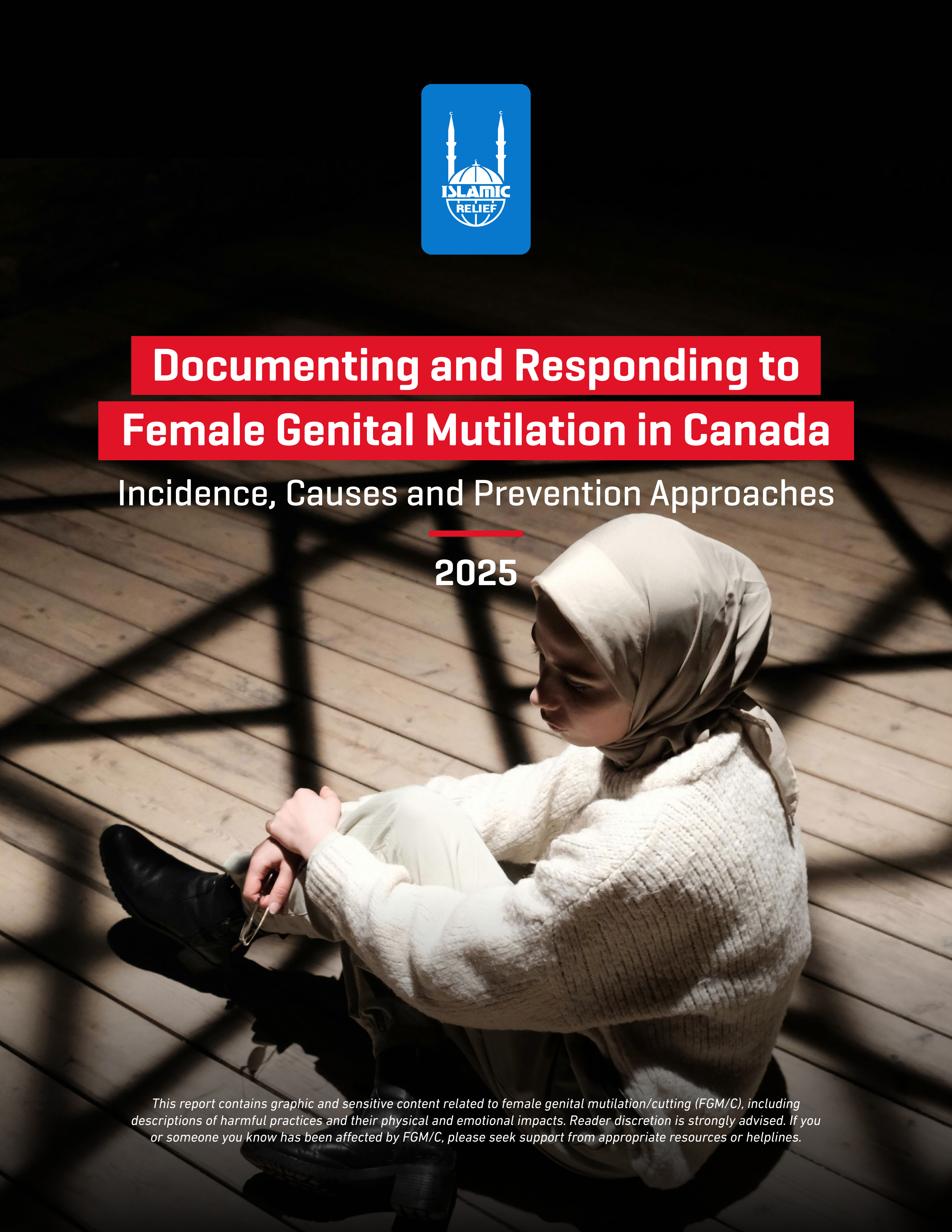
Documenting and Responding to Female Genital Mutilation in Canada

Incidence, Causes and Prevention Approaches

2025



This report contains graphic and sensitive content related to female genital mutilation/cutting (FGM/C), including descriptions of harmful practices and their physical and emotional impacts. Reader discretion is strongly advised. If you or someone you know has been affected by FGM/C, please seek support from appropriate resources or helplines.

FOREWORD

One of the most pressing issues affecting women and girls worldwide is female genital mutilation/cutting (FGM/C). Over 200 million women and girls across diverse faiths and cultures have endured the devastating consequences of this practice. FGM/C, also referred to as female genital cutting or female circumcision, includes procedures that intentionally alter or injure female genital organs for non-medical reasons. The physical, psychological, and social repercussions of this practice are severe, often resulting in lifelong health complications, reproductive issues, and even death.

My work to end FGM/C began in the United Kingdom, where the government made substantial investments in prevention initiatives, legislative reforms, and survivor support services. I later traveled to Indonesia to conduct an in-depth study on the cultural and societal factors that sustain this practice. Over the past decade, I have dedicated significant time to researching the religious and cultural influences that drive FGM/C and exploring how organizations and faith communities can effectively work to eradicate it.

When I arrived in Canada in 2016, I began hearing anecdotal evidence that FGM/C was occurring in the country. However, there was little to no data available to understand the extent of the practice, its underlying motivations, or the support services available for survivors. Instead of a comprehensive approach to prevention, existing efforts primarily relied on a “barbaric cultural practices” hotline, leading to the stigmatization of communities rather than any real progress towards prevention and changing attitudes and beliefs.

This study was initiated to fill that gap. We sought to understand the prevalence of FGM/C in Canada, the cultural and traditional drivers behind it, and whether survivors had sufficient access to healthcare and support services. Our research revealed that FGM/C is happening in Canada, both in private homes and through girls being taken abroad and then brought back. We found that the primary motivations stemmed from a range of factors, including, culture, tradition and religion. Alarmingly, we also discovered significant gaps in the healthcare system, where a lack of awareness among providers often resulted in inadequate and alienating care for survivors.

However, our study also uncovered a strong commitment from community groups, healthcare practitioners, faith leaders, survivors, and women’s organizations, to end FGM/C. There is a growing desire to raise awareness about its harmful consequences and to build community-led initiatives that drive change.

In my experience, the most effective campaigns against FGM/C and other forms of gender-based violence (GBV) are those that are community-led, culturally sensitive, and supported by governments through policies, research, and partnerships. This study, the first of its kind to provide insights into FGM/C in Canada, aims to do just that. The findings from our interviews, focus groups, survey, and discussions highlight the urgent need for action and offer a pathway toward meaningful, lasting change.

Reyhana Patel
Director of Communications
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- Islamic Relief Canada

Islamic Relief Canada’s Commitment to Eradicating FGM/C

Islamic Relief Canada is one of Canada’s largest Muslim non-governmental organizations (NGOs), aiming to alleviate global poverty and suffering – regardless of religion, race, ethnicity or gender. Much of our work over the last 10 years has focused upon eradicating the structural and systemic causes of poverty. Now, and in addition to our anti-poverty work, Islamic Relief Canada is increasing its concentration upon addressing some of the social and cultural drivers of poverty and suffering – especially where they are related to pseudo-religious justifications.

For millions of women and girls worldwide, FGM/C causes massive and gratuitous suffering that encompasses both severe physical and mental trauma that can last a lifetime. We believe that as a leading Muslim NGOs, we have a responsibility to play a vital role in combating this social oppression, especially where it is carried out in the name of religion. Islamic Relief Canada believes that the suffering caused by FGM/C has no religious or cultural justification – in any of its forms – and must be brought to an end.

Discussions around Islam and FGM/C

FGM/C pre-dates Islam and the Qur’an makes absolutely no mention of the practice. There are, however, verses which warn believers that the Devil inspires changing the form created by God: ***“I will mislead them, and I will create in them false desires; I will order them to slit the ears of cattle, and to deface the (fair) nature created by Allah”*** **(4:119)**. Some disregard the relevance of this verse by comparing FGM/C with male circumcision; but physicians generally consider male circumcision to be the removal of a simple skin appendage (adnexa cutis) comparable to hair, nails and with minimal physical repercussions.

In religious terms, male circumcision is an established practice (sunnah) from the time of Prophet Abraham, peace be upon him – whereas notions of female circumcision almost certainly originate from pharaonic traditions. Prophetic traditions (hadiths) attributed to Prophet Muhammad, peace be upon him, are a secondary authority in Islam and have various degrees of authenticity. Here, the most direct reference to FGM/C is a tradition in which the Prophet is said to have in passing witnessed a female circumcision taking place – and suggested that the cutting not be ‘excessive.’

As a result, some Muslims today hold the position that FGM/C of a ‘lighter’ type is a legitimate tradition (sunnah) and that, as such, it is a commendable – but not necessarily an obligatory – practice. Other major Islamic scholars (both past and present) argue, however, that the historical authenticity of this tradition is unsound and so it may not be rightly introduced into Islamic law and practice. They further argue that if a particular practice is fundamentally unlawful and forbidden in Islam – then a supposedly ‘lighter’ version of it is also prohibited. Just as alcohol does not become lawful if is diluted in strength, equally, the practice of FGM/C does not suddenly become lawful in any ‘FGM/C-lite’ version. Theologically, this would also include what some proponents call the ‘medicalization’ of the practice, where ‘FGM/C Type I and IV’ is applied under relatively hygienic medical conditions. The other major argument against FGM/C is that it damages or destroys a woman’s access to marital pleasure – which the vast majority of Islamic authorities accept as a God-given right.

ACKNOWLEDGEMENTS

We would like to acknowledge the valuable contributions of the community leaders, healthcare practitioners, and academics who were consulted during the development of our survey and research design. Additionally, we extend our sincere gratitude to all participants who generously and courageously shared their voices and lived experiences, making this research possible.

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Women and Gender Equality Canada
Femmes et Égalité des genres Canada

EXECUTIVE SUMMARY

Female genital mutilation/cutting (FGM/C), sometimes referred to as female genital cutting or female circumcision, is defined by the World Health Organisation (WHO) as "all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons."[i] It is a practice that continues to affect women and girls worldwide, resulting in severe physical, psychological, and reproductive health consequences. Recognized internationally as a form of gender-based violence (GBV) and a human rights violation[ii] estimates of prevalence vary significantly across countries and even within regions of individual countries.[iii]

The lack of data on FGM/C in Canada is troubling, as earlier regional studies found evidence to indicate that FGM/C is practiced in parts of Ontario and Quebec.[iv] Although FGM/C is illegal in Canada under the Canadian Criminal Code, which defines it as a form of aggravated assault and makes it a criminal offence to remove a person or child from the country for the purpose of FGM/C, the practice still occurs. In some cases, families send their daughters abroad to have it performed,[v] while in other cases, it is arranged and carried out within Canada.[vi]

This report explores the prevalence of FGM/C in Canada and examines the experiences of survivors, focusing on the physical and mental outcomes, their interactions with the Canadian healthcare system, and the support measures available. It investigates community knowledge and attitudes toward FGM/C, providing insights from survivors and broader community members. Furthermore, it addresses the healthcare perspective, assessing whether healthcare practitioners are equipped to support survivors of FGM/C, highlighting gaps in knowledge, training, and available resources. By documenting the extent to which FGM/C is prevalent in Canada and its impact, the report aims to recommend policy measures and interventions to improve healthcare access and support for survivors of FGM/C, while also contributing to preventing the continuation of this practice.

This study employed a mixed-methods approach, combining both qualitative and quantitative data collection. The qualitative phase involved individual interviews and focus groups with women who have undergone FGM/C, as well as healthcare practitioners, service providers, and community members. Due to our organization's expertise and community relationships with Muslim communities, we held a specific focus group with Muslim individuals and organizations in the Greater Toronto Area (GTA) to gather specific insights. The quantitative phase consisted of a national online survey targeting healthcare practitioners to assess their knowledge and the challenges they face when providing care and support to survivors of FGM/C. Ethics approval was obtained from Canada's Community Research Ethics Office (CREO).

One of the key findings of this study reveals FGM/C is occurring in Canada, although the true extent and frequency of the practice remain unclear. While some of the women we spoke to confirmed that they or others had undergone FGM/C in Canada, it is important to note that we cannot speak definitively to its scale. The practice appears to remain highly secretive, often taking place in private homes rather than medical or healthcare settings. The hidden nature of the practice, as well as the fear of legal consequences and social ostracism, make it challenging to accurately measure the prevalence of FGM/C in Canada.

Our findings suggest that, while not widespread, the practice does persist within some communities, and it remains a deeply embedded part of some cultural, social, and religious traditions. This report is a case study, and while it provides significant insights into the experiences of those directly impacted by FGM/C, the sample is not representative of all survivors of FGM/C, nor does it capture the full scope of the practice across the country. As such, the findings should be interpreted with caution, and further research is needed to explore the full extent of FGM/C in Canada. This includes more targeted data collection and outreach to communities that may be less visible or harder to reach.

Furthermore, the report reveals that the healthcare system faces a systemic challenge in adequately supporting survivors of FGM/C. Both healthcare practitioners and women with lived experience of FGM/C expressed a shared concern that the system is not equipped to meet their needs. There are critical gaps in healthcare practitioners' knowledge and training regarding FGM/C in Canada. Over half of the surveyed practitioners rated their understanding of FGM/C as "Fair" or "Poor," and nearly half were unfamiliar with the different types of FGM/C.

Despite many practitioners encountering FGM/C cases in their careers, many are not equipped to effectively address the needs of survivors. Additionally, the dissatisfaction with current training programs, with many considering them "Not at All Useful," highlights the need for more relevant and comprehensive educational initiatives. Healthcare practitioners identified critical gaps in their knowledge and training, particularly around best practices and protocols for treating and supporting women impacted by FGM/C. They emphasized that the healthcare system often falls short in addressing the full spectrum of needs, leaving women without the comprehensive care they require.

Healthcare practitioners also highlighted the urgent need for better access to mental health professionals, such as counsellors or trauma specialists, to whom they can refer patients. This highlights the necessity for a more holistic approach to care that goes beyond physical health to include integrated mental health support. There is a need for targeted policy interventions, including better training and education for healthcare practitioners, the development of culturally sensitive healthcare protocols, and the creation of support systems for survivors of FGM/C that include access to free mental health services.

Community-based interventions play a central role in addressing FGM/C. Community members and service providers recognized the critical role that community leaders, including elders and religious leaders, play in shaping attitudes toward the practice. Many participants called for greater involvement of these leaders in education and advocacy efforts aimed at preventing FGM/C and providing support for survivors. This community-based approach is essential to challenging the social, cultural, and religious norms that perpetuate the practice. Raising awareness about the health risks and legal consequences of FGM/C, while also addressing the root causes that sustain the practice, is important to reduce its occurrence and support survivors living in Canada.

In conclusion, this report calls for a multi-faceted approach to addressing FGM/C in Canada. This includes the creation and implementation of healthcare training and more culturally sensitive healthcare systems, improving public and professional awareness, and developing community-based support systems that can better meet the needs of survivors.

While the legal framework in Canada condemns FGM/C, legal action alone is not enough to eradicate this embedded practice. It requires a coordinated effort that involves healthcare practitioners, community and faith leaders, and policymakers working together to create a more supportive and inclusive environment for survivors.

By addressing both the medical and psychological needs of survivors, and challenging the norms that perpetuate FGM/C, we can work towards ending this harmful practice and providing better care and support for those impacted. A more compassionate, culturally sensitive approach is necessary, one that empowers communities to create meaningful change from within, rather than relying exclusively on punitive measures that may fail to address the root causes and dynamics of the issue.

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INTRODUCTION

Female genital mutilation/cutting (FGM/C) remains an embedded practice that intersects cultural, religious, and societal beliefs, with devastating health implications for women and girls. It continues to affect millions of women, particularly in Africa, Asia, and the Middle East[vii] and has been documented in up to 92 countries.[viii] It is estimated that over 230 million women and girls have undergone FGM/C worldwide, and over three million girls are at risk each year.[ix] FGM/C encompasses a range of practices (usually referred to as types I to IV) that involve varying degrees of cutting or removal of parts of the external genitalia, as well as the suturing of the labia (see figure 1).[x]

Recognized internationally as a form of gender-based violence (GBV) and a human rights violation,[xi] estimates of FGM/C prevalence vary significantly across countries and even within regions of individual countries.[xii] Rates of FGM/C in Europe, North America, Australia and New Zealand may be more common than is often assumed, due in part to the growing number of international migrants, refugees and asylum seekers from FGM/C practicing countries.[xiii] For instance, over 20,000 women and girls seek asylum from FGM/C practicing countries in the European Union every year.[xiv] Recent research estimates that 500,000 women and girls in Europe have undergone or are currently at risk of FGM/C,[xv] and more than half a million in the United States.[xvi]

FIGURE 1:

The Four Types of FGM/C

Type I: Clitoridectomy Partial or total removal of the clitoris.

Type II: Excision Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are 'the lips' that surround the vagina).

Type III: Infibulation Narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner or outer, labia, with or without removal of the clitoris.

Type IV: All other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

Source – World Health Organization

Unlike the United States and Europe, there are no reliable statistics available on the prevalence of FGM/C in Canada. This data gap was emphasized on the International Day for Zero Tolerance for FGM/C in 2021, when Prime Minister Trudeau called for better data to address FGM/C within the country.[xvii]

The lack of data on FGM/C in Canada is troubling, as earlier regional studies found evidence to indicate that FGM/C is practiced in parts of Ontario and Quebec.[xviii] In some cases, families accompany or send their daughters outside the country to have FGM/C performed,[xix] while in other cases the procedure is arranged and performed within Canada.[xx] Investigative journalism by prominent Canadian news outlets has highlighted significant gaps in support for individuals who have experienced FGM/C, revealing their struggles in accessing both physical and psychological healthcare, as well as social support resources related to FGM/C.[xxi]

The practice is often perpetuated by beliefs surrounding social conformity, marriageability, and female purity, yet it is linked to a range of severe physical, psychological, and reproductive health consequences.[xxii] These include chronic pain, infections, complications during childbirth, and long-term mental health issues.[xxiii]

Research indicates that the persistence of this practice is largely due to deeply entrenched customs, cultural beliefs, social pressures, and religious practices.[xxiv] In some societies, the desire for marriage plays a critical role in the continuation of FGM/C. Women often experience socioeconomic disadvantages and view marriage as a means to improve their future prospects.[xxv] This pressure to marry can make it difficult for women to avoid undergoing FGM/C, as some communities only accept women who have undergone the practice, further reinforcing its perpetuation. Even for women who may be economically independent, the pressure to conform to social norms within these structures often compels them to undergo the practice to align with societal expectations and secure their place within the community.[xxvi]

In Canada, the practice of FGM/C presents unique challenges. While the practice was criminalized in 1997 under the Canadian Criminal Code and is considered a form of aggravated assault,[xxvii] its criminalization does not always prevent it from happening, nor does it address the needs of women and girls who have already experienced it.[xxviii] Many immigrant women, particularly from communities where FGM/C is prevalent, face significant barriers to accessing appropriate healthcare and support. These women often navigate a healthcare system unfamiliar with their specific needs and encounter stigma related to their bodies, which are marked by the physical and psychological scars of FGM/C. This can result in a sense of exclusion from both the broader Canadian healthcare system and their cultural communities.[xxix] Furthermore, cultural and community pressures persist, as women and girls often face the challenge of reconciling their cultural traditions with the laws and values of Canadian society.[xxx]

Research on FGM/C presents significant challenges due to its complex cultural, social, and political implications. Historical parallels between the anti-circumcision campaigns in colonial Kenya and the current global moral panic surrounding FGM/C reveal a tendency to frame the practice through a lens of moral certainty, particularly from a 'Western' perspective.[xxxi] This often involves focusing on the bodies and reproductive systems of racialized girls and women in various regions, which can oversimplify cultural practices and perpetuate harmful stereotypes.

While some literature indicates that FGM/C was once practiced in Western countries[xxxii] it is now largely viewed as a harmful practice associated with non-Western cultures.[xxxiii] This shift reinforced the idea of 'Othering,' where FGM/C was portrayed as a cultural anomaly specific to 'backward' or 'barbaric' societies, thus distancing Western countries from the practice and positioning it as a problem to be eradicated in distant lands rather than within their own borders.

As Nahid Toubia[xxxiv] critiques, the West tends to portray FGM/C as a "dangerous epidemic" and uses it as evidence of the "barbarism" and "vulgarity" of certain cultural groups, including those in Africa, the Middle East, and Asia.[xxxv] This perspective frequently overlooks the diverse and nuanced cultural contexts in which FGM/C occurs, potentially alienating the communities affected by the practice. It is also essential to acknowledge that disapproval of FGM/C is not limited to the West; many critics from within FGM/C practicing communities, across various cultural and geographic contexts, also question the practice, demonstrating that the issue is not simply a matter of 'Western' versus 'non-Western' values.[xxxvi] Although not commonly found in the literature, there have been cases of FGM/C being practiced in Western countries.

As such, research on FGM/C must be approached with sensitivity to these complexities, ensuring that the voices and perspectives of those directly impacted are not overshadowed by moralistic narratives or external judgments.[xxxvii]

This report focuses on the prevalence of FGM/C in Canada and the experiences of survivors. It examines the ways in which women who have experienced FGM/C navigate life in Canada, the enduring physical and psychological impacts, and their interactions with the Canadian healthcare system and other measures of support available. Furthermore, it investigates community knowledge and attitudes toward FGM/C, providing insights from survivors and members of the broader community. A combination of individual interviews, focus groups, and community insights were used to conduct the analysis.

It also explores the healthcare perspective, assessing whether healthcare practitioners feel adequately prepared to support survivors of FGM/C. It highlights the experiences of healthcare practitioners and the challenges they face in providing care, identifying critical gaps in knowledge, training, protocols, and resources that limit their ability to effectively address the needs of patients. Additionally, the report evaluates the availability and adequacy of existing services for survivors. To gain a deeper understanding of healthcare practitioners' experiences, a nationwide survey was conducted to assess the challenges they face when providing care for survivors. Individual interviews with healthcare practitioners and service providers were also carried out to identify additional gaps in resources and support that may limit their capacity to offer comprehensive care.

Ultimately, this report seeks to collect data that will enhance our understanding of the prevalence of FGM/C in Canada. By documenting the extent of this practice, the report will inform culturally sensitive policy recommendations to improve healthcare access and support for girls and women affected by FGM/C. It will explore the role of community-based interventions, legal frameworks, and educational campaigns in preventing FGM/C and supporting survivors. By addressing these issues, this report will contribute to the development of evidence-based policies and programs that will strengthen the healthcare and social integration of women impacted by FGM/C in Canada, while also helping to end this harmful practice.

METHODOLOGY

This study adopted a mixed-methods approach to explore both the prevalence of FGM/C in Canada and the lived experiences of individuals affected by it. The qualitative phase seeks to understand the personal narratives of survivors and gather insights from healthcare practitioners, service providers, and community members. Data was collected through one-on-one interviews with survivors, healthcare practitioners, service providers and community members as well as focus groups with survivors and community stakeholders. This phase aimed to examine the prevalence and underlying causes of FGM/C, as well as the social, psychological, and healthcare challenges these women face, particularly in their interactions with healthcare systems. The quantitative phase involved a national survey of healthcare practitioners to assess their knowledge and the obstacles they encounter when providing care to survivors. Ethics approval (#201) for the study was obtained from Canada's Community Research Ethics Office (CREO).

PARTICIPANT SAMPLE AND RECRUITMENT

For this study, we used a combination of community-based recruitment, organizational referral recruitment, and snowball sampling to engage participants, leveraging personal networks and community connections. This method allowed us to access participants who may have been challenging to reach due to the topic's sensitive nature. To ensure a broad range of perspectives, we also reached out to various health organizations, non-profit organizations, ethnic community groups, refugee support centres, newcomer integration services, and women's advocacy organizations across Canada. We sent emails to these groups inviting them to participate in the study. We distributed a cross-sectional nationwide survey targeting healthcare professionals for the quantitative component. Invitations were sent via email and by mail to a large number of health organizations, clinics, and health-related non-profits across Canada with instructions on how to access and complete the online survey.

DATA COLLECTION PROCEDURES

Semi-structured interview guides were created for interviews with FGM/C survivors, community members, healthcare practitioners, and service providers. These interviews lasted between 15 and 30 minutes and were conducted virtually via an online video platform. Similarly, semi-structured guides were developed for focus groups, which lasted 60 minutes and were held in-person or virtually via an online video platform. Participants were advised not to disclose their real names to prevent any sensitive information from being recorded, and strict protocols were implemented to ensure their anonymity. Survivors of FGM/C were asked to keep their cameras off during the interviews. All interviews and focus groups were transcribed using pseudonyms to safeguard confidentiality. To further protect privacy, transcripts were anonymized, and any identifying information was deliberately omitted. The interviews and focus groups occurred between March and November 2024, with thematic analysis employed to explore and interpret participant responses. An online survey was available from October 2023 to October 2024. Descriptive statistical analysis of the closed-ended questions was performed using Survey Monkey software. Participants signed an informed consent form prior to taking part in the research, ensuring their voluntary participation and understanding of the study's procedures and objectives. All data was securely stored on an encrypted USB drive until March 2025, after which it was permanently destroyed.

LIMITATIONS OF DATA COLLECTION

The data collection process for this study faced several challenges that influenced the scope and diversity of the sample. One of the primary difficulties encountered was the low response rate from healthcare practitioners for the online survey. Participation was limited despite multiple attempts to engage healthcare practitioners, including sending invitations via email, mail, and through healthcare networks. This could be attributed to various factors, such as competing priorities within healthcare settings, time constraints, and a lack of awareness or familiarity with the topic of FGM/C. As a result, the survey responses do not fully capture the breadth of healthcare practitioners' experiences or attitudes towards providing care to survivors.

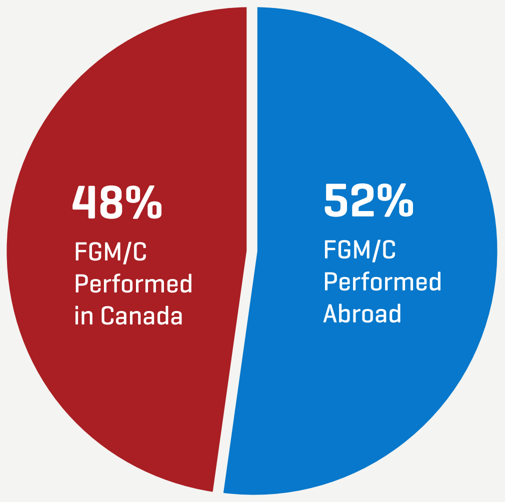
Additionally, recruiting survivors of FGM/C for interviews proved to be a significant challenge. Given the sensitive and often stigmatized nature of the topic, many potential participants were hesitant to share their experiences, further compounded by concerns over confidentiality, fear of judgment, or cultural sensitivities. The difficulty in recruiting participants also limited geographic diversity, as we were primarily able to connect with women through personal networks and community-based recruitment efforts, which were more concentrated in certain regions and communities. As a result, the sample's geographic and demographic diversity was restricted, affecting its overall representativeness. Due to these challenges, the sample does not represent all women and girls who have experienced FGM/C. The findings reflect the experiences of a small, specific group, and cannot be generalized to the broader population of those affected. These limitations should be considered when interpreting the results, as they pertain to a distinct subset of FGM/C survivors.

RESULTS

Individual Interviews with Survivors of FGM/C

Between March and November 2024, 33 interviews were conducted with FGM/C survivors, each lasting 15 to 30 minutes. Of these, 17 (52%) women reported that the practice was performed abroad before they immigrated to Canada, while the remaining 16 (48%) experienced it in Canada. Six participants (18%) were born in Canada, while the remaining 27 (81%) were born in countries such as Burkina Faso, Congo, Egypt, Ethiopia, Lesotho, Nigeria, Senegal, Somalia, South Africa, Uganda, and Zimbabwe. The diverse backgrounds of the participants reflect a wide range of experiences with the practice.

Location of FGM/C among Women Interviewed



The interviews revealed that FGM/C does occur in Canada to some extent. While many of the women interviewed had undergone FGM/C in Canada, they believe that it remains relatively uncommon within the country. However, they also noted that it is difficult to determine the true extent of FGM/C in Canada, as the practice remains highly secretive,

"It's probably happening more than we know. It's all happening behind closed doors. I know other girls who've gone through it here in Canada. We talk in secret. We have a WhatsApp group where we share our stories."

Another woman echoed similar sentiments stating,

"It's happening here, but it's very secret. People don't talk about it openly, so it's hard to know how common it really is."

These perspectives reflect that, despite its illegality, FGM/C is practiced within certain communities and kept hidden due to fear of stigma and legal consequences,

"I know one other girl that had it done in Canada. Not common. But even if it was, no one openly talks about it."

These views suggest a shared perception that FGM/C does take place in Canada in some capacity, yet they are grounded in personal experiences and community knowledge, highlighting the challenge in accurately assessing the practice's prevalence. For the women who had FGM/C done in Canada, they shared a sense of confusion and sadness, as they believed Canada would protect them from such practices. Moving to, or being born in Canada was seen as an escape from social norms and traditions associated with their countries of origin, however some women still found themselves subjected to FGM/C. One participant described,

"My mom's friend performed the procedure on me. It happened in her home. One day, my mom woke me up and told me that I was going to see someone. I was excited to go, but I didn't know that I was going to get it done. After, I asked my mom why I didn't see any other girls [in my community in Canada] who had been circumcised. She told me, 'This is something you have to do whether we are in our country or not. We must carry our culture with us wherever we are."

Many participants questioned the necessity of continuing the practice in Canada, where it held no cultural significance beyond family expectations. "If I had been back home, I could have understood, but here in Canada, it made no sense to me." When it did occur in Canada, it was often performed in private homes, rather than medical facilities, with those performing it typically being community members with no formal medical training. One participant recalled being visited by a woman described as an "expert" who performed the practice at her family home, with no medical oversight and inconsistent pain relief. Another woman shared,

"It happened in Canada. I didn't want to do it, but I had to, because in my culture, it's what makes you a woman. I remember feeling so confused, so scared. It was done in secret, at [my] home. My mom was there, and she kept telling me that it was important, that it was part of being a woman in our culture, that I would understand when I was older. I didn't understand why I had to go through this. It was so painful, and after it happened, I just felt so empty. I felt violated. It's illegal here, so I felt like it shouldn't have happened. But I didn't know what to do. The woman who did it wasn't even a medical professional, just someone my mom knew, and they said she had done it for many years. I was given some painkillers afterward, but that didn't take away the trauma. I haven't talked to anyone about it since, because it's not something people in my community talk about. It's a secret."

In one case, the practice was carried out by a family member who travelled to Canada specifically for this purpose. The grandmother, who had performed the practice many times before, came from her country of origin to Canada.

"Since people from our community are very few in Canada, my grandmother visited us. She did it at our home. And that was it. She purposely travelled to have me circumcised."

The decision to have the practice done in Canada was driven by the belief that it was an important part of the family's cultural heritage. The grandmother felt that it was necessary to maintain this tradition, especially in a foreign country where the community was small. She believed that by living in Canada, the woman might lack a connection to the community, which could lead to difficulties if anything were to happen in the future,

"I think the reason why she did it to me is because she felt that since I'm in Canada, I might not have a community [country of origin] to go back to in case of anything, so now that it's done, my community can take me back. That was the main thing."

The emotional and physical toll of FGM/C, heightened by isolation and secrecy, left lasting scars on many of the women interviewed. The pressure to conform to cultural expectations lead to strong sentiments of powerlessness, confusion, and betrayal. Others felt that their options were limited and that they simply had to adhere to generational traditions. ***"My mom said it was part of the culture. She said it was necessary, and I had no choice."*** The pervasive culture of silence surrounding FGM/C in Canada prevented many women from seeking protection. Despite being born in or relocating to a country where FGM/C is illegal and not widely practiced, these accounts show how deeply entrenched social norms can persist and adapt in new contexts, often to the detriment of those subjected to them.

While the legal system provides protection against FGM/C, it fails to account for the cultural pressures that sustain the practice within certain communities. Laws alone cannot undo the complexities of cultural identity and social obligation that bind individuals to these practices. In this context, the fear of legal consequences and societal judgment is not merely about compliance with the law, but also about maintaining belonging within a community that views such practices as integral to its cultural heritage. This emphasizes the need for a more nuanced approach that acknowledges the deep emotional and social stakes involved in practices like FGM/C and recognizes that legal enforcement alone cannot sever these ties.

FGM/C is commonly viewed as a rite of passage that marks the transition from childhood to womanhood, signifying purity, cleanliness, marriageability, and cultural identity. The justifications for FGM/C expressed in the interviews align with prevailing perspectives found in the broader academic literature. Several participants highlighted that the practice is crucial for preserving cultural traditions, particularly for families in the diaspora. As one participant explained, ***"I didn't want to do it. But I had to, because in my culture, it's what makes you a woman no matter where you are."*** This sentiment reflects the strong link between FGM/C and a sense of belonging to one's community and culture, with the practice often seen as essential for cultural identity. Here, culture can be defined as "the space of signifying practice, the semantic ground on which human beings seek to construct and represent themselves and others – and, hence, society and history."[xxxviii]

The interviews also revealed a divide in attitudes toward FGM/C. For some women, it is considered necessary for gaining respect and acceptance within the community. ***"From what my sisters and I were taught, if you don't do it, you'll be shunned."*** This illustrates how deeply embedded the practice is, with social exclusion serving as a powerful motivator. Many women agreed that FGM/C is not considered a personal decision, but a communal necessity, passed down through generations. Elders in the community were identified as having a strong role in perpetuating the practice, often framing it as a way to ensure that future generations remain connected to their heritage. This cultural expectation is reinforced by family pressure, particularly from parents and grandparents who are determined to pass down these traditions. For some, this dynamic caused strained relationships within families, as parents actively facilitated the practice. One participant recalled being woken by her mother and taken to a community elder's home without explanation, while another described how her father insisted on the practice despite her mother's objections. However, the women interviewed expressed a growing awareness of bodily autonomy, gender equality, and the violence inherent in the practice. One woman, who had previously supported FGM/C, shared her changed perspective after her daughter underwent it.

"Personally, I didn't want my daughter to go through it... but since I didn't want my daughter to be left out from their community... I just encouraged her to do it. But personally, after seeing what she went through, I just thought about it, and I'd encourage her not to do it to her daughters when she gets them."

Her experience with her daughter, and the pain she endured, led her to reconsider the practice, its significance, and pledge to support her daughter's decision in the future. A similar story was told by another woman whose daughter experienced FGM/C many years ago in her country of origin. She described her evolving understanding of it after witnessing the physical harm it caused,

"I feel like it's inhumane to make someone go through that kind of pain... but it was my fear of her being rejected by my community... Now, I really don't believe in it anymore. I think it's painful, and there's no real benefit to it."

This internal conflict reflects the challenge many face in reconciling cultural practices with the desire to protect their children from harm. Despite the cultural significance of FGM/C, witnessing the trauma it caused on their loved ones led women to ultimately rethink and reject the practice. Some participants discussed the difficulty of stopping the practice due to resistance within their communities,

"But in my community, it's something that's been practiced for generations, and if you choose not to do it, there will be resistance. People will reject you... In my community, this practice is normal. It's just part of life, like waking up and eating."

This highlights the immense pressure to conform to cultural expectations, even when women have developed personal objections to the practice.

Another key theme that emerged from the interviews was the significant role of pain and pain management, as well as the fear of stigma and judgment from healthcare practitioners. Many women shared stories of enduring extreme pain due to a lack of proper anesthesia or painkillers. In some cases, women were subjected to FGM/C without any pain management at all, leading to serious complications such as recurrent infections and infertility. One participant, who had been advised to clean her wounds with salt and water, shared the emotional and physical toll, saying,

"It was so traumatic. I begged not to do it, but they still made me. My mom and dad were there. I can't forget that pain. I will never forget it. It was done by someone who was referred to us by a community member, not a medical professional."

This highlights both the physical suffering and the absence of medical oversight. Another participant described the lengths her family went to keep the practice private, saying,

"We didn't want to create any publicity around it. So, you see, the moment you go to the pharmacist, and you ask for anesthesia, and they would ask, 'Are you getting a surgery?' So, it was done traditionally, with no medicine to avoid any questions."

Others reported ongoing health complications such as pain during menstruation and intercourse, a lack of sexual desire, and in extreme cases, death. Infertility and birth complications were recurring themes among the women interviewed, with several participants attributing their reproductive challenges because of FGM/C. One woman shared her personal story of being diagnosed with infertility,

"When I went to the hospital, I got the diagnosis of infertility. I believe it is the cutting that caused it, because it damaged some part of my genitalia. I had to go through IVF[xxxix] and it was a hard process. I'm still depressed from [FGM/C] as an adult."

This testimony highlights the long-term physical and emotional consequences of FGM/C, emphasizing the serious impact it has on women's reproductive health and well-being. Psychologically, participants cited struggling with shame, low self-esteem, depression, anxiety, and challenges with intimacy and trust. The trauma was elevated by the stigma surrounding FGM/C, making it difficult for participants to receive medical or psychological help. The healing process was often described as long and agonizing,

"The healing took so long. I couldn't go to the hospital and tell them that this is what happened, but I had complications like, I'll get infections on and off."

All the women interviewed mentioned physical pain in some capacity,

"It was very painful. You know the fact that there is no anesthesia. There is no numbing cream, you have to see the person doing it... someone is holding your hands to pin you down. Another one is holding your legs, it's so traumatizing."

For some, the practice has led to the most extreme consequences, including death. One participant recalled a tragic incident that occurred abroad involving a neighbour who died because of FGM/C, stating,

"One of my neighbours died because of it. The cut was very deep, and the bleeding wouldn't stop. She couldn't heal from it and bled until she died."

This incident highlights the severe and potentially fatal risks associated with FGM/C. Accessing healthcare posed significant barriers for many FGM/C survivors due to the fear of judgment and the stigma associated with the practice. Even in cases where women did not experience negative treatment from healthcare practitioners, the shame surrounding FGM/C often led them to avoid seeking medical care altogether. Many expressed anxiety and embarrassment when visiting healthcare sites.

"I went to a doctor for a check-up once, and I was so embarrassed, I couldn't even speak. I just wanted to run out of there."

This fear of judgment was so overwhelming for some women that they refrained from seeking care even when it was necessary. Negative experiences, such as a participant's encounter during a pap smear, where the doctor was visibly shocked and asked, "What happened to you?" further reinforced the reluctance to access healthcare. As she explained, ***"That experience made me not want to go back."*** For others, the emotional toll of FGM/C exacerbated the feelings of shame, fear, and low self-esteem in healthcare settings. One participant reflected,

"I feel like I've lost something. I don't feel like a complete woman anymore. I'm always scared of infections. Every time I go to the doctor, I feel like they're judging me."

The stigma of FGM/C created an additional layer of anxiety, making it difficult for women to access the care they needed, even when physical or emotional pain persisted. The fear of being stigmatized was often heightened by a general lack of understanding about FGM/C within the medical community, leaving women feeling isolated and unsupported."I didn't want to go to the hospital. I didn't want to talk to anybody. I was just scared."

However, participants who had positive experiences with informed, empathetic healthcare practitioners emphasized the importance of culturally sensitive care. A woman shared her positive experience saying,

"I finally found a doctor who understood FGM/C. She didn't judge me, and that made all the difference."

The need for healthcare practitioners to be knowledgeable in FGM/C and its emotional and physical consequences was a key takeaway. Additionally, participants stressed the need for healthcare practitioners who are not only knowledgeable about the medical and psychological consequences of FGM/C but also equipped with the cultural understanding necessary to navigate the sensitive social and emotional aspects of working with those impacted.

Participants called for the establishment of more community-based resources to support survivors of FGM/C, emphasizing the need for spaces that accommodate both their physical and emotional healing. Support groups, counselling, and group therapy were expressed as desirable options, providing a space where they could connect with others who share similar experiences, creating a sense of solidarity and reducing the isolation that many felt. These groups could serve as a platform for women and girls to share their stories, seek emotional support, and access important information about their rights and options. Safe spaces in the medical sphere were also highlighted as essential, offering a secure and non-judgmental environment where women and girls could get help without fear of stigmatization or discrimination. A safe space allows for open discussions about the physical and mental effects of FGM/C, and it can be a starting point for many to access the medical or therapeutic support they need.

In addition, the need for free, widely available therapy services was also emphasized, recognizing the profound and enduring mental trauma that FGM/C can cause. Many participants explained that the psychological scars often persist long after the physical wounds have healed. Therapy services, especially those tailored to the unique cultural and emotional needs of those affected by FGM/C, were seen as crucial for helping them manage anxiety, depression, and trauma. Access to free therapy ensures that financial barriers do not prevent women and girls from receiving the care they need.

Lastly, themes surrounding education and awareness as essential in the effort to eradicate FGM/C were common among the women interviewed. They highlighted the importance of engaging elders and community leaders, as they are respected figures, key influencers and decision-makers who have the ability to stop the practice.

Advocacy should focus on raising awareness of the severe health risks associated with FGM/C and challenging the cultural beliefs that support it. While some participants called for stronger legal enforcement and harsher penalties, others pointed out that criminalizing the practice alone does not lead to real change. Many of the women who have experienced FGM/C are reluctant to report family members to authorities, leaving them in a difficult position with limited support options. Legal measures, while necessary, must be complemented by efforts to provide culturally competent healthcare, engage with community leaders, and establish resources for emotional and physical support. Only through these efforts can we hope to protect the health and well-being of women and girls impacted by FGM/C.

Focus Groups with Survivors of FGM/C

Between May and August 2024, two focus groups were conducted, each lasting 60 minutes and consisting of six women, for a total of 12 participants. All participants were survivors of FGM/C and were based in Ontario. Prior to the focus groups, each woman had been individually interviewed and, following those interviews, expressed an interest in further sharing their experiences in a group setting. The discussions revealed common themes about the emotional, social, and medical difficulties faced by those affected by FGM/C, as well as the need for cultural sensitivity and improved services.

A significant barrier identified in the focus groups was the fear and shame associated with seeking medical care, mirroring findings from the individual interviews. Many participants reported a reluctance to disclose their experiences with FGM/C due to concerns about judgment from healthcare practitioners. The trauma associated with the practice made it difficult for the women to trust doctors and openly discuss their past experiences. However, some participants shared that finding healthcare practitioners who were knowledgeable and empathetic made a considerable difference in their care. There was also a clear need for more accessible and specialized support systems. The women emphasized that emotional care is crucial for healing, yet these services were often difficult to obtain due to the cost. They expressed a strong desire for specialized clinics focusing solely on FGM/C, where they could receive comprehensive physical and emotional care without fear of stigma. These clinics should be staffed with professionals who are trained in the unique needs of survivors of FGM/C.

The idea of establishing dedicated healthcare spaces, such as a specialized clinic or a designated wing/area within a hospital or clinic, was widely supported. The women believed that such spaces, where trained medical practitioners could offer non-judgmental care, would significantly improve their comfort and willingness to access help and healthcare. Additionally, there was a call for free or affordable therapy services to support their emotional healing, with several participants mentioning the positive impact of therapy on their recovery process thus far.

Healing was viewed as a long, complex process involving both physical recovery and emotional support. Many women found that being able to share experiences with others who had experienced similar trauma helped them process their emotions and feel less isolated. Similar to the individual interviews, group therapy, support groups, and community forums were identified as helpful resources, providing both a sense of belonging and the opportunity to share experiences. Some also found comfort in engaging with podcasts, books on the topic, or attending workshops that offered both emotional and educational support. Others spoke about the importance of exercise in allowing them to feel more confident and empowered.

The emotional and physical consequences of FGM/C had significant impacts on the women's relationships with family members, intimate partners, and the broader community. Many participants described strained relationships with family members, particularly mothers and grandmothers, who were either directly involved in or supportive of the practice. This experience often led to feelings of betrayal, as the women struggled to understand why their loved ones subjected them to such a painful procedure. These feelings of betrayal extended to intimate relationships, where women expressed concerns about intimacy, fear of judgment, and anxiety over how their partners might perceive them.

The physical pain associated with FGM/C further complicated these relationships, as many women experienced discomfort during sex and struggled to communicate their feelings to their partners. Some women mentioned that discussing their experiences with partners was difficult, especially when they feared being seen as "less" than other women due to the lasting effects of FGM/C. Additionally, the women described challenges in building friendships due to the stigma surrounding FGM/C. Given that the practice is relatively uncommon in Canada, they often felt the need to conceal their experiences, which made it difficult to form genuine, trusting relationships. This secrecy contributed to a sense of isolation, which was further exacerbated by the societal stigma attached to FGM/C. The women emphasized the importance of broader societal education to alleviate this isolation. If there were a greater understanding of FGM/C, both within affected communities and in the general Canadian public, the stigma and shame surrounding the practice could be mitigated, facilitating more open, supportive relationships and reducing the emotional burden carried by survivors.

In terms of raising awareness, participants expressed a desire for broader public education on the issue. Many felt that Canadians needed to understand the practice, its harmful effects, and the complexities surrounding it. However, they stressed the importance of approaching the topic with sensitivity and respect, particularly when framing the issue in discussions with the wider community. Participants also discussed the cultural dimensions of FGM/C, acknowledging that the practice is embedded in specific social norms and traditions. Religion was not mentioned during the focus groups, although the broader literature acknowledges its role in perpetuating the practice. Framing FGM/C as a form of GBV, rather than a cultural tradition, was recommended for shifting public perception and policy. The women believe that the distinction is crucial for breaking the cycle of silence and stigma surrounding the practice. Public education campaigns were identified as ways to help raise awareness about the harmful effects of FGM/C and to encourage greater empathy and understanding. The lack of understanding in society makes it harder for women to discuss their experiences openly, and it's clear that education, particularly around the psychological and social consequences, is key to breaking down these barriers.

While some women felt empowered to speak out about their experiences, others remained hesitant, still grappling with shame and the fear of being misunderstood. However, the opportunity to participate in the focus groups helped some women gain confidence, providing them with a platform to share their stories in a safe space. The focus group discussions were seen as a significant step in helping them find their voice, as they could connect with other FGM/C survivors.

The participants offered guidance to other survivors of FGM/C, advising them to pursue medical care and not to hide in shame. They emphasized the importance of self-acceptance and loving one's body despite the trauma that FGM/C may have caused. They encouraged others to take the healing process one day at a time and to seek support from those who have experienced similar struggles. Regarding future steps, the idea of creating refuge centres or shelters for those fleeing the practice was discussed as a potential solution. Although existing women's shelters across Canada offer essential services for those fleeing violence, the participants in the focus group did not view their experiences with FGM/C as qualifying for shelter or support, highlighting a significant gap in awareness. FGM/C survivors may not fully recognize their specific situation as a form of GBV per se. Reframing FGM/C as GBV has the potential to make services and shelters more accessible to survivors and those at risk. Such steps are essential for bridging the gap between the existing services and the specific needs of those impacted by FGM/C.

The role of community leaders in educating others and promoting a safe environment for those impacted by FGM/C was seen as central in moving towards long-term change. Also recommended was the creation of more accessible support networks, such as counselling services and survivor groups, as well as greater enforcement of laws against FGM/C.

Focus Groups and Individual Interviews with Muslim Communities, Service Providers, and the Broader Community

Between March and September 2024, a series of individual interviews were conducted with 28 participants, consisting of 23 community members and 5 service providers working with populations where FGM/C is prevalent. Additionally, two focus groups were facilitated, one of which was composed exclusively of 12 Muslim community members and another with five members of the broader community.

The insights derived from these discussions offer valuable perspectives on community members' perceptions, attitudes, and beliefs regarding FGM/C. The findings also address key themes, including awareness of FGM/C, its perceived relationship with Islam, cultural influences, health consequences, gaps in educational and healthcare responses, and the availability of support systems for survivors.

A key finding from these conversations was the strong consensus that FGM/C is not linked to Islam. When asked about the role of religion, the participants overwhelmingly rejected the notion that FGM/C is an Islamic practice. ***"From what I've learned, it's a myth that it's religion-based,"*** a sentiment reflected by others. Another participant commented, ***"I didn't even know people thought this was a religious practice until I searched it up,"*** highlighting the frequent misconception that FGM/C is an Islamic practice.

A strong majority of participants firmly believe that the practice is connected to traditions and customs, particularly in specific African communities, but not rooted in Islamic teachings. ***"People who are a little uneducated on religion may think this is an Islamic issue, but it's not."*** This misconception, often propagated by a lack of cultural understanding, has significant implications for how FGM/C is perceived within both Muslim and non-Muslim communities. By falsely framing FGM/C as an Islamic practice, harmful stereotypes about Muslim communities are perpetuated. Not only does this stigmatize individuals from these communities, but it also diverts attention from the factors that are the true drivers of the practice. It is essential to address this issue by separating the teachings of Islam from FGM/C. This, in turn, helps combat Islamophobia and reduces the pressure on Muslim communities to "prove" their innocence in response to false associations.

Faith and community leaders were identified as key figures in combating the misconception of FGM/C being linked to Islam. Several participants suggested that faith leaders could use their platforms, such as mosques, to address the practice and spread awareness. ***"Religious leaders could do more to speak on the matter."*** This was articulated by another participant, ***"Having education sessions about the harms and [explicitly stating that the practice is not rooted in or endorsed by Islam] would be a big starting point."*** These suggestions highlight the critical role that faith and community leaders can play in dispelling myths and educating their communities about the harmful nature of FGM/C.

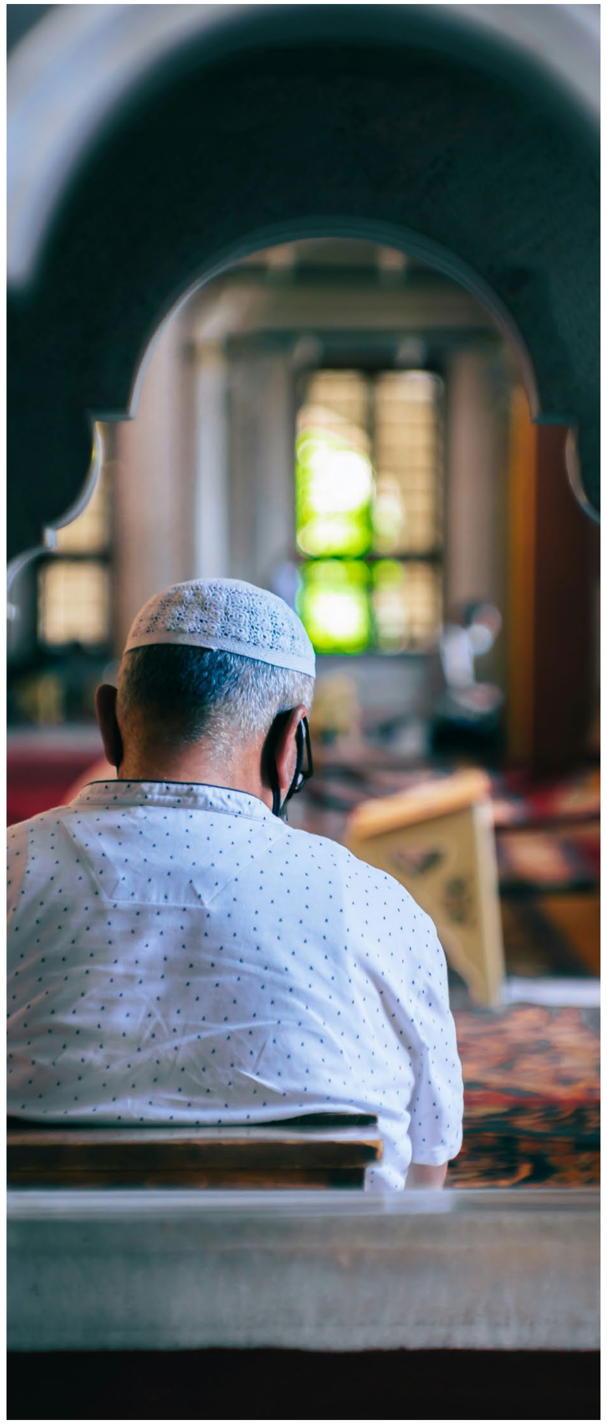
Despite this, some participants did acknowledge religious justifications for FGM/C, a finding consistent with the broader literature on the subject. For example, a participant shared that, ***"The majority of those who practice FGM/C in my community are Muslim… some believe that it's good for cleanliness, some believe it's good for fertility,"*** while another pointed out that, ***"People take it as a religious requirement and that's why it's done."*** However, many believe that FGM/C is primarily a cultural and social practice. Societal pressure to conform to cultural norms, even after migration, was cited as a significant barrier to challenging the practice,

"It's a big, huge societal norm throughout the entire African continent. It translates over here because I mean, just because you get on a plane and come to a whole new hemisphere, a whole new continent, doesn't mean you leave your cultural norms, even the toxic norms, behind. So, I find that's how it's played a role here in Canada".

Several participants pointed to the pressure to conform to traditional practices and the desire to maintain family honour and social respect. A participant explained, ***"If they don't do it, it might be causing disrespect to their family,"*** illustrating the social stigma associated with not adhering to these deeply embedded practices. Although participants were generally aware of FGM/C through personal experiences and educational channels, many expressed shock at the possibility of it occurring in Canada. ***"I didn't realize this was happening in Canada or could happen here at all."*** While the group generally felt that FGM/C does not occur in Canada, there was acknowledgment that some families may still send their daughters abroad (referred to as "vacation cutting") to undergo the practice.

The role of men in perpetuating FGM/C was also a theme discussed, with many emphasizing that the practice is associated with control over women's bodies. For instance, some believe FGM/C ensures women's sexual purity, thus restricting them to one partner, reflecting the broader patriarchal norms that drive the practice. This belief in maintaining control over women's sexuality is central to the perpetuation of FGM/C, illuminating the gendered power dynamics. Resistance from within affected communities, particularly from men, was another challenge discussed in focus groups and interviews. This resistance often stems from men feeling threatened by discussions of FGM/C. To address this, a more inclusive approach is needed, involving healthcare practitioners, community leaders, elders, and policymakers. Engaging men in the conversation is crucial, as they play a key role in the perpetuation of the practice.

Additionally, the participants unanimously acknowledged the severe physical and psychological harm caused by FGM/C, noting that FGM/C affects ***"how a woman experiences her period, how she navigates life, as well as pregnancy and childbirth."*** Others highlighted the long-term health complications, such as chronic pain, infections, and difficulties during childbirth. The psychological consequences were also recognized, with one participant stating that the ***"psychological implications are lifelong for the girl."***



A significant concern expressed by community members and service providers was the stigma surrounding FGM/C, which contributes to the isolation of survivors. Many expressed that women often feel shame, particularly when seeking medical care, due to a lack of cultural understanding among healthcare practitioners. For example, one participant explained that women "often choose midwives from their own community for childbirth instead of doctors or nurses, in order to keep their FGM/C status private." This lack of cultural competence in healthcare settings, combined with broader societal stigma, prevents many women from accessing medical and psychological support. As one service provider stated,

"There's a lack of understanding for what they've gone through, not just physically, but especially psychologically."

Service providers stressed that integrating FGM/C education into medical training could address these gaps, as ***"If doctors were familiar with it, and maybe it was an optional module that they could learn, things would get better."***

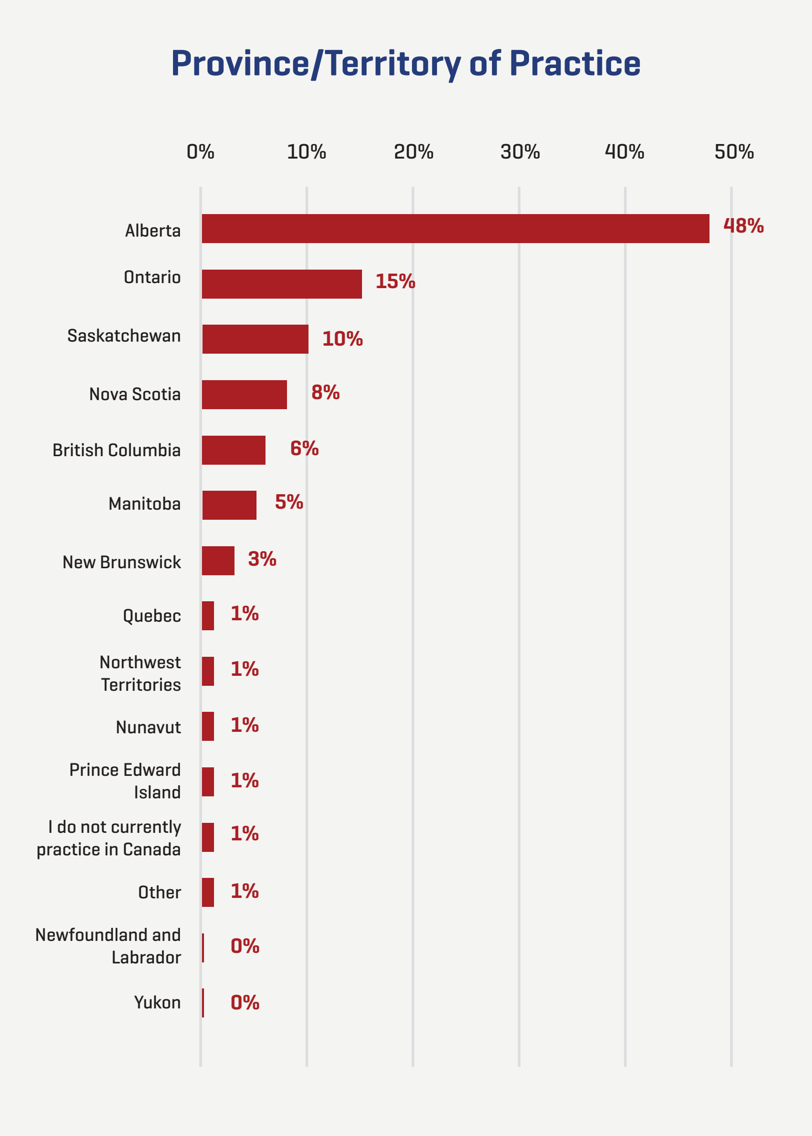
In terms of available resources, service providers highlighted the insufficiency of support systems for survivors of FGM/C. While some organizations, such as End FGM/C Network and Women's Health in Women's Hands, have made progress, the overall availability of resources and support services remains limited. Service providers emphasized that many of the services available are often not culturally sensitive enough to meet the needs of those impacted by FGM/C. Furthermore, women are often reluctant to seek help due to fear of judgment or misunderstanding, as one provider noted, ***"There's a clear lack of cultural sensitivity within healthcare. That piece is huge."***

The need for global action to combat FGM/C was also strongly conveyed.

Participants stressed the importance of international collaboration to recognize FGM/C as a violation of women's rights and to work toward its eradication. Engaging women who have experienced FGM/C in educational and prevention efforts was seen as vital, as they could help bridge cultural gaps and facilitate change. Involving community leaders and elders in these efforts is equally important for shifting cultural attitudes and reducing the practice's prevalence.

Online Survey

The survey was designed to assess healthcare practitioners' knowledge of FGM/C and to understand how frequently they encounter it in their practice. A total of 141 respondents participated, representing a range of healthcare roles across Canada. The survey was conducted between October 2023 and October 2024. The regional representation of healthcare practitioners in the survey shows considerable imbalances, with Alberta having the highest participation rate at 48%. Ontario represents 15% of the responses, while other provinces, including Saskatchewan (10%), Nova Scotia (8%), British Columbia (6%), Manitoba (5%), and New Brunswick (3%) account for the majority of the remaining respondents.

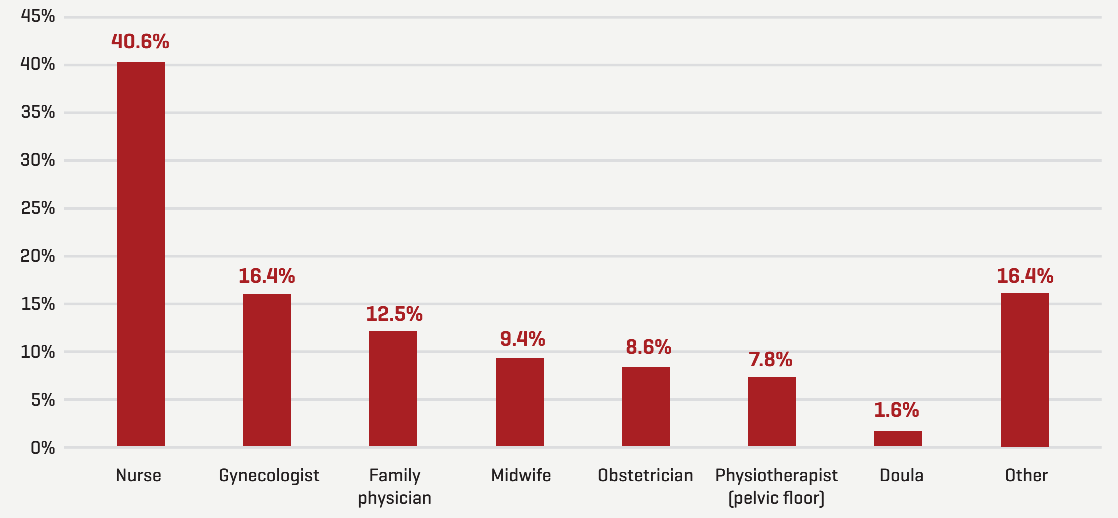


Province/Territory of Practice

Among those practicing in Ontario, 50% are located within the GTA, while the other 50% are situated outside of it. Despite being a culturally diverse region with a significant immigrant population, the GTA is underrepresented in this survey. This highlights a potential gap in engaging practitioners from this pivotal area. The predominance of urban practitioners (68%) reflects the concentration of healthcare infrastructure in cities. In contrast, the 20% representation from rural areas highlights the distinct challenges of addressing FGM/C in regions with limited resources and access to specialized care.

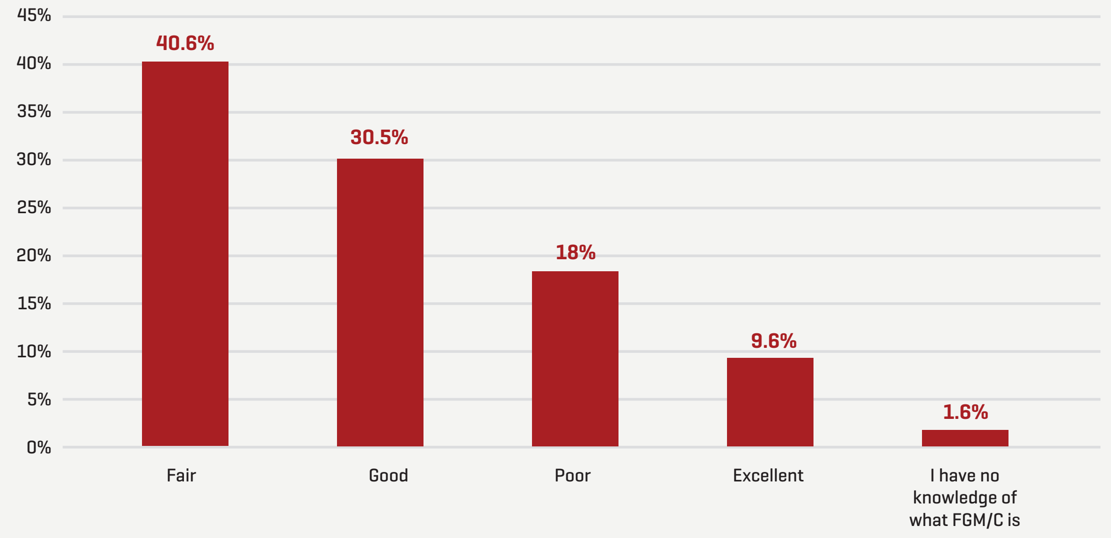
In terms of professional backgrounds, the respondents included nurses, gynecologists, family physicians, midwives, and obstetricians, among others.[xl] Most respondents had 0-5 years or 11-20 years of experience working in the healthcare sector. The remaining had 6-10 years, over 30 years or 21-30 years of experience.

Type of Healthcare Practitioner



The survey results reveal gaps in healthcare practitioners' understanding of FGM/C, especially in terms of self-assessed knowledge. Only 9% of participants rated their knowledge as "Excellent," while 30% rated it as "Good." A combined 57% assessed their knowledge as either "Fair" or "Poor," highlighting a significant lack of confidence in their expertise on the issue. In response to the question, "Did you know there are four different types of FGM/C?" the results revealed a nearly even split among participants. A slight majority, 52%, reported being aware of the four distinct types of FGM/C, while 48% indicated they were unfamiliar with this information. Despite FGM/C being widely recognized as a severe health issue, the results illustrate the inadequacy of FGM/C training. This suggests that many healthcare practitioners may lack detailed knowledge about FGM/C, which could impact diagnosis, treatment, and support efforts.

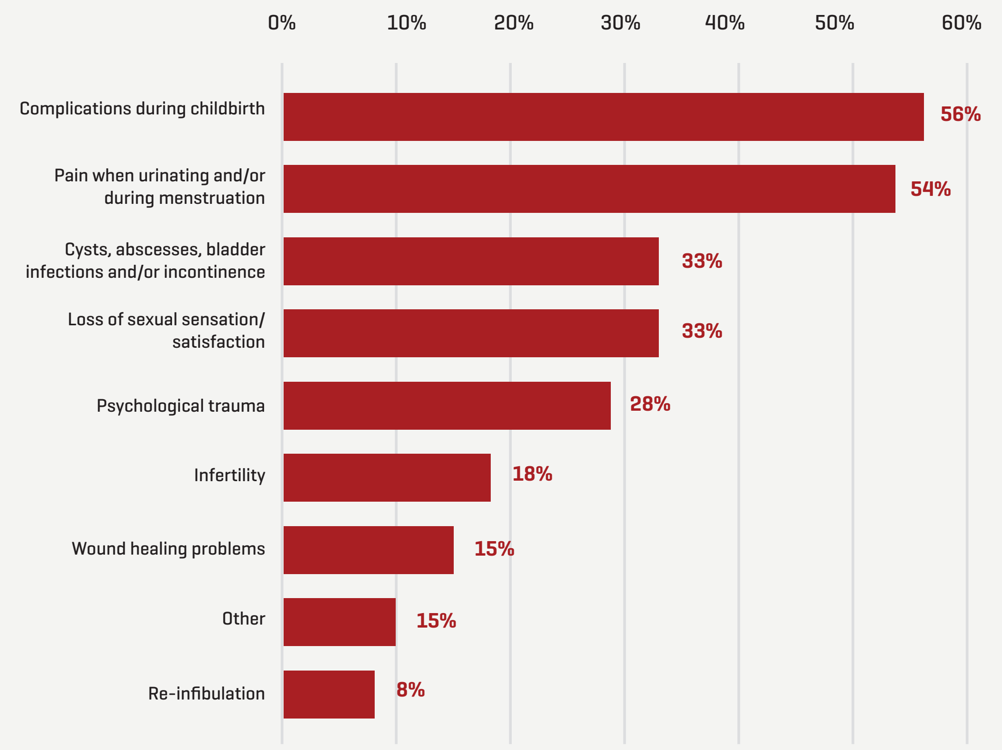
Self-Assessed Level of Knowledge on FGM/C



Confidence in identifying the four types of FGM/C varied significantly among participants. Respondents expressed the highest confidence in identifying Type III (Infibulation), with 51% indicating they were "Very Confident." In contrast, Type IV (All other harmful procedures) was associated with the lowest confidence, as 41% of participants reported being "Not at All Confident." This disparity reflects the differences in visibility and diagnostic challenges between the types, with Type III being more visually distinct and easier to recognize, while Type IV, being subtler, presents greater identification difficulties. These results highlight the importance of targeted training to enhance healthcare practitioners' ability to identify and address all forms of FGM/C accurately.

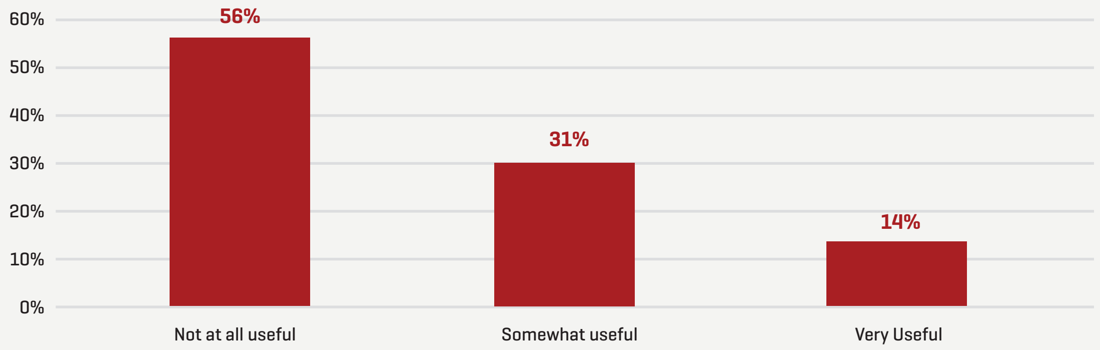
A majority of respondents (55%) reported encountering cases of FGM/C during their careers. Among those, 62% had observed Type III cases, and 56% Type II cases. Regarding providing adapted care, 62% of respondents reported having provided such care to between 1-10 patients, while 15% provided such care to 11-25 patients with FGM/C related needs during their careers. Healthcare practitioners most frequently encountered childbirth complications (56%) and pain during urination or menstruation (54%) in patients who have experienced FGM/C. Other common complications included cysts, abscesses, bladder infections, or incontinence (33%), loss of sexual sensation or satisfaction (33%), and psychological trauma (28%). A smaller proportion of respondents reported encountering infertility issues (18%).

FGM/C-Related Health Complications Treated in Patients



Furthermore, significant gaps were found in healthcare practitioners' formal training on FGM/C. The majority (60%) reported having no formal education on the topic, while smaller proportions indicated receiving training in specific areas such as health complications arising from FGM/C, the types of FGM/C, and providing care to survivors of FGM/C. Training on laws pertaining to FGM/C, culturally competent care, and FGM/C identification techniques was also limited. Among those who did receive training, the majority considered it "Not at All Useful," indicating dissatisfaction with its quality or relevance. These findings point to a lack of adequate preparation for healthcare practitioners to address FGM/C related health issues, emphasizing the need for more comprehensive, evidence-based, and culturally sensitive training programs. The dissatisfaction in training points to a significant need for more meaningful and relevant educational initiatives. Healthcare systems must prioritize addressing these knowledge gaps and enhancing the quality of training to ensure that practitioners are equipped to meet the complex needs of FGM/C survivors.

Usefulness of FGM/C Training in Formal Medical/Health Education



Healthcare practitioners cited various informal and experiential sources for learning about FGM/C; the most common being continuing education or professional development (41%) and learning through patient care or work experience (40%). Other sources included reading research publications (50%), formal medical or health education (32%), and peer learning (31%). This fragmented approach suggests that many healthcare practitioners rely on informal learning. This reliance may contribute to significant gaps in their knowledge, potentially limiting the quality of care and support provided to those affected by FGM/C.

In open-ended responses, participants voiced frustration with existing formal education programs, pointing to a lack of depth and practical relevance. Many expressed concerns about gaps in training, particularly regarding culturally competent care and practical methods for identifying FGM/C. They highlighted the urgent need for enhanced education on the types of FGM/C, its health impacts on women and girls, and how to provide culturally sensitive care. Several healthcare practitioners also expressed feeling underprepared or unaware of FGM/C, both through formal education and clinical experience.

Healthcare practitioners identified several barriers that survivors of FGM/C face in accessing care. A significant majority (92%) acknowledged that adult women encounter challenges in accessing sexual and reproductive healthcare, with an even higher percentage (94%) recognizing similar barriers for minors. A common concern was the fear of judgment or being labelled by healthcare practitioners, which often deters women and girls from seeking care. Many emphasized the need for cultural sensitivity and empathy to avoid further trauma. In open-ended responses, several practitioners stated that women may hesitate to disclose their experiences due to these fears or cultural pressures.

Both adult women and minors face barriers to care, including stigma, prejudice, and cultural misunderstandings. Minors, in particular, encounter additional challenges such as parental control and limited awareness of their health rights. Many practitioners expressed frustration over the lack of clear protocols for managing patients who are survivors of FGM/C, particularly during childbirth. Several respondents called for more structured approaches, such as early identification and respectful communication regarding care options, including de-infibulation. There was also a strong emphasis on increasing public and professional awareness, with a focus on advocacy within high-risk communities to prevent FGM/C and ensure proper healthcare for those impacted. This includes educating healthcare practitioners on the legal aspects of FGM/C, such as the reporting of suspected cases, and addressing the lack of clear, standardized protocols for managing survivors of FGM/C. Given the significant gaps in knowledge, training, and resources identified in the survey, there is an urgent need for reforms in healthcare education and clinical practice to improve the care and reduce the barriers women and girls with FGM/C face in accessing care.

Individual Interviews with Healthcare Practitioners

Between August and October 2024, individual interviews were conducted with healthcare practitioners in Canada who provide care for survivors of FGM/C, aiming to gain a deeper understanding of their experiences and perspectives. Eight female practitioners participated, representing diverse professional backgrounds, including family medicine, obstetrics, urology, and reproductive health. These participants were based in Alberta and Ontario, with some working in refugee clinics and others in general healthcare settings.

The interviews provided a diverse range of viewpoints due to the participants' varied experience levels and regional practices. This diversity allowed for a comprehensive understanding of the challenges and realities healthcare practitioners face when addressing FGM/C in clinical settings. Through these discussions, valuable information emerged regarding the prevalence of FGM/C, related complications, and the barriers healthcare practitioners encounter when offering care to survivors.

Results revealed that FGM/C is frequently encountered in clinics that serve refugee populations, particularly those from East African communities. ***"We encounter it fairly frequently, especially in refugee clinics,"*** stated one participant, adding that over 90% of cases were discovered incidentally during routine exams. Despite the frequent identification of FGM/C, patients often do not disclose it, as many view it as a normal part of their cultural identity. ***"The cultural normalization of FGM/C means many women don't associate it with any health complications. For many, it's just part of their identity, and they don't think it's an issue."*** This cultural normalization complicates healthcare practitioners' ability to address the potential health risks of FGM/C. Many patients do not associate FGM/C with health problems unless they experience complications such as difficulty during childbirth or recurrent infections. Practitioners highlighted several common health complications linked to FGM/C, including chronic pelvic pain, painful intercourse, infertility, and recurrent urinary tract infections. In obstetric care, FGM/C can exacerbate childbirth difficulties, particularly in cases of infibulation, where vaginal scarring restricts the opening. A practitioner recalled a delivery involving a woman with type III FGM/C, where ***"the opening was too restrictive for a safe delivery, so we had to perform an episiotomy at the same site. Thankfully, both the mother and the baby were fine, but it was a clear reminder of the complications FGM/C can cause during labour."***

One significant issue identified across the interviews was the lack of formal training and clear clinical guidelines for managing FGM/C cases. Many healthcare practitioners expressed concerns about the limited education on FGM/C during their medical training. "There really isn't much training on FGM/C in medical school or residency. I've had to learn most of what I know on the job." This gap in training leaves many practitioners feeling unprepared to address FGM/C cases effectively,

"There's not enough exposure in medical and nursing schools to FGM/C, and that lack of training leaves healthcare workers unsure of how to address the issue when they encounter it."

Alongside the knowledge gap, healthcare practitioners emphasized the lack of interdisciplinary support for patients affected by FGM/C. Several participants expressed the need for psychological and social support, particularly counselling services, to address the emotional and mental health challenges faced by these patients. As observed by a practitioner, ***"Many of my patients with FGM/C also need emotional support, and it's challenging because we don't always have those resources readily available in the clinic."*** These comments point to a broader gap in the healthcare system, where the focus remains primarily on physical health, often overlooking the emotional and psychological dimensions of care.

The interviews also illuminate the importance of cultural competence and sensitivity when addressing FGM/C with patients. Practitioners highlighted the need for a trauma-informed approach and a non-judgmental environment to develop trust and ensure open communication. ***"We need to approach these conversations with a trauma-informed perspective. We have to respect cultural differences while also addressing potential health risks."*** Most participants agreed that it is essential to engage in a respectful and curious conversation, often with the assistance of interpreters, to create a safe space for dialogue.

"I always try to have a curious conversation. I noticed this, have you experienced any issues with it? It's about creating a space for open communication."

Furthermore, the lack of clear, practical clinical guidelines for managing FGM/C cases was also emphasized throughout the interviews. Although organizations like the Society of Obstetricians and Gynaecologists of Canada (SOGC) have issued guidelines, many practitioners felt these were insufficiently detailed for everyday use in clinical practice,

"While the guidelines are helpful, there's still a lack of clarity in terms of what should be done in practice. It's not enough to just have guidelines; we need clear protocols and more practical resources for healthcare providers."

This gap highlights the need for actionable protocols that healthcare practitioners can easily integrate into their daily practices.

Additionally, the interviews revealed a call for enhanced education and training on FGM/C, particularly within medical and nursing schools. Healthcare practitioners emphasized the importance of specialized workshops and national training programs to address the knowledge gap, ***"There should be more specialized workshops or national training programs to bridge this knowledge gap."*** There was also a strong consensus on the need for a more holistic, interdisciplinary approach to FGM/C management, including the establishment of specialized teams or clinics offering more targeted care.

The findings from these interviews demonstrate significant gaps in healthcare practitioners' training, resources, and interdisciplinary support in managing FGM/C cases in Canada. Addressing these gaps through improved education, the development of clear and practical clinical guidelines, and the creation of comprehensive, trauma-informed care systems would contribute to better healthcare experiences for women and girls affected by FGM/C. The need for systemic changes to improve not only clinical care but also the emotional, psychological, and cultural support offered to patients is paramount,

"We need to ensure that healthcare providers are equipped with the knowledge and resources they need to provide the best care possible for these women."

POLICY RECOMMENDATIONS

The following policy recommendations are designed to address the key issues identified in this study, offering a more inclusive and effective approach to supporting women and girls impacted by FGM/C in Canada.

Governments and Policy Makers

1 Funding for Public Awareness Campaigns on FGM/C

There is an urgent need to increase visibility and understanding of FGM/C in Canada, as well as address gaps in funding. To ensure that efforts are culturally sensitive and effective, the Government should create a pool of funding for community-driven public awareness campaigns on FGM/C. These campaigns should be led by the communities most affected, to avoid further stigmatization and to ensure that the messaging is respectful, relevant, and supportive of survivors. Empowering these communities to take the lead will create trust, improve engagement, and promote a more nuanced understanding of FGM/C, ultimately leading to better prevention and support strategies.

2 Addressing FGM/C with Compassionate and Contextual Legal Measures

While some participants expressed support for stricter enforcement of FGM/C laws and the imposition of harsher legal penalties, many emphasized the complexities surrounding the issue. The fear of seeing family members face legal repercussions often leads to silence and inaction, perpetuating the practice. Given these challenges, the policy recommendations we are advancing, focused on education, community engagement, and comprehensive support systems, may prove more effective in addressing the root causes of FGM/C. A more compassionate, culturally sensitive approach is necessary, one that empowers communities to create meaningful change from within, rather than relying exclusively on punitive measures that may fail to address the underlying root causes and dynamics of the issue.

3 Providing financial and technical support for the expansion of Alternative Rites of Passage (ARP) Programs in countries where FGM/C is practiced

Historically, efforts to eradicate FGM/C primarily focused on awareness campaigns about sexual and reproductive health and rights, along with the enforcement of established laws. However, these programs have often proven only partially effective, and in some cases, they have had unintended consequences, such as reinforcing commitment to FGM/C or pushing the practice underground.

A more recent approach, which aims to consider the cultural significance of FGM/C, is the use of alternative rites of passage (ARP). This method, pioneered by Amref Health Africa in 2007[xli], seeks to provide a culturally sensitive alternative that preserves the cultural meaning of initiation ceremonies while eliminating the harmful practice of FGM/C. In this program, rather than undergoing FGM/C, girls participate in a series of educational and community-based activities that mirror the traditional rites of passage. Efforts at eradicating FGM/C around the world should include funding and technical assistance for ARP programs in FGM/C practicing countries. This in turn would reduce the cases in Canada.

4 Establishing Specialized and Free Mental Health Services for Survivors

It is essential to establish specialized mental health services for FGM/C survivors to address the emotional and psychological toll of this practice. These services should include counselling, support groups, and therapy designed to meet the unique needs of survivors of FGM/C.

We recommend that training organizations[xlii] and regulatory bodies[xliii] for therapists and counsellors include FGM/C as a specialization under GBV in their curricula. This will ensure that mental health professionals are equipped to provide culturally sensitive, trauma-informed care, effectively supporting survivors and addressing both the immediate and long-term mental health impacts of FGM/C. Additionally, these mental health services should be free of charge to ensure accessibility for all survivors, regardless of their financial situation, and to remove any barriers that may prevent them from seeking the care they need.

5 Creating Designated Healthcare Spaces for FGM/C Survivors

It is strongly recommended that specialized clinics or designated wings/areas within existing healthcare spaces be established, providing comprehensive physical and emotional care for FGM/C survivors without the fear of stigma. These spaces should be staffed with professionals trained in the unique needs of FGM/C survivors, ensuring they receive culturally sensitive and non-judgmental care. Such dedicated areas would create a more comfortable and supportive environment, encouraging survivors to seek the care they need with confidence and trust.

Medical Professionals and Healthcare Regulatory Bodies

6 Creation of Guidelines and Raising Awareness of Existing Guidelines for FGM/C Case Management

While some regulatory bodies, such as SOGC, have already developed comprehensive guidelines for the management of FGM/C cases, many healthcare practitioners remain unaware of these protocols, which creates a significant gap in care. Raising awareness of these existing guidelines is crucial, as is ensuring that other regulatory bodies, such as those governing family doctors, mental health professionals, and allied health services, also create and promote their own specific guidelines for addressing FGM/C. It is essential for healthcare systems to have standardized, but specialized, guidelines to ensure that all practitioners can provide informed care that meets the unique needs of FGM/C survivors.

7 Incorporating FGM/C Training as a Formal Component of Medical Education and Ongoing Professional Development for Healthcare Practitioners

FGM/C training should become a formal component of medical education in some capacity. For practitioners working in regions with higher concentrations of racialized communities, where FGM/C may be more prevalent, the need for culturally informed care is particularly urgent. These communities may face distinct barriers when accessing healthcare, including mistrust of providers who are unaware of or untrained in the specific needs of women impacted by FGM/C.

NGOs, Community, Grassroots, Women's, Faith-based Organizations and Leaders

8 Creating a Holistic Support System

To provide a holistic approach to supporting FGM/C survivors, it is crucial that mental health services be integrated into both healthcare settings and community centres. These are environments where women and girls are more likely to feel comfortable seeking support, especially if the services are adapted to their specific needs.

A holistic model would empower women and girls to get the help they deserve, creating an environment that encourages healing from the trauma they have endured. However, to make this a reality, greater investment in resources is necessary, as well as a shift in how women's health issues are prioritized within the broader healthcare system.

9 Engaging Community and Faith Leaders in Advocacy Efforts

Engaging community and faith leaders, such as Imams, and respected elders within the community is crucial for meaningful change in addressing FGM/C. These leaders hold significant influence in many immigrant and refugee communities, and their involvement is key to shifting cultural attitudes and practices.

Change must start from within these communities, and faith leaders and elders can play an important role in guiding their communities toward abandoning FGM/C. To support this effort, they should be provided with specific training and resources that equip them with the knowledge to understand the physical and psychological harms of FGM/C, as well as the legal and ethical implications. By leveraging their respected positions and their connections, faith leaders and elders can challenge harmful traditions, provide culturally appropriate education, and advocate for healthier and safer alternatives to FGM/C.

CONCLUSION

This report addresses the complex nature of FGM/C in Canada, drawing on a combination of individual interviews, an online survey, and focus groups with FGM/C survivors, healthcare practitioners, community members, and service providers. The findings from this research provide a nuanced and detailed exploration of the persistence of FGM/C in specific communities within Canada, its emotional and physical consequences, and the significant gaps in the healthcare and social support systems that hinder support for survivors.

One of the key findings is that FGM/C is occurring in Canada, although the true extent and frequency of the practice remain unclear. While some of the women we spoke to confirmed that they or others had FGM/C carried out in Canada, it is important to note that we cannot speak definitively to its scale. The practice appears to remain highly secretive, often taking place in private homes rather than medical or healthcare settings. This secrecy, as well as the fear of legal consequences and social ostracism, makes it challenging to accurately measure the prevalence of FGM/C in Canada.

Our findings suggest that, while not widespread, the practice does persist within some communities, and it remains a deeply embedded part of some cultural, social, and religious traditions despite being illegal. This report is a case study, and while it provides significant insights into the experiences of those directly impacted by FGM/C, the sample is not representative of all survivors of FGM/C, nor does it capture the full scope of the practice across the country. As such, the findings should be interpreted with caution, and further research is needed to explore the full extent of FGM/C in Canada. This includes more targeted data collection and outreach to communities that may be less visible or harder to reach.

The emotional and psychological outcomes of FGM/C on those impacted are profound and enduring. Many of the women interviewed described feelings of violation, confusion, and trauma, which continue to affect their daily lives. The experience of FGM/C, particularly in the context of social norms, leaves women struggling with issues of identity, body image, and often a sense of betrayal from their families and communities.

The stigma surrounding the practice further exacerbates these feelings, creating an isolating environment where women feel unable to seek help or share their experiences. In some cases, these feelings are intensified by chronic health problems that result from the practice, such as pain, infections, loss of sexual desire, infertility, complications during childbirth, depression, anxiety, and low self-esteem. These findings highlight the need for mental health support that specifically addresses the trauma associated with FGM/C, as well as a broader cultural shift to reduce stigma and offer survivors a space to heal.

In terms of healthcare access, our research reveals significant barriers faced by survivors in obtaining appropriate care. Many healthcare practitioners lack the necessary cultural sensitivity and knowledge to effectively treat and support FGM/C survivors. The healthcare system, as reported by participants, is often unprepared for the unique needs of these women, particularly in understanding the long-term physical and psychological complications associated with FGM/C. Despite the majority of practitioners encountering FGM/C cases in their careers, many are not equipped to effectively address the needs of survivors. Additionally, the dissatisfaction with current training programs offered to healthcare practitioners, with many considering them “Not at All Useful,” highlights the need for more relevant and comprehensive educational initiatives. Healthcare practitioners identified critical gaps in their knowledge and training, particularly around best practices and protocols for treating and supporting women impacted by FGM/C. This knowledge gap is particularly concerning, as FGM/C can result in a wide range of health issues. The lack of formal training on FGM/C and the scarcity of culturally competent care means that many women feel overlooked and marginalized by the healthcare system, further isolating them and contributing to their reluctance to seek help.

Moreover, a critical barrier to addressing FGM/C in healthcare settings is due to its cultural normalization. When women view FGM/C as a regular part of life, they may not associate it with health complications, leading to a lack of awareness and underreporting in healthcare encounters. As many practitioners articulated, FGM/C is often intertwined with identity, making it less likely that women will seek medical help or disclose the practice unless prompted. This normalization complicates the diagnosis and treatment of FGM/C-related health issues, signalling the need for healthcare practitioners to actively address and raise awareness about the potential risks associated with the practice.

The findings also highlight the need for a more integrated and holistic approach to care for women and girls who have experienced FGM/C. Many healthcare practitioners reported a lack of clear protocols or guidelines for supporting FGM/C survivors, which often leads to confusion and inconsistent care. The absence of these protocols makes it difficult for healthcare practitioners to address the specific needs of these patients in a meaningful way. Participants in the survey and interviews stressed the importance of developing clear, standardized procedures for treating FGM/C related health issues, as well as improving healthcare training to ensure that practitioners are equipped to deliver culturally competent, trauma-informed care. This includes ensuring that healthcare practitioners are trained not only in the medical aspects of FGM/C but also in understanding the cultural and psychological aspects of the practice.

The report stresses the importance of community-based interventions in addressing FGM/C. Community members and service providers recognized the critical role that cultural leaders, including elders, faith and community figures, play in shaping attitudes toward the practice. Many participants called for greater involvement of these leaders in education and advocacy efforts aimed at preventing FGM/C and providing support to impacted individuals. This community-based approach is essential in challenging the social, cultural, and religious norms that perpetuate the practice. Raising awareness about the health risks and legal consequences of FGM/C, while also addressing the cultural, social, religious, and economic pressures that sustain the practice, is important in reducing its occurrence and supporting those who have been impacted.

In conclusion, this report calls for a comprehensive approach to addressing FGM/C in Canada. This includes enhancing healthcare training and creating more culturally sensitive healthcare systems, improving public and professional awareness, and developing community-based support systems that can better meet the needs of survivors. The legal framework in Canada condemns FGM/C, but legal action alone is not enough to eradicate this embedded practice. We have seen countries where legal action alone actually has little progress in prevention and eradications. To end FGM/C entirely, it requires a coordinated effort that involves policymakers and the border community working together to create a more supportive, inclusive, and culturally competent environment for FGM/C survivors and for communities that are impacted by the practice. By addressing both the medical and psychological needs of these women and challenging the social norms that perpetuate FGM/C, we can work towards ending this harmful practice and providing better care and support for those impacted.

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i (WHO, 2024)

ii (UNICEF, 2016)

iii (Findlay et al., 2023)

iv (Department of Justice Canada, 1995)

v (Davidson, 2017; Gutbi, 1995)

vi (Taher, 2017)

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xix (Davidson, 2017; Gutbi, 1995)

xx (Taher, 2017)

xxi (Poisson, 2017; Henry, 2017)

xxii (Boddy, 2016; Jacobson et al., 2023; Johansen, 2017; WHO, 2024)

xxiii (Boddy, 2016; Jacobson et al., 2023; WHO, 2024)

xxiv (Alradie-Mohamed et al., 2020)

xxv (Alradie-Mohamed et al., 2020)

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xxvii (Department of Justice, 2017)

xxviii (Jacobson et al., 2023)

xxix (Jacobson et al., 2023)

xxx (Jacobson, et al, 2018)

xxxi (Hughes, 2018)

xxxii (Kleinsorg et al., 2024)

xxxiii In the 20th century, discourse surrounding FGM/C shifted significantly in Western countries, where the practice was initially discussed within the context of moral concerns and medical treatments. While clitoridectomies were performed by physicians in some Western countries to curb masturbation or sexual desire, these practices were eventually discredited and banned by the early 20th century. As a result, the focus of FGM/C discourse moved away from its presence in Western contexts and was reframed as a practice predominantly associated with non-Western, often African or Middle Eastern, communities (Kleinsorg et al., 2024).

xxxiv (Toubia, 1988)

xxxv (Hughes, 2018)

xxxvi (Hughes, 2018)

xxxvii (Hughes, 2018)

xxxviii (Abu-Lughod, 1991, p.21)

xxxix In Vitro Fertilization is a medical procedure used to help individuals or couples conceive a child. It involves fertilizing an egg outside the body, in a laboratory, and then implanting the fertilized egg (embryo) into the uterus. IVF is commonly used when other fertility treatments have not been successful or in cases of infertility due to various factors such as blocked fallopian tubes, male infertility, or age-related issues. IVF can also involve the use of egg or sperm donors and can be combined with genetic screening or freezing of embryos (Yale Medicine, n.d.).

xl Radiology, Urology, Urology resident, Gynecology resident, Lactation consultant, Specialist, Birth assistant

xli (Esho et al., 2023)

xlii Canadian Counselling and Psychotherapy Association (CCPA), Canadian Psychological Association (CPA), The Association of Marriage and Family Therapy Regulatory Boards (AMFTRB)

xliii College of Registered Psychotherapists of Ontario (CRPO), College of Psychologists of Ontario (CPO), Canadian Counselling and Psychotherapy Association (CCPA) (Also serves as a regulatory body), College of Alberta Psychologists, British Columbia Association of Clinical Counsellors

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