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Improving sexual and reproductive health of migrant girls and women living with female genital mutilations providing them with specific maternity care

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Abstract

Background: Worldwide, 200 million girls and women have been estimated as living with female genital mutilation/cutting. Today, this phenomenon does not only concern the countries where this practice is widespread, but also in many other nations where the immigrant female population comes from the countries with high prevalence, or is clandestinely practiced in the countries of destination of immigrant girls and women. It has been estimated that 50 to 80% of all African women who migrated to Italy more than 5 years ago, underwent some form of FGM. Two-third of these have been found to be afraid of seeking gynecological care. Only a small proportion of the 60% who have a vaginal delivery receive appropriate care (anesthesia and de-infibulation). FGM is responsible for specific short and long-term complications that include uro-gynaecological, obstetric, infectious, psychological and sexual consequences requiring appropriate care.

The Department of Reproductive Health and Research (RHR) of the WHO has recently published new guidelines on the management of health complications from FGM with up-to-date, evidence-based recommendations. The European Union has also recently launched an E-learning tool to improve knowledge of healthcare for asylum-seekers among professionals. Its aims are to provide easily accessible information and support to professionals dealing with FGM

Aim: The main scope of the project proposed is: to map existing referral centres and centres with expertise on women and girls living with FGM in Italy and make this information available for professionals and the women concerned (website, professional boards). In addition we aim to define the scientific, clinical and organisational requirements for such centres and to implement updated and evidence-based training courses in obstetric and gynaecological diagnosis and management of FGM (in particular defibulation) and its complications at a national level. Training courses will also provide useful information on further subjects, such as asylum-seekers and FGM and the legal situation concerning FGM. Finally we hope to promote research on the economical impact of FGM.

Keywords: *Female genital mutilations; clinical management; reproductive health; migrants*

Introduction

We wish to draw the attention of your readership to the presence in Europe of a sizable number of women who had been subjected to one of the numerous variants of female genital mutilations or cutting, a dangerous procedure that can cause negative health consequences to affected women. Specific actions are needed to promote health among affected women and prevent the practice in future generations. In the present letter we move from the definition of the phenomenon, to a summary of the situation worldwide and in Europe and end with an outline of a project that we wish to carry out in a number of European Countries, starting with Italy.

This new situation calls for specific action, which we would like to outline here, moving from the definition of the phenomenon, to a summary of the situation worldwide and in Europe and ending with an outline of a project that we wish to carry out in a number of European Countries, starting with Italy.

Definition

Several United Nations organizations have agreed on the definition of Female Genital Mutilation (FGM), or cutting (FGC) as "All procedures involving partial or total removal of the female external genitalia, or other injury to the female genital organs for non-medical reasons". These practices are further defined as "not for health purposes" [1].

FGM can be responsible for specific short and long-term complications that include uro-gynecological, obstetric, infectious, psychological and sexual consequences that require appropriate care.

It is estimated that, worldwide, 200 million girls and women live with female genital mutilation/cutting [2].

They mainly live in African and Asian countries where this practice is traditional, but also in many other high-income countries where they have migrated.

Background

On September 2015, the United Nations General Assembly approved an important continuation of the Millennium Development Goals originally set for the first 15 years of the new millennium [3, 4]. This new document set out 17 Sustainable Development Goals for Member Countries to adopt in their national policies and implement by 2030. In particular, under Objective 5 on Gender Equality, Target 5.3 aims at completely eliminating by the target date the practice of Female Genital Mutilations (FGM) carried out on female infants and girls.

In the eyes of the United Nations, FGM or FGM/C represent a clear violation of the human rights of girls and women in the light of the wide range of literature demonstrating the negative health consequences of this practice in the short, medium and long term. Since in most instances FGM are practiced on children they also represent a children's rights violation, as well as being a direct consequence of the existence of gender inequality. It is for these reasons that in many countries this practice is explicitly prohibited by law.

Among the 230 indicators for monitoring the attainment of the Sustainable Development Goals, the FGM-specific indicator approved by the United Nations Statistical Commission, is represented by "the percentage of girls and women between the ages of 15 and 49 who have undergone FGM compared to total population in the same age range" [5].

The source of data suggested in the methodology developed by the United Nations Statistical Commission is the household survey, such as that currently conducted by UNICEF, the world's largest agency coordinating data collection of this indicator. This survey has been conducted in low to middle income countries since the late 1980s [6]. In some countries, data are collected through other national household surveys. The methodology also includes a breakdown by age, income, place of residence, geographical location, ethnicity and level of education. In the future, Statistical Institutions of the various nations will provide national data.

Currently available data from the United Nations Statistical Office website [7] shows a partial framework, focused on 29 low and middle-income countries, where data are available. The indicator is for the proportion of girls with FGM between 15 and 19 years of age (**Table 1**). From recent estimates for the 29 countries where the procedure is in widespread use, it appears that 45.8% of women in the age range 15-19 had FGM in 2000, the percentage dropping to 34.8% in 2015 in the same age range.

As shown in Table 1, currently countries most affected by the phenomenon are in Africa and the Middle-East. In 2000, the average percentage of women with FMG in West Asia (Yemen and Iraq) was 14.1% (age range 15-19) and in 2015 the percentage fell to 10% in the same age range of the female population. In the North African countries (Egypt, Sudan), on average 91.3% of women in the age range 15-19 had FMG in 2000. Fifteen years later this percentage dropped to 73.9% in the same age range. In Sub-Saharan Africa countries (Djibouti, Eritrea, Ethiopia, Kenya, Somalia, Uganda, Tanzania, Cameroon, Central African Republic, Chad, Benin, Burkina Faso, Ivory Coast, Gambia, Ghana, Guinea, Guinea Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Togo) on average, 37.1% of women in the age range 15-19 had a FGM in 2000. In 2015 this percentage decreased to 25.8% in the female population with the same age range.

All other countries will have to wait for the world statistical system to be put in place to have national data for corresponding world areas available. Meanwhile, there are estimates calculated on the basis of the immigrant resident population from countries that habitually practice FGM.

Table 1. Proportion of female aged 15-19 with FGM, years 2000, 2004, 2005, 2010-2016

	years										
Country or Area Name	2000	2004	2005	2006	2010	2011	2012	2013	2014	2015	2016
World	45,84		42,96		39,69					34,81	
Eastern and South-Eastern Asia	49,2		49,2		49,2					49,2	
South-Eastern Asia	49,2		49,2		49,2					49,2	
Northern Africa and Western Asia	68,02		65,04		58,68					50,97	
Western Asia	14,08		12,47		11,94					10	
Iraq						8,1					
Yemen								18,5			
Northern Africa	91,29		88,75		82,93					73,92	
Egypt										87,2	
Sudan									86,6		
Sub-Saharan Africa	37,12		33,24		30,7					25,76	
Djibouti				93,1							
Eritrea					83						
Ethiopia											65,2
Kenya									21		
Somalia				97,9							
Uganda						1,4					
United Republic of Tanzania											10
Cameroon		1,4									
Central African Republic					24,2						
Chad										38,4	
Benin									9,2		
Burkina Faso					75,8						
Côte d'Ivoire							38,2				
Gambia								74,9			
Ghana						3,8					
Guinea							96,9				
Guinea-Bissau									44,9		
Liberia								49,8			
Mali										82,7	
Mauritania										66,6	
Niger							2				
Nigeria								24,8			
Senegal										24,2	
Sierra Leone								89,6			
Togo									4,7		
Landlocked developing countries	55,32		50,13		44,5					37,13	
Least developed countries	51,59		47,47		43,69					38,71	
Small island developing States	46,7		47,7		45,9					41,9	

Source: UNSTAT database on SDGs indicators [7]

The European situation

Over the years European countries have been the object of a major migratory flux from, Africa, Asia and the Middle East. This has created enormous problems in many areas, health being an important one. Within this context, women migrating from certain areas of Africa and the Middle East have unique sexual and reproductive health needs that European physicians all ill equipped for. Probably, the most cogent problem is represented by FGM.

The European Institute for Gender Equality (EIGE) [8] has carried out a thorough analysis of the FGM and collected various studies conducted in European countries that quantify the consistency of the phenomenon by means of estimates. In most cases estimates are made on the basis of population data, showing residents coming from the countries concerned by this practice and achieving the potential consistency of the phenomenon by calculating the percentage of presence of the country of origin in relation to the age of women and girls from those countries.

From the data made available by EIGE it is difficult to make a comparison between countries as the methods adopted are different and are mostly indirect methods.
In 2011, over half a million first-generation women and girls in the EU, Norway and Switzerland had undergone FGM before immigration. One in two was living in the UK or France, one in two was born in East-Africa, where infibulation (FGM type III) is most prevalent.

National estimates indicate that in 2007 Great Britain, with more than 65,000 girls and women with FGM, was the country with the highest number of affected female, followed by France with 61,000 girls and women in 2007, Italy with 35,000 cases in 2009, Germany with over 19,000 cases in 2007, Belgium with over 6,000 cases in 2011, Ireland with over 3,000 cases in 2011 and Hungary with an average of 250 cases in 2012.

Certainly, measuring the extent of the presence of this phenomenon in Europe is both complex and difficult, because direct household surveys often do not have samples to adequately capture that population, so there should be targeted samples and hope for a truthful response from the female population surveyed, or think of different forms of detection, such as capturing information when women go to hospitals or medical centers in immigration countries.

At the European level, there is a need for an effort to harmonize methods of measuring this phenomenon in order to be enable comparison of data. In this sense, the statistical system developed by the United Nations can represent an important stimulus for National Statistical Offices of the countries of the Union.

The Italian situation

Although no firm statistics exist for the number of women affected and the types of mutilation prevailing, it has been estimated that 50 to 80% of all African women who migrated to Italy more than 5 years ago underwent some form of FGM. Two-third of these have been found to be afraid to seek gynecological care. Due to inexperience by attending obstetricians, 40% of women with FGM end-up with a caesarean section. Only a small proportion of the 60% who have a vaginal delivery receive appropriate care (anesthesia and de-infibulation) [9].

Italy has been one of the first EU countries to create a referral clinical center for preventing and curing the complications of FGM. The center, at the University Hospital of Florence, has been officially active since 2003 in clinical, surgical and culturally sensitive psychosexual management of women with FGM [10]. Its personnel have also been working in clinical research and in training other caregivers at a national level.

In response to the increasing number of migrant women and girls with FGM, other Italian regions have introduced specific outpatients' clinics or referral centers, such as Friuli-Venezia Giulia, Lazio and Umbria. Over the last 6 years at the "Policlinico Umberto I" University la Sapienza Hospital, women with FGM can follow a specific socio-sanitary course, sponsored by the Project "Women from the Horn of Africa". Between 2009 and 2014, 157 patients with FGM have been identified in this center and followed-up; 28 of them were pregnant when first seen. Among these, only 7 followed all the proposed screening procedures. Out of 26 women delivering at the Center, 19 had a caesarean section, sometimes on maternal request. Analgesia during labor was offered to all women but was refused by most of them [11].

The Karol Wojtyla International Association

Clearly, the specific health needs of these women need to be addressed but, so far there are entire areas with no specific care available. Also, data collection and analysis to assess the phenomenon and the care proposed are crucial. It is for this reason that the International Association "Karol Wojtyla", dedicated to an inter-religious dialogue aimed at promoting support and medical care for the relief of human sufferance, decided to create an initiative aimed at improving the access to medical care specifically focused on the needs of women with FGM living in Europe, starting with Italy.

Within this initiative, a number of priorities have been identified, first and foremost, the creation of well-defined clinical curricula for the implementation of the World Health Organization Guidelines for the Healthcare of Migrant Women with FGM [12]. In this context, it is of fundamental importance that these clinical guidelines be implemented in the event of a pregnancy, starting early during a gestation.

Since the majority of general practitioners and obstetricians are neither familiar with FGM in general, nor with the course of action to be taken at the time of delivery, a multi stakeholder approach involving associations and healthcare organization is required to reach these women and promote the implementation of the WHO's Guidelines.

Outside pregnancy, specific clinical curricula need to be created for a number of conditions affecting, in a specific way, women with FGM:

1. Prevention and control of uro-gynecological complications;
2. Screening of cervical cancer;
3. Psychosexual support.

In addition to specific health conditions associated to FGM, this population of women represents a vulnerable group, with other frequent psycho-physical co-morbidities and past traumatic events that require specific care and a health personnel adequately trained. Unfortunately, the vast majority of Italian medical and paramedical personnel is unprepared to deal with FGM and their consequences.

Under the circumstances, developing and implementing prevention strategies against the practice is equally important as providing adequate and evidence-based health care to the women who have already undergone the practice. This requires specific training, but teaching about FGM is not always included in pre- and post-graduate curricula of healthcare professionals. This implies that health workers are often unaware of the negative health consequences of FGM, or inadequately trained to recognize and treat them properly.

Training should involve all professionals, including general practitioners, gynecologists, obstetricians, urologists, plastic surgeons, psychologists, psychiatrists, pediatricians, midwives and nurses.

Developing and implementing prevention and protection strategies against the practice is equally important as providing adequate and evidence-based health care to the women who have already undergone the practice.

The work of the world health organization and of the European Union

As mentioned, the Department of Reproductive Health and Research (RHR) of the World Health Organization (WHO) has recently published new guidelines on the management of health complications from FGM that contain up-to-date, evidence-informed, recommendations [12]. These guidelines offer clinical recommendations within four key domains:

a) Obstetric and gynecological health complications;
b) Mental health issues;
c) Sexual health;
d) Information and education interventions.

In March 2017, WHO announced that a training package, based on the content of the guidelines, will be developed together with a standardized questionnaire to assess knowledge, attitude and practices of caregivers and the effect of training interventions [13].

In Europe, to address the specific needs of migrant women, the WHO Regional Office has recently organized an "Expert consultation on implementation of WHO Guidelines on FGM in Europe" [14]. Subjects discussed were current trends of immigration and FGM in Europe, the WHO guidelines and forthcoming training materials, experiences with already existing training material and the need to address FGM-related issues within the health sector, as well as possible specific research initiatives.

The European Union has also launched an e-learning tool to improve knowledge among healthcare providers of asylum-seeking persons [15]. Its aim is to provide easily accessible information and support to professionals dealing with FGM; raise awareness by improving knowledge and prevent stigmatization in the media. The instrument also aims at increasing the capacity of professionals across EU to provide gender and culturally sensitive support and protection.

Training of healthcare professionals must be associated to the improvement of women's access to care. Proper information and health education can make women aware that they can seek information, antenatal care or treatments of complications in ad hoc centers. Such information can reach migrant communities through Women's and Migrants' Associations and Cultural mediators.

The project

Within this context, the Karol Wojtyla Association Project aims, in the long term, at:

- Mapping existing referral centers/outpatient clinics with expertise on women and girls living with FGM in Italy and make this information available to professionals and women affected (website, professional boards).
- Promoting communication, coordination, collaboration and data collection of these centers.
- Evaluating regional needs for further clinical centers. Defining the scientific, clinical and organization requirements of such centers.
- Improving connection, communication, collaboration and data collection among the existing centers/clinics and the associations of migrant women and girls.
- Implementing at a national level updated and evidence-based training courses in diagnosis, obstetric and gynecological management of FGM (in particular defibulation) and its complications. The human resources to be used as teaching experts are available in the existing Italian centers and associations.
- Organizing training courses to provide and diffuse useful information on further subjects, such as asylum and FGM and legal aspects. Already available resources (learning tools; Italian and WHO guidelines, regional protocols, regional prevention strategies, etc.) will be provided and published on the websites of the Provincial Professional Boards (*Ordini dei Medici ed Odontoiatri*).
- Assessing pre- and post- knowledge, attitudes and practice of the healthcare professionals participating in the courses. The first three professional categories to be investigated would be midwives, pediatricians and obstetricians and gynecologists.
- Promoting research to evaluate the impact of applying preventive measures in the field of uro-gynecology, oncology and infectious diseases in

subjects with FGM on health care costs in European countries, starting with Italy.

In conclusion, we hope that the results to be obtained through the project outlined above, will assist in developing and evaluating protocols for multicenter trials aimed at finding adequate solutions to this difficult issue.

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