state of "contemporary global conditions" that other feminisms could not account for, citing that their anthology aims to "raise as many questions as possible about how and why such denials and erasures have occurred as well as how to practise feminism differently" (p. 1). In alignment with Mohanty's (1988, 1997, 2003) concepts, Grewal and Kaplan (1994) explain that theory and practices coming from a western-as centre perspective takes on a homogenizing nature stating, "we would like to explore how we come to do feminist work across cultural divides" (p. 2). This is an important approach in a world that is heavily influenced by globalization, capitalism, and colonial legacies, while experiencing continued forms of structurally harsh neocolonialism. Grewal and Kaplan (1994) argue that these areas induce power relations that are significant for the creation of culture (p. 3). The authors state, "there remains a great need for *feminist* critiques of the Western model of sisterhood in the global

context," which is a critique of Morgan's (1984) western perspective of idealistic thinking (Grewal & Kaplan, 1994, p. 4). They later add, "conventionally, 'global feminism' has stood for a kind of Western cultural imperialism. The term 'global feminism' has elided the diversity of women's agency in favor of a universalized Western model of women's liberation that celebrates individuality and modernity" (Grewal & Kaplan, 1994, p. 17). The western world subjugates non-western cultures to the neocolonial imposition of their own values and concepts of knowledge onto those deemed different, which is synonymous with being inferior.

During the height of colonial imperialism, colonizers forcibly removed traditional cultural practices of the Other and correspondingly forced assimilation into their own cultural ideals. These violent campaigns perpetrated the idea that the beliefs of white colonizers were superior to the cultures they were overtaking, and that their culture needed to be universally adopted. Other feminisms, especially white, western, liberal feminism, continue a similar, but less blatantly violent, neocolonial approach to women's empowerment by offering the idea that the "Third World woman" needs saving, especially from her own culture and family (Mohanty, 1988). There is a false assumption that western moral imperialism will save subaltern women who lack agency. As such, "without an analysis of transnational scattered hegemonies that reveal themselves in gender relations, feminist movements will remain isolated and prone to reproducing the universalizing gestures of dominant Western cultures" (Grewal & Kaplan, 1994, p. 17). This is exactly the problem that transnational feminism condemns.

Likewise, Richa Nagar and Amanda Lock Swarr's (2010) anthology *Critical Transnational Feminist Praxis* brings transnational feminism further into the modern context. They advocate "a transnational feminist praxis that is critically aware of its own historical, geographical, and

political locations" (Nagar & Lock Swarr, 2010, p. 3). Nagar and Lock Swarr (2010) claim that transnational feminisms:

> (a) attend to racialized, classed, masculinized, and heteronormative logics and practices of globalization and capitalist patriarchies, and the multiple ways in which they (re)structure colonial and neocolonial relations of domination and subordination; (b) grapple with the complex and contradictory ways in which these processes both inform and are shaped by a range of subjectivities and understandings of individual and collective agency; and (c) interweave critiques, actions, and self-reflexivity so as to resist a priori predictions of what might constitute feminist politics in a given place and time. (p. 5)

This understanding of the theory supports transnational feminism as an activist-based feminism that works through collaborative solidarity to support women of differing backgrounds and sites of marginalization. Through this, feminist academia can disengage with feminisms that propose the imposition of western values and morality to "save" women who are assumed to be suffering elsewhere in the world and focus on reclaiming power through dismantling harmful hierarchies and oppressions. A step toward dismantling hierarchies between FGC and more generally accepted concepts of genital alteration surgeries would be to reassess the harm caused by all forms of alteration and accept those practices that are less physically invasive and have limited long-term health complications (Arora & Jacobs, 2016).

Medical Education Training and Marginalized Bodies

As previously discussed, for colonized and moreover racialized peoples, there already exists deeply ingrained trauma from legacies of colonialism and the modern structural violence of social organizing. Inadequate healthcare that does not consider the need for harm reduction through well-informed cultural competency practices can be a source of trauma, especially for people who may have already experienced a great deal of trauma throughout their lives (Evans et al., 2019; Johnson-Agbakwu & Manin, 2021; Perron et al., 2020; Public Health Agency of Canada, December 2017a, December 2017b; Vissandjée et al., 2014). Women affected by FGC are potentially already

experiencing issues of oppression and discrimination in western society based on their perceived racial, gender, and national identity. Inadequate healthcare in terms of knowledge, attitudes, and skills creates multiple sites of trauma, especially through the power dynamics in the patient-HCP relationship coupled with the assertion of neocolonial patriarchy on marginalized bodies.

Through my research, I found that undergraduate medical education training for prospective OB-GYNs in Canada is misaligned with the GoC national policy guidelines and SOGC clinical practice guidelines concerning health-based treatment of women affected by female genital cutting. The national policy guideline specifically references care for affected women multiple times and posits this care alongside issues that may be considered more prevalent "Canadian" or "western" health concerns. Yet, the documents I analyze suggest that there is a lack of consideration of culturally appropriate care for women affected by FGC in undergraduate medical education, let alone in training specifically for obstetrics and gynaecology at this level, when other health concerns listed alongside women with FGC in the national policy guideline are considered within those medical training documents. This is coupled with the fact that the SOGC clinical practice guideline is surprisingly thorough and does emphasize cultural competency. Based on my research, this approach is mostly not taught in Canadian undergraduate medical education but is attempted in the University of Toronto "Case 2: Genital Cutting" module for their Obstetrics and Gynaecology residents.

In this section, I am concerned with what is missing from the educational materials that I analyze, and especially, the narratives that are presented about HCPs and their patients. Four of eight medical schools sent me their training documents (see Appendix B). Importantly, topics grouped with FGC in the GoC's National Guidelines, like mental health and mature pregnancies, are in fact referenced in the training documents from three of the medical schools that gave me

access to their training materials. The documents I acquired from University of Saskatchewan, Northern Ontario School of Medicine, and University of British Columbia do provide general clinical education that could be applied to the altered anatomy of women with FGC. However, there is no discussion of the importance of cultural competency or reducing stigma through appropriate communication in these documents, not even in the sections that are directly linked to the CanMEDS framework.

The generalized medical education documents from the medical schools I had access to were based on the Royal College of Physicians and Surgeons of Canada clinical guidelines, such as, the (2019) "Obstetrics and Gynecology Competencies" along with the (2016) "Objectives of Training in the Specialty of Obstetrics and Gynecology." Perron et al.'s (2020) SOGC Clinical Practice Guidelines are also influenced by these standards. These training guides are reflective of the CanMEDS best practices framework that "identifies and describes the abilities physicians require to effectively meet the health care needs of the people they serve" (Royal College of Physicians and Surgeons of Canada, n.d.b). This is expressed through seven key roles: "Medical Expert (the integrating role)," "Communicator," "Collaborator," "Leader," "Health Advocate," "Scholar," and "Professional" (Royal College of Physicians and Surgeons of Canada, n.d.b). Through this framing, it is unclear to what degree duties such as "Listener" or "Self-Reflective" are seen as necessary, if at all, especially considering that these qualities were never explicitly referenced based on my reading of the Competencies and Objectives of Training guides. There was reference to communicating effectively and appropriately with patients in a way that reduces stigma and considers cultural competency, but the emphasis seems to refer to the authority of the HCP as the expert within the doctor-patient relationship (Royal College of Physicians and Surgeons of Canada, 2016, 2019).

One Queen's University professor suggested that it is possible to effectively treat affected women with the generalized OB-GYN clinical skills that are taught, but this is not true as there needs to also be concern over the role of cultural competency and sensitivity within treating patients as Perron et al. (2020) and the GoC's National Guidelines assert. The email in question was relayed on behalf of an Associate Professor in the Department of Obstetrics and Gynaecology at Queen's University to the research facilitator who I was in contact with:

> I passed along your question to our faculty and received the feedback below:
> *It does not exist in the undergraduate or postgraduate medicine curriculum. Therefore, no explicit teaching. Different aspects of OBGYN care may not be specifically in a curriculum but may be taught informally in rounds/ etc and case-based teaching which would not appear in a formal curriculum. For instance, a researcher may look at the list of academic halfday subjects across the country and find that this does not exist – and publish a paper saying that OBGYNs are not trained in this important area. While in fact in cities where there is a large North African community there is a lot of case-based teaching and rounds such that residents are well-trained where they are seeing it. Also, a non-surgical researcher may not realize that learning to do other vulvar procedures allows you enough knowledge of anatomy to be able to manage conditions that you have not seen before.* (J. Pudwell, personal communication, 10 May 2021)

With a focus on informal teaching through medical rounds, there is greater chance of implicit bias being transferred from established professionals to students in training, as there are reduced opportunities for regulating the attitudes and assumptions that may be subtly or overtly expressed through language and framing of the practice of FGC and the lives of affected women. The medical rounds represent informal experiential methods of training while the syllabi are directly linked to the CanMEDS framework and the SOGC clinical practice guidelines, both of which are instances of the formal institution of medical education. More attention must be paid to the nuance of FGC-specific care, particularly given the fact that the GoC National Guidelines and SOGC clinical practice guidelines on FGC state multiple times that HCPs are not adequately trained – surgically or in bedside manner – for treating affected women and have especially high rates of unnecessary caesarean births and disrespectful treatment of patients and their families. This professor also

makes a large assumption and generalization about the identities and countries of origin of women who have experienced FGC and that the area of Kingston, Ontario does not have a need for such training. Further, the reference to knowledge about other vulvar procedures as being adequate directly opposes what the GoC and SOGC report about HCP knowledge of clinical practices for treating FGC. Finally, in the way the professor has written this response, there are subtly patronizing tones about the accuracy of non-surgical and social science-based research into medical care practices. This tone is a major part of the issue in how marginalized peoples seek out and access healthcare services and their potentially traumatic experiences because of HCPs viewing themselves as more informed than patients on their own bodies and experiences.

Further, the email responses suggested that care for women affected by FGC was not considered a standard concern for Women's Health/OB-GYN rotations at the level of undergraduate medical education but could be an issue of postgraduate medical education, Global Health courses at the undergraduate level, Clerkship, Residency, Integrative Small Group Learning discussions, or was a part of undergraduate curriculum but has since been removed. Across the medical schools' responses, there was no agreement on when this should be taught, if at all. And if it was taught, that it would only be relevant for geographic areas in Canada where there is a presumed higher community population of affected women. Also, my findings suggest that medical school curriculum does not prioritize specifically teaching this type of clinical care along with potentially little to no concern over cultural competency. Although medical education is standardized to the extent of the Royal College of Physicians and Surgeons of Canada and the various medical societies' clinical practice guidelines along with the GoC's National Guidelines, there is seemingly a wide discrepancy in if, when, and how information should be prioritized and taught. This finding suggests that there is no specific oversight on these curriculum standards and

structuring. Training practices and healthcare provision would improve with more consensus on when and how FGC related healthcare should be taught and by seeking out the opinions and experiences of affected women to create curriculum content and harm-reducing cultural competency training.

This framing within the documents requires updating and deeper concern over cultural competency and reducing harm associated with internalized biases and Eurocentrism that was present in the medical training documents that I was given access to. Some of the students themselves from Western University responded to the way that the FGC-related content was creating narratives about these patients. Furthermore, the alarming lack of any specific inclusion of treatment for women affected by FGC at the other six medical schools who responded to my request for research information suggests that the practice of FGC and affected women are unimportant, irrelevant, or even fall into the framing of a "barbaric" cultural practice that is illegal within Canadian. These tensions are reflective of some serious problems, especially with concern to value being removed from subaltern bodies who are identified as different and lesser, thus can be pushed through the cracks of society.

Another narrative that was reproduced within the health training documents, especially those from University of British Columbia, is the clustering of women and children under one grouping. As Ann McClintock (1995) reminds us, "the metaphoric depiction of social hierarchy as natural and familial…depended in this way on the prior naturalizing of the social subordination of women and children within the domestic sphere" (p. 358). This has also involved the framing of women as synonymous to their uteruses and as tools of the nation to reproduce the population. Reducing women to their reproductive and maternal categorization is a technique of suppression within patriarchy. When specifically examining obstetrics and gynaecological care, it is of course logical

that women's reproductive systems would be central to this field of study. However, as the University of British Columbia's training documents place obstetrics and gynaecology education under the "OB-GYN Rotation Clinical Objectives - Women and Children's Health Block" there is a subtext that women's health is moreover solely concerned with maternal and reproductive health. Including children's health training within this same curricular document works to infantilize women and reduce them to their reproductive potential, especially as this training is related to care ranging from babies into adolescents. This structuring is linked to the ever-present narratives around women who are affected by FGC as having very limited knowledge over their own bodies and claims to human rights, especially pertaining to their reproductive health. Women become equated to their children with the positioning of their role within society at the same value and simultaneous need for protection as children would, while ignoring their own autonomy and agency. Affected women's voices are smothered as they are assumed to be people who need protection from their cultures, extended family, and husbands. Even in the SOGC clinical guidelines there is reference to this narrative of HCPs feeling anger toward the people who practice FGC (Perron et al., 2020, p. 211). Assumptions are made about what a woman has experienced in life including her presumed lack of education and knowledge about her own body and how to care for herself. These assumptions are further complicated based on the power differentials of the identities of immigrant women with FGC versus those of doctors in Canada. This is because she comes from a culture that values FGC, so there is an assumption that she does not understand the needs and safety over her body or any potential daughters' bodies. This rhetoric is highly problematic as it views affected women as Other and devalues their own ability to express their needs and real-life experiences without fearing further stigmatization if they do not align with the assumptions that HCPs and the Canadian medical system has made about them.

When starting this research, I was expecting that there would be some inclusion of FGC-specific care in the syllabi or at least a response telling me where else I might be able to find this information, however, my results showed that this was perhaps an overly generous expectation toward how much information exists at the level I was looking. In the training documents I accessed, other than those from Western University and University of Toronto, the information pertained to general undergraduate medical education for obstetrics and gynecology rotations and women's and children health block rotations. Within these documents, it is clear, like the Queen's University professor reminds us, that doctors can perform surgeries on women affected by FGC using their knowledge and clinical skills gleaned in a generalized context. However, there are specific surgical concerns that FGC can cause that were not necessarily covered in the syllabi like deinfibulation. Not having specific and appropriate training on treating women affected by FGC results in HCPs resorting to unnecessary caesarean sections because of inadequate training and confidence, as well as, limited cultural competency training and methods to prevent stigmatizing patients.

Along with the recommendations of most of the literature in this area and Perron et al.'s (2020) SOGC Guideline No. 395-Female Genital Cutting, I conclude that there needs to be more research, training, and awareness of FGC itself with particular focus on exploring the missing nuance in outsider conceptions of the practice. This can be addressed through further research studies and prioritizing education that investigates the lived experiences and perspectives of affected women. While healthcare interventions are encouraged to focus on prevention of reinfibulation and eradication of FGC as a practice, there are still women currently in need of appropriate, effective, and competent care.

To be disregarded in healthcare practice represents the wider issue of marginalized peoples. The GoC's National Guidelines indicates that women affected by FGC and their associated care should be prioritized and that the current gaps in programming are problematic. The framing of FGC in the policy document is relatively open minded in that there is an admittance that HCPs have contributed to harm physically, mentally, and emotionally due to lack of adequate and appropriate training (Public Health Agency of Canada, December 2017b). Although HCPs themselves may not generally be outwardly racist or sexist toward patients, especially BIPOC women, the system is designed in a way that fails people whose bodies fall outside of the "norm" while also removing the blame from any one individual or organizing body. This is partially due to a narrow and limited understanding of what and who constitutes the norm based on colonial legacies of social hierarchy and value. It is challenging to identify these issues as they often are more subtle, but when it comes to instances of healthcare and potentially life and death situations, the discrepancies and cracks in the system become clearer. The policy has shifted to include women affected by FGC, so why has the programming aspect not caught up yet? Before the 2020 version, the SOGC published their last clinical practice guideline on FGC in 2013. That leaves nearly a decade for medical education to better incorporate some elements of this care, even if this is only in the realm of specific cultural competency training that focuses on not stigmatizing patients or making assumptions about their lives. This has evidently not been a priority and reflects the notion that women affected by FGC are cast aside as people whose lives and success within Canadian society do not matter.

While the other Canadian medical schools may not have provided me with any FGC-based training materials, Western University sent two particularly noteworthy documents. Their response was one of the most interesting as it indicated that certain medical students themselves may already

be knowledgeable and have concerns surrounding training and FGC. The professor I was in contact with sent: the "Integrative Small Group Learning & Application – Female Genital Cutting (From Course: Principles of Medicine 2)," which is part of the second-year medical school curriculum on gynaecology; along with a "Student Response Memo to the ISGL FGC Case" (see Appendices C & D). According to the professor from Western University who I was in contact with:

> [FGC] was presented as part of a small group discussion (groups of 8 students meet weekly with a non-expert facilitator to discuss many topics). However, we received some appropriate feedback from students that we needed to provide more background around the module to improve discussion, particularly when it came to certain cultures that may be negatively impacted by the way that FGC in the module was presented. I've attached the original module with comments included of how we may modify it for next year. We have not yet finalized how the module will look for next year. I've also included a student created memo that was sent retrospectively to address some of the issues. There is no other coverage of this topic in the curriculum. (C. Shoesmith, personal communication, 19 May 2021)

Firstly, although the non-expert facilitator oversees leading the Integrative Small Group Learning and Application (ISGL) course, this does not mean that the information provided should be assessed more leniently, as the knowledge itself should be at the expert level. Next, three students submitted a response to the ISGL's content with special concern over how FGC is framed and what narratives this spreads about the women who are affected plus the presented narrative on Muslim communities. I appreciate how direct this professor was with providing a detailed answer to my inquiry, and I informed him that I agree with the comments and recommendations made by the students. I hope that their concerns are taken seriously and that this becomes a wakeup call for universities to decentre the white gaze in medical systems.

In the ISGL document that I was sent, one student has commented throughout the document (see Appendix C). This student along with two others then wrote up a response memo critiquing the shortcomings of the training information (see Appendix D). The students' analysis identifies the harmful narratives that are presented about being oppressed by a conservative culture that exists

in opposition to western liberalism. The ISGL represents FGC and Muslim communities as both existing as singular patriarchal cultures that do not value women and girls. It represents a dichotomy between western liberal thought and Muslim conservatism, which is a point that the student also addresses in their comments on the ISGL document (see Appendix C). There are clear assumptions that FGC is rooted in traditional religious practices of the Other that are in opposition to western morals by situating the girl in the sole case study as being Muslim, from a conservative family, and as being less devoted to religion than her parents.

The ISGL has a heading declaring, "Focus on Cultural Competence and Bias Awareness" but then proceeds to state, "consider which cultures practice FGC and their reasons for it. What barriers might be faced by Sahra as she adapts to her Canadian life?" (see Appendix C). This presents affected women as being completely different than Canadians and perpetrates the west vs the Rest binary, which is also something that the student comments on. The student illuminates that "presenting FGC as not a norm in Western Society erases the history of the practice which did occur in North America and Europe until about the 1960s" and elaborates on this in the response memo (see Appendix C). Further, the ISGL lists six session objectives that "by the end of this session, students will be able to" do, of which numbers 2, 3, and 6 are the most remarkable:

> 2. List where and by whom FGC is performed.
> 3. Describe the different cultural and religious practices and the reasons cited for performing FGC for various countries . . .
> 6. Reflect on your own views and biases regarding FGC and outline strategies to deal with FGC sensitively and to provide support and information. (see Appendix C)

Numbers two and three are problematic as those questions both disregard the nuance that is involved with the practice of FGC and the variety of places and reasons that are involved. This also associates FGC with more generalized religious practices when that is not correct. Further, variation exists within countries themselves. Altogether, these questions present the factually

incorrect idea that FGC is a universal practice within different country contexts that can be easily itemized into a list. Lastly, number six is a questionable attempt considering that the ISGL language itself represents biases against marginalized peoples – women affected by FGC and Muslim communities – as being victims of culture, repressive values, and Othered. As I stated in the Introduction chapter of this thesis, FGC is not associated with one religion, nation, or ideology nor one universal community within these groupings. There needs to be more nuanced understandings of FGC as a social practice if the goal is to create effective health training.

This document demonstrates that women affected by FGC were not consulted, FGC experiences are seen as homogeneous, and Africa is considered as a monolith (see Appendix C). This could not be further from reality. The same type of narrative is exemplified in how Islam is presented as being in opposition to Canada in the case study, especially when they state, "her parents are Muslim, and Sahra considers them traditional and 'old-fashioned'…even they are not as strictly religious as they were in Africa. Sahra considers herself Canadian and does not associate too closely with Muslim culture" (see Appendix C). This training document is riddled with misconceptions about both FGC and Muslim communities and works to problematically homogenize these nuanced and diverse practices.

Finally, the case background relates to Sahra's experience having her first sexual encounter with her boyfriend, Kyle, and the post-coital bleeding that occurs. It gives information to situate her case and goes on to explain, "she thought Kyle might find it gross or that he might label her a freak. She also thought intercourse might be painful or that it wouldn't work the same way as usual" (see Appendix C). Classifying Sahra as a potential "freak" and that her anatomy would be outside of the "usual" furthers the white, colonial gaze that marks racialized bodies as necessarily lesser. There is an attempt to consider cultural competency and bias awareness since that is stated

as the main goal of this training; however, there is no real effort to accomplish either of those things when the knowledge represented in the training centres the white gaze and systematic Othering of "Third World women."

Furthermore, the second document was the student response memo to the ISGL FGC case that addresses and identifies the problematic undertones of the education training (see Appendix D). Their main points refer to the false narratives, misconceptions, and stereotypes presented in the ISGL of FGC being a practice of the Other and existing outside of the western world. They condemn the presentation of FGC as an African, Islamic, and Global South practice, which ignores the complexities of the specific ways and reasons it is practiced and valued. The students remind us that "relegating the practice to the Global South also fits into a colonial narrative of a civilized West needing to protect an uncivilized Global South from harm" (see Appendix D). The students continue, "Western countries have in the past performed a variety of surgeries similar to the practice. American obstetricians conducted "clitoridectomies" as late as the 1960s for causes such as hysteria (Werunga et al., 2016)" (see Appendix D). Conveniently, this history is erased when discussing FGC in Canada and is instead positioned as a cultural ritual of the Other.

Lastly, the students refer to the article by Werunga et al. (2016) "A Decolonizing Methodology for Health Research on Female Genital Cutting." The specific recommendations of Werunga et al. (2016) are:

- "Resist the universalizing tendencies of Western paradigms;
- Historicize and contextualize FGC;
- Challenge imperialist dualisms and binaries;
- Recognize intersectionality and hybridity; and
- Create a space for honoring subaltern voices and women's ability to embody agency" (p. 159).

These decolonizing strategies are necessary moving forward with healthcare that is inclusive and seeks to improve the lives of patients and comfort them.

Based on the lack of training at the other medical schools, I was surprised that Western University teaches medical students about FGC in a specific small group lesson devoted to this topic. While it is hopeful that this training exists in the first place, the narratives presented in the lesson reproduce potentially harmful and reductive assumptions about the lives of women and girls who have experienced FGC. They also make assumptions about so-called Muslim values and incorrectly associate FGC as a practice that is based on religious mandate and tie it to one specific religion. This stereotypes a highly nuanced cultural practice and reproduces the issue where practices of the Other are made into hegemonic and homogeneous cultures like the contested image of the "Third World woman." This reductive and violent stigmatization is rampant within outsiders' assumptions on cultures that practice FGC and Muslim communities. In the west, there is pervasive rhetoric that people who exist outside of the geographical and social borders are backwards and have questionable ethical and moral standards. These assumptions contrast Canada's multicultural mosaic of official nationalism and imagined community ideations, but Canada's imposition of a diverse national image contradicts the reality of a limited accepted identity.

Toward the Centering of Immigrant Women in Canadian Healthcare

The task of centering the voices of marginalized communities in healthcare is a lofty one. It involves critically examining the structures of society the uphold binaries and assert power through difference. There is a need for more information on FGC for HCPs to provide more appropriate and effective care that does not cause harm. There are major shortcomings in the limited literature surrounding healthcare and FGC (Abdulcadir et al., 2015; Calvert et al., 2020; Einstein, 2008; Joesph & Mullen, 2021; Little, 2015; Lussiez et al., 2020; Shahawy & Mour, 2021). A focus on decolonial transnational feminist practice where the needs, experiences, and bodies of immigrant

women are centred means looking to create solidarity networks that seek out, value, and uplift the voices of marginalized peoples. For decolonizing healthcare specifically, there needs to be an acknowledgement of the neocolonial systems that uphold binaries and look to community-based networks that empower marginalized peoples to dismantle the imaginary aspect of the community that allows issues to persist (Bradley, 2016; Darroch & Giles, 2014; Krusz et al., 2020; Reimer-Kirkham, 2003; Werunga et al., 2016). To do this also means removing politics from healthcare in the sense of decolonizing the knowledge of experts and determining who gets to become an expert (Bleakley et al., 2011; Camporesi et al., 2017; Lilja & Vinthagen, 2014). This shift relies on examining whose knowledge is considered valid and is used to regulate bodies hierarchically under coloniality (Bishop & Jotterand, 2006; Dhamoon, 2015; Moore, 2007; Nicholls, 2012; Yancy, 2008).

Through my research, I did find one specific curriculum module on FGC through the University of Toronto. Although this document is for training at the level of obstetrics and gynaecology residency programs, it is important to include this document in my analysis as it is a key example of what specified training for treating patients affected by FGC might look like at Canadian medical schools. As mentioned in Chapter 1, this document was produced as part of a collaboration from four medical schools across Canada as a response to a 2015 survey on Canadian obstetrics and gynaecology residency training on global women's health. This is one of six available modules from the University of Toronto Obstetrics and Gynaecology department's Global Health Education curriculum that aim to educate residents on health issues that are both of international and Canadian concern (Obstetrics and Gynaecology University of Toronto, n.d.c). "Case 2: Genital Cutting" is the document that I analyze (Obstetrics and Gynaecology University of Toronto, n.d.b). The document contains: a brief case study and five follow-up questions; two

journal articles published in 2014; the 2013 version of the Perron et al. SOGC clinical guideline on FGC; and a link to a FGC documentary via a private YouTube video. The two articles are: Berg et al. (2014) "Effects of Female Genital Cutting on Physical Health Outcomes: A Systematic Review and Meta-Analysis" and Vissandjée et al. (2014) "Female Genital Cutting (FGC) and the Ethics of Care: Community Engagement and Cultural Sensitivity at the Interface of Migration Experiences." Aside from the first page of the document providing a list of these resources, there is no context to this document or any follow-up questions or notes on the articles, SOGC clinical guideline, or documentary that are included.

Overall, the curriculum module attempts to show different facets of FGC related care and does include discussion of cultural competency and the HCP's potential bias (Obstetrics and Gynaecology University of Toronto, n.d.b). There is clear concern over the illegality of FGC in Canada and the human rights offences of FGC. The module also importantly questions how HCPs can reduce their own potential to induce trauma in patients. This approach is especially clear through the third follow-up question listed after the case study; "how should a health care provider reconcile his or her beliefs with the health care needs of the patient?" (Obstetrics and Gynaecology University of Toronto, n.d.b). This question opens space for discussing how to reduce harm by reducing cultural bias. There is an effort to recognize that FGC is illegal in Canada and considered harmful to young girls and women while also being aware that the healthcare system is flawed in how marginalized peoples currently receive care. Question five asks, "how can the healthcare system be improved to respect human rights and ensure health care?" (Obstetrics and Gynaecology University of Toronto, n.d.b). Open-minded critical thinking like this allows HCPs to identify areas that need to be improved in current practices and brings attention to how these flaws may impact current patients. Having this type of approach to healthcare and medical training is necessary for

progress as it challenges practices that may be outdated or harmful, especially toward marginalized patients and immigrant populations in Canada.

The information given in this document comes from the medical perspective of approaching FGC and related care. It is unclear if women affected by FGC themselves were included in the process of creating this document. The module represents FGC as a global health concern that has increased prevalence in Canada, but still seems to direct attention to prevention and intervention of the practice through the case study. The case study focuses on the health concern of a baby who underwent FGC and now has a resulting anatomical genital health concern that the parents want surgically removed (Obstetrics and Gynaecology University of Toronto, n.d.b). The mother of the baby is identified as a medical fellow from Oman who is returning home soon. The father was deeply upset that he was unaware when the ritual happened and did not give his consent to have their daughter undergo FGC. The case study explains that the Canadian HCP educates the parents on the illegality of the practice in Canada and that the parents agree that FGC should not continue (Obstetrics and Gynaecology University of Toronto, n.d.b). While the case study is quite short, it does show that FGC is a complex topic and there are different perspectives on the practice even amongst family members. It also suggests that a higher education level of the parents does not necessarily equate to critical opinions on FGC, especially as the mother is a medical fellow but seemingly supported the practice until speaking with the Canadian doctor who performs the surgery on her daughter. It is interesting that the case study written for this University of Toronto Global Women's Health curriculum module focuses on a baby instead of the health concerns of an adult woman who has been affected by FGC. It is also peculiar since the baby underwent FGC internationally, where maybe this case would be more applicable to adult health if the parents were asking a Canadian obstetrician to perform FGC on their newborn. Perhaps it would be more useful

if this case study was more detailed, or there was an additional case study that focused on health concerns of adolescents or adult women affected by FGC.

The University of Toronto curriculum module on FGC for Canadian obstetrics and gynaecology residents is a promising example of how Canadian medical curriculum can approach the topic of FGC. This module presents the necessary clinical and Canadian legal information through the Berg et al. (2014) article and the Perron et al. (2013) SOGC clinical guideline on FGC. It tries to convey nuance and address the complexities of FGC and related healthcare through the Vissandjée et al. (2014) article that focuses on cultural sensitivity. Finally, throughout the module and especially in the case study and its follow-up discussion questions it reflects on the role of HCPs in challenging medical care systems and disseminating essential knowledge to patients and their families. I cannot speak to the linked documentary on FGC as it is a private video that I could not access. However, the first page of the module document does state, "this 47-minute documentary explores the cultural, social, religious, and economical factors contributing to the practice of female genital cutting. The film was produced by SafeHands for Mothers and FIGO," so it seems that the documentary attempts to explain and better contextualize the role of FGC in practicing communities for OB-GYNs (Obstetrics and Gynaecology University of Toronto, n.d.b). This curriculum module is a solid start for Canadian medical training to better consider the healthcare needs of women affected by FGC living in Canada, but there is room for improvement in the stories that are told through selected case studies to further consider the complexity and often glazed over nuance of the practice. Furthermore, I recommend that this information be incorporated at the undergraduate medical education level and not left to global health focused obstetrics and gynaecology residency courses. If this were taught earlier in their training, medical students could learn the complexities of this topic and use the case of FGC as a prime example of

the need for cultural sensitivity and competency training that is meticulously integrated through all levels of their education starting at the undergraduate level.

Women who have experienced FGC and immigrate to Canada should not be forced to exist within the borders of belonging and unbelonging, especially in terms of medical care. Cultural sensitivity training is a decolonial task, but it is not going to dismantle the potential for creating trauma. For instance, whose vagina is considered as the context of neutral, referential, and the basis of learning and normalcy in western medical education? The answer cannot be any other than the white, western vagina that is the mother of the nation. As Mohanty (2003) writes, "if we begin our analysis from, and limit it to, the space of privileged communities, our visions of justice are more likely to be exclusionary because privilege nurtures blindness to those without the same privileges" (p. 231). The blindness to structural violence within these narratives is because those with power do not need to situate knowledge or experience beyond their own to belong. By looking outside our personal life experiences, privileged people especially can reflect on the impact of power structures and the limited and forced conception of the imagined community in which everyone is supposedly accounted for. In considering the realities of life for people with different identities, people in privileged positions of power can begin to delink from current systems of social organizing, accepted norms, and structural violence that enforce differentiation and exclusion of marginalized peoples.

Marginalized Bodies in the Imaginary of the Gendered Nation State

Knowledge production is tied up with nationalism. As Rivers-Moore (2016) clarifies, "transnational feminist scholarship has provided an important counterbalance to theories of globalization that have so frequently decentred the nation-sate and its gendered itineraries" (p. 154). By illuminating the gendered aspects of nationalism, it becomes clear how masculinist

histories of imperial expansion mesh with the feminine conception of cultural production to create a gendered nation of exclusion. Globalization is tied up with nationalism and thrives on the colonial legacies that created global systems of inequality. According to Fanon (2004), "nationalism is not a political doctrine, it is not a program. If we really want to safeguard our countries from regression, paralysis, or collapse, we must rapidly switch from a national consciousness to a social and political consciousness" (p. 142). This switch is synonymous with delinking and decentring. To mobilize decolonial work, society needs to become aware of how the implicit gendering and imaginary nature of the nation works to reduce marginalized peoples.

In *Imperial Leather,* McClintock (1995) writes, "women are typically constructed as the symbolic bearers of the nation, but are denied any direct relation to national agency" (p. 354). The construction of the nation is tied up with asserting gender difference along with racial hierarchy. The nation is both the motherland of cultural reproduction and the fatherland of the production of imperial violence. According to McClintock (1995):

> A feminist theory of nationalism might thus be strategically fourfold: (l) investigating the gendered formation of sanctioned male theories; (2) bringing into historical visibility women's active cultural and political participation in national formations; (3) bringing nationalist institutions into critical relation with other social structures and institutions; and (4) at the same time paying scrupulous attention to the structures of racial, ethnic and class power that continue to bedevil privileged forms of feminism. (p. 357)

My work directly aligns with point number 3 and 4 through my critical analysis of Canadian official nationalism and my discussion of transnational feminism. I am also interested in underlining McClintock's second point, "women's active cultural and political participation in national formations," as it helps to consider the added layer of race within concepts of contributions to the national project (p. 357). If marginalized bodies are not accounted for in policy and social programming, does this mean that their contributions to nation building are not desired? Racialized women's bodies have a long history of not being valued in the hegemony of western medical

services. This shortcoming creates literal life and death scenarios that could be avoided with a systemic shift to focus on inclusion, real respect for diversity, and acknowledgement of the problems that remain inherent in the system. Racialized women are not accounted for in the medical system, but then viewed as physically stronger and not requiring thorough health provision or pain management (Labuski, 2017). This framing of the value of marginalized bodies suggests that they are not considered necessary components of the national cultural mosaic.

Marginalized peoples exist in the margins or the outer contours of the imagined nation. Community assumes that everyone is accounted for and taken care of with a certain degree of equality, but in settler societies such as Canada, there must be clearly imposed indicators of difference to legitimize the assertion and retention of power. The hierarchy of difference is used as a justification for leaving certain bodies outside of the norm, separate from care, and glossed over by programming. Women affected by FGC are not accounted for in Canadian society, not because they are not members of society, but because the imagined community does not have a place for them. Their lives and their needs are not considered worthy or prevalent enough to bother learning about before an OB-GYN is tasked with treating a patient who has undergone FGC. Why should it be both the responsibility and fault of women affected by FGC to educate their own doctors on the practice, and moreover, on how to respect people who fall outside of a harmful and reductive ideation of the norm that is not necessarily reflective of the reality of a supposedly diverse society?

Educating HCPs on how to be medical *professionals* should not fall on a patient's shoulders but that seems to be the case for women affected by FGC even though some of the documents I have examined in this thesis strive to deal with cultural competency, respect, and de-stigmatization. This issue is exacerbated by the fact that marginalized women are not often given

the space to voice their own concerns or express their autonomy but are still expected to advocate for themselves. Women affected by FGC are often seen as needing protection from their own culture, but that protection does not involve a concern over autonomy or expressing agency. Improving Canadian healthcare would entail conducting a nation-wide study on the experiences of women with FGC in the Canadian healthcare system and then consulting community groups to create appropriate training that aims to reduce harm.

When Canadian health-based discourse suggests that affected women need protection but then places them outside of the bounds of health programming, it becomes clear that the concern for the healthcare of immigrant women is not being derived from their lived experiences. The disconnect between rhetoric of care and reality of those lived experiences shows a desire for control over certain bodies considered outside the scope of western ideals. The need for power and control does not come with a desire to accommodate marginalized peoples' welfare, otherwise they would be effectively represented in policy and programming. A system or process that accounts for an equitable relationship between those who have authority (such as medical experts) and those who occupy a marginalized status would require a dismantling of the legitimacy associated with social hierarchies of power. Unfortunately, the unwillingness of those with power to relinquish their control and create space for marginalized peoples means that issues like harmful gaps in healthcare will continue to persist if there are not significant calls to action and steps toward dismantling current structures of society.

Conclusion

Systemic issues persist within the nationalist framing of society as an imagined community because there are limited instances for critical reflection or a drive for change. In Canada, the GoC presents an official nationalism image of Canada as a cultural mosaic of diverse peoples. However, through this rhetoric, issues of disconnect between policy and practices are ignored. Marginalized peoples are left as an afterthought in institutionalized programming like healthcare. As an approach toward rectifying these systemic issues, I offer up the methodology of transnational feminist practice. These strategies illuminate the existence of harmful power structures that are predicated on the imposition of difference imposed and upheld by (neo)colonialism. The knowledge, attitudes, and skills taught and reinforced in Canadian healthcare represent the interests of Canadian nationalism. Through considering transnational feminism, the implicit violence that these structures and institutions uphold become more apparent. To dismantle these systems of inequality and asymmetrical power, we need to delink from current ideas of superiority of knowledge and cultural values that reinforce binaries of western epistemology versus the Other, which works to harm marginalized peoples and reduces them to an oppositional existence of unbelonging. Through taking steps to identify the existing issues, why and how they persist, and seeking out methodologies of change, Canada and Canadians can begin to decolonize themselves and the way they mobilize within society to work toward equality.

This research has left me with more questions than answers. Initially, I set out to answer the research questions of: to what extent is obstetrics and gynaecology training in Canada structured to provide adequate, effective, and culturally sensitive care for women who have undergone FGC; and, if and how does this training reflect the broader framing of FGC as a “barbaric” cultural practice? Exploring these questions ultimately led me to ask: how and why are women affected by

FGC still considered as a cast aside Other in medical education and not treated as a special case for both clinical and cultural competency whose treatment must be learned within this context?

I argue that undergraduate medical education training does not sufficiently, effectively, or appropriately teach prospective OB-GYNs how to treat women affected by FGC. Further, I explore how and why the overall lack of training has not been already disputed to the point where change has been made. This is particularly questionable as the knowledge, attitudes, and skills presented in Perron et al.'s (2020) SOGC guideline on FGC is relatively thorough and should be introduced at the undergraduate level of medical education. Based on the medical education guides I obtained from both the undergraduate and residency levels, these standards, especially the standard of well-informed cultural competency training, have clearly not been effectively implemented in programming. From my background knowledge of studying FGC academic discourse for four years, I argue that this standard of care needs improvement for better-informed cultural competency information and a focus on the language used around the practice to help de-stigmatize and reduce assumptions about patients' own morals and their broader lives. The SOGC states that they will be updating this document in the near future. It is hoped that they seek out the opinions of affected women themselves in Canadian care and rework the guidelines based on this evidence. The SOGC benchmark is limited in its current state. A major part of my analysis evaluates the regulation of healthcare through formal and informal institutions that are influenced by social norms and values of the communities that make up Canada. In feminist methodology, the community is supposed to be a site of allyship and inclusion. The imagined community wants to fulfill this idea, but it remains unattainable as a false narrative that does not reflect the realities for marginalized people who are Othered within Canadian society.

There are no existing "best" practices that "do no harm" if patients are reporting being mistreated when accessing obstetrics and gynaecological services. This thesis aims to illuminate the fact of the matter of missing education practices and explore some of the structural issues of systemic violence that have allowed for these concerns to go unaddressed, especially as the institutional healthcare policies suggest an acknowledgement that the training is lacking and should be improved. There is a disconnect between what changes have been proposed and the reality of lack of training that has been the centre of this analysis. Going forward, I suggest four key steps to improve the benchmark for Canadian healthcare training and provision for women affected by FGC. These action points create a new benchmark for a standard of care rooted in seeking out situated knowledge of marginalized peoples, particularly community members who are personally involved with FGC and would be the recipients of this specified care.

First, institute an oversight body for medical education curriculum standards. Based on my research findings, healthcare education is not necessarily standardized in practice. There needs to be a consensus on when and how FGC-related care should be taught. Second, initiate a regular comprehensive consultation with organizations of people who have been affected by FGC to gain their insight and perspectives. Community groups and individuals who are cultural "insiders" to FGC must be included in the creation of healthcare knowledge. Problematic assumptions and stigmatizing attitudes can be rectified by collaborating with the people directly affected by this area of healthcare. Third, improve strategies to reduce harm because it is inevitable, including accountability models for when that harm happens. Based on the structural violence that permeates the healthcare system along with the knowledge that humans are inherently flawed, we need to start from the premise that HCPs will likely cause harm on some level. Despite the Hippocratic Oath, doctors are still going to cause harm through the power imbalances between themselves and

patients and their families. So, the oversight body must create strategies to deal with this problem and continually advance knowledge, attitudes, and practices on FGC within healthcare by regularly updating benchmark standards. Fourth, impose anti-racist transnational feminist cultural sensitivity training. To do this, Werunga et al.'s (2016, p. 159) recommendations, as previously listed in Chapter 3, can prove to be a solid foundation. Generally, this type of training would seek out the missing nuance in current FGC discourse and look to decolonize health approaches by dismantling hierarchies and recognizing the agency and autonomy of women affected by FGC. By seeking out different critical perspectives to approach the topic of FGC in healthcare, we can shift the way FGC and affected women are treated to represent more nuanced understandings and respect of lived experiences.

Limitations and Future Steps

For the future, I suggest that policymakers and institutional medical societies and associations conduct a wide-scale investigation and intake of information from women affected by FGC nationally and transnationally to see what they report their own specific needs to be, then to shape the healthcare system to reflect this. Working toward decolonizing Canadian healthcare will entail delinking from current systems of power that reinforce inequality and seeking out community-level change of how citizens treat each other outside of the confines of an imagined community. This work needs to be informed by anti-racist transnational feminist practice to incorporate methodologies of care, solidarity, and allyship.

This research has been limited in breadth as it seeks to approach a vast area of discourse both with FGC and healthcare evaluation and is reduced to the scope of a Master's thesis. There are certain tensions tied up within the problems I have explored that I could not address. These areas provide branches for future research into FGC and healthcare. A major concern is how the illegality

of FGC in Canada affects health-seeking behaviours of affected women and their families along with more research into how this may shape biases and experiences of medical provision from HCPs. Additionally, this topic closely aligns with the grey area of the law, ethics, and human rights of the comparison of FGC to western-based genital alteration surgeries in terms of consent, gender norms, and mental health surrounding physical appearance that inform the decisions to undergo these medically unnecessary practices. Beyond the cosmetic genital surgeries that adult women undergo, there is a need to compare FGC as a practice to the western practice of "corrective surgeries" for intersex babies that parents choose on their behalf to align more closely with what are considered acceptable appearances of "unambiguous" genitalia in western contexts. There are many research avenues to be explored through these tensions. Finally, another concern I could not address effectively within the scope of this research is the purported myths and assumptions about universal sexual dysfunction within women who have undergone FGC, and how this reflects a western-framing of sexual, cultural, and medical epistemology (see Ahmadu and Dopico in Hernlund & Shell-Duncan, 2007). FGC discourse is vast and riddled with tensions of opinion, contradictory claims, and diversity of nuanced experiences. There are significant knowledge gaps in the international literature that can be investigated through future research. I have conducted this thesis work with the intention to help fill gaps in information and critique the basis of western epistemology on the important social issue of FGC in which its complexity and nuance often remains universalized, and thus, misunderstood.

Final Reflections

A lasting issue from this research is that changes in policy cannot dismantle the social norms surrounding FGC practices or regarding how racialized women are marginalized in Canada. Rather, improving quality of care is a way of enacting positive structural changes that have

beneficial implications of shifting deeply ingrained harmful social norms and systemic violence. Through my methodology of content analysis of training documents for prospective OB-GYNs, Canadian government policy reports, and relevant academic scholarship, my research concludes with the broader question of: who are Canadian OB-GYNs trained to be ultimately accountable to? Ahmadu (2007) reminds us that much of the scholarship published concerning FGC is not written by people who have undergone the practice. As such, "'insider' voices from initiated/'circumcised' African women scholars can go a long way toward providing fresh approaches to our understanding of these practices and their continued significance to most African women" (Ahmadu, 2007, p. 283). By listening to people who are directly affected by FGC, health discourse and practice has the potential to decolonize to become inclusive, effective, and ultimately, accountable to those accessing this care.

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Appendix A: Letter of Intent

Carleton UNIVERSITY
Canada's Capital University

Pauline Jewett Institute of Women's and Gender Studies
1401 Dunton Tower
1125 Colonel By Drive
Ottawa, ON K1S 5B6
Tel: (613) 520-6645
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Re: Do No Harm? Female Genital Cutting, Canadian Health Policy, and Obstetrics and Gynaecology Training

Funding Source: Social Sciences and Humanities Research Council Canada Graduate Scholarship–Master's Funding

April 28, 2021

To Whom It May Concern:

My name is Hailey Johnston, and I am a Master of Arts Candidate in the Pauline Jewett Institute of Women and Gender Studies at Carleton University under the direction of Dr. Valerie Percival. I am contacting you to request assistance in sourcing medical training syllabi for my Master's thesis research study titled: "Do No Harm? Female Genital Cutting, Canadian Health Policy, and Obstetrics and Gynaecology Training."

Female genital cutting (FGC) (also known as female genital mutilation and/or female circumcision) is a flashpoint feminist issue. It is a deeply stigmatised cultural practice that affects millions of women and girls internationally and is criminalised in Canada. Unfortunately, Western-based media and academic scholarship tend to focus on morality debates that outright condemn the practice and frame it as 'barbaric,' 'tribal,' and 'dangerous' without a greater concern for how this stance affects women who have already experienced FGC. Through this rhetoric, biases are presented that shape how women who have undergone FGC navigate Western society and the social challenges that ensue. Access to appropriate and adequate healthcare is just one of the potential challenges that arises.

Thus, my research will address how obstetrician-gynaecologists (OB-GYNs) receive appropriate and culturally sensitive training for treating female immigrants to Canada who have experienced FGC. This research aims to address what this level of nuanced feminist training means in terms of Canada's policies toward and treatment of immigrant women. This research will identify any gaps in programming and policy that are mentally, emotionally, and physically harmful for affected immigrant women, as inadequate healthcare can be a site of trauma especially within the context of FGC.

I will primarily investigate training for OB-GYNs. Thus, my research questions are: to what extent is obstetrics and gynaecology training in Canada structured to provide adequate, effective, and culturally sensitive care for women who have undergone FGC; and, if and how does this training reflect the broader framing of FGC as a 'barbaric' practice? By gathering syllabi from medical schools across Canada, I am creating a sample of research data that reflects the most up to date training that current and future OB-GYNs receive. This knowledge is the basis of my research study and aims to reflect the importance of this type of training in Canadian healthcare.

I am seeking your assistance to help build the foundation of my research sample. I am looking for course syllabi that are used in core and foundational training courses for students in your university's Obstetrics and Gynaecology department, especially those that might mention medical treatment that is outside of the Canadian norm i.e., for treating women affected by FGC. I would greatly appreciate if you could please email me (or direct me to where I can find) any relevant syllabi documents that you think match what I am looking for or may be of interest. Your help is invaluable, and I look forward to any assistance you may be able to provide.

I can be contacted by email at haileyjohnston@cmail.carleton.ca.

Thank you in advance for your interest and support in this project. I hope to hear back from you soon.

Sincerely,

Hailey Johnston, MA Candidate

Appendix B: Sample Documents

Document Type	Title	Author(s)	Inclusion of FGC (YES/NO)	Inclusion of Cultural Competency (YES/NO)
Curriculum	2021-2022 Phase 3 Core Rotation Outcomes: Women's Health Rotations	Northern Ontario School of Medicine	NO	NO
Curriculum	Curriculum Explorer Year 4 – Course Objectives	University of Saskatchewan	NO	NO
Curriculum	OB-GYN Rotation Clinical Objectives - Women and Children's Health Block Curricular Details – Sessions 2020-2021 Academic Year (From Faculty of Medicine Curriculum Management Unit)	University of British Columbia	NO	NO
Curriculum	Objectives for Obstetrics and Gynecology Year 3 Clerkship Formal Teachings	University of British Columbia	NO	NO
Curriculum Module	Integrative Small Group Learning & Application (ISGL) – Female Genital Cutting (Course: Principles of Medicine 2)	Western University	YES	YES
Curriculum Module	Case 2: Genital Cutting	University of Toronto	YES	YES
Memo	Student Memo	Western University Students	YES	YES
Policy	Family-Centred Maternity and Newborn Care: National Guidelines (Preface, Chapters 1, 2, 4, & 5)	Public Health Agency of Canada	YES	YES
Policy, Best Practices	CanMEDS: Better Standards, Better Physicians, Better Care	Royal College of Physicians and Surgeons of Canada	NO	YES
Policy, Best Practices	Guideline No. 395-Female Genital Cutting	Society of Obstetricians and Gynaecologists of Canada (Perron et al.)	YES	YES

Appendix C: Western University ISGL

Integrative Small Group Learning & Application

Female Genital Cutting

Week: 4

Course: Principles of Medicine 2

Lead Authors: Debbie Penava

Version: 1.1 (Edited on 10-Sep-2020)

INTRODUCTION

CONTEXT FOR THIS SESSION

The focus of ISGL this week is Female Genital Cutting (FGC). A teenager who underwent FGC as a young girl presents with post-coital bleeding. This case builds on your learning of reproductive anatomy and understanding of the sexual response.

Focus on Cultural Competence and Bias Awareness:

While FGC is not the norm in Western society, it is a part of many other cultures. As you go through this module, consider which cultures practice FGC and their reasons for it. What barriers might be faced by Sahra as she adapts to her Canadian life?

SESSION OBJECTIVES

By the end of this session, students will be able to:

1. Describe what FGC is and the anatomic differences in the various types of FGC.
2. List where and by whom FGC is performed.
3. Describe the different cultural and religious practices and the reasons cited for performing FGC for various countries.
4. Discuss the implications of FGC for sexual activity and obstetrical management.
5. Compare the CPSO/WHO policies statements on FGC.
6. Reflect on your own views and biases regarding FGC and outline strategies to deal with FGC sensitively and to provide support and information.

Summary of Comments on FGC-ISGL-comments (1).pdf

Page: 1

Number: 1 Author: haileyjohnston Subject: Sticky Note Date: 2021-10-29, 5:10:25 PM -04'00'
Western University

Number: 2 Author: [redacted] Subject: Highlight Date: 2020-09-21, 5:47:41 PM -04'00'

Number: 3 Author: [redacted] Subject: Sticky Note Date: 2020-09-21, 5:49:37 PM -04'00'
There is a presentation of a dichotomy here between a "Canadian" life vs. life in the Global South. Presenting FGC as not a norm in Western Society erases the history of the practice which did occur in North America and Europe until about the 1960s.

Number: 4 Author: [redacted] Subject: Sticky Note Date: 2020-09-21, 5:50:33 PM -04'00'
Based on the rest of the ISGL, students may have the misconception that FGC occurs in "Africa" and in Muslim communities. I think it's important to emphasize that FGC is nuanced and occurs in specific communities that belong to a variety of nations and religions.

Number: 5 Author: [redacted] Subject: Highlight Date: 2020-09-21, 5:49:53 PM -04'00'

PREPARATORY WORK

The following are some suggested resources that you can use to start your investigation of some of the issues, topics and subject matter you will encounter this week. You are expected to go beyond these beginning resources.

SUGGESTED READING:

FGC Overview

- The World Health Organization provides good background information including prevalence, areas of practice, and trends. The WHO uses the term Female Genital Mutilation (FGM) in its condemnation of the practice. The definition and classification of FGC can be found here:
- More information can be found HERE:

*****CPSO Policy on FGC*****

- We strongly suggest you read this to understand Canadian law around this practice

Defibulation (Reversal of FGC)

- Defibulation to Treat Female Genital Cutting: Effect on Symptoms and Sexual Function. Obstet Gynecol. 2006;108:55–60

Management of pregnancy in the presence of FGC

- WHO Prospective Study on FGM and Obstetric Ourcomes

Continuance of FGC

- Numbers of women circumcised in Africa

Mariya Taher. Sahiyo Stories: Shattering the Silence on Female Genital Mutilation and Cutting.

Male and Female perspectives:

- Berggren, V et al. Being Victims or Beneficiaries? Perspectives on Female Genital Cutting and Reinfibulation in Sudan. African Journal of Reproductive Health. 2006 Aug;2(10):24-36. http://www.bioline.org.br/request?rh06024

Support and Education

- The FGM Network

CASE BACKGROUND

Sahra is a 16 year old high school student who attends the clinic for a note, given her absence from school exams because of the flu. On questioning about how her life is going, she breaks down crying, telling you she needed the morning after pill last week.

Sahra and her boyfriend, Kyle, had been getting along quite well, but she was hesitant about engaging in sexual intercourse. She was uncomfortable when the issue was brought up and it seems that this was because she had surgery as a young girl in Sudan. Sahra was never particularly concerned with having had this done; it is part of her culture. There was, however, some embarrassment about being different than her peers when she began to think about having sex with Kyle. Even though she was reluctant to pursue sexual intercourse because of this, she became quite drunk at a party 2 weeks ago and decided to "go all the way."

The night of the party everything happened fairly quickly, and Kyle either did not notice or did not care about Sahra's physical difference, because it did not come up during or after intercourse. Sahra did not bring it up and they did not talk about it.

The next morning she had vaginal bleeding that was light and lasted about a day and a half. She asks if you are familiar with female circumcision procedures. She wonders whether the bleeding means she broke something and whether the bleeding will happen every time she engages in sexual intercourse.

Since they were both inebriated, neither Sahra nor her boyfriend took measures to protect themselves from sexually transmitted infections or unintended pregnancy. This is Sahra's first experience with sexual intercourse. Sahra is not sure about Kyle's sexual history.

Sahra has not yet told anyone else about having sex other than her best friend (who did not have any bleeding after her first or subsequent experiences with sexual intercourse). Sahra comes from a traditional background and her parents and culture do not approve of pre-marital sex. Pregnancy in an unmarried female would bring disgrace to the family within the community.

Menstrual History

- Sahra's last period was 3 weeks ago. Her periods are regular, about 5 weeks apart. The flow is never particularly heavy, lasting about 5 days. She started menstruating at age 12.

Medical History

- FGC at age 3. She does not remember anything about the procedure and is not aware of any complications previous to this bleeding. She accepts it as part of her culture. The only issue that has arisen is mild embarrassment about being different than her peers.

Family History

- Mother, 39, underwent FGC as a young girl in Sudan. No other remarkable history.
- Father, 41, has high cholesterol but has seen a doctor and modified his diet.
- Older brother and sister are healthy. Sister also underwent FGC.

Life Situation

- Sahra emigrated with her family to London, Ontario from Sudan when she was 4 years old. She has adapted quite well to the culture here and enjoys her Canadian life. She hardly remembers her life in Africa. Her parents are Muslim, and Sahra considers them traditional and "old-fashioned." She does not practice the faith the same way they do, and even they are not as strictly religious as they were in Africa. Sahra considers herself Canadian and does not associate too closely with Muslim culture but is still close to her parents and siblings.

Sahra was doing well in school, fitting in with her peers, and had a good relationship with her boyfriend. Kyle and she had become close over 6 months, but Sahra was reluctant to have sexual intercourse because of her operation. She thought Kyle might find it gross or that he might label her a freak. She also thought intercourse might be painful or that it wouldn't work the same way as usual.

Sahra does not smoke or use illicit drugs, and only drinks at parties.

Page: 4

Number: 1 Author: [redacted] Subject: Highlight Date: 2020-09-21, 5:51:05 PM -04'00'

Number: 2 Author: [redacted] Subject: Sticky Note Date: 2020-09-21, 5:51:47 PM -04'00'
This might contribute to the misconception that FGC is performed by traditional, conservative Muslim communities. Especially during a time when Islamophobia is rampant, it's important to be careful and aware of stereotyping. FGC is not associated with Islam, and there are people who belong to a variety of other regions that practice it as well.

Number: 3 Author: [redacted] Subject: Highlight Date: 2020-09-21, 5:52:11 PM -04'00'

Number: 4 Author: [redacted] Subject: Sticky Note Date: 2020-09-21, 5:52:34 PM -04'00'
This might also play into the "traditional, conservative" muslim family stereotype, vs. the Western, liberal free society. This might be harmful to read and hear for Muslim classmates and trainees.

During the visit, you spend a lot of time discussing female genital cutting with her and plan another visit to discuss it further. You provide her with information about Plan B and some counselling about STIs and ongoing contraceptive needs. She will return in 2 weeks to follow up on these issues.

SUGGESTED ACTIVITIES

Here are some examples of suggested activities

Activity Description	UME Objectives	Learning Modalities
Discuss current information campaigns utilized in the countries most affected by FGC customs. Why have attempts failed in many regions? Working as a group, propose effective educational strategies for rural areas, taking into consideration literacy rate, sources of funding, a strong sense of tradition, and lack of reporting.	• Communicator • Educator • Advocate • Collaborator/Resource • Evaluation	Resource Development Group Building Consensus Activity
Practices deeply rooted in culture can be a source of conflict, even amongst health professionals. How would you deal with a colleague whose culture promoted illegal practices? How would you deal with good friends whom you suspected to have had FGC performed on their daughter? Discuss approaches and legal obligations.	• Advocate • Person	Role Play Discussion
Role play: Counsel a teenaged patient with respect to normal versus altered abnormal physical issues and the impact on esteem and sexuality. Consider cerebral palsy, obesity, autism, etc. When would you think about referring to a specialist for psychological issues or for medical/surgical augmentation of the abnormality?	• Communicator • Educator • Steward	Role Play Discussion
CHOOSE YOUR OWN ADVENTURE: Decide on your own approach to this topic based on the potential study areas. Design a GROUP ACTIVITY that allows you to cover a learning objective in depth but also allows you to meet at least 2 UME objectives and experience at least 2 different learning modalities.		

Appendix D: Western University Student Memo

Authors: [Redacted], [Redacted], and [Redacted]

This memo is in response to the ISGL case centered around the topic of Female Genital Cutting.

Female Genital Cutting (FGC) is a nuanced and deeply complex practice. While it is currently illegal and recognized as harmful by the Canadian government, as future physicians it is important to understand the ways in which FGC has been framed and constructed by colonial and Western discourses. To truly deliver care with cultural humility, we must decolonize the methodology with which we think and discuss this practice.

FGC is largely discussed as a problem of the Global South, with many often purporting the misconception that the practice is founded in Islam and only occurs in Africa. Africa is not a monolith, but a continent consisting of diverse countries. While some countries such as Guinea and Somalia have a 90% prevalence of FGC, Cameroon and Ghana have a prevalence of 1-3% (Boyes, 2014). In addition, FGC is not an Islamic practice and no formal religion directly prescribes it. Rather, it is practiced in specific communities across the globe of a variety of religions.

Relegating the practice to the Global South also fits into a colonial narrative of a civilized West needing to protect an uncivilized Global South from harm. In fact, Western countries have in the past performed a variety of surgeries similar to the practice. American obstetricians conducted "clitoridectomies" as late as the 1960s for causes such as hysteria (Werunga et al., 2016). When discussing this practice with patients, it is also important to acknowledge that imposing a Western framework may cause harm in certain cases. FGC is a complex subject to navigate, and it is important to recognize the many ways in which individuals may center this practice with regards to their identity, health and community.

Werunga et al., recommends a 5 step process for decolonizing methodology surrounding FGC:
- Resist the universalizing tendencies of Western paradigms
- Historicize and contextualize FGC
- Challenge imperialist dualisms and binaries
- Recognize intersectionality and hybridity
- Create a space for honoring subaltern voices and women's ability to embody agency

The links below provide a more in-depth and thorough discussion of the aforementioned points. We hope that this memo allows medical students to think more critically about the ways in which power dynamics between the Global North and South can alter discourse on cultural practices. In addition, we hope that they will recognize the complexity and nuance that surrounds this practice and prevent employing harmful stereotypes. Applying an intersectional and antioppressive lens to care involves decolonizing the way we view and regard cultural practices that are often associated with the Global South. This in turn, will allow us to create safer spaces for our patients to discuss the ways in which cultural practices may impact their health.

Resources

1. http://www.inquiriesjournal.com/articles/1780/the-social-construction-of-female-genital-mutilation

2. http://natoassociation.ca/the-colonial-divide-the-perception-of-female-genitalcutting/
3. https://journals.lww.com/advancesinnursingscience/Abstract/2016/04000/A_Decolonizing_Methodology_for_Health_Research_on.6.aspx?fbclid=IwAR0tHnM9%20%20MoACZl7qr-KlG1hJL0kzYDIEPgmN6tmd0f_9QYSQcXN6W843aUc