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Health care for immigrant women in Italy: are we really ready? A survey on knowledge about female genital mutilation

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Abstract

Background. Because of immigration, female genital mutilation (FGM) is an issue of increasing concern in western countries. Nevertheless operators without a specific training may ignore the health condition of women subjected to this practice and fail to provide them adequate assistance. The purpose of the study was to estimate the current knowledge about FGM among social and health care assistants working with asylum seeker.

Material and methods. From October to December 2012, a questionnaire was used to interview 41 operators working in CARA (Shelter for Refugees and Asylum Seekers) in central and southern Italy.

Results. Only 7.3% of respondents states to know well FGM, while 4.9% do not know it at all. 70.7% declare to have never met or assisted a woman with FGM, nevertheless all respondents work with asylum seeker from countries where FGM are performed.

Conclusions. Migration fluxes to Italy over the past decade created a healthcare challenge: women with FGM have specific medical and psychological problems that doctors, nurses and social assistants without specific training are not usually able to manage.

Key words
- female genital mutilation
- female genital cutting
- infibulations
- survey
- migration
- women's health
- transcultural medicine

INTRODUCTION

The terms female genital mutilation (FGM), female genital cutting and female circumcision all describe the cultural practice of partially or totally removing the external female genitalia.

Many women's health organizations, international human rights activists, nongovernmental organizations and international children's rights groups have condemned FGM. While they acknowledge the practice is based on cultural tradition, they also describe it as violence against women and female children, due to undesirable effects on health.

WHO define as FGM all the procedures that involve partial or total removal of female external genitalia or injury to the female genital organs for cultural or any other non-therapeutic reasons [1]. The form of FGM performed varies not only from one country to another but also among different ethnic groups within the same countries.

Four types of FGM are classified:

- *type I* is the excision of the clitoral prepuce or the entire clitoris (clitoridectomy);
- *type II* is the excision of the clitoris with partial or total excision of the labia minora (also called excision or cutting);
- *type III* is excision of part or all of the external genitalia with stitching of the vaginal opening (also called infibulation or suturing);
- and the heterogeneous *type IV* includes pricking, incising or piercing of the external genitalia, stretching of the clitoris and or labia, cauterisation and burning of the clitoris and surrounding tissue or any other procedure that is performed to cause vaginal narrowing or tightening [2].

Health consequences vary depending on the degree of anatomical alteration and are most severe in case of type III FGM.

Although international policies and laws have been enacted to ban all forms of female circumcision, it still continues in many countries. In the world today there are an estimated 130-140 million girls and women who have been subjected to FGM [1]. Due to international migration, the practice is no longer restricted only to countries in which it has been tra-

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Table 1
Female genital mutilation (FGM) prevalence among women aged 15 to 49 by country (C). Data for Egypt, Yemen and Sudan are based on a sample of ever- married women. It is assumed that FGM/C prevalence rate is no different among un-married woman. In bold: country of origin of female immigrants to Italy

FGM/C prevalence among women aged 15 to 49 by country	
Benin (2001) 17	Burkina Faso (2003) 77
Cameroon (2004) 1.4	Central African Republic (2000) 36
Chad (2004) 45	Côte d'Ivoire (1998) 45
Djibouti (2006) 93.1	Egypt (2003) 97
Eritrea (2002) 89	**Ethiopia (2000) 80**
Gambia (2005) 78.3	Ghana (2003) 5
Guinea (1999) 99	Guinea-Bissau (2005) 44.5
Kenya (2003) 32.2	Liberia* (variety of datas) 45.0
Mali (2001) 92	Mauritania (2001) 71.3
Niger (1998) 5	**Nigeria (2003) 19.0**
Senegal (2005) 28.2	Sierra Leone (2005) 94.0
Somalia (2005) 97.9	Sudan, northern (2000) 90.0
Togo (2005) 5.8	Uganda (2006) 0.6
United Republic of Tanzania (1996) 18	Yemen (1997) 22.6

ditionally practiced but has become an issue of increasing concern also in western countries such as Italy [3]: many European countries and their health services have been increasingly confronted with FGM and their medical consequences [4, 5]. It is estimated that 39 000 women who underwent FGM now reside in Italy [6].

In the last two years migration flows to Italy were composed mainly by males, nevertheless in 2011 a significant number of female immigrants were registered from north African and middle eastern countries, such as Somalia, Eritrea, Nigeria, Tunisia and Afghanistan with an incidence of almost 2000 women. In 2012 female immigrants towards Italy were 1000, mainly from Somalia, Eritrea, Nigeria, Ethiopia, Afghanistan, Syria and Tunisia [7].

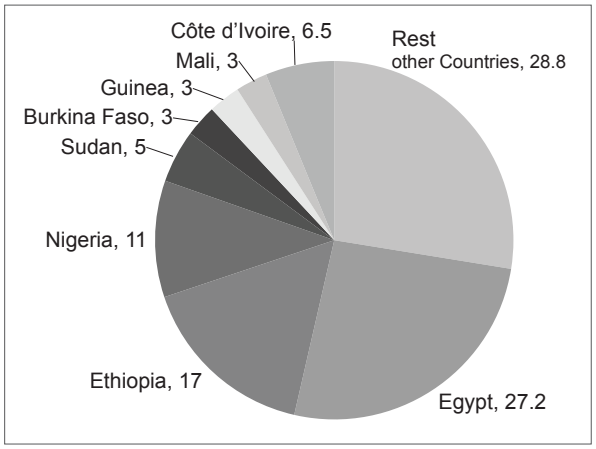


Figure 1
Countries of provenience of women with female genital mutilation (FGM) (% of the 91.5 million of women and girls with FGM). The figure shows the distribution of the 130-140 millions of women with FGM per country.

As shown in *Table 1*, FGM is perform in 28 countries worldwide, mainly in the African continent and Middle East [8], and many of this are the countries of provenience of female immigrants to Italy.

Of the estimated 130 million of women who received worldwide a form of FGM, nearly half are from two countries: Egypt and Ethiopia *(Figure 1)* [9].

Women from those countries are often accepted as refugees and have access to asylum-seekers shelter. In CARA (Centri di Assistenza per Richiedenti Asilo: shelter for refugees and asylum seekers) has been reported a high incidence of women from countries where FGM are practiced such as Somalia, Eritrea, Nigeria and Ethiopia, but physicians, psychologists, nurses or social assistants without a specific training may ignore the health condition of a woman subjected to FGM and fail to recognise the direct consequences of it, hence to provide adequate assistance.

The aim of the study was to investigate the current knowledge about FGM among the operators of CARA, in order to assess if they would be able

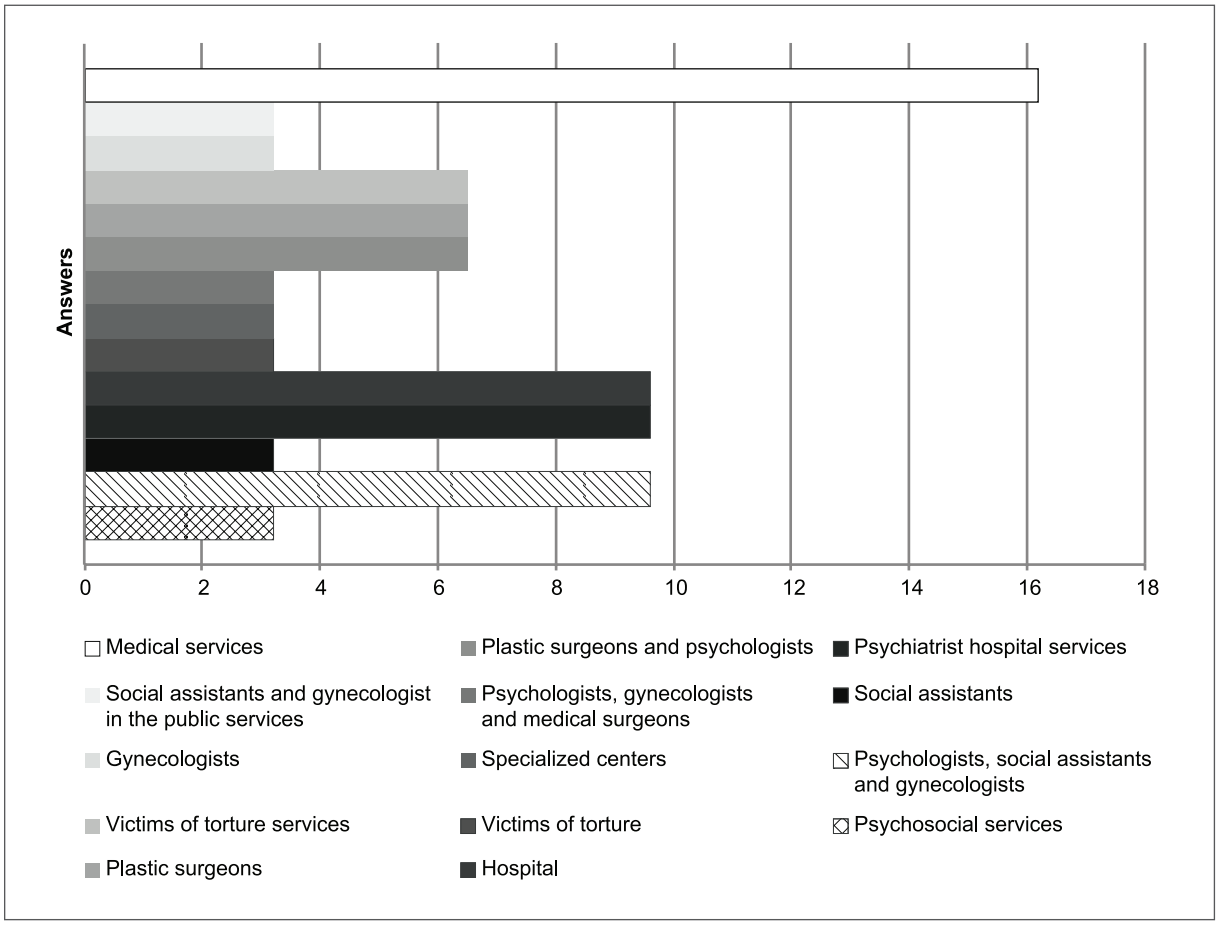


Figure 2
Graphical representation of the answers given by respondents of the questionnaire about female genital mutilation (FGM) in Italy.

to recognize and assist properly a woman with FGM. Furthermore the aim was also to briefly describe the possible health complications due to the practice and to recognize when surgical reconstruction is indicated.

MATERIAL AND METHODS

From October to December 2012, 41 social and health care assistants working with asylum seekers were asked to participate. The population interviewed works in CARA of central and southern Italy, in particular Borgo Mezzanone (FG), Salinagrande (TR), Bari Palese (BA), Pian del Lago (CT) and Sant'Anna (KR), for an overall capacity of 4220 refugees of whom there are around 280 women. CARA are non-health facilities where health assistance can be provided, hence operators are not only social assistants but also doctors, nurses and psychologists.

This particular population has been chosen as a representative survey sample since CARA often represent the first structures where refugees are received after their arrival in Italy therefore it is where there is a first impact with the traditional practices. All of the respondents work with female asylum seeker coming from countries where FGM is performed, therefore they may have been subjected to a form of FGM and need specific assistance. Information has been collected through a specific 14-items questionnaire composed by demographic data (item 1 to 5), individual knowledge (items 6, 10, 14), individual experience (items 7, 8, 9) and management inside the CARA (items 11, 12, 13).

Questionnaires were created in order to be administered and answered quickly (from 3 to 5 minutes) and were anonymous, apart from identification of gender and profession.

RESULTS

Among the 41 questionnaires administered, 100% of them were returned with a high responding rate. Out of the 41 operators who participated in the survey, 31.7% were males and 68.3% females; 36.6% were doctors, 24.4% social assistants, 17.1% psychologists, 12.2% nurses, 7.3% health assistants, 2.4% educators.

Only 7.3% of them affirmed to know well what FGM are, while 4.9% did not know it at all. 70.7% of the answer stated to have never met or assisted a woman with FGM, nevertheless all the respondents work with asylum seeker from countries where FGM is performed.

9.2% of the answer ignored that the type of mutilation may differ with the region of provenience; 95.1% did not know how to manage a woman with FGM and 65.8% ignored whether or not there is a standardized procedure to manage women with FGM.

Out of 41 respondents, 75.6% admitted that in case they would happen to assist a woman with FGM they

would send her to external care services *(Figure 2)*.

From the *Figure* it is clear that there is a high tendency (75.5%) to send the "problem" to "others", in particular: 16.2% of the responders declare that they would send those woman to a "medical facility"; 9.6% to "hospital" or "psycho- social ambulatory + hospital" or "Psychologist + social assistant + Gynecologist"; 6.5% "psychiatric centre for victims of torture", "plastic surgeon" or "plastic surgeon + psychologist" and "counselling centre"; 3.2%: "social assistant + gynecologist", "gynecologist", "psychologist + gynecologist + surgeon", "specialized centre", "centre for victims of torture", "social assistant", "psycho-social ambulatory", "psychologist", or "psychologist + counselling centre".

Furthermore, 56% ignored that a law that prohibits any practice of FGM (Law 9 January 2006, n. 7) exists in Italy.

DISCUSSION

Among the female refugees that reside in CARA, 73% came from countries where FGM are traditionally performed including Somalia, Mali, Syria, Eritrea, Nigeria, Ethiopia, Tunisia and Afghanistan, therefore they may have subjected to this practice and need specific assistance. Considering the WHO estimation of prevalence of FGM in these countries *(see Table 1)* it is possible to assume that among female immigrants from these countries that reside in CARA a high percentage may have been subjected to FGM. Nevertheless, 70.7% of the workers of CARA stated to have never met or assisted a woman with FGM. This discrepancy of data can be due to two factors: the tendency of immigrant women who received FGM of not mentioning the practice and the lack of adequate training of operators who are not able to recognize women with FGM.

Immigrant women are hesitant to speak about their experiences or eventual gynecological problem because of the fear of being judged as a barbaric and uncivilized population or simply because they do not consider FGM as an alteration of anatomical structures: the practice is performed to young girls, later in life they might not consider FGM as the cause of the gynecological problem they have. The lack of training of Italian operators is not a surprising result and it is similar to other studies carried out in Europe about the knowledge on FGM among health operators [10-12].

A woman subjected to FGM may experience many different health complications: the most common conditions affecting women's everyday life are difficulty on urination, menstrual problems, recurrent infections and severe pain during sexual intercourse [13].

Young women and second generation who grow up in a western country such as Italy, are often taken to their country of origin so that FGM can be carried out during the summer holidays, allowing them time to heal before they return to school [14]. The psychological consequences can be tremendous especially in the girls or young women who are integrated in the social context of the host country, such as school or university: the body itself became an "ethnic boundary" that limit their integration process and socialization.

For those young women de-infibulation or vaginal scar treatment assume an important role in the perception of the own body and in the integration progress. De-infibulation procedure is very simple and can be performed in local anaesthesia. It is important not only to allow vaginal delivery during pregnancy and sexual intercourse but also to guarantee a rapid outflow of blood during menstruation and urine during urination in order to reduce pain, discomfort and infections in everyday life [15]. In women who underwent de-infibulation or FGM type I and II, retractile scars and keloids can occur causing pain and discomfort either for sexual life or the perception of their own body leading to dysmorphic syndrome, reactive depression and eating disorder [6]. Many techniques are available for a plastic surgeon to reduce hypertrophic scar and keloids and those procedure should be guaranteed by the National Health System.

CONCLUSION

The data above show how important is a specific training of health-care assistants in western countries on FGM: migratory waves to Europe in the last years are shaping new societies that are increasingly more complex and different. The way to deal with the health problems affecting female immigrants represents a challenge for the healthcare system and for the professionals working within.

Difficulty in urination, menstrual problems and recurrent infections are only few of the problems that women with FGM may experience, with a negative effect on their quality of life.

The psychological difficulties arise especially in the experience of emigration with the comparison, for both young and adult women, with other models of socialization and construction of female identity.

In case of severe anatomical alteration a surgical intervention is indicated in order to restore the physiological functions. Several techniques are available for women asking for surgery and the type of reconstruction depends on the type on mutilation they underwent.

A multidisciplinary team approach including psychologists, plastic surgeons, gynecologists and nurses is necessary for the appropriate management of women subjected to the practice.

When facing FGM, physicians are not only confronted with a medical issue but also to an ethically and culturally sensitive issue. Operators' training should focus not only on healthcare medical aspects but also on the human context that surrounds the practice: only understanding the multi-dynamical cultural reason and considering the entire people's history will ensure the health and well-being of these women.

Conflict of interest statement

There are no potential conflicts of interest or any financial or personal relationships with other people or organizations that could inappropriately bias conduct and findings of this study.

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