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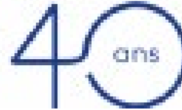

Medical Certificate for Female Genital Mutilation/Cutting (FGM/C) for Immigration Purposes: What Information Should Be Included?

GUIDE FOR
HEALTH CARE PROFESSIONALS AND SOCIAL SERVICES PROVIDERS

by
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TCRI is a Quebec-based cluster of over 150 organizations serving refugees and immigrants. Its mission is to protect and defend the rights of refugees and immigrants in Quebec in their process of immigration, settlement, and integration, by providing services, assistance, support, critical reflection and solidarity across Quebec.

As the umbrella organization for the community organizations in Quebec's immigration and integration network, TCRI contributes to the independent community action movement, deploying its expertise as an agent of social change and development. With their diversified practices and intercultural approach, TCRI-member organizations work towards an inclusive and richly diverse Quebec.

Tasked with implementing these guidelines, TCRI's Women's Component aims to ensure that immigrant, refugee and non-status women and girls' realities are reflected and considered, and that this population receives appropriate services tailored to its needs.

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ABBREVIATIONS AND ACRONYMS USED

CBSA	Canada Border Services Agency
QCC	Quebec Civil Code
HC	Request for visa exemption on humanitarian considerations
IRBC	Immigration and Refugee Board of Canada
ALJR	Application for Leave and Judicial Review
DYP	Director of Youth Protection
PRRA	Pre-Removal Risk Assessment
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
BBSTI	Blood-borne and sexually transmitted infections
CVC	Compensation for victims of crime
YPA	Youth Protection Act
FGM	Female genital mutilation
FGM/C	Female genital mutilation, including cutting (excision)
SDG	Sustainable Development Goals
WHO	World Health Organization
UN	United Nations
RIVO	Réseau d'intervention auprès des personnes ayant subi la violence organisée
SOGC	Society of Obstetricians and Gynaecologists of Canada
RAD	Refugee Appeal Division
RPD	Refugee Protection Division
TCRI	Table de concertation des organismes au service des personnes réfugiées et immigrantes
UNICEF	United Nations of International Children’s Emergency Fund

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PREAMBLE

Today, female genital mutilation/cutting (FGM/C) is practiced all over the world, including in the Western hemisphere.[1] In January 2020, TCRI produced a report on the situation of FGM/C in Quebec.[2] Its main conclusion was that women and girls who have undergone and/or fear undergoing FGM/C would benefit from access to a continuum of cross-sectoral and specialized services to ensure they receive support and that all their needs in this area are met.

Women and girls who have undergone or fear undergoing FGM/C in their country of origin are to provide evidence for their immigration application, particularly when they are applying for asylum in Canada.[3] Among other requirements, they are often asked to produce a medical certificate and a psychosocial and/or psychological report showing whether they have undergone FGM/C and documenting any resulting complications. Considering the potentially crucial importance of the medical certificate and the complexity of immigration programs, particularly the Canadian asylum system, we deemed that it was relevant to develop guidelines to better equip the social services providers and/or health care professionals who are called upon to produce these documents.[4]

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[1] The term "FGM/C" was chosen for this document to "account for the different uses and functions of the various terms (...)." Quote taken from: *Les mutilations génitales féminines, Un état de situation au Québec, Réalités, besoins et recommandations*, January 2020, p.14 [Online; our translation] [https://tcri.qc.ca/wp-content/uploads/2023/02/Etat-de-Situation-sur-les-MGF_Sommaire_TCRI_2020.pdf] (hereinafter "The Report"). In addition, FGM/C is: "widely used by the Multi-Sectoral Committee to refer to all practices and contexts." Female genital mutilation is "...an umbrella term designating a set of traditional practices covered by international law and UN agencies, and on which most national legislation, including Canadian law, is based." (p.13) while the terms "excision" "...and "infibulation" are used to designate specific practices. These terms are intended to be neutral, factual and detached from the political and historical processes that led to their definition on the international arena." (p.13)

[2] The Report*, op. cit.*

[3] Medical certificates can also be used for immigration procedures following the refusal of an application for asylum. Such procedures might include an appeal request, an application for visa exemption on humanitarian and compassionate considerations and a pre-removal risk assessment request.

[4] This term refers to all health care professionals ad service providers such as nurses, doctors, midwives, psychotherapists, psychologists, psychiatrists, social workers, outreach workers.

1. BACKGROUND

Female genital mutilation, including cutting (FGM/C), has been practiced since ancient times[5] and is documented on every continent except Antarctica. The World Health Organization (WHO) estimates that, today, over 200 million women and girls have undergone FGM/C.[6,7] The United Nations Population Fund (UNFPA) has revised this number upwards, as it noted an upsurge in gender-based violence, including FGM/C, during the COVID-19 pandemic.[8]

Although information on the practice of FGM/C in Canada is only anecdotal, there are several thousands of women and girls in Canada who have undergone or are at risk of undergoing the procedure.[9] It is therefore important that social services providers and health care professionals have the required knowledge to offer these women and girls services that are appropriate and adapted to their needs.

For several decades now, international and national players have been acting around FGM/C and fighting to end it.

Following the example of the African Union and its *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa*, which prohibits "all forms of female genital mutilation [...] and all other [harmful] practices" (section 5, *Maputo Protocol*[10]), Europe has adopted legislative instruments such as the Istanbul Convention, to which many European states are signatories. As such, many credible documents already provide information for those on the frontlines working with women and girls who have undergone or who fear FGM/C. Most of these signatory countries have also adopted national action plans to eradicate the practice. Although some reference documents exist in Canada, there is no national plan to address FGM/C.[11]

FGM/C was recognized as a violation of women and girls' basic rights only in the 1990s.[12] Both traditionally practiced and medicalized FGM/C have been classified as a violation: "Mutilation performed by doctors is still mutilation. Trained social services providers and health care professionals who practice FGM violate girls' fundamental rights, physical integrity, and health," said UNICEF executive director Henrietta Fore. "Medicalizing the practice doesn't make it safe,

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[5] "Female Genital Cutting (FGC) and the Ethics of Care: Community engagement and cultural sensitivity at the interface of migration experiences," Bilkis Vissandjée, Shereen Denetto, Paula Migliardi, and Jodi Proctor, BMC, *International Health and Human Rights*, 2014, [Online] [https://bmcinthealthhumrights.biomedcentral.com/articles/10.1186/1472-698X-14-13]

[6] *Female Genital Mutilation,* WHO, February 3, 2020, [Online] [https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation]

[7] *Mutilations génitales féminines : plus de 4 millions de filles menacées cette année, alerte l'ONU, ONU Info*, February 6, 2020, [Online] [https://news.un.org/fr/story/2020/02/1061322] Data was pre-COVID-19. Since the start of the pandemic, FGM/C has been on the rise. *Plan International reports significant increase in FGM in Somalia during period of confinement,* May 27, 2020 [Online] [https://www.plan-international.fr/info/actualites/communiques-de-presse/plan-international-augmentation-mgf-somalie-confinement] and *Confinement et après Covid-19 : le risque d'excision en hausse, les associations donnent l'alerte*, June 4, 2020, [Online] [https://information.tv5monde.com/terriennes/confinement-et-apres-covid-19-le-risque-d-excision-en-hausse-les-associations-donnent-l]

[8] UNFPA, *Impact of the COVID-19 Pandemic on Family Planning and Ending Gender-based Violence, Female Genital Mutilation and Child Marriage*, April 27, 2020, [Online] [https://www.unfpa.org/sites/default/files/resource-pdf/COVID19_impact_brief_for_UNFPA_24_April_2020_1.pdf]

[9] See the *Policy on Female Genital Mutilation*, The Ontario Human Rights Commission, last revised in 2009, Section 4: FGM in Canada, [Online] [https://www.ohrc.on.ca/en/policy-female-genital-mutilation-fgm/4-fgm-canada] Testimonials that FGM is practised in Ontario and elsewhere in Canada. Another article states that FGM/C is also practised in Quebec, see *Les mutilations génitales féminines, une forme extrême de violence faite aux femmes*, February 6, 2006, by Aoua Bocar Ly-Tall, [Online] [http://sisyphe.org/spip.php?article2150]

[10] Guignard, L. (2016). "La construction d'une norme juridique régionale : le cas des mutilations génitales féminines en Afrique." *Critique internationale*, 70(1), 87-100. https://doi.org/10.3917/crii.070.0087

[11] Among others, the *Guide for Health Professionals Working with Immigrant and Refugee Children and Youth*, [Online][https://kidsnewtocanada.ca/screening/fgm] Note that many of the links require a paid subscription.

[12] The Report, op cit., p.6

moral or defensible."[13] The Society of Obstetricians and Gynaecologists of Canada (SOGC) endorses the eradication of FGM/C and condemns its medicalization.[14]

2. DEFINITIONS AND TYPES OF FGM/C

FGM/C constitutes gender-based violence because "...it is rooted in gender inequalities and power imbalances between men and women and prevents women from fully and equally enjoying their human rights."[15]

A joint statement for defining types of FGM/C emerged in 1997 and continues to be a reference to this day.[16]

The WHO classifies FGM/C according to the severity of the intervention:[17]

> Female genital mutilation (FGM) comprises 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 (WHO, UNICEF, UNFPA, 1997).
>
> Type I: Partial or total removal of the clitoris and/or prepuce (clitoridectomy).
>
> Type II: Partial or total removal of the clitoris and labia minora, with or without excision of the labia majora (excision).
>
> Type III: Narrowing of the vaginal orifice with creation of a covering seal by cutting and repositioning the labia minora and/or labia majora, with or without removal of the clitoris (infibulation).
>
> 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.[18]

This classification of FGM/C has been challenged, partly because it is impossible, even in the most extreme forms of mutilation, to "totally remove" the clitoris given its anatomical structure.[19]

The clitoris is:

> "*...a small erectile organ of the female reproductive system, located in the front of the vulva. The little button you can see and feel is just the tip of the iceberg. Nine-tenths of the clitoris is*

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[13] *Mutilations génitales féminines : plus de 4 millions de filles menacées cette année, alerte l'ONU*, ONU Info, February 6, 2020, [Online; our translation] [https://news.un.org/fr/story/2020/02/1061322]; See also, from UNICEF, *Approximately 1 in 4 Survivors of Female Genital Mutilation Were Cut by a Health Care Provider*, February 6, 2020 [Online] [https://www.unicef.org/press-releases/approximately-1-4-fgm-survivors-were-cut-health-care-provider]

[14] *SOGC policy statement, Female Genital Cutting/Mutilation*, No. 272, February 2012 [Online] https://www.jogc.com/article/S1701-2163(16)35164-7/pdf

[15] *Eliminating Female Genital Mutilation, Interagency Statement*, 2008, p. 10, [Online] [https://iris.who.int/handle/10665/43839]

[16] *Eliminating Female Genital Mutilation, Interagency Statement*, 2008, p. 4, [Online] [https://iris.who.int/handle/10665/43839]

[17] For a more detailed classification, see p. 7 of the Report which includes *Care of Girls and Women Living with Female Genital Mutilation*, WHO, pp. 27–31, [Online][https://apps.who.int/iris/bitstream/handle/10665/272429/9789241513913-eng.pdf?ua=1]

[18] *Eliminating Female Genital Mutilation, Interagency Statement*, 2008, p. 4 [Online] [https://iris.who.int/handle/10665/43839]

[19] On this subject, see: "Une ouverture aux mutilations vaginales? Stupéfaction au Québec," *Le Devoir*, Amélie Daoust-Boisvert, April 16, 2014, [Online] [https://www.ledevoir.com/societe/405697/une-ouverture-aux-mutilations-vaginales-stupefaction-au-quebec]

internal and invisible.” [20] Generally, “*the visible part of the clitoris measures between 0.5 and 1 cm, while the invisible shaft, located after the glans, can measure up to 10 cm*.” [21]

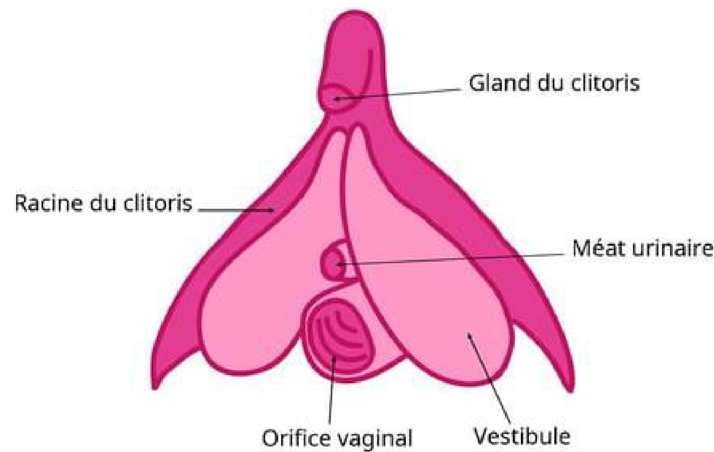

Diagram taken from *Journal des Femmes*, Santé, June 19, 2019

As such, in the case of the so-called total removal of the clitoris, it is in fact the glans and not the entire root that is excised, as the later is not at all accessible. When the types of FGM/C were defined, scientific knowledge of the clitoris was in fact minimal; it was perceived as nothing more than a “little button.”[22]

Types 1 and 2 are the most commonly practiced types of FGM/C.[23] Type 3 FGM/C accounts for around 10% of cases, and it is mainly practiced in Somalia, Northern Sudan and Djibouti.[24]

According to the WHO,[25] FGM/C is most often practiced on girls aged 15 and under. However, it is also performed in some communities on infants and, under certain circumstances, on adults. In short, all age groups are at risk of FGM/C.

After having undergone a type of excision, a woman or girl may be forced to undergo further types in her life.[26]

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[20] “*Clitoris : anatomie, taille, zone érogène*,” *Le Journal des Femmes, Santé*, June 19, 2019, [Online; our translation] https://sante.journaldesfemmes.fr/fiches-sexo-gyneco/2538496-clitoris-anatomie-taille-zone-erogene/

[21] Idem.

[22] The Report, op. cit. p. 9.

[23] *Female Genital Mutilation (FGM): Frequently asked questions*, UNFPA, July 2019 [Online] [https://www.unfpa.org/resources/female-genital-mutilation-fgm-frequently-asked-questions] The same data can be found in FPS Health, Food Chain Safety and Environment, and GAMS Belgium. *Mutilations génitales féminines : Guide à l'usage des professions concernées.* Brussels; 2011, p. 22 [Online] [http://www.strategiesconcertees-mgf.be/wp-content/uploads/guide-mgf-fr_web.pdf,]

[24] *Female Genital Mutilation (FGM): Frequently asked questions*, UNFPA, July 2019 [Online] [https://www.unfpa.org/resources/female-genital-mutilation-fgm-frequently-asked-questions]

[25] *Female Genital Mutilation: Key facts.* WHO, February 3, 2020. [https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation]

[26] *Guidance Note on Refugee Claims relating to Female Genital Mutilation*, 2009, UNHCR [Online] [https://www.unhcr.org/fr/publications/legal/4fd737379/note-dorientation-demandes-dasile-relatives-mutilations-genitales-feminines.html], para. 6 (hereinafter UNHCR Note)

2.1 Complications stemming from FGM/C

Deinfibulation involves "cutting open the narrowed vaginal opening in a woman who has been infibulated, which is often necessary for improving health and well-being as well as to allow intercourse or to facilitate childbirth."[27]

Re-infibulation is the procedure that re-establishes infibulation,[28] i.e. narrowing the vaginal opening in a woman after she has been deinfibulated (i.e. after childbirth); also known as re-suturing.[29]

Also, when a woman or girl has been subjected to a less extreme type of FGM/C, a more severe form may be carried out later in her life.

Furthermore, the type of FGM/C performed can vary within the same country, ethnic group or cultural community. All affected women and girls from the same country should not be presumed to have undergone, or to face undergoing, the same type of FGM/C.

FGM/C has no medical benefit, and it can cause a host of immediate and long-term complications. It is difficult, if not impossible, to provide an exhaustive list.

Furthermore, complications can be physical, psychological,[30] social, sexual and reproductive.

The complications of FGM/C can be "... different depending on the type of mutilation and the conditions in which it was performed (e.g., whether it was performed under sterile conditions, the instruments used, the experience of the person performing the mutilation)."[31]

Immediate complications[32]

- Severe pain
- Severe shock (trauma)
- Excessive bleeding (hemorrhage)
- Infections
- Difficulty urinating (pain, incontinence)
- Human immunodeficiency virus (HIV), hepatitis and other blood-borne and sexually transmitted infections (BBSTI)
- Death from severe hemorrhage or septicemia

[27] *WHO Guidelines on the Management of Health Complications from Female Genital Mutilation.* WHO, Glossary p. vii [Online] [https://iris.who.int/bitstream/handle/10665/206437/9789241549646_eng.pdf?sequence=1]
[28] *Global Strategy to Stop Health-care Providers from Performing Female Genital Mutilation*, WHO, 2010, p. 1 [Online] [https://www.who.int/publications/i/item/WHO-RHR-10.9]
[29] *WHO Guidelines on the Management of Health Complications from Female Genital Mutilation.* WHO, Glossary p. vii [Online] [https://iris.who.int/bitstream/handle/10665/206437/9789241549646_eng.pdf?sequence=1]
[30] For a list of consequences, please refer to the *WHO Guidelines*, pp. 6–7 [Online] [https://iris.who.int/bitstream/handle/10665/206437/9789241549646_eng.pdf?sequence=1]
[31] *Prise en charge des mutilations sexuelles féminines par les professionnels de santé de premier recours, Recommandation de bonne pratique,* Haute autorité de santé, February 2020, p. 27 [Online; our translation] [https://www.hassante.fr/upload/docs/application/pdf/202002/reco307_argumentaire_mutilations_sexuelles_feminines.pdf]
[32] *Care of Girls and Women Living with Female Genital Mutilation,* WHO, p. 87, [Online] [https://apps.who.int/iris/bitstream/handle/10665/272429/9789241513913-eng.pdf?ua=1]

Long-term complications

- Problems related to childbirth:[33] 1) delivery by cesarean section, 2) children born to women who have undergone FGM/C are at greater risk of neonatal death, 3) high incidence of post-partum hemorrhage, etc.[34]
- Chronic pain (vulvar, urinary, menstrual, etc.)
- Incompetent cervix
- Edema or keloid scars
  - Edema or keloid scarring (commonly known as "genital tissue swelling")
- Genital cysts and/or clitoral neuroma
- Infections (including sexually transmitted infections (STIs)[35]
- Reduced sexual pleasure (reduces libido, but not sexual function) and/or other psychosexual consequences[36]
- Post-traumatic stress disorder, anxiety disorders, depression, low self-esteem, memory loss, avoidance[37]

The consequences of FGM/C can vary from one woman or girl to the next, so it is important not to make any assumptions and instead to listen carefully. Further, a woman may not have any memory related to her FGM/C.

Many reasons are given for why FGM/C is practiced:

- Hygiene and/or esthetics
- Rite of passage
- Religion (all faiths)
- Identity and perpetuation of the tradition
- Sex[38]

It is important to note that, more than anything else, c*ultural tradition* usually seems to be the reason for the persistence of these practices.[39]

Lastly, a scientific essay published in February 2020 by France's Haute autorité de Santé, entitled Prise en charge des mutilations sexuelles féminines par les professionnels de santé de premier recours (*Taking Care of Female Genital Mutilation by Primary Care Healthcare Professionals*), presents a detailed description of the consequences of FGM/C and many relevant references.[40]

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[33] *The Obstetric Consequences of Female Genital Mutilation/Cutting: A Systematic Review and Meta-Analysis* Rigmor C. Berg and Vigdis Underland, Hindawi, received April 27, 2013; accepted June 10, 2013, pp. 11–12, [Online] http://downloads.hindawi.com/journals/ogi/2013/496564.pdf

[34] WHO Guidelines, p. 12 and 38

[35] *SOGC Policy Statement, Female Genital Cutting/Mutilation*, No. 272, February 2012 [Online] [https://www.jogc.com/article/S1701-2163(16)35164-7/pdf]

[36] *Prise en charge des mutilations sexuelles féminines par les professionnels de santé de premier recours, Recommandation de bonne pratique,* Haute autorité de santé, February 2020, pp. 41–48 [Online] [https://www.hassante.fr/upload/docs/application/pdf/202002/reco307_argumentaire_mutilations_sexuelles_feminines.pdf]

[37] *Trop de souffrance – MGF et asile dans l'Union européenne, une analyse statistique*, UNHCR, p.21 [Online] https://www.refworld.org/cgi-bin/texis/vtx/rwmain/opendocpdf.pdf?reldoc=y&docid=5163edf14

[38] For details on each of these arguments, see "Le praticien face aux mutilations sexuelles féminines," *Gynécologie sans frontière*, July 2010, pp. 24–25 [Online][https://www.gynsf.org/MSF/praticienfaceauxmsf2010.pdf]

[39] "*Female Genital Cutting (FGC) and the Ethics of Care: Community engagement and cultural sensitivity at the interface of migration experiences*," Bilkis Vissandjée, Shereen Denetto, Paula Migliardi, and Jodi Proctor, BMC, *International Health and Human Rights*, 2014, [Online] [https://bmcinthealthhumrights.biomedcentral.com/articles/10.1186/1472-698X-14-13]

[40] *Prise en charge des mutilations sexuelles féminines par les professionnels de santé de premier recours, Recommandation de bonne pratique,* Haute autorité de santé, February 2020, p. 27 [Online] [https://www.hassante.fr/upload/docs/application/pdf/202002/reco307_argumentaire_mutilations_sexuelles_feminines.pdf]

2.2 FGM/C often fits into a spectrum of violence against women

FGM/C is a form of gender-based violence or violence against women and girls that is rarely an isolated case. FGM/C generally fits into a broader context of inequality between men and women. A woman or girl who has undergone FGM/C, or who is worried she will, has very often already been exposed to a range of gender-based violence and/or discrimination in her immediate family. However, she may also experience it in other spheres of her life, such as in the extended family, places of worship, social settings (at the market, when using public services, in school, etc.), in the community, and so on.

It is important to be sensitive to these and other elements when interacting with the woman or girl:

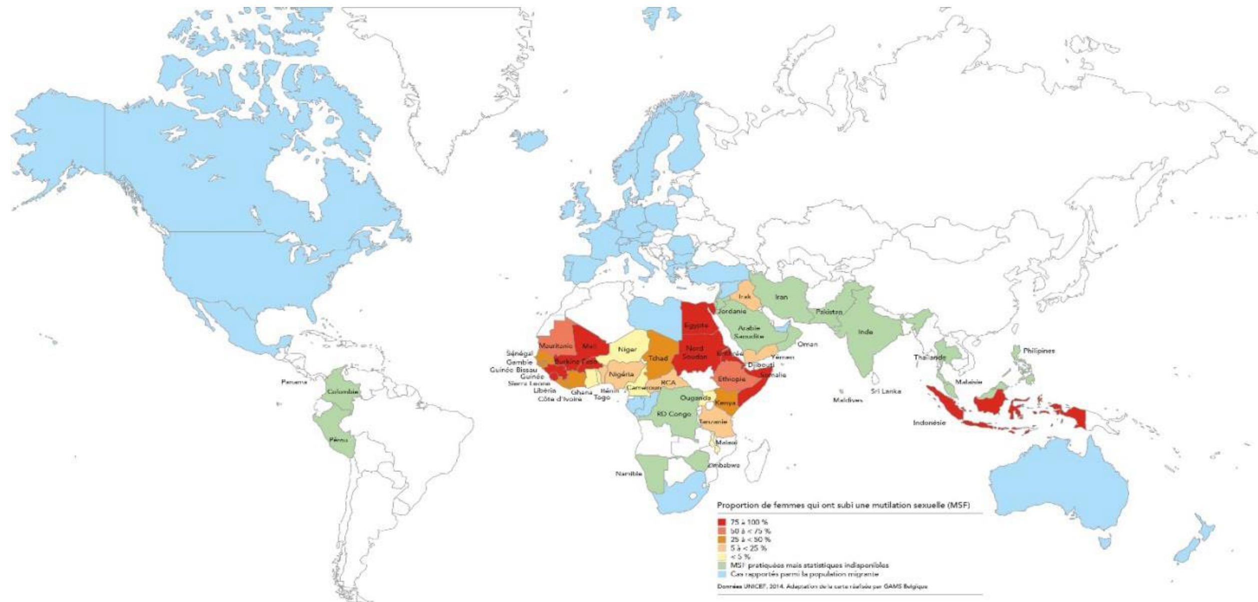
- Social decisions (education, employment, etc.) may be made or may have been made by other people.[41]
- Family decisions may also be made by people outside of the family. These decisions might include forced and/or early marriage (both the choice of partner and the timing of the union), levirate marriage (marriage to the deceased husband's brother), where the couple will live and the number of children they have.
- It is possible these women experience and/or have experienced domestic and/or family violence, including economic, physical, psychological and sexual abuse.

It should not be assumed that this continuum of violence ends when the woman or girl arrives in Canada. We should therefore be aware that FGM/C may be determined, in whole or in part, by someone other than the woman or girl herself. Furthermore, the immigration process can itself add another layer to this continuum of violence in Canada, for example, if decision-makers question the testimonials of women who have survived FGM/C or who fear for their daughters or themselves.

Although most often experienced in the extended family, the violence and/or discrimination women and girls experience can also play out in other spheres of their life, such as in places of worship, in social settings (at the market, when using public services, in school, etc.), in the community. Women and girls perceive and experience this continuum of violence and/or discrimination in a variety of ways, so, once again, it is crucial to listen attentively and not make any assumptions about their current or past experience.

[41] Often the man or men in her family, but also sometimes those of her husband's family (i.e. the patriarch).

2.3 Countries where FGM/C is practiced[42]



According to the UNFPA, FGM/C is practiced on women and girls in every region of the world[43] though it is most prevalent in Africa, Asia and South America.

Although laws have been passed to criminalize FGM/C in several countries where it is practiced, this legislation has had very little effect to date. Among other things, it can be noted that:

- societal attitudes towards FGM/C have not changed,
- legal consequences, which are often minimal, are not dissuasive,
- laws on FGM/C are not rigorously enforced,
- laws on FGM/C are not always clear.[44]

3. CANADIAN CRIMINAL LAW AND FGM/C

In Canada, FGM/C has been a crime since the 1997 adoption of section 268 (3) of the Criminal Code.[45] It is included under the section on aggravated assault.

A person can be held criminally responsible for performing or participating in FGM/C in Canada and abroad. This is well documented, particularly in Europe, where specific campaigns aim to prevent "vacation cutting."

Health care professionals and social services providers must be aware that a girl living in Canada may be at risk of FGM/C. Several publications have been produced, mainly in Europe, to help identify these at-risk girls.

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[42] The following map was copied from: http://www.strategiesconcertees-mgf.be/wp-content/uploads/GAMS-carte2017FR-1.pdf

[43] *Demographic Perspectives on Female Genital Mutilation*, UNFPA, p.6 [Online] https://www.unfpa.org/publications/demographic-perspectives-female-genital-mutilation

[44] "Female Genital Mutilation: A Literature Review of the Current Status of Legislation and Policies in 27 African Countries and Yemen," Jane Muthumbi, Joar Svanemyr, Elisa Scolaro, Marleen Temmerma and Lale Say, *African Journal of Reproductive Health*, September 2015: 19 (3)

[45] Criminal Code (R.S.C. (1985), c. C-46), [Online] https://laws-lois.justice.gc.ca/fra/lois/c-46/section-268.html?wbdisable=true

Criteria to look for when assessing a girl's risk of FGM/C[46]:

- The family belongs to a community known for practicing FGM/C.
- The girl's mother, sister or cousin has undergone FGM/C.
- The girl's father comes from a community known for practicing FGM/C.
- The family shares that older people in their community have great influence or are involved in young girls' education.
- When the topic of FGM/C is raised with the family:
  - the parents have little access to information about FGM/C,
  - the parents believe that the risks associated with FGM/C are relative,
  - the parents are unaware of the FGM/C legislation,
  - the parents believe the risk of FGM/C is lower if their child is out of the country of origin for an extended period,
  - the family and the daughter have not integrated into the host country,
  - the family has no contact with any professionals (health, social services, education or other), or the family is already known to the health and social services system for other child-protection issues.

Criteria to look for when assessing **imminent risk**:

- The parents state they intend to take their daughter abroad for an extended period.
- The parents ask for their daughter to be vaccinated for an upcoming trip or the daughter has recently received travel vaccines (e.g. for yellow fever).
- A parent or family member expresses concern that FGM/C may be performed on the girl.
- The girl confides in a health professional that she is going to take part in a very special celebration, will "become a woman", or is going on a long vacation in her country of origin or another country where FGM/C is practiced.
- A girl talks about FGM/C in a conversation, for example, referring to another child.
- A girl asks a teacher or other adult for help because she knows or suspects she is at immediate risk of FGM/C.

We should be aware and communicate that if a parent allows to perform a type of excision on their child or does not take all the necessary measures to prevent FGM/C, they are committing the same criminal offense as the person committing the act (sec 21, Criminal Code).

However, it is important to be able to distinguish between illegal FGM/C and the obstetric care practice of "deinfibulation"[47] or "defibulation" in Canada.[48] Some specialists believe that: "Major obstetric complications can arise in the absence of deinfibulation. An occluded, scarred or sclerotic vulva is a mechanical obstacle to the progress of the birth."[49]

Re-infibulation is a criminal act. In 2009, the Collège des Médecins du Québec warned its members that: "...when a patient asks a physician to perform an act that may be harmful to her health, the

[46] All the listed criteria were taken from *Prise en charge des mutilations sexuelles féminines par les professionnels de santé de premier recours, Recommandation de bonne pratique*, Haute autorité de santé, February 2020, pp. 55–56 [Online, our translation] [https://www.hassante.fr/upload/docs/application/pdf/202002/reco307_argumentaire_mutilations_sexuelles_feminines.pdf]

[47] "Deinfibulation: Incision of the vulva to open the vagina of a woman who has undergone infibulation" WHO definition taken from the glossary of the clinical practice guideline No. 395 *Female Genital Cutting*, SOGC. February 2020 (replaces No. 299, November 2013).

[48] Term used by the SOGC. See clinical practice guideline No. 395 *Female Genital Cutting,* SOGC. February 2020 (replaces No. 299, November 2013).

[49] "Le praticien face aux mutilations sexuelles féminines," *Gynécologie sans frontière*, July 2010, p. 59, [Online] [https://www.gynsf.org/MSF/praticienfaceauxmsf2010.pdf]

physician is bound not to perform that act, particularly FGM."[50] This guide was modified in February 2020, and today, there is no specific mention of FGM/C.

However, the Society of Obstetricians and Gynaecologists of Canada (SOGC) clinical guidelines explicitly state that requests for re-infibulation must be refused.[51]

Re-infibulation is a form of FGM/C and it is condemned in several countries, including Canada. The Ontario Human Rights Commission states that FGM/C, including re-infibulation, is an aggravated assault under the Criminal Code of Canada:

> If a physician licensed in Ontario were to perform FGM, including infibulation or re-infibulation, the College of Physicians and Surgeons of Ontario would also consider it to be professional misconduct, and it could result in criminal charges for assault.[52]

To date, no criminal charges have been filed under section 268(3) of the Criminal Code. Nonetheless, you must share with the women and girls you meet for proof of FGM/C that Canada criminalizes this practice, even if the procedure is performed beyond its borders. Moreover, the SOGC encourages its members to use their expertise to educate and provide counselling to families against FGM/C.[53]

4. DIRECTOR OF YOUTH PROTECTION (DYP)

The DYP can intervene in situations where a girl may be forced to undergo or may have already undergone FGM/C. Although the DYP's constitutive law does not explicitly mention FGM/C, some of its provisions can be invoked to ensure protection.

For instance, section 38 of the Youth Protection Act[54] (YPA) sets out the grounds by which a child's safety or development is considered to be in danger. In cases where FGM/C is invoked, there are three possible reasons:

- 38 c) Psychological ill-treatment
- 38 d) Sexual abuse
- 38 e) Physical abuse[55]

According to the foregoing, the YPA has a broader scope than the Criminal Code of Canada.[56] It is also important to note that it is more difficult to fulfill the burden of proof in criminal cases than it is to establish that a child is at risk.[57] The two laws also differ in their objectives. The Criminal Code aims to punish the act of FGM/C and the people who perpetrate it; meanwhile, the YPA focuses on the child and the deleterious consequences of the practice on its physical and psychological integrity, in order to put an end to the compromising acts and to address and manage the consequences within a systemic psychosocial intervention centered on the child and family.

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[50] *Legal, Ethical and Organizational Aspects of Medical Practice in Québec* ALDO-Québec 2009 edition available online, July 2009, Collège des Médecins du Québec, [Online; our translation] [https://www.mcgill.ca/medicine-academic/files/medicine-academic/Legal-Ethical-Organization-Aspects-Medical-Practice-Quebec.pdf]

[51] Clinical practice guideline No. 395 *Female Genital Cutting,* SOGC. February 2020 (replaces No. 299, November 2013).

[52] *Policy on Female Genital Mutilation*, Ontario Human Rights Commission, last revised in 2009, section 5 [Online] [https://www.ohrc.on.ca/en/policy-female-genital-mutilation-fgm/5-ontario-human-rights-code]

[53] Clinical practice guideline No. 395 *Female Genital Cutting*SOGC. February 2020 (replaces No. 299, November 2013).

[54] Chapter P-34.1

[55] Data taken from a legal opinion produced by DYP litigators in November 2019. This opinion was presented at an event on FGM/C on January 28, 2020, led by Marie-Aimée Beaulac, from the legal department at the CIUSSS du Centre-Sud-de-l'Île-de-Montréal, and Annie-Claude Bibeau, Head of Youth Protection at the CIUSSS du Centre-Sud-de-l'Île-de-Montréal.

[56] See the Report, op. cit., p. 33

[57] See https://educaloi.qc.ca/capsules/le-droit-criminel-cest-quoi/ and https://www.barreau.qc.ca/media/1590/guide-droit-jeunesse.pdf

As for the above-mentioned grounds for risks to the child, the YPA makes it possible to invoke the psychological consequences for girls subjected to FGM/C as well as for those who have already undergone the procedure. If it is found that the guarantor(s) of parental authority have not met the child's psychological needs after an FGM/C, it may be determined that the child's safety and development are in danger.

Furthermore, the guarantor(s) cannot invoke their values or traditions[58] to justify performing FGM/C on a minor (section 38.3)

Importantly, health care and social services providers have the obligation to report "…to the DYP, notwithstanding the duty of professional secrecy, as long as there is reasonable cause to believe that the security or development of a child is or may be compromised (...)."[59] Lawyers[60] who, in the course of their work, receive information that a child's safety or development is in danger have no obligation to report it.

In the event of a referral, intake services will first assess the situation and determine the need for support or care. If need be, an intervention plan can be put in place, in consultation with parental authorities, to ensure that the child and family have access to the necessary resources to support them with any difficulties they are experiencing. It is important to note that the Youth Protection Act (YPA) is class legislation that is enforced only during the intervention plan. Withdrawal from the family is an exceptional provision applied only in cases where the level of urgency and danger justifies it.

In such situations, the law gives the DYP significant "immediate protective measures[61]" to remove the child from their present environment if they are deemed to be in imminent danger. The Youth Court can also issue an emergency order to seize a child's passport if the DYP has credible reason to believe that the child is at risk of being taken abroad to be subjected to practices that are illegal in Canada, including FGM/C and forced or early marriage.

Finally, the YPA also has limitations in that it applies exclusively to compromises perpetrated by or linked to breaches by individuals. Thus, the DYP has no jurisdiction to intervene if the Government of Canada, via its Canada Border Services Agency (CBSA), deports a girl (even if she is a Canadian citizen) who is in real and imminent risk of FGM/C in the country to which she is being sent.

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[58] The Report, op. cit., p. 33.
[59] Section 39 of the YPA.
[60] Excluding consultants and other forms of paid or unpaid representatives (notaries are included with lawyers).
[61] Section 46 of the YPA. https://www.legisquebec.gouv.qc.ca/fr/document/lc/P-34.1

5. COMMUNICATION AS PART OF AN FGM/C CASE

Communication may be difficult with women or girls who come to you for proof as part of their application for asylum. Even though they need a document from you, their life experience may make it difficult for them to talk with you. From the outset, a woman may not want to openly discuss FGM/C with you because she[62]

- is in distress,
- fears judgment and stereotypes,
- believes that FGM/C is a private matter or something that belongs to the past, or
- is uncomfortable because you're a man.

It is important to find ways to build trust with these women and girls. Canada has yet to produce any guidelines or documents to help in this regard. Belgium has produced a guide for social services providers and health care professionals who are concerned about FGM/C that offers relevant advice, including the importance of:[63]

- Being a good listener and not forcing the woman to talk more than she feels able to (i.e. being patient).
- Not suggesting you know what future events or consequences she will face.
- Being empathetic.
- Making it clear how the conversation is constructive.
- Staying objective.
- Addressing the resulting health concerns.
- Showing no judgment of the woman's culture or person (e.g. avoiding words "normal" or "abnormal").
- Being aware of our own biases and prejudices (their existence and potential impact).
- Demonstrating cultural competency (i.e. considering the woman's experience and choices from *her* frame of reference, not ours).

5.1 How to talk about FGM/C with women and girls

For the purpose of this document, we presume that the woman or girl is seeking a medical certificate (i.e. proof) of the FGM/C she has experienced, or fears will occur. This means the reason for the appointment(s) is clear, but that does not make the conversation any less difficult. It is of the utmost importance you guarantee confidentiality to gain her trust. A trusting relationship will encourage her to share the information you need to prepare the documents.

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[62] Based, in part, on *Manuel pratique à l'usage des avocats*, updated June 2014, p. 94 [Online; our translation] [https://www.intact-association.org/images/outils/manuel-avocats-2014.pdf]

[63] FPS Health, Food Chain Safety and Environment, and GAMS Belgium. *Mutilations Génitales Féminines : Guide à l'usage des professions concernées*. Brussels; 2011 pp. 72–73 [Online; our translation] [http://www.strategiesconcertees-mgf.be/wp-content/uploads/guide-mgf-fr_web.pdf,]

Furthermore, as a professional, you must adapt your behaviour according to whether you're dealing with an adult or a child.[64] For girls, please refer to section 4, part 5 of the *Istanbul Protocol* on examining children.[65] The information it contains is succinct but relevant, even though it does not specifically address FGM/C.

To ensure good communication, you must tell the woman or girl what to expect. She must be informed about and, above all, understand how the appointment will go and what examinations, if any, will need to be done.[66] You need to make sure that she speaks your language well or that someone she trusts can faithfully translate for her. It may be necessary to use the services of an interpreter. If so, it is important to choose an interpreter according to the following criteria[67]:

- Do not allow the woman's child, spouse, mother-in-law, etc. to serve as interpreter.
- If possible, choose a female interpreter.
- Carefully assess how the interpreter is presenting FGM/C (be sure that they do not hold a bias in favour of the practice).
- Ideally, the interpreter should have received training about FGM/C and already have some knowledge of the issue.
- If this is the interpreter's first time translating on this topic, pay close attention in their debriefing to see how they felt about the subject.

It may be relevant for the woman or girl to be accompanied. Of course, if the girl is under 14, a parent or guardian must be present and consent to the care. However, if the woman or girl comes with someone else, it is necessary to ask and understand her own wishes.

Using the term "female genital mutilation/cutting" with the woman or girl is certainly inappropriate.[68] When talking with her, it is a good idea to use the word in her language and/or the term that she uses.[69] Often women or girls use the words "*circumcision*,"[70] "*closed*," "*cut*", "*excised*" or "*sewn up*."[71]

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[64] Reference to the section "Comment aborder la question des mutilations sexuelles féminines" pp. 57–95 of the French document: *Prise en charge des mutilations sexuelles féminines par les professionnels de santé de premier recours, Recommandation de bonne pratique*, Haute autorité de santé, February 2020, [Online] [https://www.hassante.fr/upload/docs/application/pdf/202002/reco307_argumentaire_mutilations_sexuelles_feminines.pdf] This document deals with the issues that arise when working with girls at risk of FGM/C. However, some information is also relevant for women and girls who have already undergone FGM/C.

[65] *The Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment/Punishment: Medical physical examination of alleged torture victims: A practical guide to the Istanbul Protocol – for medical doctors*, Ole Vedel Rasmussen, M.D., DMSc, Stine Amris, M.D., Margriet Blaauw, M.D., MIH, Lis Danielsen, M.D., DMSc, International Rehabilitation Council for Torture Victims (IRCT) 2004, p. 34, [Online] [https://www.intact-association.org/images/documents/guide-protocole-Istanbul.pdf

[66] The appointment may also be the woman's first gynecological examination, so it is good practice to describe your actions and show her the instruments beforehand. See p. 92, *Prise en charge des mutilations sexuelles féminines par les professionnels de santé de premier recours, Recommandation de bonne pratique,* Haute autorité de santé, February 2020, pp. 41–48 [Online] [https://www.hassante.fr/upload/docs/application/pdf/202002/reco307_argumentaire_mutilations_sexuellesfeminines.pdf

[67] *Prise en charge des mutilations sexuelles féminines par les professionnels de santé de premier recours, Recommandation de bonne pratique,* Haute autorité de santé, February 2020, p. 27 [Online] [https://www.hassante.fr/upload/docs/application/pdf/202002/reco307_argumentaire_mutilations_sexuellesfeminines.pdf]

[68] FGM terminology positions the practice of FGC as an extreme human rights violation. This term is often perceived as inflammatory, judgemental and stigmatising, particularly for women previously exposed to the practice who do not view their bodies, or the bodies of their daughters, as mutilated. *Female Genital Cutting (FGC) and the Ethics of Care: Community engagement and cultural sensitivity at the interface of migration experiences.*

[69] *Mutilation génitale féminine, Guide à l'usage des professions concernées*, FPS Health, Food Chain Safety and Environment, and GAMS Belgium, Brussels, 2011 [Online] [http://www.strategiesconcertees-mgf.be/wp-content/uploads/guide-mgf-fr_web.pdf]

[70] Other terms, such as "female genital cutting (FGC)," "excision" and "infibulation," are perceived as more neutral. *Female Genital Cutting (FGC) and the Ethics of Care: Community engagement and cultural sensitivity at the interface of migration experiences*

[71] *Prise en charge des mutilations sexuelles féminines par les professionnels de santé de premier recours, Recommandation de bonne pratique,* Haute autorité de santé, February 2020, p. 57 [Online] [https://www.hassante.fr/upload/docs/application/pdf/202002/reco307_argumentaire_mutilations_sexuelles_feminines.pdf]

When raising the topic of FGM/C, the SOGC suggests using simple sentences and interactive communication (e.g. use images and diagrams) whenever possible.[72] This is even more relevant with children. For example, you could ask a child: "Has something been done to you down there?"[73]

However, it may be relevant to use the words "female genital mutilation/cutting" in the medical certificate you must produce for the Court or other immigration procedures.[74] Using the word "mutilation" in these documents: "... establishes a clear linguistic distinction from male circumcision, and emphasizes the gravity and harm of the act..."[75] You should therefore explain to the woman or girl the importance of the word "mutilation" in the evidence which will need to be produced.

6. DOCUMENTS FOR HEALTH CARE PROFESSIONALS AND SOCIAL SERVICES PROVIDERS

An immigration application that addresses the issue of FGM/C almost always requires a medical certificate from a health and/or social services professional. Such document(s) must be written with professional impartiality and objectivity.

Since the document will reflect the woman or girl's lived experience, it is crucial you listen attentively to the facts she tells you.

Remember that the document requested may be for a child. As mentioned earlier, the approach taken when producing a certificate for a child will be different than that for an adult.

It is important to know that it is a professional's expertise and competence that determine the probative value of the evidence they produce, not its title alone. Therefore, you do not need to be a member of a professional association.

6.1 Medical certificate for FGM/C

For an application for asylum or another immigration process, a medical certificate can establish the presence or absence of FGM/C and/or establish proof of past mistreatment (whether or not it has left visible marks on the body)[76]. Moreover, the absence of such a document can lead decision-makers to make negative inferences about the applicant's credibility.[77]

A host of issues can arise when a medical certificate is requested for a minor. In particular, it can be difficult to reconcile the request with your moral values or ethical/professional obligations. Should this be the case, it may be appropriate to discuss the document with the parents, but also, with their consent, to discuss it with their legal representative, as the document may be a central piece of evidence in the application for asylum.

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[72] Clinical practice guideline No. 299, *Female Genital Cutting*, SOGC, November 2013.
[73] Id, p. 57.
[74] If you choose a more medical (neutral) term, it may be relevant to explain this choice to decision-makers since not all of them have the same level of knowledge about FGM/C. Your choice of terminology could, in such cases, suggest the FGM/C is of "lesser" severity.
[75] *Eliminating Female Genital Mutilation, Interagency Statement*, 2008, Appendix 1, p. 26, [Online] [https://iris.who.int/handle/10665/43839]
[76] Old fractures, for example.
[77] X (Re), 2019 CanLII 136668 (CA CISR)

In Canada, there is no standardized medical certification form for FGM/C. It is up to each professional to create the document as they see fit. However, here are some suggestions for the content of this certificate:

- Identify the expert (consider including curriculum vitae or other information on the expertise of the professional who carries out the exam).
- Specify the appointment date(s).
- Classify the type of FGM/C using the WHO classification, with a description of your observation (with or without diagram, see section 2 for the different types of FGM/C and for reference materials); however, note that identifying the FGM/C type is not a requirement, and the certificate may be relevant without classification.
- List past, present and future complications of the FGM/C (ask the applicant for their past medical records, if possible).
- Name what can be done about these complications and your prognosis.
- Use a supporting diagram to identify any other scars from gender-specific maltreatment[78] and mention, if applicable, that identified acts of torture align with the woman/girl's allegations, or specify the degree to which they support her version of the events.

Several documents may be required in order to provide all the above elements. For example, if the medical certificate of the absence of FGM/C is produced by a specialist, this clinician may not have the expertise to assess scars attesting to other forms of violence.

A few templates of medical certificates for FGM/C in use in France and Belgium are presented in the appendix. Although they do not include all of the above information, they remain relevant examples.

6.1.1 Identifying other scars

A medical certificate should identify not only the presence or absence of FGM/C, but also any other visible or internal scars. Many European experts refer to the *Istanbul Protocol* when reporting and documenting torture (including FGM/C) in their reports.[79] This reference provides diagrams of the female and male bodies, as well as the feet, hands, head, skeleton and mouth/teeth.[80] Known for their clinical expertise in torture identification, the physicians at the Centre d'expertise sur le bien-être et l'état de santé physique des réfugiés et des demandeurs d'asile (CDAR), a Montreal clinic for asylum seekers and refugees, regularly produce medical certificates with diagrams of the signs of physical torture.

The Istanbul Protocol also includes the *Guidelines for the Medical Evaluation of Torture and Ill-Treatment*.[81] These can be used to guide the choice of content for the medical certificate.

Another relevant document for identifying and documenting torture scars is *Medical Physical Examination of Alleged Torture Victims: A practical guide to the Istanbul Protocol – for medical doctors*.[82] While it only briefly mentions FGM/C in the "Gynaecological Examination" section,[83] the

[78] This avoids the need for multiple appointments to collect evidence.
[79] *Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, *Professional Training Series No. 8, Rev.1*, United Nations, 2005, [Online] https://www.refworld.org/cgi-bin/texis/vtx/rwmain/opendocpdf.pdf?reldoc=y&docid=50c83f6d2
[80] See the appendices for various diagrams.
[81] See the appendices for various diagrams.
[82] *Medical Physical Examination of Alleged Torture Victims: A practical guide to the Istanbul Protocol – for medical doctors*, p. 32
[83] *Istanbul Protocol*, p. 32

document provides detailed explanations of various other forms of torture and how to represent them in a written document.

Also highly relevant to documenting torture is the *Model Curriculum on the Effective Medical Documentation of Torture and Ill-Treatment*.[84] Although issued in Denmark, it can be of use to experts in Canada and Quebec, as it draws its content from the aforementioned Office of the United Nations High Commissioner for Human Rights (OHCHR) manual and the *Istanbul Protocol*. The model curriculum offers a detailed list of

- forms of torture (with images and drawings),[85]
- physiological evidence of torture and/or ill-treatment (with some pictures and drawings),[86]
- neurological evidence of torture-related trauma.[87]

6.2 Psychosocial, psychological and psychiatric documents

A woman or girl who has undergone FGM/C, or fears she will, may experience a variety of psychological complications. These will depend on a number of factors, including "her thought and value system, personal development, and various social, political and cultural factors".[88] As a result, the effects experienced can vary greatly from a woman or girl to the next.

For applications for asylum and other immigration applications, a psychological or psychiatric assessment, a psychologist's certificate, a psychosocial report, etc. may be necessary and highly relevant. These can be used to:

- lay out the difficulties in pleading the case and/or testimonial (difficulty presenting the events accurately, coherently and spontaneously); reports may therefore safeguard the woman's and/or girl's credibility.
- clearly describe the consequences of the cutting/excision to show how FGM/C can be a "continuing form of harm"[89] or constitute "compelling reasons,"[90]
- present the difficulties of applying for protection in the home country, but also in Canada, or
- present the difficulties of relocating within the home country ("possibility of internal refuge" or PIR).

Producing a follow-up report or certificate can be very beneficial. However, the document can also be used to justify a decision-maker's negative response. For example, certain statements may be

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[84] *Model Curriculum on the Effective Medical Documentation of Torture and Ill-treatment, Educational Resources for Health Professional Students*, 2006-2009, International Rehabilitation Council for Torture Victims, Denmark, [Online][http://phrtoolkits.org/files/model-curriculum.pdf]

[85] Id. See module 4, section 2, pp. 94–119.

[86] Id. See module 5, section 2, pp. 128–143.

[87] Id. See module 5, section 3, pp. 143–145.

[88] United Nations, *Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, *Professional Training Series No. 8, Rev.1*, para. 234, p. 51, 2005, [Online; our translation] https://www.refworld.org/cgi-bin/texis/vtx/rwmain/opendocpdf.pdf?reldoc=y&docid=50c83f6d2

[89] Continuing form of harm: "…a woman or girl who has already undergone the practice before she seeks asylum may still have a well-founded fear of future persecution. Depending on the individual circumstances of her case and the particular practices of her community, she may fear that she could be subjected to another form of FGM and/or suffer particularly serious long-term consequences of the initial procedure." Para. 14 of the UNHCR Guidance Note [https://www.refworld.org/pdfid/4a0c28492.pdf] In Canada, the concept of "continuing form of harm" is very rarely invoked by lawyers during a hearing.

[90] In FGM/C cases, compelling reasons may exist "...to grant the claimant refugee status. This may be the case where the persecution suffered is considered particularly atrocious, and the woman or girl is experiencing ongoing and traumatic psychological effects, rendering a return to the country of origin intolerable." Para. 15 of the *UNHCR Guidance Note* [https://www.refworld.org/pdfid/4a0c28492.pdf] This argument is seldom plead in Canadian courts, but it is highly relevant to the case of a woman or girl who has undergone FGM/C.

taken out of context; hence the extreme importance of having the necessary knowledge to draft the document. To minimize the chances of this occurring, documents should be drafted jointly with the woman or girl and her legal representative.

6.2.1 Follow-up certificate and expert report on social functioning

When a woman or girl is being followed by health care professionals and/or social services providers, it may be appropriate to produce a follow-up certificate and/or an expert report on social functioning.

However, sometimes: "You have to ask yourself whether it is appropriate to write the document, given the length of the therapy time, and in some cases, you may prefer not to write anything at all." [91] For example, it may not be relevant to write a document if :

- the person is not involved in the psychological, therapeutic and/or psychosocial process,
- the therapeutic care does not address issues related to asylum seeking, including FGM/C,
- the document would have to contain "negative" facts about the woman or girl; for example, if the mother is allegedly violent toward her daughter, whom she has come to Canada to protect, and this is the main topic discussed with the professional,[92]

Such a document should contain the following elements:

- The expertise of the health care professional and/ore service provider
- The period of therapeutic consultation, follow-up, etc.
- The diagnosis, if made, and observed symptoms (not just those described by the woman or girl)
- Prescribed medications, if applicable
- Topics addressed in the therapeutic sessions or meetings (minimum necessary detail)
- Evaluation of "malingering"

6.2.2 Psychological report

A psychological report should be produced by a "neutral" professional and include all the following elements:

- The expert's curriculum vitae
- The context in which the report was requested.
- Dates and time spent with the applicant to prepare the report.
- A VERY brief summary of the facts (important: the facts in this report must corroborate those in the other documents in the application).
- Diagnosis and treatment needs.
- The examinations performed during the appointments (also mention that "malingering" has been ruled out for the following reasons…).
- Explanation of the possibilities of re-victimization, if applicable, and the reasons.

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[91] *Femmes, Excision et Exil: Quel accompagnement thérapeutique possible*, coordinated by Annalisa D'Aguanno, Psychologist and Clinician, GAMS Belgium since 2009 [Online; our translation] [https://sites.uclouvain.be/reso/opac_css/doc_num.php?explnum_id=9013] GAMS Belgium (groupe pour l'abolition des mutilations sexuelles) is an NGO that has been offering since 1996 a full range of services to women and girls affected by FGM. Its main objective is to "contribute to the abolition of female genital mutilation in Belgium and the rest of the world," [Online; our translation] [https://gams.be/qui-sommes-nous/missions-et-valeurs/]

[92] It is impossible to cover all the reasons that could justify not producing a document. It is thus very important to coordinate with the legal counsel, who is in the best position to assess what would or would not be detrimental to the case.

- If problems with the application for asylum have been brought to the expert's attention, find out whether the applicant's psychological state could, in whole or in part, constitute a plausible explanation and why.
- Explanations of whether the applicant's condition could affect her ability to testify (it is important to explicitly mention specific symptoms and the possible negative effects on an eventual testimony).[93]
- Explanation of whether symptoms could worsen if the applicant is returned to her home country and the effects these symptoms have on the applicant and her ability to live there.[94]
- Not mention whether or not the request should be accepted.

As mentioned above, a psychological report may be a relevant way to present the difficulties that would result from the applicant's return to the country where they have experienced persecution or fear experiencing it. Please see the Olalere case,[95] in which it was concluded that:

> [60] In each individual case, it seems to me, it will be necessary to examine what the psychological report says, and whether it raises issues that should be addressed in the second prong of the IFA analysis. Here, the report says that '**Ms. Olalere's return to Nigeria will very likely cause her mental and physical stress symptoms to increase considerably, and for her psychological and emotional state to deteriorate**.' It seems to me that this is a consideration that is material to the Applicant's ability to function in one of the suggested IFAs and should have been addressed. The Refugee Appeal Division (RAD) did not need to accept it as decisive, but it is material and was either overlooked or ignored. In any reconsideration the RAD will need to consider whether there is any evidence presented to show that the psychological help the Applicant needs is not available at one of the IFAs in Nigeria. (Our emphasis)

In addition to any mention that "the application for asylum should be accepted", there are several other mentions that should be avoided in a psychological report. In the Egbesola case,[96] the Honourable Mr. Justice Zinn found that:

> [13] Like Justice Mosley, **it is my view that the doctor became an advocate and the statement that the principal applicant will not feel safe anywhere in Nigeria has virtually no probative value.** To the extent that the report does offer expert opinion, the RAD did consider whether the applicant would have access to health care in Port Harcourt and found that she would. This is not challenged by the principal applicant. Accordingly, the failure to directly address the medical report does not render the IFA finding unreasonable. (Our emphasis)

It is imperative that, when producing documents for submission as part of an immigration process, health care professionals and social services providers avoid stepping out of their field of competence; they must never present a plea on the woman's or girl's behalf.

Finally, to ensure the relevance of your document's content, you should share a draft with the applicant's legal representative.

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[93] X (Re), 2019 CanLII 133698 (CA CISR), para. 41.
[94] *Ambrose Esede v. Canada*, 2018 CF 1241 (CanLII), para. 51.
[95] *Olalere v. Canada (Citizenship and Immigration)*, 2017 FC 385 (CanLII)
[96] *Egbesola v. Canada (Citizenship and Immigration)*, 2016 FC 204 (CanLII)

7. IMMIGRATION PROCEDURES IN WHICH A DOCUMENT FROM A HEALTH AND/OR SOCIAL SERVICES PROFESSIONAL MAY BE RELEVANT

A person may seek protection in Canada under two provisions of the Immigration and Refugee Protection Act[97] (IRPA): they may be determined as a refugee under section 96 and/or as a person in need of protection under section 97.

In FGM/C cases, section 96 of the IRPA is generally invoked for women and girls. The alleged fear is based on the social group of women or girls who are at risk of these practices. If a mother or father fears reprisals for refusing that FGM/C be performed on their daughter, the claim is still based on the category of the social group, but this time as a family member of the girl fearing FGM/C. Obviously, other reasons can be given when a person opposes or fears FGM/C, including:

- religion-based fear (when FGM/C is rooted in a community's religious values, opposition to tradition may be perceived as a total or partial rejection of the religion), and
- politics-based fear (when FGM/C is rooted in a community's values, opposing it may be perceived as an affront to community politics).

The process of applying for asylum in Canada begins upon arrival either at the U.S.-Canada border, at the airport and/or on Canadian soil, at one of the Immigration, Refugees and Citizenship Canada (IRCC) offices.[98]

Applying for protection in Canada can be a lengthy process. In the past, a timeline for all the stages of the process was clearly laid out. However, as these guidelines are being written, a backlog of cases pre-dating and during the COVID-19[99] pandemic has led to slower and/or significantly modified deadlines. There are over 90,000 refugee cases pending with the Immigration and Refugee Board (IRB),[100] which is no longer able to meet the demand with the resources at its disposal. From the moment a person applies for refugee status, it can take months, even years, for the case to be heard by the IRB's Refugee Protection Division (RPD).

Applicants should start gathering the evidence required for a refugee claim as soon as the process is initiated.[101] However, it is wise for health care professionals and/or social services providers to wait before writing documents, as this ensures they are up to date at the time of the hearing.[102]

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[97] S.C. 2001, c. 27

[98] In Canada, a person can only make one application for refugee status in their lifetime.

[99] Pre-Covid-19, the number of pending cases before the IRB increased annually: for 2016: 17,537; for 2017: 43,250; for 2018: 71,675; and for 2019: 87,270. Information taken from the IRB website, which can be consulted at: https://irb-cisr.gc.ca/en/statistics/protection/Pages/RPDStat.aspx

[100] This data was valid as of June 30, 2020, and was taken from the IRB website, which can be consulted at irb-cisr.gc.ca/fr/statistiques/asile/Pages/SPRStat.aspx

[101] Found on the IRB website, the *Claimant's Guide* provides a thorough overview of the process and the steps to take to ensure a smooth process. Consult the Guide at irb-cisr.gc.ca/en/refugee-claims/Pages/ClaDemGuide.aspx

[102] This is less applicable to the medical certificate vouching for the presence or absence of FGM/C. It is also less applicable to cases in which several complementary documents are submitted over time in order to measure progress (positive or negative).

7.1 “Less complex” claim for asylum

The RPD may identify a case as “less complex” due to a number of factors, including the applicant’s country of origin.[103] A case in this category will proceed to a short hearing (not to exceed 1–2 hours)[104] or to no hearing.

In cases where a hearing is determined to not be necessary, a notice from the tribunal is sent to the applicant and their legal representative informing them that the application has been selected. A **confirmation form** will be attached to this notice. It must be completed and returned to the tribunal within 15 days of receipt.[105] The application must then be completed and all relevant evidence sent to the tribunal.

At this stage, the presence or absence of FGM/C and the woman’s or girl’s general state of health must be documented. The more relevant and credible the corroborating evidence is, the more likely it is that the application for asylum will be accepted.

Finally, a “less complex” case can change category at any time, requiring a hearing to be scheduled.[106]

7.2 Request for “due process” asylum

As mentioned above, a person seeking protection in Canada will have to wait for their case to be heard by the RPD and then for a decision to be rendered.

Currently, it is the RPD that schedules the hearings and informs those concerned.[107] However, legal representatives are usually informed of the hearing date several weeks before the notice is issued. When a date has been set for the hearing, evidence must be submitted no later than ten (10) days prior to the hearing.[108]

Proof is essential as an applicant is rarely taken at their word; their credibility is indeed often a determining factor in the case. Thus, evidence provided by health care professionals and/or social services providers is key to FGM/C cases, as this proof corroborates the case’s central elements. Sometimes documents are not enough and the professional is strongly recommended to attend.

On the scheduled day, the hearing may proceed in several ways, but the most common are that the case :

- is proceeding and the decision is under “deliberation” and will be rendered and communicated later,
- is proceeding and an oral decision is rendered,
- is proceeding but needs to be continued later,[109]
- could not proceed.

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[103] *Instructions Governing the Streaming of Less Complex Claims at the Refugee Protection Division* [Online][https://irb-cisr.gc.ca/en/legal-policy/policies/Pages/instructions-less-complex-claims.aspx]
[104] A short hearing can become a regular hearing, which normally lasts three hours.
[105] *Less Complex Claims: The short-hearing and file-review processes*, IRB, [Online] [https://irb-cisr.gc.ca/en/information-sheets/Pages/less-complex-claims.aspx]
[106] *Less Complex Claims: The short-hearing and file-review processes*, IRB, [Online] [https://irb-cisr.gc.ca/en/information-sheets/Pages/less-complex-claims.aspx]
[107] *Claimant’s Guide*, IRB, v. 5, 2018, [Online] [https://irb-cisr.gc.ca/en/refugee-claims/Pages/ClaDemGuide.aspx]
[108] *Claimant’s Guide*, IRB, v. 5, 2018, [Online] [https://irb-cisr.gc.ca/en/refugee-claims/Pages/ClaDemGuide.aspx]
[109] For instance, a rescheduling can be requested and/or granted because of the claimant’s state of health and the need to document it.

Finally, a legal representative can apply to the tribunal to request that an asylum application proceed as a priority matter because of the applicant's vulnerability. In this situation, one or more documents from health care professionals and social service providers are crucial to justify the exceptional request.

7.3 Steps after the refusal of a refugee claim

Following an unsuccessful refugee claim, the applicant can usually enquire about the process of appealing[110] to the IRB. Like an application for asylum, this request suspends deportation from Canada. For such a request, which is usually made on paper,[111] it is permitted to produce new evidence, although it must meet strict criteria.[112]

In an appeal, a document from a health and/or social services professional could be relevant as the following documents:

- A first document (for claims for asylum with missing/absent evidence).[113]
- A follow-up to the first letter written for the claim for asylum.
- A response to the RPD's reasons for refusal, when this refusal calls into question a document produced by a health and/or social services professional.

Hearings before the RAD are held primarily when new evidence is submitted and the Commissioner[114] is of the opinion that this same evidence

- raises a major issue affecting credibility,
- is essential for the decision on the application for asylum,
- would, assuming it is accepted, justify granting or rejecting the claim submitted to the RPD.

As for the outcome of an appeal to the RAD, there are three (3) possible scenarios:

- Appeal rejected.
- Appeal granted and file returned to RPD.
- Appeal granted and the person is recognized as a refugee and/or person in need of protection.

People who do not have the right to appeal to the RAD must apply for leave and judicial review[115] before the Federal Court (hereinafter the Court). This is not an appeal. New evidence cannot be submitted, besides exceptional cases,[116] and the Court cannot replace a decision by the tribunal. If the judgment establishes that the tribunal has erred, the case is returned to the RPD for adjudication by a differently constituted panel. For decisions made by the IRB's (…)' Refugee Protection Division, the removal order is not on hold requiring that the person would need to leave Canada. If, however it is

[110] Refugee Appeal Division (RAD)
[111] Hearings are sometimes granted, but only rarely and according to strict criteria.
[112] "New evidence" must meet one of the following three criteria: 1. It did not exist when the RPD rejected the claim; 2. it was not reasonably available when the RPD rejected the claim; or 3. in the circumstances, the RPD could not reasonably have expected to obtain the evidence from the claimant when it rejected the claim. See irb-cisr.gc.ca/en/refugee-claims/Pages/ClaDemGuide.aspx#who
[113] The legal counsel will have to explain why the document could not have been produced earlier.
[114] This is the title given to those who render decisions in the various IRB tribunals.
[115] Often referred to as "judicial review."
[116] If it is shown that there has been a "violation of procedural fairness," new evidence can be produced to demonstrate the violation, but not to establish its content.

the RAD making the decision, the removal order is on hold, until the Court decides. This process suspends deportation.[117]

Finally, should all other recourse related to the refugee claim be rejected, there are other immigration procedures that apply to certain categories of people, for which proof may be requested and/or required.

7.3.1 Application for visa exemption on humanitarian considerations

Exemption on humanitarian considerations (HC) is a recourse available only when no other Canadian immigration program applies. Asylum seekers whose application has been refused must wait 12 months from the last judgment before they are entitled to submit a HC application.[118] However, two exceptions allow an HC application to be filed before the time limit is up:

- The best interests of a child or children are at stake.
- The person or rejected asylum seeker, who is included in the application, suffers from a health problem that would endanger their life if deported.[119]

However, many applicants are not entitled to this recourse, since the IRPA provides for exceptions in addition to the 12-month time limit.

An HC application is submitted in writing. It is reviewed by an IRCC officer with **discretionary power**. In exceptional cases, a telephone or face-to-face interview may be requested.

It is the applicant's and/or their legal representative's responsibility to produce a complete application file. Supplementary information can and should be submitted periodically to keep the information in the file up to date, given that it takes 22–36 months on average for these applications to be processed.[120]

A non-exhaustive list of the criteria to meet in such an application includes:

- How settled the person is in Canada.
- General family ties to Canada.
- The best interests of any children involved.
- What would happen to the person should the request be refused.[121]

An HC application is not a right. Canada is neither obliged to offer this option to foreign nationals nor to consider such requests prior to deportation. However, the Government of Canada undertakes to study the HC application and render a decision even once the applicant is outside Canada.

A document from a health and/or social services professional can be very relevant in an HC application, especially in regard to documenting the suffered or feared FGM/C. The following is a

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[117] With the exceptions provided for in section 231 of the Immigration and Refugee Protection Regulations, (SOR/2002-227) (IRPR). https://www.canada.ca/en/immigration-refugees-citizenship/services/refugees/claim-protection-inside-canada/after-apply-next-steps/refusal-options/federal-court-review.html

[118] Information taken from the IRCC website, at the following address: https://www.canada.ca/en/immigration-refugees-citizenship/corporate/publications-manuals/operational-bulletins-manuals/permanent-residence/humanitarian-compassionate-consideration/intake-who-may-apply.html.

[119] This information was taken from one of the forms included in a HC application: *Supplementary Information* (IMM-5283) 06-2020 E, [Online][https://www.canada.ca/content/dam/ircc/migration/ircc/english/pdf/kits/forms/imm5283e.pdf]

[120] This information was taken on September 22, 2020, from the IRCC website at the following address: https://www.canada.ca/en/immigration-refugees-citizenship/services/application/check-processing-times.html.

[121] This list was taken from IRCC at the following address: https://www.canada.ca/en/immigration-refugees-citizenship/services/refugees/claim-protection-inside-canada/after-apply-next-steps/refusal-options/humanitarian-compassionate-grounds.html. It is not exhaustive.

case in point: A mother who has experienced FGM/C from “country x” fears FGM/C, among other forms of violence, for her daughter who is a Canadian citizen and has not been exposed to FGM/C.[122] For her case, it is necessary to produce evidence to establish that: 1) the mother has experienced FGM/C, and 2) the girl has not been exposed to FGM/C. Thus, if medical certificates have not been produced for previous applications, they should be produced for the HC application. A psychosocial and/or psychological follow-up report or certificate could also be produced to establish how the mother’s fear impacts her parenting capacities, her ability to adapt.

7.3.2 Pre-Removal Risk Assessment (PRRA) request

Unlike the HC application, a PRRA request is conducted in a meeting with a CBSA officer.[123] However, it is the IRCC that reviews these requests.

For an applicant to be eligible to the PRRA program, the CBSA must be in the process of removing them and, generally, 12 months must have elapsed since:

- the application for asylum was withdrawn or abandoned or the IRB rejected it,
- another PRRA application was withdrawn, abandoned or rejected, and
- the Federal Court dismissed the judicial review of the refugee claim or the resolution of a previous PRRA application.

People who have previously applied for refugee status in Australia, New Zealand, the United Kingdom or the United States of America have immediate access to the PRRA program, as they are not eligible to apply to the IRB for asylum.[124]

A PRRA application consists of a form, pieces of evidence and written arguments. As with the HC application, it is very rare to have an interview.

New proof is required, and it must meet strict criteria. A document from a health professional is very important at this stage of an applicant’s migration process, as this is their last chance to have their risk of removal assessed. As with an application for asylum, the applicant must demonstrate a well-founded fear of persecution.[125] However, the chance of success is 2%.[126]

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[122] A mother from a country other than Canada cannot apply for protection in Canada for her Canadian child or children.
[123] Once the applicant receives the PRRA request form they have 15 days to return it and another 15 days to submit arguments and evidence in support of the case.
[124] There are other exceptions to the 12-month rule.
[125] For more information on how to apply for PRRA, please consult https://www.canada.ca/en/immigration-refugees-citizenship/services/refugees/claim-protection-inside-canada/after-apply-next-steps/refusal-options/pre-removal-risk-assessment/how-to-apply.html.
[126] “Expulsion : l’impossible dernier appel,” Annabel Nicoud, *La Presse*, November 14, 2012 [Online][https://www.lapresse.ca/actualites/national/201211/14/01-4593759-expulsion-limpossible-dernierappel.php#:~:text=Environ 2% of all asylum seekers oféboutés.]

8. CONCLUSION

Documents issued by health care professionals and/or social services providers are often central to various immigration processes involving a girl or woman who fears or has suffered FGM/C. However, it is important to bear in mind that while medical certificates and other documents may be helpful in the asylum process, they may also be detrimental. To ensure a document' is beneficial, it must be co-produced with the applicant and their legal representative.

In the Canadian asylum system, the benefit of the doubt is often called into question and, as a result, asylum seekers' allegations need to be supported by corroborating evidence. When a woman or girl alleges fear of undergoing FGM/C, a medical certificate is the only objective and credible proof that she has not already undergone the mutilation. Without such evidence, the tribunal may call into question the validity of the applicant's fears.

Furthermore, when a woman or a girl has already undergone FGM/C, a psychological report and/or follow-up certificate can also serve as key evidence in demonstrating that the severity of the consequences merits the tribunal's consideration as a "continuing form of harm" or "compelling reasons". Too often, when a woman or girl has undergone FGM/C, her fear for the future is dismissed on the argument that she has already been persecuted. In this way, the fear is tied to past events. When the facts align, medical certificates can remedy a credibility that is called into question.

Finally, although a document from health and/or social services professionals is very often central to the application for asylum by women and girls who have undergone or who fear FGM/C, sometimes it proves relevant and even more favourable not to produce such a medical certificate.

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APPENDIX A

CHECKLIST

Content to include in evidence of FGM/C

☐ From the outset, make sure a certificate is appropriate for this case.[127]
☐ Enclose your curriculum vitae (specifically listing your expertise in FGM/C or related fields)
☐ Include the date the evidence is produced, your full name (with signature) and professional title
☐ Use the term "female genital mutilation"[128]
☐ Identify the type of document to be produced (certificate, follow-up, report, etc.)
☐ Note the date and duration of the appointment(s) with the woman or girl
☐ State the diagnosis (prognosis, prescribed medication, symptoms observed, etc.) or copy a diagnosis previously confirmed by a qualified professional
☐ Explain that you have assessed the possibility of the applicant "malingering" (and substantiate by stating whether exams have been performed to confirm the FGM/C)
☐ Identify and clearly explain the tests the applicant has undergone
☐ Have the applicant AND their legal representative read and approve your document

ACCORDING TO YOUR FIELD(S) OF EXPERTISE

☐ If possible, identify the type of FGM/C according to the WHO classification, with a description of your observations (with or without diagram)
☐ Identify the past, present and future complications of FGM/C
☐ If applicable, list any difficulties that could have an impact on the applicant's ability to testify; identify these difficulties and explain how her testimony could be affected (e.g. revictimization, memory problems, flashbacks, health-related physiological tics)
☐ If applicable, identify all visible and non-visible indications (including X-rays) of violence on the applicant's body with a diagram
☐ If they can be determined, identify the effects that returning to the country of feared persecution could have on the applicant's health (e.g. potential worsening of symptoms, impact of worsened symptoms on the applicant and her ability to be in the country)

DO NOT:

☐ Make a diagnosis that falls beyond your field of expertise
☐ Repeat in their entirety the facts as the applicant reported them
☐ Analyze the laws of the applicant's country of origin
☐ Comment and/or conclude on the condition of girls and women in the country of origin
☐ Advocate on behalf of the applicant
☐ Give an opinion on the outcome of the claim (e.g. "The claim should be accepted")

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[127] See p. 25 of this document.
[128] See p. 20 of this document.

APPENDIX B

CERTIFICATE TEMPLATE I

[Letterhead of your institution or organization]

[Date and place certificate is produced]

CERTIFICATE OF FGM/C

FOR: [Applicant's name and an identifier] (date of birth, eight-digit IRCC identification number, etc.)

To whom it may concern,
I, the undersigned, am a ___________________ [profession and/or title] at _______________ [entity and/or organization worked for].
I hereby certify that I met with ____________________ [applicant's name] on ____________ [date] for the purpose of examining their external genitalia.
Examination of their external genitalia reveals ________________________________ [e.g. intact labia majora, but complete absence of labia minora and clitoris].
My physical examination confirms that the applicant has undergone female genital mutilation.
[Your choice of greeting]
[Signature]
[Full name and title]
[Your full contact information]
N.B. Although not required, a diagram could also be added for better visualization of the information. Also, if the entity for which you work is not known to the tribunal and/or IRCC, it may be relevant to provide a description and/or add your CV.

CERTIFICATE TEMPLATE II

[Letterhead of your institution or organization]

[Date and place certificate is produced]

CERTIFICATE OF THERAPEUTIC CARE[129]

FOR: [Applicant’s name and an identifier] (date of birth, eight-digit IRCC identification number, etc.)

To whom it may concern,[130]
This certificate confirms that I, __________________________ [full name and professional title], have been providing care to _____________________ [applicant’s name] since _________________ [date] every ___________________________ [frequency of meetings].
She was referred to me by [name of resource and/or intermediary, if applicable] _____________________. The doctor diagnosed her with __________________ [insert diagnosis].
When she came to my office, she had the following [list symptoms]: ______________________________. She had been prescribed with _______________ [list medications].
Our sessions focused mainly on __________________________________ [non-exhaustive list of reasons for the consultation]. During our sessions, I have observed that ____.
[Warnings, if necessary] ____________________________
Please do not hesitate to contact me should you have any questions regarding this certificate or should you require additional information.
[Greeting] (e.g. Thank you for your attention in this matter).

[Signature]
[Full name and title]
[Your full contact information]

[129] A CV is relevant for establishing your expertise and/or skills.
[130] Since it is often the legal counsel who requests the documents, this certificate can be addressed to this specific person. 131 129 A CV is relevant for establishing your expertise and/or skills

CERTIFICATE TEMPLATE III

[Letterhead of your institution or organization]

[Date and place certificate is produced]

PSYCHOSOCIAL ASSESSMENT[131]

FOR: [Applicant's name and an identifier] (date of birth, eight-digit IRCC identification number)

To whom it may concern,
[Identify yourself and the entity you work for, if applicable, to establish your and your employer's credibility]
At the request of their legal counsel, I am producing this assessment for ______________________ [applicant's name].

[Sections to include]

Context of psychosocial assessment and support
- Methodology(ies) used during the appointments
- Tests undergone
- Evaluation of "malingering"
- Documents consulted
- Period during which appointments were held and whether ongoing
- Frequency of appointments
- Facts (very briefly)

Observations during appointments
- Symptoms, difficulties, etc. observed as very important (should be explained with context)
- Symptoms, difficulties, etc. reported by the applicant and explanations, if possible, of why they are noteworthy
- How the symptoms, difficulties, etc. may be perceived as tainting the applicant's credibility

Recommendations
- Need(s) for follow-up care with you and others, if applicable
- Specific need(s) regarding the asylum hearing (how the applicant is to be questioned, the need to be sensitive to the possibility that questioning may revictimize the applicant, etc.)
- Difficulties and how such challenges might affect the applicant's relocation to the country of origin and/or their ability to stay safe should they return

[Signature]
[Full name and title]
[Your full contact information]

[131] A CV is relevant for establishing your expertise and/or skills.