Your role as a health-care provider is to support girls and women who seek care at health care facilities. Every contact with a girl or woman who has experienced FGM represents an opportunity to provide her with accurate information about her body and health.

World Health Organisation - WHO

FGM

FEMALE GENITAL MUTILATION

a global phenomenon

Outcome of the research, training path and campaign to raise awareness

Regione Umbria

USLUmbria2

ONE HEALTH - GLOBAL HEALTH
CERSAG

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Preface

Female Genital Mutilation (FGM) is a global phenomenon that involves at least 200 million women and girls in several countries and constitutes a violation of their human rights. In a recent report, UNICEF estimated that a further 68 million girls will undergo genital mutilation between now and 2030 unless there is an increased effort to put a stop to such a harmful practice to the physical and mental health of women and girls.

Even though prohibited in Italy, this procedure is still performed illegally in our country, too, and the risk for migrant women and girls becomes even higher when they visit their home countries.

A complex issue as such, that intertwines individual and collective dimensions as well as cultural, medical and legal aspects, can only be tackled through team work and joint discussions.

Regione Umbria, in order to carry out a rolling work program to improve the system of prevention and healthcare promotion, has started a project to meet the needs of women at risk of FGM (or living with the effects of it) and raise awareness on this incredibly serious global issue.

Aware of the fact that there is still a long way to go, we tried to follow the data and information available to us as well as the facts and practices tested until now.

All of this was done by providing extensive training to the social and care workers of the Local Health Units and different municipalities of our region as well as the cultural mediators and those somehow involved with this phenomenon.

Our work is the result of a preliminary epidemiological investigation, targeted workshops followed by focus groups and an in-depth qualitative analysis.

We have also addressed the issue of communication and created educational material, both on line and on paper, for all areas of interest.

A 360 degree multi-sectorial work that obviously does not cover all the necessary requirements to tackle this problem but at least opens a door to future activities with heightened awareness and a common language.

Luca Coletto
Health and Social Services Commissioner
Umbria Region

Introduction

Female Genital Mutilation (FGM) comprises all procedures that involve partial or total removal of the female genitalia or other injuries to the female genital organs for non-medical purposes. There are multiple types of female genital mutilation with different severities, of which the most radical one is commonly known as infibulation.

Female Genital Mutilation is a gender-specific type of abuse, a clear violation of women's human rights and constitutes an extreme form of gender discrimination. Girls and women who undergone the procedures are completely deprived of the ability to decide for their own well-being.

In addition to being very humiliating, genital mutilation is extremely painful physically and incredibly traumatic psychologically. Girls subjected to this practice can die from immediate complications such as haemorrhagic or neurogenic shock, caused by trauma and pain, and infections. Female Genital Mutilation can cause short, medium and long-term complications that include urinary, vaginal, sexual and psychological problems as well as scar tissue, keloids and increased risk of childbirth complications.

Female Genital Mutilation constitutes a tradition that marks the passage from childhood to adulthood; according to this ritual, through physical manipulation, a socially constructed gender identity gives meaning to a biological one.

The Region of Umbria stands out for having a big presence of foreign citizens, experiencing one of the highest in Italy at a regional level equal to 11,2% (ISTAT). In addition to this numbers, the flow of asylum seekers registered in the last few years should also be considered. These findings make it necessary for the institutions and bodies in Umbria to activate services capable to handle the needs of the new population (both residents and non-residents). The positive trend of the migration phenomenon, especially from countries with a high percentage of female genital mutilation, shows us that we need to monitor this problem constantly in our region, too, and pay closer attention to the young girls at risk.

In light of this awareness, the present project aims to educate and raise awareness on Female Genital Mutilation (FMG) with the support of Regione Umbria in collaboration with AUSL (Local Health Unit) Umbria 2, CERSAG (Regional Centre of Global Health) and CIDIS.

Female Genital Mutilation: a global phenomenon

Female Genital Mutilation: definition

Female Genital Mutilation (FGM) comprises all procedures that involve partial or total removal of the female genitalia or other injuries to the female genital organs for non-medical purposes. There are multiple types of female genital mutilation with different severities, of which the most radical one is commonly known as infibulation.

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Female genital mutilation is mostly carried out on young girls at the request of the mother, parents and entire community for a series of reasons related to:

1. Culture and tradition: FGM is considered a way to ensure premarital virginity.
2. According to certain cultures a woman should remain a virgin until married, which in many cases also means access to a land and, therefore, a livelihood. There is a strong social pressure on the younger generation from the entire community, older people in particular.
3. Family honour and respectability: some communities believe FGM is necessary to prevent compulsive sexual behaviour in young women and to protect men and the community from a dissolute life.
4. Hygiene and aesthetics: The partial or total removal of the external female genitalia makes a woman more beautiful from an aesthetic point of view and much cleaner from a hygienic one. A concept of beauty associated to a deeper meaning of spiritual purity.
5. False beliefs: it is believed, in some places, that genital mutilation promotes fertility in women and the survival of the child during pregnancy, facilitating birth and the treatment of certain illnesses and conditions.
6. Religion: Some communities believe that genital mutilation is essential for young women to become pure in spirit. Some Muslim communities believe it was written in the Quran. No religious scripts, however, prescribe the practice.

7. Level of education of the mother: UNICEF (2016) pointed out a correlation between the level of education of the mother and the probability of the daughter being subjected to FGM. Out of the 28 countries of which data was provided, 1 out of 5 girls of uneducated women has been subjected to FGM; the average number drops to 1 out of 9 among children of women who attended at least lower secondary school.

Female genital mutilation constitutes a tradition that marks the passage from childhood to adulthood; according to this ritual, through physical manipulation, a socially constructed gender identity gives meaning to a biological one. The procedure is generally carried out by older women and their work is highly valued and generously remunerated.

The legal context: international conventions and normative references

The Sustainable Development Goals adopted by the United Nations in September 2015 include, amongst others, the elimination of intolerable practices such as female genital mutilation and forced marriage.

According to the latest data provided by UNICEF (2016), approximately two thirds of men and women living in countries where FGM is common would like to put an end to it and are opposed to the recurrence of the practice in their communities.

In addition to this, there has been an increasing commitment to end FGM in countries where the practice has been banned and access to protection, prevention and treatment services is allowed.

From 2014 to 2017, the number of FGM carried out on girls between the age of 15 and 19 has declined in 10 of the 17 countries taking part in the program against genital mutilation launched by UNICEF and the United Nations Population Fund -UNFPA (UNICEF 2016).

Italy was one the countries to support the resolution adopted by the general Assembly of the United Nations 67/146 in 2012 to universally ban female genital mutilation.

Italy has ratified different international conventions that condemn FGM, among which the Convention of the Council of Europe on preventing and combating violence against women and domestic abuse (also known as the Istanbul Convention). It is the first regional treaty to recognise the existence of female genital mutilation in Europe and the need to address the issue systematically. All of this, by increasing and implementing preventative measures to protect women and girls and approaching the communities involved, the general population and those working in the relevant sectors. An explicit obligation to protect was also introduced (AIDOS 2018).

Since 2006, Decree-Law 7 of January 9th lays downs specific measures to deal with the issue of female genital mutilation. The principle of extraterritoriality is applied and the procedure is criminalised even when carried out abroad. As a result of this, in 2007, the Department of Health issued guidelines to be followed by healthcare practitioners and other professionals working with people from countries where FGM is performed in order to create ways to assist and support women and girls already subjected to the procedure.

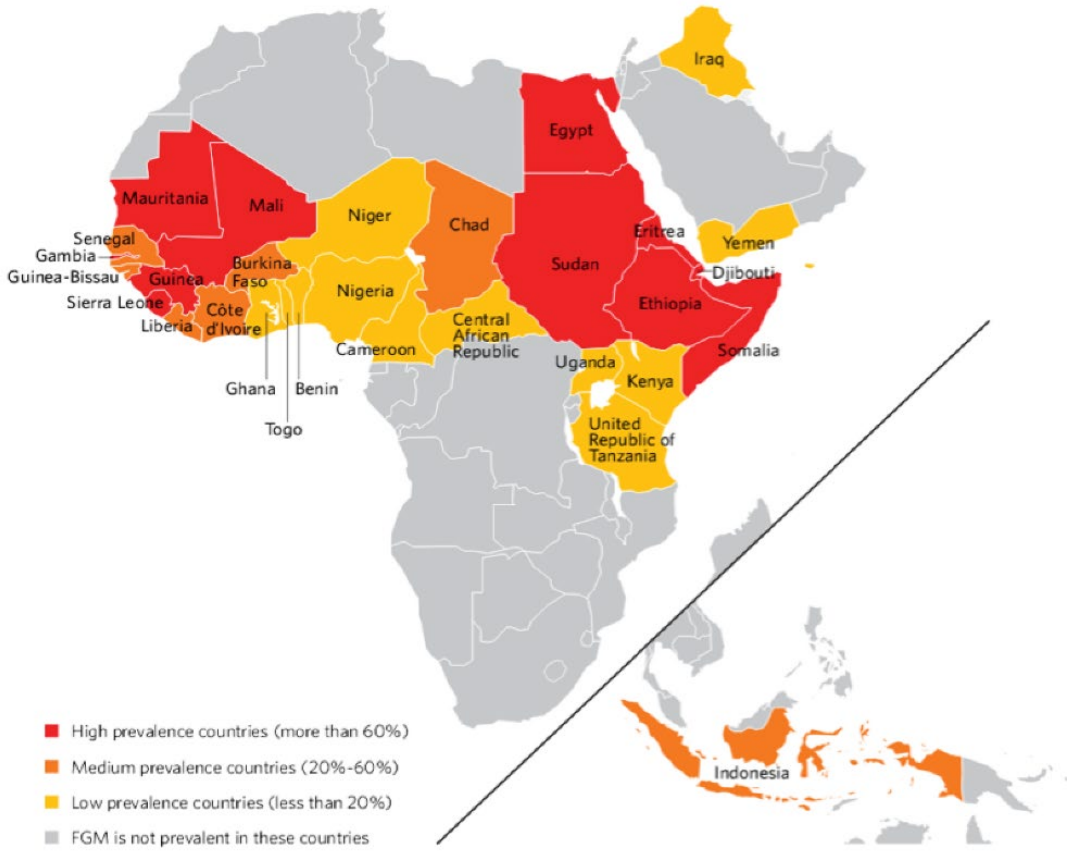
Decree-Law 119 of 2013, 'urgent provisions in terms of safety and to combat violence against women', states that a permit to stay can be released also to women who are victims of domestic violence, including FGM. The law includes a National Plan of Action: the Extraordinary Plan against violence

towards women and sexual abuse, adopted on August 25th 2015. The Plan follows the same approach of the Convention of Istanbul in combating all forms of violence against women, including FGM and forced marriage. In 2018, guidelines[1] to be followed by first aid and reception centre employees were published in order to help them recognise victims of FGM or other dangerous practices. The objective was to provide professionals involved with asylum seekers the necessary tools to deal with suspected victims of FGM, forced marriage and other harmful practices and help them access proper resources and international protection.

The spread of Female Genital Mutilation: international context

It is estimated that the number of women in the world who have undergone female genital mutilation is around 125 million. Based on the latest demographic trends, we can calculate that around 3 million girls under the age of 15 are added every year to these statistics (UNICEF, 2016).

Female genital mutilation is mostly widespread in 29 African countries, whilst a significantly lower percentage lives in predominantly Muslim countries in Asia.



Source; DHS and MICS, 2002-2014 cited in UNFPA, Demographic Perspectives on Female Genital Mutilation, 2015.

Figure 1 Countries where FGM is practiced and level of prevalence

1 By Parsec Research and Social Interventions Association, Coop. Soc. Parsec, University of Milan-Bicocca, A.O. San Camillo Forlanini, Nosotras Onlus and Trama di Terre Association.

In some African countries, the incidence of the phenomenon remains very high, reaching 90% of the female population (Somalia 98%, Guinea 97% and Djibouti 93%). In many other places, on the other hand, female genital mutilation involves a minority.

The spread of the problem is very inconsistent depending on the different ethnic groups, level of urbanisation and education of the women themselves (UNICEF, 2019).

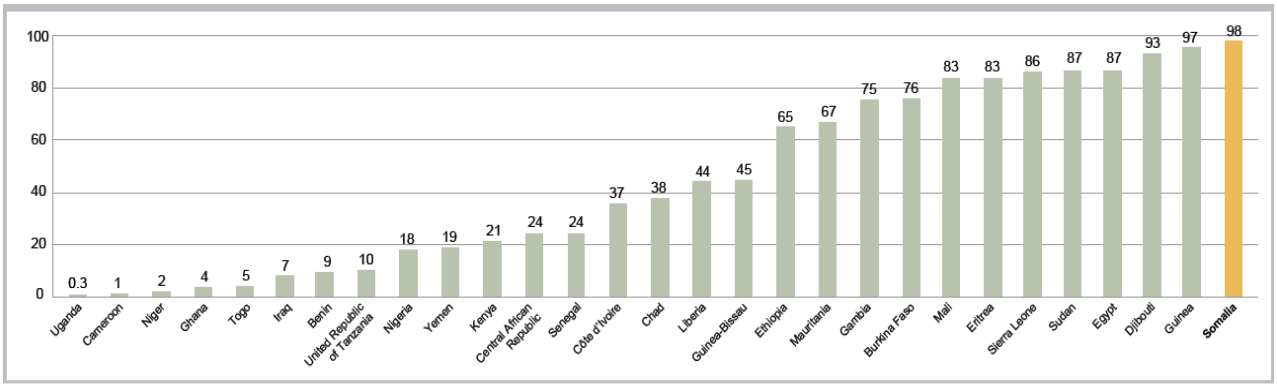


Figure 2 Percentage of women and girls aged 15 to 49 who have undergone FGM (Source UNICEF, 2019)

There are cases of FGM also in Europe, Australia, Canada and USA, especially among immigrants from Africa and Southwestern Asia: they take place illegally and are, therefore, more difficult to register (UNICEF, 2019).

Female genital mutilation is mainly practised on girls between the ages of 4 and 14. However, in certain countries, girls less than a year old undergo the procedure, as it happens in 44% of the cases in Eritrea and 29% of the cases in Mali. In Yemen even newborn babies are subjected to it (ibidem).

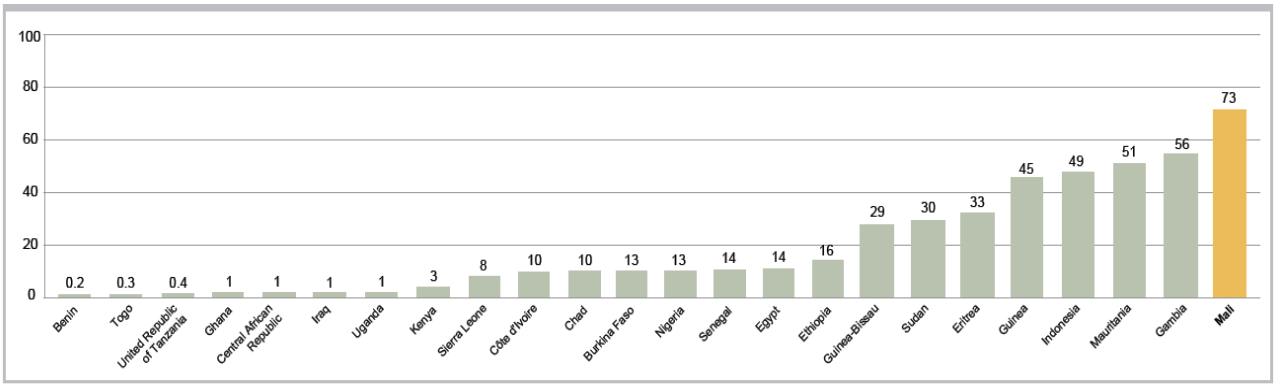


Figure 3 Percentage of girls aged 0 to 14 who have undergone FGM - data reported by mothers (Source UNICEF, 2019)

Recent studies have shown a steady decline in the age of girls undergoing genital mutilation which can be explained by the fact that it is easier to hide the practice where it is not allowed and to overcome the resistance of girls aware of the situation (Department of Health, 2007).

The practice of female genital mutilation by health care providers (known as medicalisation) has become quite popular and represents an important risk factor. It has made the procedure acceptable in some cases as it is viewed as more hygienic and less painful (European Institute for Gender Equality, 2018).

Following the Covid 19 pandemic, according to reports from UNFPA (2020a), there could be a significant impact on the efforts to stop FGM with an estimated reduction of one third of the progress made before 2030 as stated by the Sustainable Development Goals. Therefore, UNFPA claims that, due to interruptions of FGM prevention programs as a result of the pandemic, in the next decade we could see 2 million cases of genital mutilation that could have otherwise been avoided.

Estimates in Italy

On January 1st 2019 (ISTAT), Italy registered 5,225,503 foreign residents, 2,718,716 of which were women. 7% of the women, equal to approximately 184,235 people (172,722 on January 1st 2018; ISTAT 2019a), come from countries where female genital mutilation is a traditional practice. Nigeria, Egypt, Senegal and Ghana, in particular, are the most represented ones and, in the last few years, the number of women from these countries has steadily increased (+6.6% from 2018 to 2019).

Out of 64,819 residence permits released to non-EU citizens on humanitarian grounds or for asylum reasons (ISTAT, 2019 b), 18% are for women. 33% of these women are from Nigeria, followed by, as regards to countries with FGM tradition, Ghana, Senegal and Egypt.

The absolute number of girls at risk of genital mutilation has increased as the total population of women from FGM countries now living in Italy has grown as well (Farina, Ortensi, Menonna, 2016).

The latest study conducted (Farina et al., 2020) estimates that, on January 1st 2018, Italy registered the presence of 87,600 women who had been subjected to FGM. As shown in Figure 4 below, 7,600 of these women were underage.

Origin	Total:	Of which:	
		Majors	Minors
Nigeria	28.037	24.392	3.645
Egypt	19.403	18.354	1.049
Senegal	8.007	7. 170	837
Ethiopia	6.806	6.670	136
Ivory Coast	6.137	5.529	608
Somalia	4.752	4.635	117
Eritrea	3.810	3.731	79
Burkina Faso	3.531	2.894	637
Guinea	1.129	998	131
Mali	805	648	157
Sudan	685	644	41
Other provenances	4.498	4.335	163
Total	87.600	80.000	7.600

* medium variant

Source: Female mutilation survey, University of Milan Bicocca and Equal Opportunities Department 2019

Figure 4 Estimate of residents with FGM in Italy as of 1 January 2018 (Farina et al., 2020)

The estimated percentage of mutilated women from Mali, Somalia, Sudan and Burkina Faso exceeds 80%; other countries, however, do not go beyond 30%.

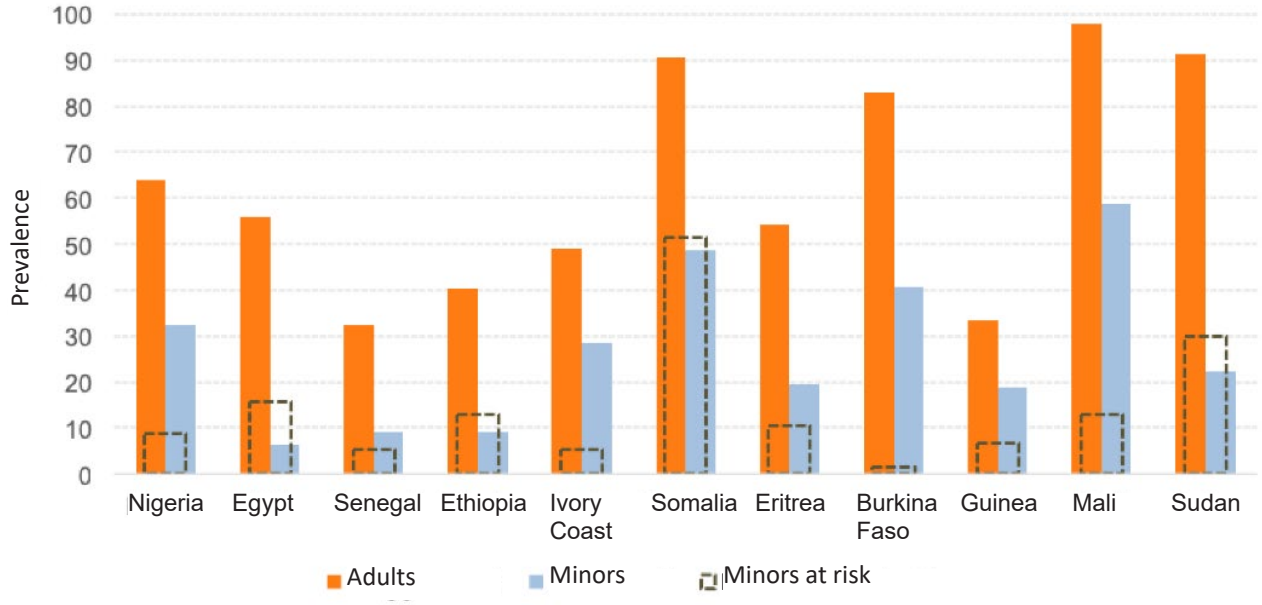


Figure 5 FGM prevalence estimated among adult and minor women in Italy, with indication of minors at risk among the indicated origins (Source: Female Mutilation Survey, Milan Bicocca University and Equal Opportunities Department 2019 - Farina et al., 2020)

In most cases, if we make a comparison between adults and minors we can see a substantial reduction in numbers among the latter, confirming what is happening in their countries.

As far as danger is concerned, when it comes to underage girls there seem to be different types of risks. Among the nationalities at high prevalence, only Somalian girls are at risk of undergoing genital mutilation, whilst Malian, Sudanese and Burkinabe girls are at less risk than their Egyptian counterparts. Italy is one the countries to host the largest number of FGM women, as a result of a consistent migration flow from countries where female genital mutilation is prevalent, such as Egypt, Nigeria, Ethiopia and Senegal. It is believed (Farina, Ortensi, Menonna, 2016) that the number of women currently living in Italy who have been subjected to a form of genital mutilation during childhood is between 60,000 and 81,000. The most affected group seems to be from Nigeria that, along with Egypt, constitutes more than half of the estimated total.

The presence of such a large number of mutilated women, a big part of which on humanitarian grounds, signals the need to implement preventative measures and support actions. As a matter of fact, these numbers do not include girls at risk of mutilation: in Italy they are estimated to represent 15-24% of girls from FGM countries between the ages of 0 and 18 (European Institute for Gender Equality, 2018).

Even though it has been proven that such risk diminishes in emigration (Farina, Ortensi, 2014), it is clear that preventative measures to protect girls and women are urgently needed. According to an Italian investigation (ibidem), in fact, one-quarter of immigrant women believes that the practice should continue.

Estimates in Umbria

On January 1st 2019 (ISTAT, 2019c), the region of Umbria registered 97,541 foreign residents, 55% of which women, indicating a feminisation of the migrant population that characterises the two provinces as well (Bigi, 2019). Even though the number of foreign residents in Umbria has been falling in the past 5 years, compared to the ageing and declining native population, their incidence has actually increased and reached the levels of 2013 (11,1%) (ibidem).

4% of the women living in Umbria, equal to 2,351 people (ISTAT, 2019c), come from FGM countries, the most represented being Nigeria, Ivory Coast, Cameroon and Egypt.

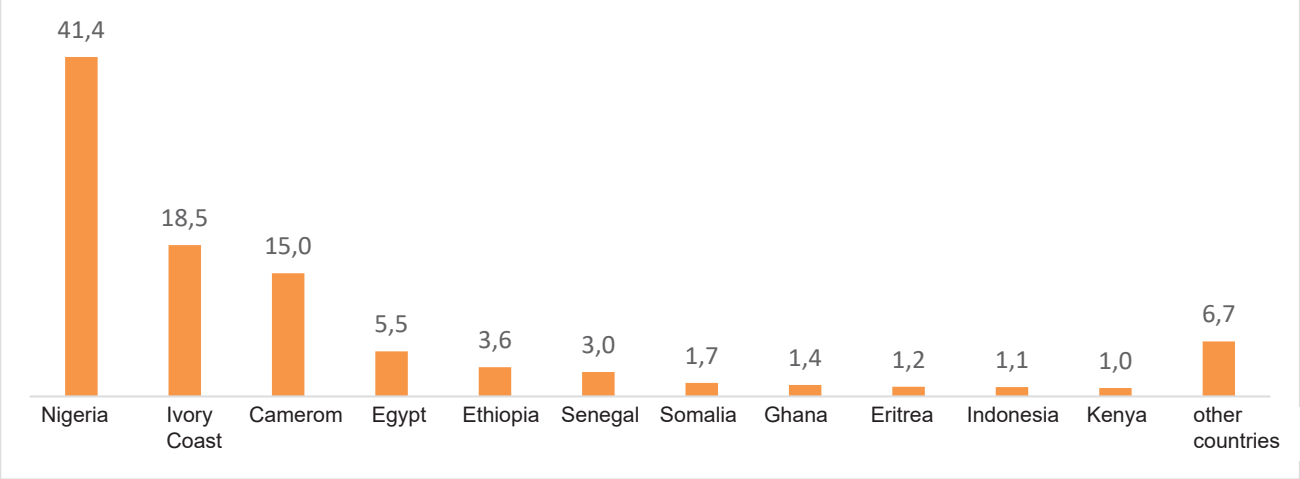


Figure 6 Percentage of women from countries with a cutting tradition residing in Umbria (ISTAT data processing, 2019c)

Out of a total of 625 residence permits granted to non-EU residents on January 1st 2019, for asylum reasons and on humanitarian grounds (ISTAT, 2019b), 23% were for women with 45% of them being from Nigeria. 66% of the women from FGM countries reside within the area of the AUSL (Local Health Unit) Umbria 1.

Shown in the chart below are the percentage figures of women from FGM countries living within the territories of AUSL (Local Health Unit) Umbria 1 and AUSL (Local Health Unit) Umbria 2.

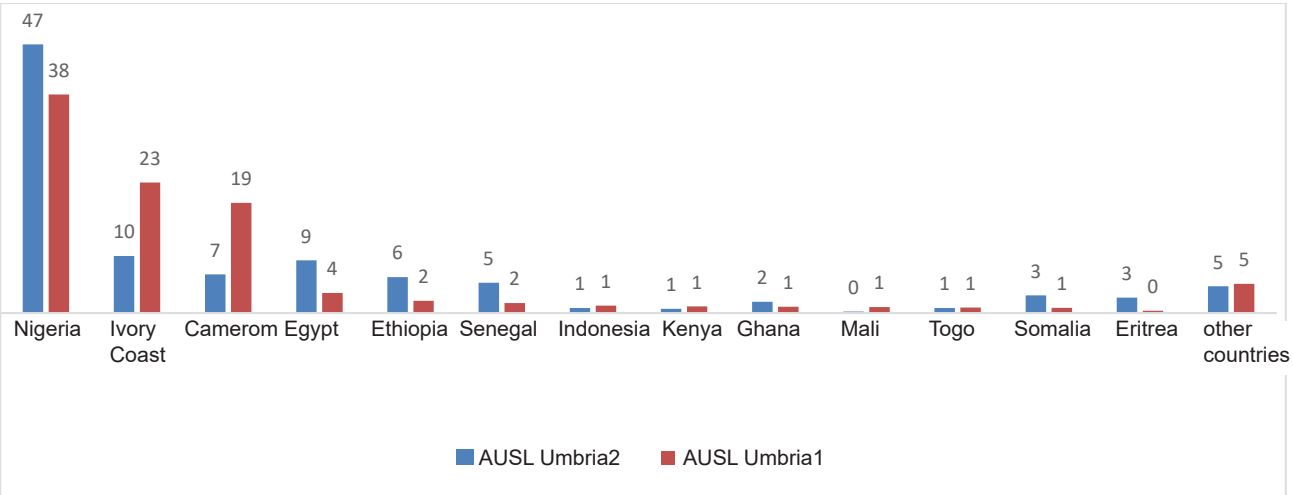


Figure 7 Percentage of women from countries affected by FGM residing in the territories of AUSL Umbria1 and AUSL Umbria2 (ISTAT data processing, 2019c)

With regard to AUSL (Local Health Unit) Umbria 1, the female population from FGM countries is mostly present within the territories of the Perugino, Alto Chiascio and Assisano Districts.

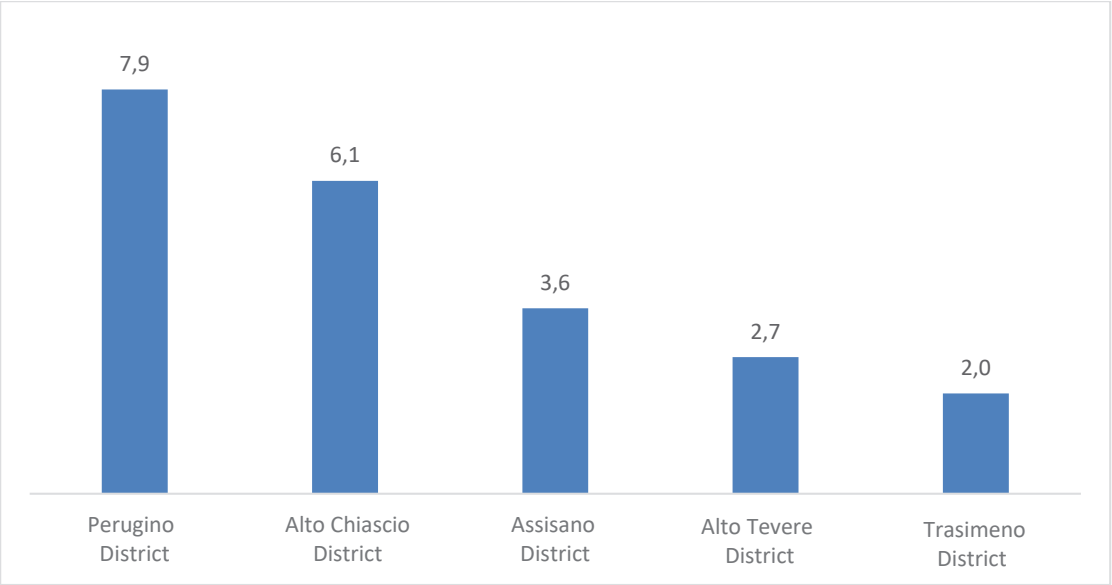


Figure 8 Percentage of women from countries affected by FGM residing in the territories of the AUSL Umbria1 districts (ISTAT data processing, 2019c)

With regard to AUSL (Local Health Unit) Umbria 2, on the other hand, it is mostly present in the territories of the Districts of Narni-Amelia, Terni and Foligno.

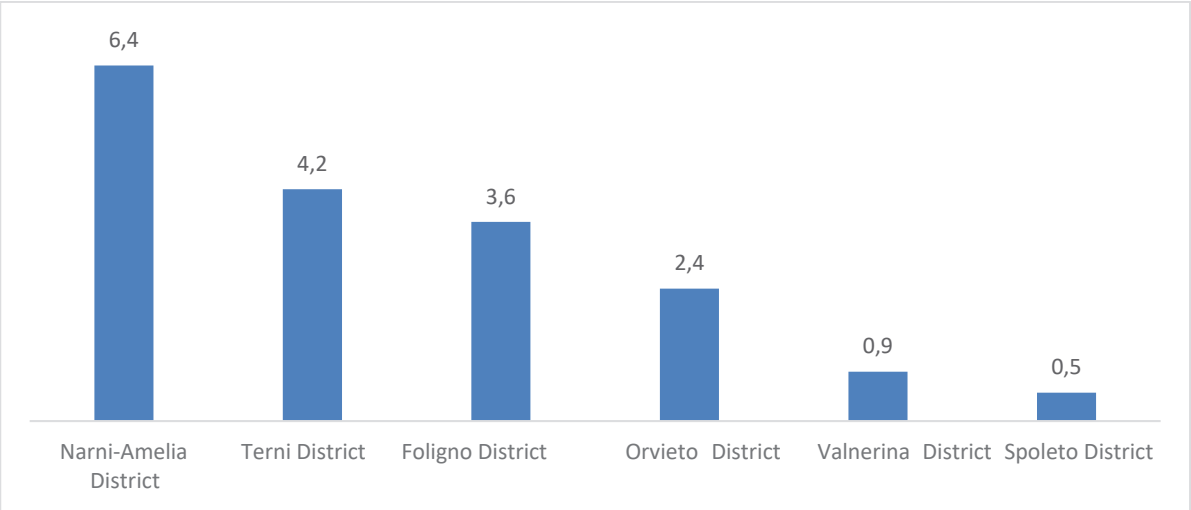


Figure 9 Percentage of women from countries affected by FGM residing in the territories of the AUSL Umbria2 districts (ISTAT data processing, 2019c)

verify the presence of women already subjected to the practice in their own countries and test the knowledge of the professionals. Combining the updated 2010 number, subdivided by gender, of foreign people living in the different districts of the local health authorities in which the region was divided until 2012, with the incident rates of FGM in various African countries available at the time, it was estimated that more than 600 women and children living in Umbria had suffered some form of genital mutilation.

The qualitative research included in the investigation (ibidem), revealed that many women from countries where female genital mutilation is traditionally practised consider the procedure to be completely normal and suitable for themselves and their daughters. To explore the extent of the problem and understand how FGM is perceived by healthcare professionals in Umbria (also to identify possible cases of women and girls interested in the practice), the study (ibidem) has included a specific questionnaire for general practitioners, paediatricians, gynaecologists, midwives, nurses and social workers within the health and care system of the region. The majority of the healthcare workers (69%) reported difficulties in recognising female genital mutilation.

On the basis of the critical issues and needs emerged from the research, a training course of two years (2014-2015) aimed at healthcare and social workers specifically (100 hours of training, approximately 200 professionals involved) was developed. Different activities involving key players such as teachers, students, social care workers, families, administrators and policy makers were carried out (AIDOS, 2018).

The objectives of the action research

The project, carried out between February and December 2020, was intended to explore the phenomenon of female genital mutilation (FGM) at a regional level. Its goals were to raise awareness, provide training for the healthcare professionals involved and promote the development of preventative measures and ways to support women and girls subjected to or at risk of genital mutilation.

The project was designed as an action research, namely a project of research intervention, and followed this two directions based on specific goals. A research activity carried out using quantitative and qualitative techniques through different survey tools (such as questionnaires and focus groups) was created with the objective to gauge people's perception and understand the extent of the problem and its geographical distribution at a regional level.

Moreover, with the help of our partners, it aimed to identify ways to raise awareness, combat the problem and promote the best practices related to female genital mutilation. At the same time, the project developed a training program for all the different professionals working across the region using workshops to improve their skills and raise awareness on the issue with a socio-cultural and anthropological perspective.

The action research involved several healthcare practitioners operating in Umbria: those affiliated with the SSD Health Surveillance and Promotion department of the AUSL (Local Health Unit) Umbria 2 and CERSAG (Regional Centre of Global Health), midwives, gynaecologists, psychologists, social workers, cultural and linguistic mediators from Local Health Authorities and the Regional Agency of Cultural and Linguistic Mediation of CIDIS and CSC (Cooperative society) as well as social workers from reception centres (CAS, SAI – previously known as SIPROIMI).

Due to the medical emergency caused by the spread of the COVID-19 virus, it was not possible to involve paediatricians and general practitioners along the journey as intended during the planning stage.

However, students from the Bachelor Nursing Degree of the University of Perugia (based in Terni), enrolled in their final year and who had already started their internship at the Terni Hospital, took part in the project. The fact that the action research project was acknowledged as part of their training program was an unexpected outcome. The work was carried out during the course of 12 workshops, of 4 hours each, for a total of 48 hours of class. The seminars were held remotely through the online platform GoToTraining provided and managed by the AUSL (Local Health Unit) Umbria 2. The different editions of the workshops made it possible to include more specific targets divided into homogeneous groups.

The present report illustrates the results of the analytical activity and action research conducted by CIDIS through the use of questionnaires and focus groups, namely group interviews, with the intent to explore the experiences and non-experiences reported by the different regional areas with regard to the knowledge and management of FGM and gauge the perception of the problem. The results collected in this research project were presented to all the participants of the different editions in a final meeting that took place online.

The methodological note

The action research took place between September and December 2020 and included 61 people, with different professional backgrounds, working across the region (see paragraph about the sample).

The project was directed at specific targets identified during the planning stage: professionals already taking care of women with or at a risk of FGM and individuals soon to be involved. People's participation to the action research was on a voluntary basis and promoted by the organisers through the training program of the AUSL (Local Health Unit) Umbria 2. The project focused on collecting the working experiences and non-experiences reported by the different parties involved at a regional level with regard to the understanding and management of FGM through the use of methodological tools typically adopted in social research. To achieve this, the research design planned to include more data collection techniques, in a complementary way, using a questionnaire with closed questions and focus groups as survey tools. A focus group is a research method based on an interactive discussion between a small group of people, lead by a moderator, around a topic that needs to be explored (Corrao 2005).

The focus groups were conducted with a low degree of directivity, namely the degree of freedom left to the moderator to decide how to conduct the discussion over the course of the meeting, and with a less structured outline to ensure flexibility. This method allowed us to explore significant aspects of the phenomenon in Umbria emerged from the reports of the focus groups (maximum 8-9 people per meeting) and to approach the issue from the perspective of someone who has had direct and indirect experiences (Cipolla 2003). Using this approach, we were also able to identify opinions, frustrations, views and suggestions of possible courses of action and to activate a process of sharing and comparison amongst participants.

We carried out 12 focus groups for homogeneous target groups, each lasting around 2 hours, with one of the researchers acting as moderator and another as co-moderator. During the meetings, the moderator would ask questions, giving the participants space to discuss and interact, and guide the conversion following an outline designed for information purposes and suited to people present. They would also support the discussion and lead it back to the subject in question to keep participants on track.

The meetings, aimed at the discussion and qualitative in-depth study of certain aspects of female genital mutilation and related professional experiences, were carried out following a list of questions and points to submit to the participants, starting with the ones included in the online questionnaire. These questions were a reference tool to start with in order to facilitate the dialogue among the participants and stimulate the group without being too strict. It was, in fact, a very flexible outline that was adapted each time to the social aspect of the participating group and to the topics emerged during the discussion.

All the meetings were recorded and, subsequently, transcribed verbatim, namely in full; they were then completed with the notes of the two researchers. For the analysis and processing of the data emerged, carried out following a qualitative approach (theme-based analysis), we used a table subdivided into macro-themes and comprising of key elements identified during the conceptualisation phase and categories emerged during the analysis of the material. Using this procedure it was possible to carry out a first longitudinal analysis, namely for each meeting, of the material collected and, subsequently, a cross-sectional one in relation to the entire text corpus in order to identify and codify into different categories both recurring elements and unexpected topics. The text was, therefore, subject to deconstruction and reconstruction by dividing it into groups analytically; such approach allowed us to sort all the information emerged during the meetings keeping always in mind the goals of the research. Finally, in the report, which is descriptive in nature, we reported statements (words, expressions, particularly significant quotes) from the participants as documentation of each analytical category and to restore the semantic richness of the text corpus. The words of the person interviewed, in fact, intended as the story of their social life, are the focus of attention of the researcher whose job is to give the respondent the possibility to express their views, perceptions and assessments as well as their experiences (Bichi 2007). A brief multiple choice online questionnaire consisting of 18 items (which can be viewed in the appendix) was set up to collect data. This research tool allowed us to gather information in a systematic manner and was given to the participants at the beginning of each online meeting.

Such strategy enabled us to introduce the theme of the investigation, giving the participants time to immerse themselves in the subject, start considering the questions of the questionnaire and reflecting on the issue in their own working experience before engaging in the focus group.

The research was structured according to different steps:

- Collection of data using an anonymous questionnaire given to the participants at the beginning of each online meeting to gather first information and opinions on the practice of female genital mutilation.

- A qualitative study through the implementation of focus groups that left an important space for discussion and to identify any working experiences related to the subject, starting from the questions in the questionnaire.

- Systematisation of the qualitative-quantitative data collected and analytical processing of the aspects emerged from the information gathered and the focus groups.

- Drawing up conclusions based on the data and information collected.

The sample

The action research was carried out in Umbria and involved different healthcare professionals affiliated with AUSL (Local Health Unit) Umbria 1 and AUSL (Local Health Unit) Umbria 2.

In particular, among those who took part in the project: midwives, gynaecologists, psychologists, cultural and linguistic mediators, social workers, care workers and reception centre employees. The initial target group included the participation of paediatricians and family doctors as well but, due to resurgence of the spread of the pandemic as a result of the SARS-COVID19 virus, it was not possible to have their support in the training and research proposal. Given the changes to the initial project plan, a new program that made it possible to involve students from the University of Perugia (based in Terni), in the final year of their Nursing Degree, was put into action.

Thanks to an agreement with the Education Administration Office of the University of Perugia, the work of the students taking part in the project was recognised as part of the training required for their degree. Their participation proved to be a positive and unexpected outcome. A total of 57 professionals completed the questionnaire online whilst 62 took part in the 12 Focus Groups organised remotely for further study. The slight discrepancy between the number of participants and respondents is due to the shared used of devices from which they were connecting online. Overall, the participation was attentive and open to discussion.

The sample identified is not significant in numbers but very indicative qualitatively: the objective was to obtain more detailed and descriptive information so it did not have to meet any statistical criteria. Please find below a diagram of the participants divided by gender, years on the job, geographical area and institutional affiliation.

The outcome of the action research: quantitative analysis

The objective of this work is to shed light on the social phenomenon of female genital mutilation through the experiences of healthcare professionals operating in the Umbria region. The data was collected through an anonymous questionnaire that included open and closed questions. 12 meetings involving 62 healthcare providers were carried out between September 17th and November 26th , at the end of which 57 questionnaires were received. It emerged from this that 54 of the respondents were women whilst only 3 were men.

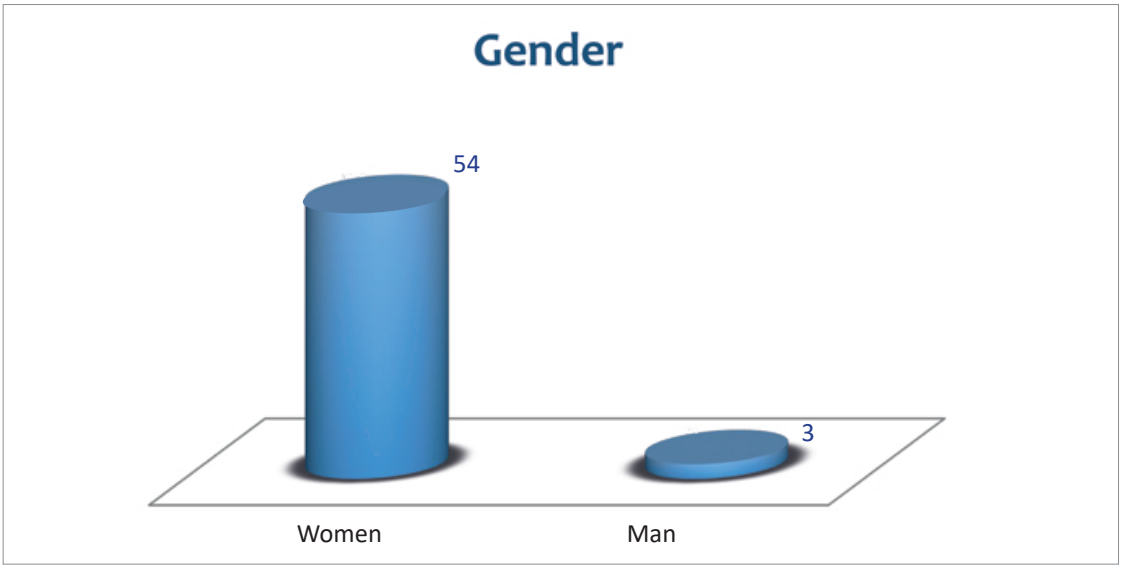


Figure 1 Genderof survey's partecipants

The questions started from a socio-demographic study of the participants, their institutional affiliation and the location of their work. Then, we examined the extent of their knowledge on FGM, the channels used to educate themselves on the subject and their opinion on the phenomenon. We wanted to find out if they were aware of the legal dispositions in place to prevent the practice and interrogated them next on their needs to be able to work more efficiently when taking care of patients. Due the fact that, although living in the country, most patients do not speak the language, one of the most important questions was about the use of cultural mediators. Lastly, we asked about their perception on the issue and ability to recognise genital mutilation on a female body.

As shown on the graphic below (Fig. 2), we can see that 28% of the respondents belong to the age group from 1991 to 2000: this is mainly due to the participation in the action research of the students enrolled on their last year of Nursing Degree at the University of Perugia (based in Terni). Following, 15 participants belong to the age group from 1971 to 1980, 12 were born between 1961 and 1970, 11 between 1981 and 1990 and 3 between 1950 and 1960.

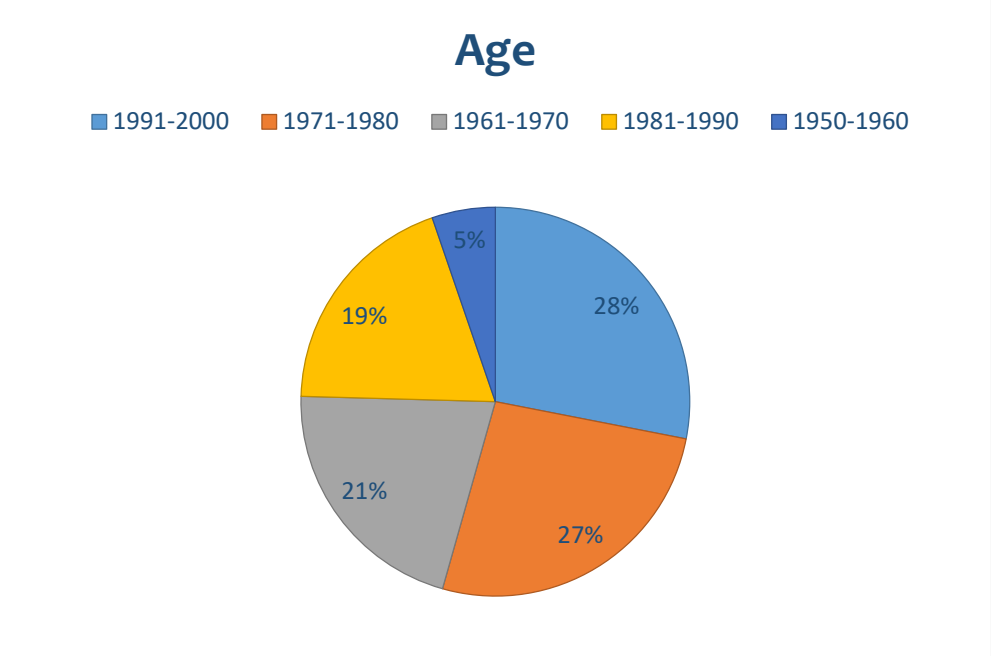


Figure 2 Age of partecipants

In regards to the different professions who took part in the completion of the questionnaire, the most dominant category was that of midwives with 28 respondents, followed by 12 nursing students, 6 psychologists and 4 cultural mediators. The lack of doctors specialised in gynaecology and obstetrics among the participants should be noted, with only 3 of them taking part. Among the remaining participants there is only one representative of each of the following professions: psycho-pedagogy, teaching, social work and nursing.

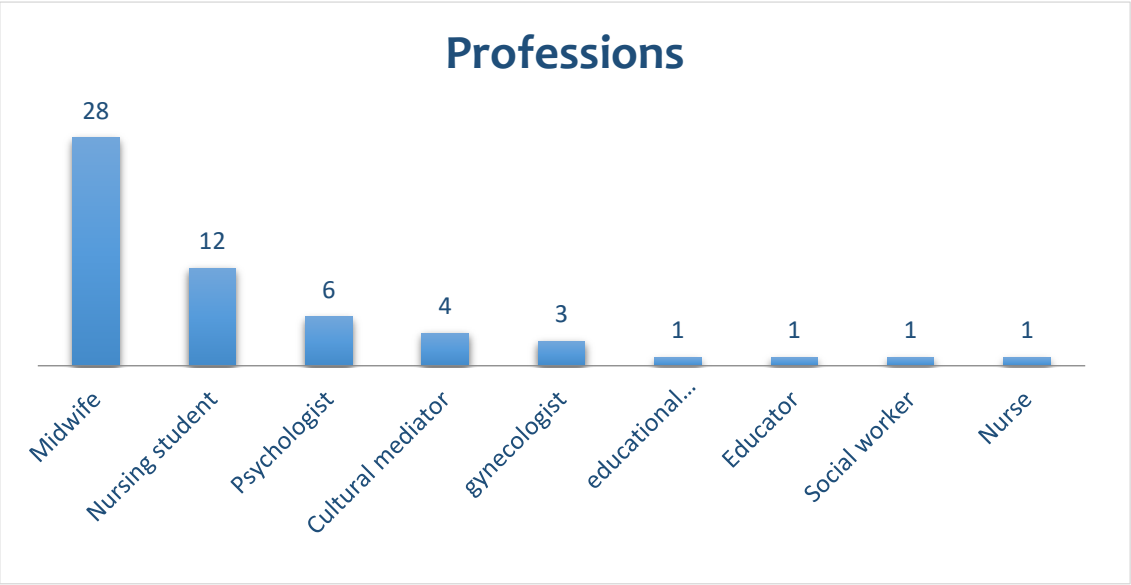


Figure 3 Professions of partecipants

As far as their institutional affiliations are concerned, comparing the data previously collected, the 28 midwives work at the Local Health Unit (AUSL) Umbria 2. The 12 university students are pursuing their studies at the University of Perugia.

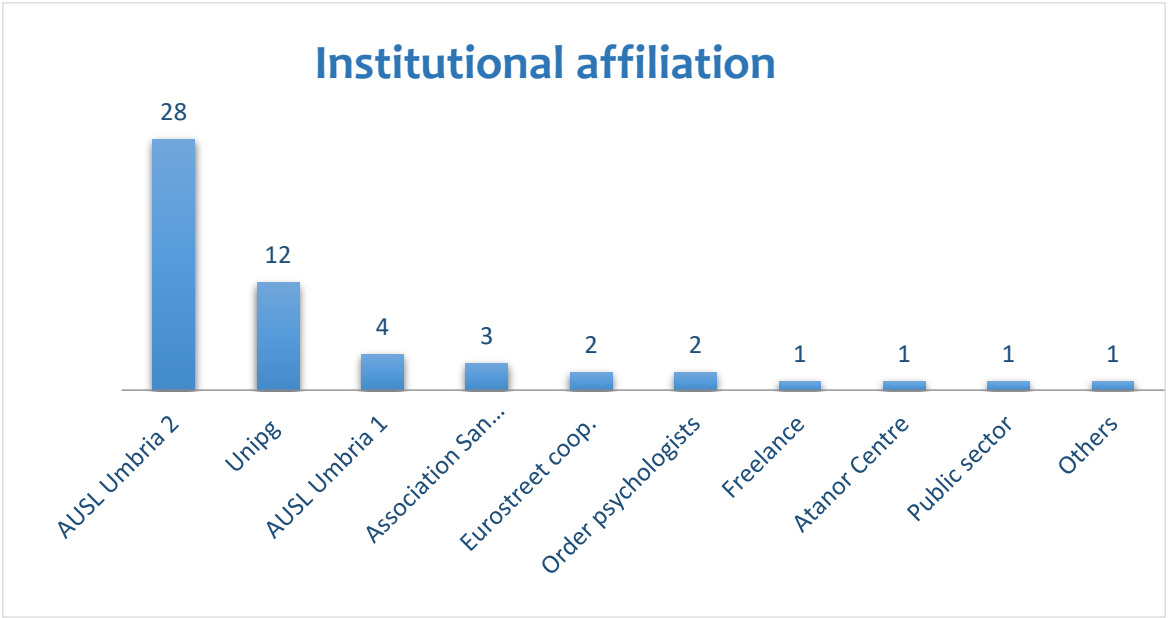


Figure 4 Institutional affiliation

Four professionals are affiliated with the Local Health Unit (AUSL) Umbria 1, 3 with the San Martino Association whilst 2 cultural mediators carry out their work at the Eurostreet cooperative society. The remaining 8% include other institutions, namely the Atanor clinical centre, and public authorities such as local health units and municipalities as well as self-employed people. Looking at the distribution of the participants in the regional territory of Umbria, it appears that the majority of them operate in Terni, representing 45% of the respondents, while 23% work in the area of Perugia, showing a big disparity

between the two provinces. 11% are located in the Narni-Amelia area while the remaining percentages come from Orvieto and Magione, representing 4% of the total number, and the Municipality of Foligno, accounting for 3%. The areas of Cascia-Norcia, in Valnerina, represent 2% and lastly one person from the Municipality of Fabro (Province of Terni).

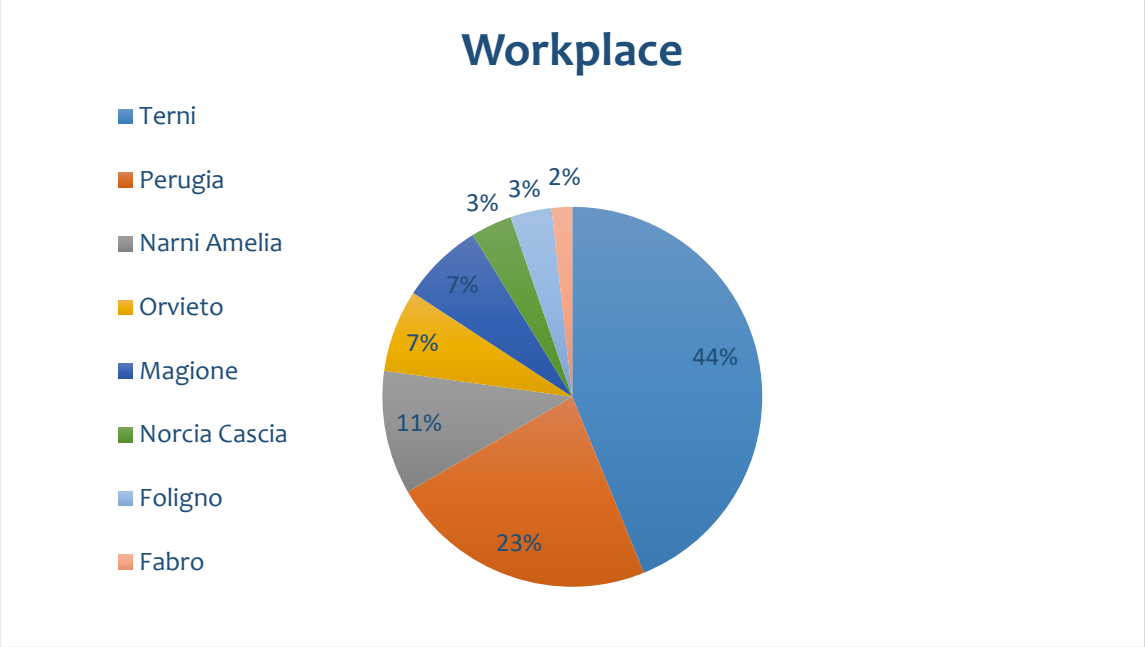


Figure 5 Workplace

The lack of a thorough understanding of this subject is a cause for concern, especially if we take into consideration that the people interviewed work in establishments where the presence of foreign citizens from FGM countries is high. As illustrated in the graphic below, 67% of the respondents, meaning 38 people out of 57, claim to have some knowledge about the phenomenon of FGM. 14 of them are not familiar with the problem, but asked to explore it further, whilst the remaining 9%, meaning 5 people, state to have no knowledge at all.

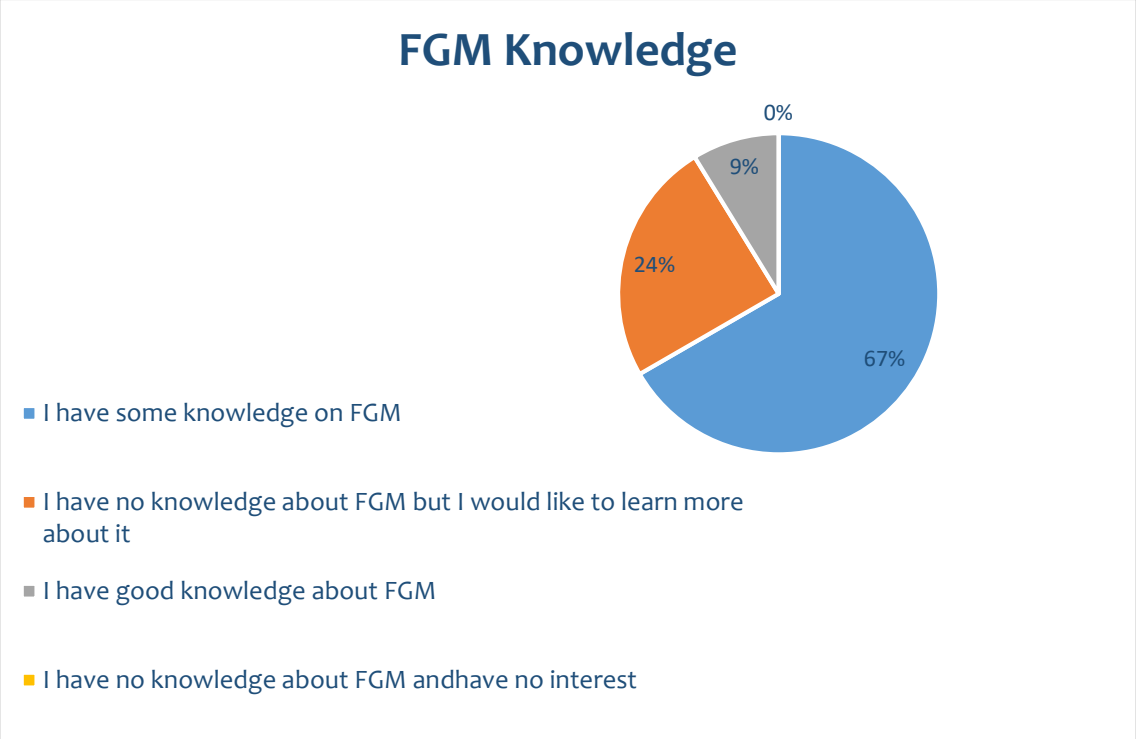


Figure 6 FGM Knowledge

Of the 38 people who claim to have some type of knowledge about the phenomenon, 12 of them gained it through training, 11 by reading specific text books and 10 by taking part in seminars and workshops that focused on FGM. Seven people reported finding out about the problem through patients/service users or mass-media whilst 7 more participants gained some insight from university classes that touched on the subject. 2 people acquired information from non-scientific text books and finally one of the people interviewed declared having experienced it directly.

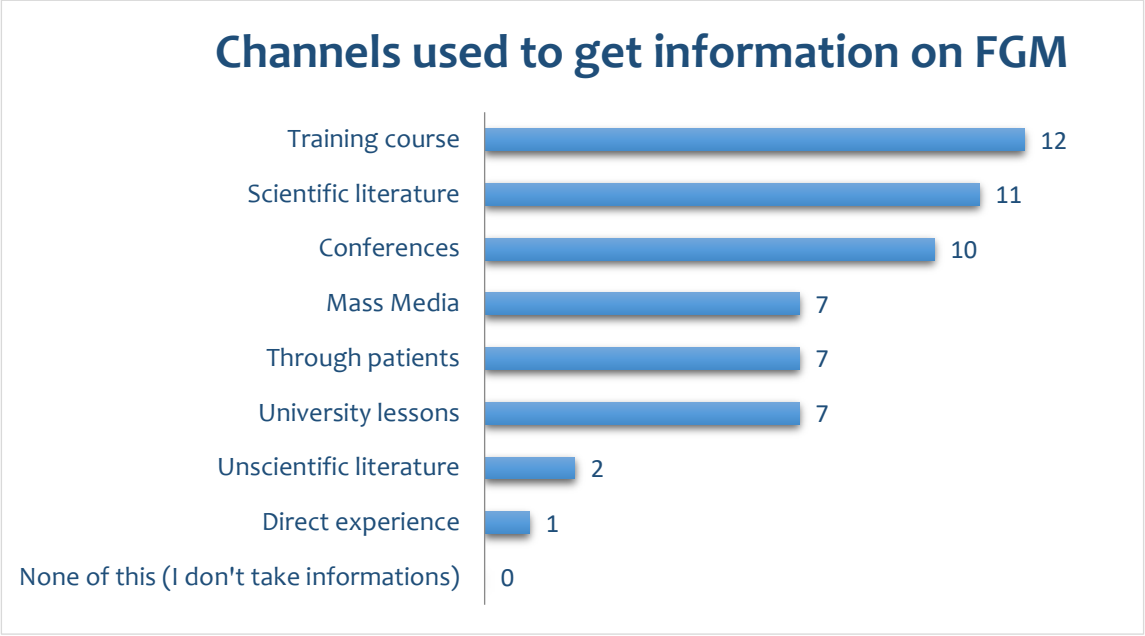


Figure 7 Channels used to obtain information on FGM

We asked the participants if they knew of any centres specialised in treating and preventing female genital mutilation. 88% of the respondents, meaning 50 people out of 57, had no knowledge, with only 12% knowing about the existence of specialised centres.

5 participants named a few known centres: 3 people claimed to know Careggi Hospital in Florence, whilst one person indicated 3 centres where it is possible to receive information and assistance: the Orim Regional Observatory in Lombardy, the S. Gallicano Institute in Rome and the S. Camillo Forlanini Hospital in Rome. Still, only one person claimed to be familiar with the work carried out in the Santa Maria Hospital of Terni.

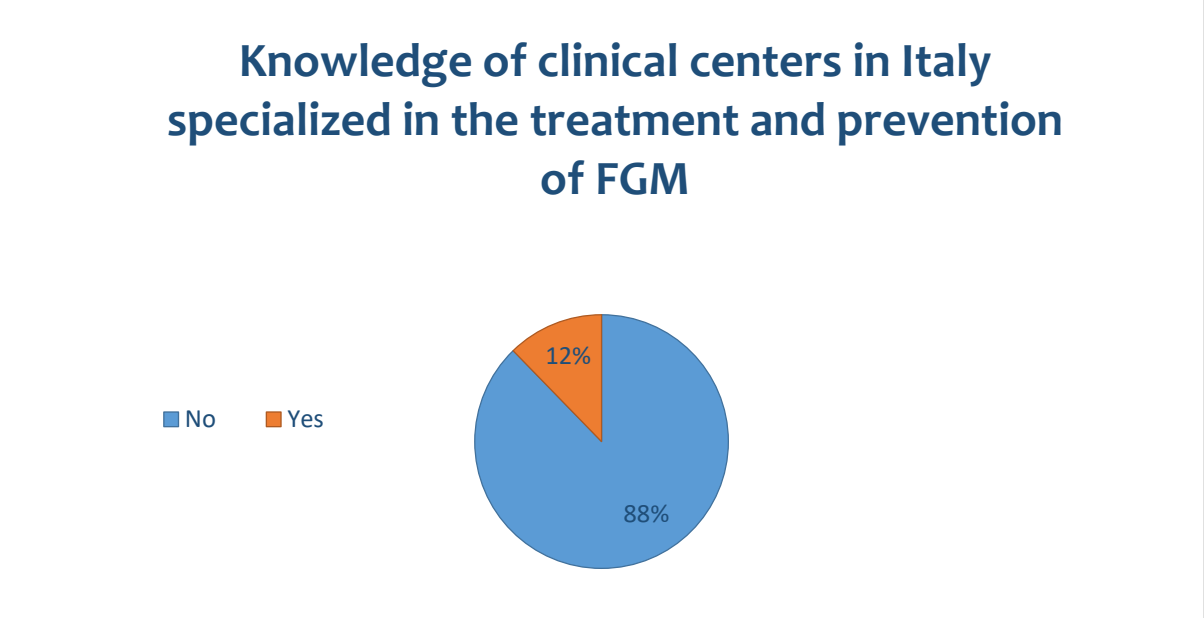


Figure 8 Knowledge of clinical centers in Italy specialized in the treatment and prevention of FGM

Based on the answers received, we can conclude that the professionals who took part in the process have a very limited knowledge of the phenomenon. Therefore, we intended to explore their views and opinions on this not well known procedure: 53% of the respondents, meaning 30 people, said it is a form of violence and 17% considers it to be a culturally unacceptable practice. For 21% of the people interviewed it is still an issue they need to understand. Comparing the data obtained from the previous question, we can assume it is most probably the same people who admitted not to be familiar with the issue but who wanted further details to understand the subject in question. Ultimately, the remaining 9%, the same percentage claiming to know nothing about the phenomenon, is unable to voice an opinion with regard to this practice.

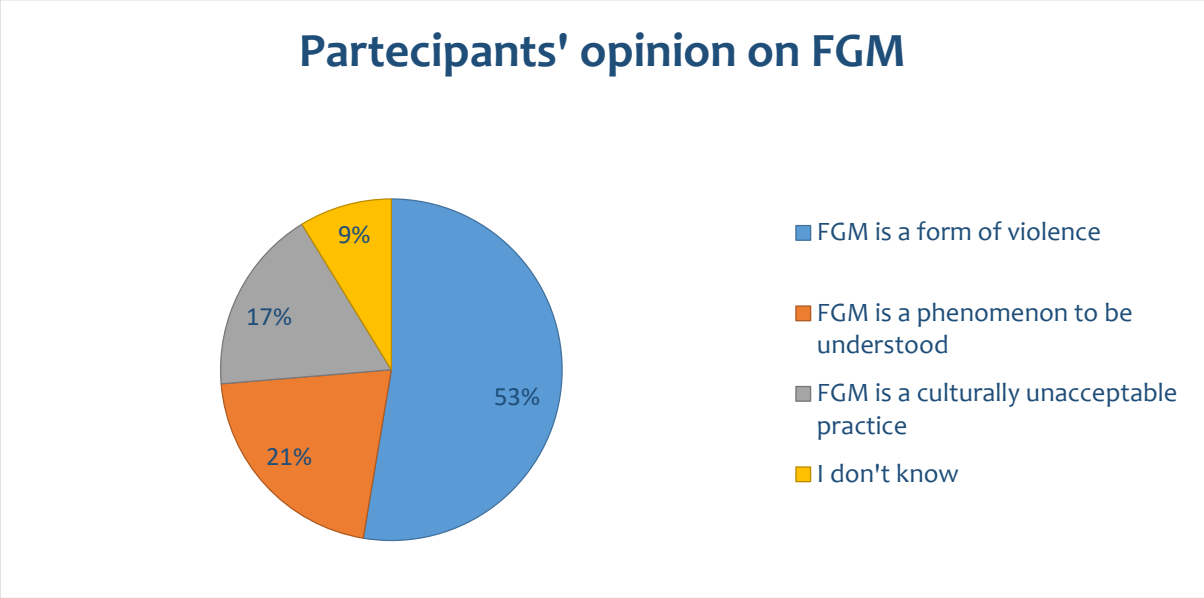


Figure 9 Participants' opinion on FGM

We investigated if any of the healthcare workers were aware of the Italian legislation that regulates the prevention and ban on female genital mutilation across the country. As shown in the graph below (Fig. 10), the level of knowledge of the Italian Legislation on the subject of female genital mutilation is definitely low. From the answers collected, it appears that 61% of the people interviewed, more than half of the total number, is not familiar with Law n.7 of 2006: *'Regulations regarding the prevention and banning of female genital mutilation practices'*.

Law n.7, issued on January 9th 2006, lays downs specific rules to address the problem of female genital mutilation. It applies the principle of extraterritoriality, criminalising the practice even when carried out abroad. As a result of this legislation, the Department of Health implemented different guidelines to be followed specifically by healthcare professionals working with communities of immigrants from FGM countries in order to carry out activities of prevention, support and rehabilitation.

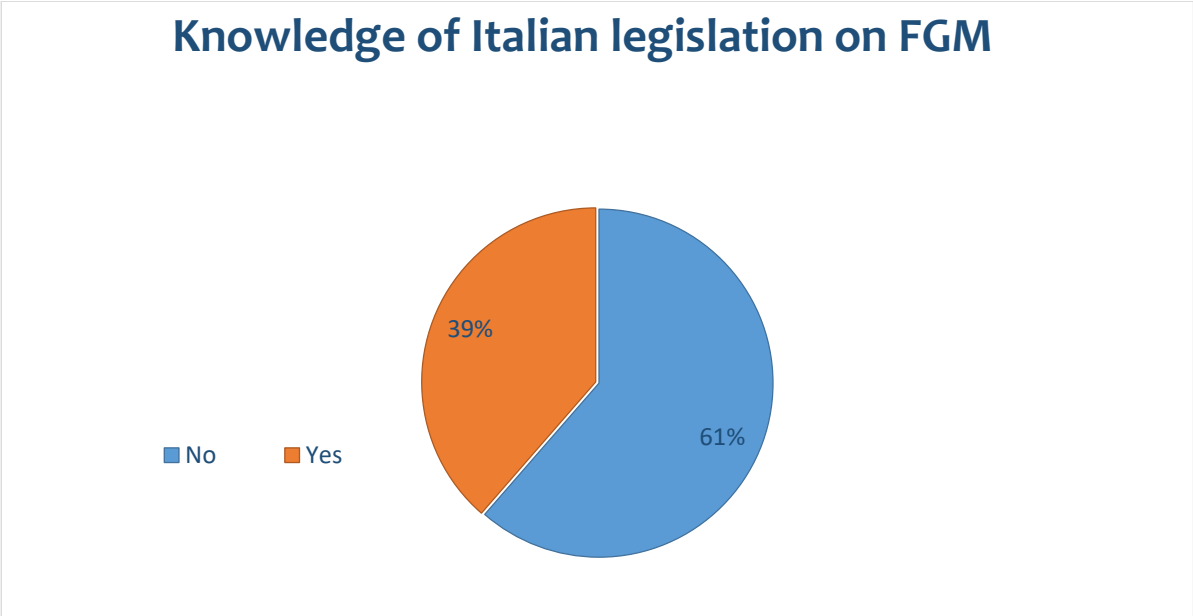


Figure 10 Knowledge of Italian legislation on FGM

Going into more detail with regard to their work, we asked the participants if they had ever met any women showing signs of genital mutilation on their bodies. Looking at the chart below, we can see with great concern that more than 60% of the professionals taking part, meaning 36 people out of 57, have never had any patients who have undergone some sort of modification to their genital parts. The remaining 37%, however, answered affirmatively.

Figure 11 Patients with FGM encountered

For a deeper understanding of how serious the problem is in Umbria, we asked the participants about the number of patients with female genital mutilation, including both girls and women, they had encountered. Comparing the data with those of the previous question, we can see that, also on this occasion, 36 people claimed to have never seen a patient subjected to the practice. However, out of the 21 people who had answered affirmatively to the same question: 16 have met between 1 and 5 patients, 2 between 6 and 10, 2 between 20 and 30 and 1 between 10 and 20. No participant reported to have seen more than 30 patients.

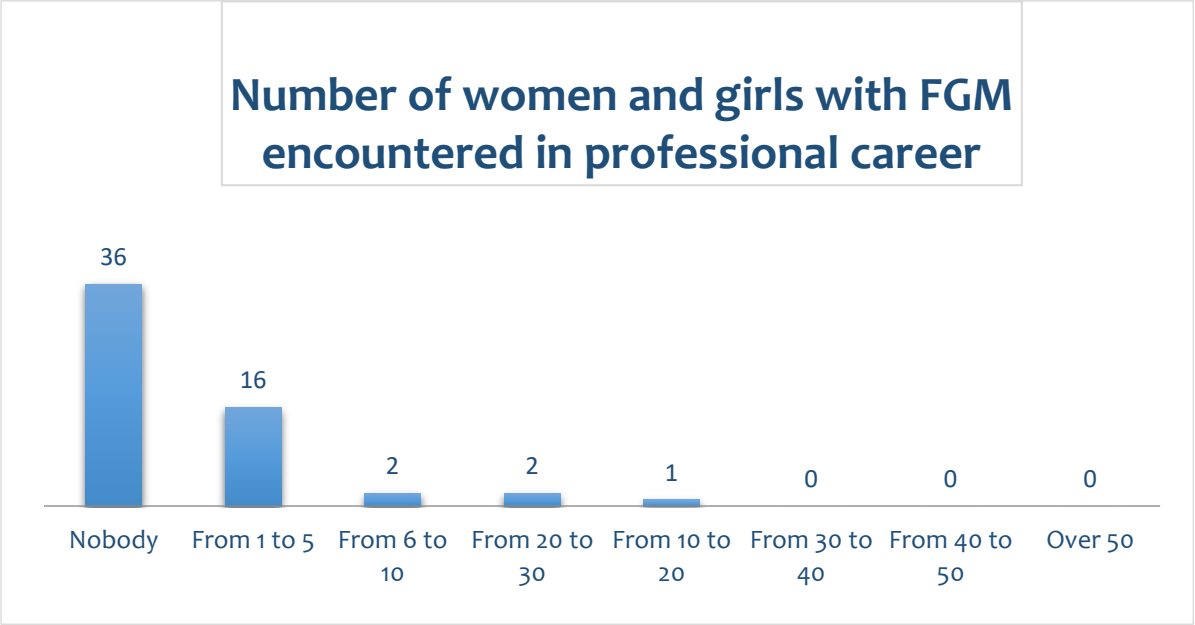


Figure 12 Number of women and girls with FGM taken into care

The healthcare professionals are overall very sensitive to the phenomenon. To the question relating to their main needs in order to be able to do their job properly and to take care of patients with FGM, 63% asked for better training, 21% for more discussions with experts on the subject, 12% for more debates and support from colleagues and, lastly, 4%, meaning 2 participants, claimed not to feel the need to address the issue.

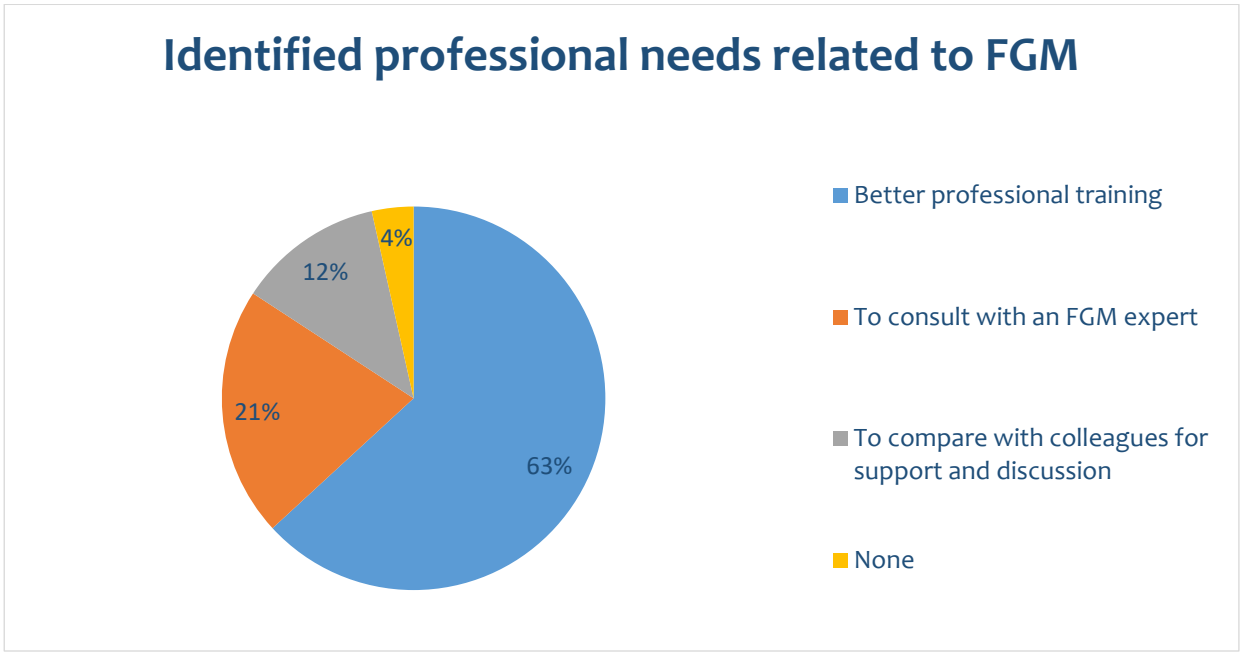


Figure 13 Identified professional needs

We asked the professionals in charge of patients who presented this type of problem if it had affected their work and how. As illustrated on the graph below (Fig.14), 43% of the respondents, meaning 26 people out of 57, paid closer attention to the information regarding the issue, 35% thought about measures to promote prevention, 11% hoped for someone else's intervention, 7% personally took action to be in charge of patients with FGM, whilst the remaining 4% did not deal with the problem nor was interested in doing so. We can see that it is the same percentage of people who claimed not to feel the need to address the situation when personally involved.

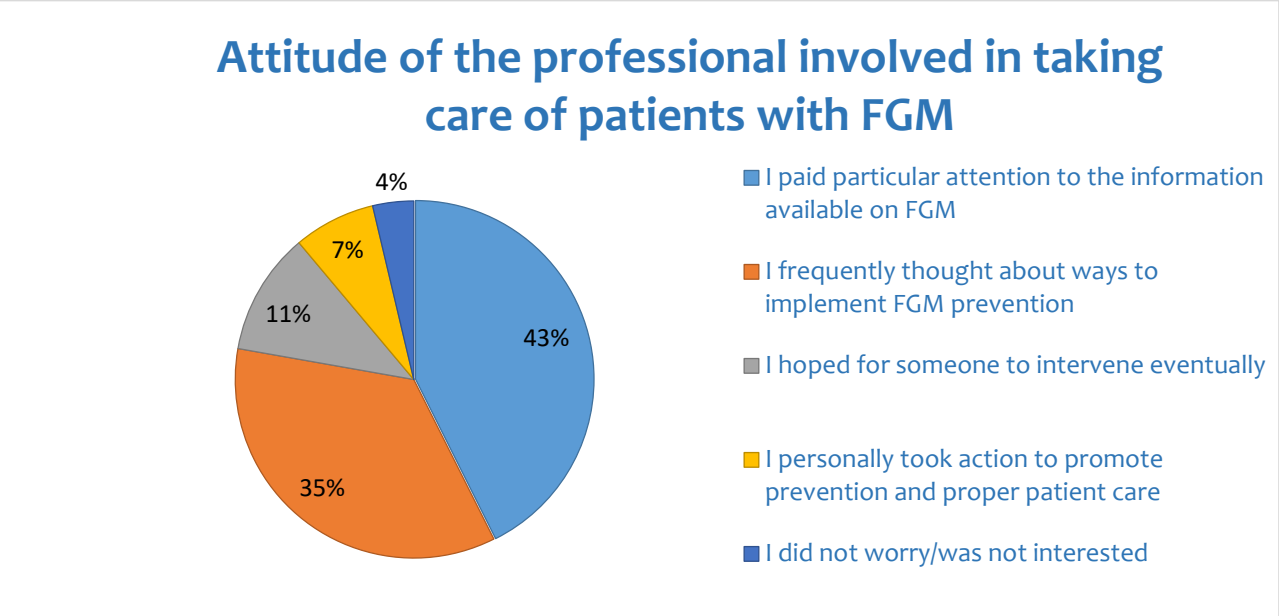


Figure 14 Social and health workers' attitude in taking care of patients

Due to the highly sensitive nature of the subject, it is essential to understand, and explain to the patient in particular, all the necessary information to be able to have a more integrated approach when taking charge. This objective can be achieved effectively thanks to the intervention of a cultural and linguistic mediator who can support both parties involved and act as a bridge between language and culture, both the patient's and the practitioner's. The communication between an immigrant and a host nation can often be disturbed by cultural and linguistic misunderstandings, especially in the healthcare sector. If the information is not conveyed in a clear and proper manner, conflicts affecting the relationship of trust between doctors and patients could arise. Mediation is a strategy aimed at cultural encoding to ensure that the patient feels welcome and not discriminated against. As we can see in the graphic below (Fig. 15), 33% of the participants stated that a mediator was never involved, 32% claimed in certain cases, 19% in every case, whilst the remaining 16% admitted to not knowing how to activate the service.

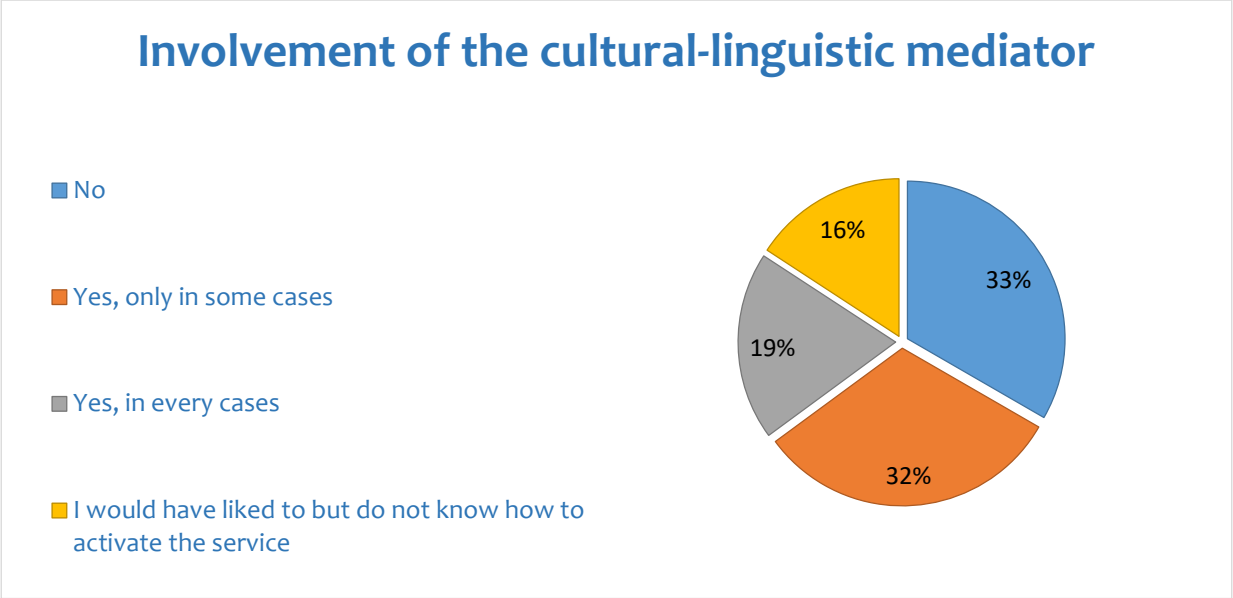


Figure 15 involvement of the cultural and linguistic mediator in taking charge of patients with FGM

The ultimate goal of this study is to understand if the issue of female genital mutilation is perceived as significant and present in Umbria Region based on the privileged point of view of the healthcare providers operating across the region.

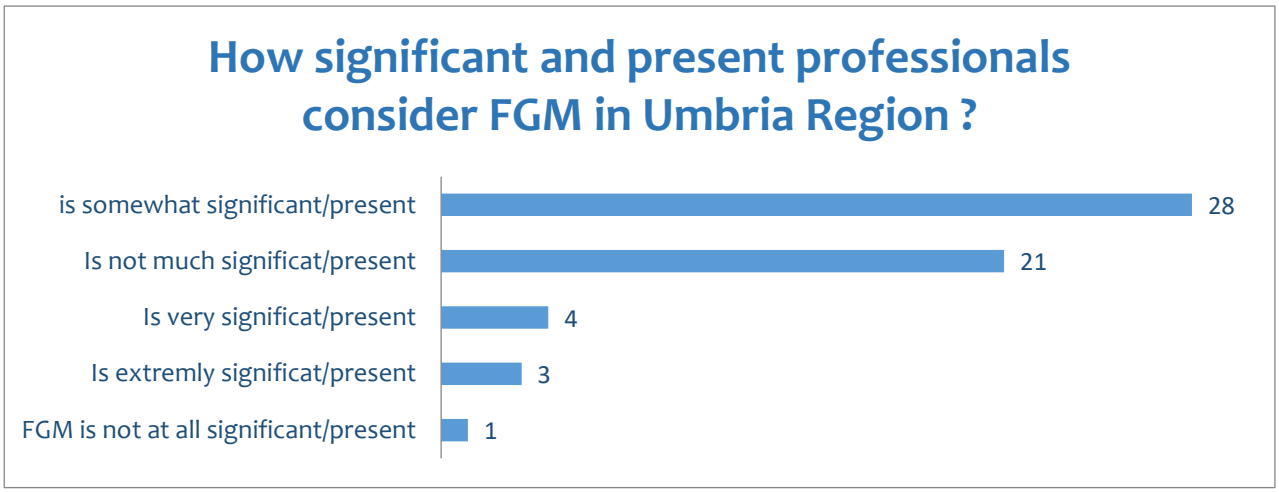


Figure 16 Relevance of FGM in Umbria Region according to social health workers

By combining all the data, it is possible to note how, for the majority of the participants, 28 respondents in absolute terms, the issue of FGM is quite significant in Umbria. In addition, for 7 people the response ranges from very significant (n. 4) to incredibly significant (n. 3), 21 think it has little significance and, lastly, one person believes it is not significant at all.

In the last question posed to the participants, we asked if it was easy or not, according to their experience, to recognise signs of FGM. For 24 people it is quite simple to identify the presence of some type of mutilation on female genitalia (Fig. 17), 4 claimed to be able to do it very easily and 3 indicated having a lot of experience recognising signs of genital mutilation on the bodies of their patients. On the

other hand, the difficulty is high for 18 respondents whilst 8 practitioners believe they are not simple to identify at all.

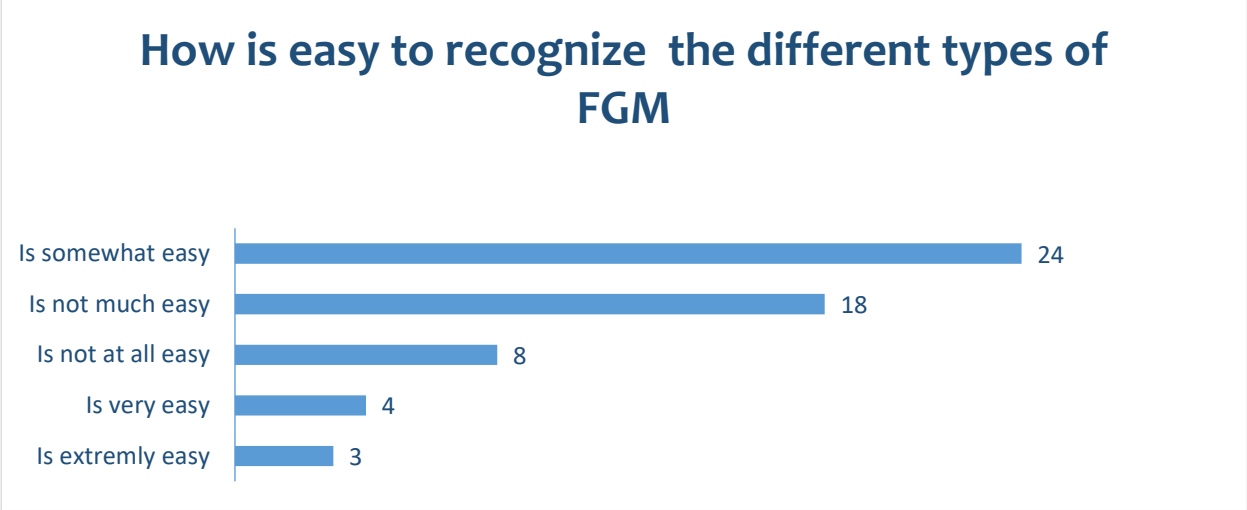


Figure 17 FGM identification in patients

Following are the comments and suggestions that some of the participants who took part in the research left at the end of the questionnaire:

1. *I would like to hear the experience of girls living in Italy who have been subjected to mutilations before our eyes.*
2. *This training course represents a great opportunity not only on a professional level but also on a human one.*
3. *To spread awareness about the issue among professionals who work with women affected by FGM to be able to understand, offer support and work on preventative measures.*
4. *Workshops and conferences need to be held to raise awareness.*
5. *I replied 'no' to one of the questions! Because I have personally never encountered cases of patients who have undergone this practice.*
6. *It is important to involve mental health services as well.*

In light of these results, it seems appropriate to implement a number of training programs for healthcare professionals, including activities to increase awareness on the issues related to FGM and, most importantly, the circumstances in which women with genital mutilation have to live with. Such activities should be planned and organised for different types of professions and working environments. They should be designed to create supportive relationships, based on the principles of cultural mediation and based on women's right to make autonomous decisions about their health, to allow practitioners to intervene properly.

Lastly, when it comes to patient care, it would be helpful to increase an exchange of good practice in Italy and Europe.

The outcome of the action research: qualitative analysis

In the next section, we present the results of the focus groups according to new analytical categories identified during the conceptualisation phase of the study and emerged throughout the analysis of the research material. To process and evaluate the data obtained with a qualitative analysis approach, we created a table with key information found during the planning phase of the project and divided it into macro-thematic categories. Through this process, it was possible to carry out an initial longitudinal study of the material collected, for each meeting, followed by a cross-sectional analysis of the content compared to the overall data collection. The objective was to identify and encode, within the different categories, both the recurrent elements as well as the unexpected topics. Subsequently, we deconstructed and reconstructed the text by breaking it down into groups analytically. This approach allowed us to sort through all the information obtained during the course of the meetings keeping always in mind the objectives of the research.

The analytical categories identified are the following:

1. Opinions
2. Patient Care
3. Emotions
4. Experiences and non-experiences
5. Professional needs
6. Cultural and linguistic mediation
7. Training
8. Racism
9. Recommendations

1. OPINIONS

What do the healthcare practitioners interviewed think of the practice of genital mutilation?

The focus groups gave them the option to expand on the answers given on the online questionnaire. Just like on the questionnaire, negative opinions emerged with significant frequency. Female genital mutilation was described as:

'It's inhumane'

'The phenomenon is unsettling and violent'

'It's a barbaric practice'

'It's an act of violence'

'It's not a mutilation for them. This is shocking!' (Midwife)

As further explored during the training course, it is a customary practice that belongs to the rooted traditions and beliefs of the communities who perpetuate and perceive them as significant socially, culturally and financially. It is something that cannot be ignored when taking charge of the health and well-being of a woman.

'It's a cultural phenomenon. It is normal for them and they don't see it as a form of violence. Every girl has to go through this step' (Midwife)

'Many of them don't experience it as a trauma (…) They don't experience it as a violence, but as Westerners we do' (Midwife)

'For us it is an anomaly. We are not used to seeing it. Therefore you doubt what you are seeing. You ask yourself if it is normal for them, if you are the one with misconceptions towards them. ***I have asked myself if what I was witnessing was actually true or just a movie in my head because I'm not used to seeing it****'* (Midwife)

Among the respondents there were people who emphasised on the cultural dimension and difficulty in understanding this phenomenon from an ethnocentric perspective. While it is important to recognise that the complexity and sensitivity of the issue require us to 'mediate without offending their culture', we cannot overlook the fact that this practice is a form of violence that adversely affects the human rights of women and girls. Inevitably, the categories 'we' and 'them' were used which highlights cultural barriers and communication obstacles with regards to traditional practices such as female genital mutilation. At the same time, however, an awareness of their own cultural framework and ethnocentric vision in relation to cultural representations that determine opinions and points of view emerged:

'It's a violence against girls ***but we have a Western point of view****. For them it's not like that, they don't realise it. If the women themselves don't see it as violence how can we possibly make any changes?'* (Midwife)

'In our society we think it's wrong but in their environment it's not like that*. We need to put things into perspective. We think this move is wrong. In our world it's wrong but we shouldn't be prejudist. How can I explain to you that it is wrong when probably in your situation it never is?'* (Midwife)

'Obviously from our perspective it's a violation but, speaking from a healthcare practitioner's point of view, I believe that ***the most difficult thing is to stand besides these women because we tend to immediately make assumptions*** *in an arrogant way, big or small…. as if our western culture was the*

best and knew it all!' (Psychologist)

'Working with completely different cultures is not easy... it's a daily challenge that we have. We need to put an end to dangerous behaviours and work towards cultural interaction. We need to work hard and it's not simple' (Gynaecologist)

'As women we feel close to these women, empathy and prejudice are taken for granted. You ask yourself 'how can you live with this thing?' (Midwife)

'It's difficult explaining to a woman that it's physical abuse. Who is supposed to go through this process, though?' (Midwife)

The professionals questioned themselves: how to become agents of change, how to make women aware of the damage caused by female genital mutilation and the fact that the practice is detrimental to health and human rights, how to **'take them out of this circle'**. (Midwife)

These questions present us with the second analytical category emerged: patient care.

2. PATIENT CARE

Based on the information collected from the focus groups, it appears that foreign women do no trust healthcare services nor the people working in them: the relationship of trust between practitioner and patient is in trouble. Midwives are very aware of this fact and many of them have stated that it is necessary to *'work on the relationship with the pregnant woman and on gaining their trust because we have 9 months. We have the possibility to build relationships based on trust. We can break the inevitable lack of faith in healthcare services'* (Midwife).

Connected to the topic of trust is the one of fear. It emerged, in fact, that many women do not contact healthcare services because of **fear of being judged, laughed at and misunderstood by the personnel**:

'The women think 'I'm not going to talk to you because you wouldn't understand'. *It's important to find the right approach when talking to them, a way for them to open up. These experiences come out during labour but we must figure out ways to address the issue'* (Midwife)

'I wish I could tell her: 'you can open up to me, I'm not going to judge. As a midwife I feel the need to do it even more. ***The women, however, don't talk because they feel ridiculed****, they don't want to open up'* (Midwife)

'The women don't like talking about this procedure and deny the obvious' (Midwife)

As a result of the rise in global mobility and international migration flows, modern societies are characterised by great diversity and have become places with multiple cultures and hybrid identities. An intercultural approach (inter-culture meant as acknowledging 'something else' and cultural affiliations) could be helpful: an evolving space where the boundaries between different realities are not fixed but dynamic and where an exchange, a trade and a dialogue between different cultures, or rather individuals ('people come together and collide, not cultures' Aime, 2004, p. 1), is possible. It is necessary, therefore, to shift the focus from the perspective of female genital mutilation as a barbaric and uncivilised practice (this is how it has been often described) to prevent the rooting of opposing views that would otherwise push away the possibility of people coming together and having a dialogue. It is essential to abandon our homogeneous and static vision of culture and replace it with a more social and dynamic perception that understands the process of negotiation and redefinition that cultures and traditions go through. In this scenario, cultures present themselves as uninterrupted negotiations of the imaginary boundaries between 'us' and 'the other', where 'the other' is always within and among 'us' and vice versa, to paraphrase the anthropologist Clifford Geertz.

The need to adopt a culturally sensible and unbiased approach, based on attentive listening and empathy, when first meeting women and girls (as well as their families) with signs of genital mutilation on their bodies strongly stands out.

Healthcare professionals are aware of the fact they need to adopt a more welcoming and empathetic approach towards these patients and try to communicate with them with *'tactfulness and patience'* (see Mediation) in order to understand the reasons behind this practice (*'to release myself from judgement'* - psychologist) without neglecting their psychological and mental health needs. They know they should not have a prejudicial attitude towards women with FGM but claim that it is difficult not to fall into this trap because *'judgement creates bias*' (Psychologist):

***'For us westerners bias can be so strong at times that we don't even realise it**, because we make diagnosis … we tell ourselves 'this woman comes from Africa and has never been able to come out of that world , poor thing. This (ed: being non-judgemental) is the most difficult aspect when facing this type of issues as they are so, so far from us'* (Psychologist)

*'This approach (ed: bias-related) needs to be exacerbated. This type of ignorant behaviour from healthcare professionals towards vulnerable people who have had negative experiences after enduring this practice is unacceptable. I think **humanity should be preserved**, in the sense that they need to be understood, listened to and supported because **this is a very serious issue'*** (Midwife)

*'It's important to know how to approach and interact with these women **using the right words and the correct way** without offending them'* (Midwife)

When taking charge, and not only, over a patient with FGM, it is important to adopt an attentive, unbiased approach and to pay particular attention to words, language (choose the right words!) and

reactions (verbal and non verbal) as they can often be a source of misunderstandings (for example, the use of the word 'mutilation' could be not understood and not describe the perception women have of themselves or how they want to be perceived), discrimination (they could feel judged) and the reason why someone does not open up.

It would be advisable to avoid patronising behaviours as well as victimising or sensationalising a woman with FGM. As previously stated, this kind of approach could make the patient feel judged and affect, if not preclude completely, a relationship of trust between physician and patient. It is worth noting that, in 2007, the Department of Health published specific guidelines for healthcare professionals taking charge over women with FGM with the objective to: *'Provide healthcare practitioners, as well as social and cultural workers, with the proper tools to accommodate and look after women who have been subjected to genital mutilation in a caring and professional way, without showing any signs of embarrassment, surprise or curiosity, as sometimes reported; in order to build that relationship of trust necessary for the women to start having a different perception of their own bodies and well-being and to open a dialogue to prevent the daughters of these same women from this practice*'.

When taking charge over a patient, in addition to the need to build relationships of trust and ensure that the women are not afraid, the topic of female genital mutilation emerges as:

'it's a phenomenon so far from us that we don't know how to deal with it' *(Midwife)* ***or 'it's something that I have always seen from behind the glass'*** (Midwife)

It is a poorly researched and studied phenomenon on which we have limited information and healthcare providers claim feeling unprepared to look after a patient with this type of issues. If these opinions are, on one hand, due to the lack of direct experience, a topic we will touch on further, on the other, they are due to lack of information and specific interdisciplinary training on the issue, the different categories listed by WHO (World Health Organisation), the physical and mental consequences, the approach (verbal and non verbal) and cultural awareness needed to interact with these women and their families in the best possible way. As a matter of fact, several people reported the need to learn how to approach women with modified genitals.

'It's a subject we know nothing about (...) we feel unprepared' (Midwife)

'If I were to find myself in front of this situation [ed: in front of a patient with FGM] I wouldn't know how to act' (Midwife)

The participants lament a lack of preparation due to the absence of theoretical and practical training aimed at providing them with the necessary tools to be able to deal with these patients, along with their problems and mental and physical distress, using a holistic, caring and mindful approach. The requirements expressed by the healthcare professionals deserve answers and consideration that have been partly given to them through the recently finished training during which the present action research was developed. However, these needs could be met even further with additional training

organised by public and private entities already dealing with the issue. In the words of one of the participants, it is essential to give visibility to the subject of female genital mutilation, acknowledge the fact that the problem is present also in Umbria and has become a global health issue:

'This subject needs to be finally recognised and exposed. If we don't talk about it, it doesn't exist. This phenomenon travels in silence' (Psychologist)

3. EMOTIONS

Compared to the conceptual framework developed in the planning phase, this is an unexpected element that emerged during the meetings. The subject of female genital mutilation and the encounters with women affected by it, in particular, can cause strong reactions. Healthcare professionals do not remain indifferent: they become emphatically involved and experience strong and different emotions, positive and negative. The following excerpts include some of the participant's thoughts on how they felt when they took charge over a patient with these marks on their bodies:

'the first impression is very subjective. I felt it on myself. I felt it on my skin. ***I put myself in the shoes of a woman*** *who has suffered and continues to suffer (…)* ***I feel helpless, it's disarming****.... a mutilation is a mutilation' (Social worker)*

'at the beginning, when I saw it for the first time, ***I was caught unprepared****... after that, whenever I would see one* ***I would feel shocked and terrified****.* ***It scared me****. Some were really frightening, I didn't think it was possible to reach such levels' (Gynaecologist)*

*'****the first time I met patients with these marks on their bodies I was speechless, bewildered****'* (Midwife)

'(a woman came to the hospital) she was about to give birth but I wasn't there throughout the whole labour. I noticed her genitals were different so I asked myself 'has she been mutilated?'.

Then I spoke to my colleagues and we wondered how she must have felt. ***During labour I looked into her eyes. I felt embarrassed*** *but maybe for her it was all natural. I couldn't understand what she was feeling and if it uncovered any psychological issues'* (Midwife)

'she was the one supporting me when I was cleaning her wound. ***I felt sick*** *and asked how she was not in pain. 'the hardest part is done' she would say. How do you do it?'* (Midwife)

I felt sad *for the women who were not aware of their rights over their own bodies.* ***I also felt anger*** *towards the system in general, the culture (…)* ***I felt frustration as well*** *in situations where the patients wouldn't see it as negatively as we did'* (Midwife)

4. EXPERIENCES AND NON-EXPERIENCES

37% of the people (n.21) who answered our online questionnaire claimed to have met one woman with female genital mutilation during their professional experience. 16 respondents, in particular, declared to have visited between 1 and 5 patients with genital mutilation, 2 had contact with a range between 6 and 10, 2 between 20 and 30 and, lastly, 1 person between 10 and 20. On the other hand, the majority, 63% of the professionals involved, reported never meeting a woman or girl with marks of genital mutilation in their career. These figures were further discussed in a focus group and this type of trend was confirmed: the majority of the people interviewed had never had any experience looking after or interacting with patients presenting modified genitals. Taking into consideration testimonies of practitioners in charge of women with these marks on their bodies, we found the experience of a gynaecologist who has encountered, throughout his career, many women with modified genitals of particular significance. Following are some passages of his story:

'I have a memory of a Somali woman who had undergone infibulation, her vaginal opening was very restricted, truly terrible. She was pregnant. We made arrangements with the Hospital of Terni where I found doctors who performed an excellent surgery. We explained to the woman that there was no turning back. We told her that closing (ed: infibulation) would have caused severe infection in the future. We talked to the midwives as well, ***I showed it to them because you need to get used to them, they are not all easy to figure out.*** *The woman was able to give birth naturally. We had good results, we have had to operate on more than one: five or six. The majority of the women are from Africa, Somalia and Ethiopia in particular, but also from other African countries' (*Gynaecologist)

Looking at the other perspective, despite having no direct experience with patients with female genital mutilation, a few healthcare providers claimed that recognising the marks of a mutilation should not be difficult:

*'it's not something that goes unnoticed. Even though I have never seen one I don't think you could... you notice a patient with genital mutilation, I think you see it. It's an area that gynaecologists and midwives examine, I think it would be quite obvious anatomically****, I don't think it's something that goes unnoticed*** *nor that could be an oversight' (Midwife)*

While a nursing student states:

'unfortunately I don't have any experience so I wouldn't know what to look for if I'm honest!'

Generally speaking, what stands out the most is the **difficulty in identifying and classifying genital modifications and marks on the body correctly,** which is not an easy thing to do as it requires expertise and cannot be taken for granted: ***'because you need to get used to them, they are not all easy to figure out'*** (Gynaecologist). The standard classification of the different categories of female genital mutilation drawn up by WHO, and globally recognised, is useful when it comes to identifying the many types and their effects on a woman's health. Nevertheless, it is not always simple and straightforward to recognise

and place the different forms of genital modification within the categories and subcategories used by WHO. From the classification drawn up by WHO, in fact, it is evident that FGM constitutes a rather diverse set. Although put together under the same acronym by convention, these practices are in fact quite diverse in terms of medical consequences and vary according to the socio-cultural system they refer to. Consequently, there is not only a variety of practices but also several ways to perform them, different cultural and anthropological reasons, ages, practitioners and ways in which communities can participate.

Most of the time, women with genital mutilation do not visit social and health services; this happens not only with regards to issues specifically related to the practice itself but in other

situations such as labour, gynaecological examinations, counselling and, in the case of children, a visit to the paediatrician. In these types of circumstances the presence of female genital mutilation may emerge (even when the medical staff do not expect it) as well as other symptoms possibly related to or a direct consequence of genital modification. Some of the participants claim to have had patients they had never met before, and who had never had an examination, come to the hospital just in time for labour. At the same time, a lack of time to speak to the women (girls) and their family and understand their socio-cultural background must be noted. All these factors are essential to help healthcare professionals identify and classify the less invasive and obvious genital modifications.

The number of women and girls with genital mutilation in Umbria is not high[2] but it is not close to zero either. However, to paraphrase one of the participants, something is missing or, as reported by another person, underestimated (in reference to a case in 2017 in Fossato di Vico where a father was arrested for having his daughter circumcised).

In 2014, around 600 women and girls with genital mutilation were estimated across the region. It is important to register, in fact, the more and more stable presence of people, groups, families and communities originally from countries with FGM traditions as shown in the data processing carried out by CERSAG in this action research **that estimates around 2000 women in Umbria**.

According to some midwives, this type of patients has never been seen in their medical facilities as **they tend to go to different establishments** (licit or not) managed by doctors originating from the same countries. Another reason is the fact **they have no access to care** which exposes them to significant mental and physical health risks and creates a loophole in health protection, a fundamental right (art.

[2] It should be reminded that, in 2007, Umbria was highlighted by the Department of Health as a target region for protection and prevention activities of FGM as part of a group of 13 regions where the issue was reported. The same document stated that the problem in Umbria was 'almost completely non-existent'. Nevertheless, the inclusion of the region in the list lead to the formation of the first working group for FGM at a regional level which included representatives of social and health services. See Department of Health, Department of Prevention and Communication, Directorate General for Health Prevention, Health Office for women and children, Recognition of services offered at a regional level to women and girls subjected to female genital mutilation, 2007, Rome, May 29th 2007. The other regions highlighted by the Department of Health are: Valle d' Aosta, Lombardia, P. A. Bolzano, Friuli Venezia Giulia, Liguria, Emilia Romagna, Marche, Lazio, Abruzzo, Puglia, Sardegna. As a result of the first document, the Department of Health introduced guidelines *'designed for healthcare providers as well as other professionals working with migrants from countries where female genital mutilation is prevalent to carry out an activity of prevention, assistance and rehabilitation for women and girls already subjected to this practice'*, art. 4 – Law n. 7 of 2006.

32 of the Italian Constitution):

'I believe they might have other channels, they don't come to our facilities … it seems strange to me, I have been here since 1988 and we haven't had anything, I don't know... I get a sense, again, they might have other channels for treatment unknown to us, this is why I think there is another path, another way. I don't know.... it's my idea, I'm probably wrong. (…) ***It's not possible to have so many cases in literature and yet so few on a practical level. Where are all these patients? This is when something is missing****'* (Midwife)

'in my opinion they never come for check-ups, ***they don't get checked at all****. Maybe because they think they don't need to'* (Midwife)

With regard to experience, present or not, and taking charge over a patient with genital mutilation the issue of **prevention** stands out. This is a fundamental action and should be one of the objectives to reach in every situation and intervention. Practitioners with experience in looking after mutilated women have talked about their commitment, whilst carrying out preventative and awareness activities, to call into question the behaviours of the patients and their families (the involvement of family members is an important aspect in this type of situation) to facilitate the process to end these harmful practices. In order to carry out a more efficient action of prevention it is necessary to involve other professions to be able to provide, through team work, a more **holistic approach** during patient care. Unfortunately, as stated by the participants, there is **no feedback** regarding this type of intervention:

'We tried to do some preventative work on changing behaviours. We wanted to make them understand they shouldn't impose mutilation on their daughters. ***We have no feedback****. There was no return, they never came with their daughters. I hope to have had some sort of effect, I*

sincerely hope so. ***There was a woman from Ethiopia who didn't understand, she said that it was absolutely necessary.*** *We told her it definitely shouldn't be done to avoid risks in the future, exaggerating as well,* ***we were trying to scare her****. We had to to fight a lot of resistance. During the meetings with the social workers and psychologists, if present, we were met with resistance not only from the women but also from the men'* (Gynaecologist)

'We try to give indications [ed: to the parents of the girls], but I don't know what happens next as I don't have the power to check [ed: she is referring to medical supervision]. This why ***it is important to have the paediatrician on our side****'* (Social worker)

5. PROFESSIONAL NEEDS

From a professional and practical point of view, some of the most pressing needs reported by

the participants are the following:

1. working on building a relationship of trust between doctor and patient, especially with pregnant women, in order to break the lack of confidence in healthcare services. '*I think it's very difficult for these women to ask for help*' (Psychologist).

2. More time for counselling and outpatient consultations is essential to be able to build relationships of trust with the women and give them the time to open up, listen and interact.

3. Access to specialised and interdisciplinary training that takes into account the social, cultural, legal, psychological and medical aspects.

4. Increasing communication between regional and hospital networks and facilitating health and social services networks for a more efficient and integrated patient care service that involves the private sector as well. ***'As with all things, if you don't talk about it, it doesn't exist. Therefore I believe that networking is very important. The time has come***' (Social worker).

5. Developing a more person-centred approach rather than focusing only on the medical side and condition of the patient. With reference, in particular, to FGM women, the focus needs to be on the woman by sharing with her the different therapeutic possibilities and treatment plan as '***we often talk among colleagues but never include the patient***' (Midwife); *'**We are adopting a wrong approach again, we are making decisions for that body**. By not asking the patient we are taking her power from her again. Someone decided for you before and now again*' (Midwife).

6. CULTURAL AND LINGUISTIC MEDIATION

The figure of the mediator and cultural and linguistic mediation play a significant role within the context of a focus group. Mediation is, in fact, considered an essential tool in order to communicate effectively with patients and be supported when adopting a culturally sensitive and non-judgemental approach. Nevertheless, despite these premises, the figure of the mediator is often not present due to time constraints (urgency at work and no time to activate he service) or the lack of a consolidated practice to use this person within social and health services.

*'being unprepared, **the cultural and linguistic mediator is an important figure but not always present'*** (Midwife)

Box - CULTURAL-LINGUISTIC MEDIATION

Cultural-linguistic mediation is a method used by public institutions with the aim to promote equal opportunities, the protection of the rights recognised by the State and access to public services. The choice to utilise mediation comes from the need to facilitate proper communication between two people (in particular between the public administration operator and the foreign user) with different languages and cultures where linguistic misunderstandings and lack of awareness of one's cultural references (value-related and symbolic) can lead to misconceptions and ambiguity. Cultural mediation allows citizens to communicate and interact in a 'shared space' that guarantees social justice, protects diversity and reinforces democracy. This is possible thanks to a working method that focuses on listening, awareness, guidance, advocacy and empowerment of all the people involved. It enables us to identify the needs expressed by the migrant population, provide guidance and support those who work in public services and take appropriate account of society's needs in general to allow all parties involved to manage relationships consciously.

'Integration is a dynamic, long-term, and continuous two-way process of mutual accommodation, not a static outcome. It demands the participation of immigrants as well as residents of the Member States (…) and the clear communication of their mutual rights ad responsibilities'.

(European Council, Common Basic Principles, CBP.1)

7. TRAINING

The subject of training on the complex and multifaceted phenomenon of female genital mutilation came up frequently in every meeting and, therefore, with that all professionals involved. Many of the participants reported a lack of vocational training programs on the topic, some have explored the theme on their own, whilst others stated having only a superficial knowledge or no experience at all. Generally speaking, all the participants claimed to be very interested in learning about the issue and believe that this type of training is necessary for mental health professionals as well. As already mentioned in section 2 (patient care), most of the participants feel unprepared and have clearly expressed their difficulties in identifying, classifying and managing (meaning how to approach) women with problems related to genital mutilation. They also recognise the need to deepen their knowledge from an anthropological and socio-cultural point of view in order to understand the reasons and traditions behind the persistence of

these practices in diasporic communities:

*'**I consider it to be a very interesting subject, current, it seems so far from us but it could happen in any moment** [ed: to have a patient with female genital mutilation]'* (Midwife)

*'**It's a topic we know nothing about and we feel unprepared'*** (Midwife)

*'**We are having an on-the-job training** as there aren't many courses on this subject that can provide information. **We need training**. We are missing distribution of information, we need to know the problem better. It has been discussed but in a superficial manner. We need to know more and know where to find help. **We are working with no preparation, no cultural background**'* (Gynaecologist)

Some of the participants reported that the Bachelors of Science in Obstetrics now includes a module on female genital mutilation whilst the Bachelors of Science in Nursing incorporates a few hours of in-depth study of the phenomenon. The decision to open the present action research to students in their last year of Nursing at the University of Perugia was an important opportunity for study and debate, thanks to the happy intuition of those in charge of the University internships and the ASL (Local Health Unit) Umbria2.

***'There is plenty of work to do with us healthcare providers**, in particular when it comes to subjects so delicate and primordial that have to do with the beginning of the world, I would say. We need to work and **we need to dissuade those who snub the issue** and think they are above it. (…) I **believe it is important to start talking about this within the services because there is total ignorance around the subject**. I think our nurses, social workers … even those in the field of addiction and mental health should be educated on these matters'* (Psychologist)

8. RACISM

During the meetings, the issue of racism in health and social services unexpectedly emerged. Several professionals, in fact, have noted a racist attitude from their colleagues towards foreign women who are treated like '**second-class patients**', met with a different approach and given a cold and annoyed welcome in that '*they don't really see the person but only the subject of the profession*' (Midwife) Discriminatory behaviour, explicit in some cases and less in others, due to misconceptions and stereotypes towards certain cultures was reported. Thinking of cultures as close, strict, unchanging traditions and, therefore, adopting an objectified view of it, in which cultural differences are naturalised, can result in new forms of racism where culture is seen as an identity marker. On the contrary, cultures are permeable systems and sharing spaces, not fixed and static realities. Judgmental and discriminatory behaviour can also result in forms of racism as stated by Marco Aime '*using culture as a cover, we have become racist without the need of race*' (Aime, 2009, p.70)

According to some professionals, it is not only a '*matter of ethnicity and colour of the skin*' but a '*question of distance in terms of culture and language*'. This results in discrimination against the patient who is seen and treated as a problem due to the difficulties in communicating and relating to her of the medical staff. Debates on this topic were always very lively during the meetings held. Racism is present in Italy and according to most of the participants it is a cultural issue and a matter of sensitivity. With regard to the discriminatory process migrant women are victims of, Gender Studies experts have identified 3 types of discrimination: migrant women are discriminated against as women, as migrants and according to their social status. They form what has been called a 'Trimurti', which defines how immigrant women are seen by receiving societies.

9. RECOMMEDATIONS

Finally, the professionals were asked what recommendations and courses of action to propose to and urge from regional public health administrators for concrete and effective taking charge of women and girls subjected to or at risk of FGM:

- Building and consolidating a multidisciplinary team of experts on the issue (even if cases are not considered huge and the subject is not seen as important by the management) made of different healthcare professionals: psychologists, midwives, gynaecologists, paediatricians, cultural mediators, general practitioners, anthropologists and social workers. This type of teams could act as a Front Unit and be flexible, meaning comprised of different experts invited when necessary by the local bodies to overlook cases, take charge over patients and do consulting work. It is a method of intervention that could be further developed in the larger context of gender-based violence.

- To activate micro-counselling and short-term counselling, which have specific characteristics and could be appropriate and efficient methods of intervention when taking charge over of families where female genital mutilation is present and during preventative and awareness actions to put a stop to the practice.

- To set up a regional register to collect case studies of female genital mutilation across health and social services.

- To create a regional protocol for patient care and the relevant steps to follow based on the different cases/situations that could arise in relation to patients with female genital mutilation.

- To include the detection of female genital mutilation in the medical records of the patients according to the categories classified by WHO.

- To implement a medical code exempting patients in need of treatment associated to consequences of female genital mutilation.

- Promoting and introducing health and social services to the different target groups interested in the procedure in order to increase access to public services and reduce marginalisation and exclusion from free medical care.

- To promote the proper use of cultural and linguistic mediation within the social and health system as a method to support healthcare workers and patients, improve verbal, non verbal and intercultural communication and make public services more accessible and efficient.

- To promote preventative measures in order to avoid genital mutilation on girls.

- To carry out research on a regional scale to monitor and assess the outcome of the activities of prevention and awareness, implemented by the services, for families interested in genital mutilation.

Conclusions

The long path of the action research carried out with and for the social and health services in Umbria has attracted great interest for the issue addressed and for the sensitivity of the professionals involved. There were differences of opinions as well as sharing of ideas and good practices present in the area. The group sessions were a harbinger of shared reflection during which the participants reported a lack of space and time to be with colleagues and the need for a more culturally sensible approach, free from stereotypes and exoticism, when taking charge over a migrant woman. In relation to this, it becomes even more important to develop a training program that focuses specifically on these issues and, more generally, on the way gender affects the health of these women, whilst adopting a holistic, multidimensional and intercultural approach (mentioned by the participants as well). As highlighted by the World Health Organisation, '*a gender approach to health is unavoidable for an effective fight against inequalities in the population's health status*' (WHO 2007). In addition to this, the need to pay more attention to and make a better use of cultural-linguistic mediation, specifically connected to the health of foreign women.

Health and social services are a particularly important resource to tackle the issue of female genital mutilation: they are not only able to demonstrate therapeutic and preventative expertise but also in a position to promote a cultural shift in the protection of health and affirmation of human rights.

Appendix

List of Participants

Gender	Profession	Years	Location	Type of service
F	Midwife Co-ordinator and Teacher	40 years	AO Perugia	Hospital
F	Midwife	Not Specified (NS)	Terni	Clinic
F	Obstetrician-Bachelor Degree in Obstetrics	5 years	AO Perugia	Hospital-Obstetrics Degree Co-ordinator
F	Midwife	N.S.	N.S.	Clinic
F	Midwife	40 years	Orvieto	Clinic
F	Midwife	N.S.	Orvieto	Clinic
F	Midwife	23 years	Norcia-Cascia	Clinic
F	Midwife	4 years	AO Perugia	Hospital
F	Midwife	14 years	AO Perugia	Hospital
F	Midwife	2 years	Terni	Clinic
F	Midwife	20 years	Amelia	Clinic
F	Midwife	32 years	Foligno-Trevi-Sant'Eraclio	Clinic
F	Midwife	20 years	Foligno	Hospital
F	Midwife	5 years	AO Perugia	Hospital
F	Midwife	2 years	AO Perugia	Hospital
F	Midwife	33 years	Citta' Giardino	Clinic
F	Midwife	11 years	Narni-Amelia	Clinic
F	Midwife	N.S.	Terni	Clinic
F	Midwife	21 years	Norcia-Cascia	Clinic

F	Midwife	N.S.	AO Perugia	Hospital
F	Midwife	16 years	AO Perugia	Hospital
F	Midwife	27 years	Cascia-Norcia	Clinic
F	Midwife	23 years	N.S.	Hospital
F	Midwife	20 years	Terni	Clinic
F	Midwife	22 years	Narni-Amelia	Clinic
F	Midwife	5 years	AO Perugia	Hospital
F	Midwife	5 years	AO Perugia	Hospital
F	Midwife	11 years	Orvieto	Clinic
M	Gynaecologist	8 years	Orvieto	Clinic
M	Gynaecologist	N.S.	Narni-Amelia	Clinic
F	Social Worker	12 years	Terni	Caritas- San Martino
F	Social Worker	15 years	Terni	Comunita' San Martino
F	Cultural Mediator	N.S.	Perugia	CIDIS/CSC Mediation Agency
F	Social Worker	N.S.	Terni	Comunita' San Martino
F	Cultural Mediator	8 years	Terni	CIDIS/CSC Mediation Agency
F	Cultural Mediator	7 years	Terni	CIDIS/CSC Mediation Agency
F	Psychologist	N.S.	Orvieto	Cooperativa Quadrifoglio
F	Nurse	33 years	Perugia	Education Administrator University of Perugia
F	Social Worker	17 years	Amelia	Clinic
F	Psychologist	30 years	Orvieto	Clinic
F	Psychologist Psychotherapist	42 years	Orvieto	Polyclinic
F	Psychoanalyst	38 years	Terni	Clinic

F	Psychologist	Few months	Terni	Clinic
F	Psychologist	Few months	Fabro	Graduate School
F	Midwife	6 years	Magione	Clinic
F	Midwife	15 years	Magione	Clinic
F	Midwife	32 years	Magione	Clinic
F	Midwife	7 years	Magione	Clinic
F	Gynaecologist	8 years	Foligno	Hospital
F	Enrolled in the third year of the Bachelor Degree in Nursing at the University of Perugia – based in Terni. The participants were completing their last internship in preparation to the end of the course.			
F				
F				
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Female Genital Mutilation: Survey Questionnaire

Gender:

Year of birth:

Profession:

Institutional Affiliation:

Place of work:

What knowledge do you have on the issue of Female Genital Mutilation (FGM)?

- I have good knowledge
- I have some knowledge
- I have no knowledge on the issue but would like to learn more about it
- I have no knowledge on the issue and have no interest

How did you learn/continue to learn about the subject?

- Scientific literature
- Non scientific literature
- Training programs
- Conferences/seminars
- Direct experience
- Mass media
- Trough patients/service users
- None of the above (not interested in learning)
- Other: _____

Are you aware of the existence of medical centres, in Italy, specialised in the treatment and prevention of Female Genital Mutilation (FGM)?

- Yes
- No

If yes, can you state which ones?

_____

What is your opinion on Female Genital Mutilation (FGM)?

- It is a form of violence
- It is a culturally unacceptable practice
- It is an issue that needs to be understood
- I am unable to form an opinion

Are you aware of the national legislation regarding the prevention and ban of Female Genital Mutilation (FGM)?

- Yes
- No

Have you ever encountered patients with Female Genital Mutilation (FGM) in your professional career?

- Yes
- No

How many women/girls subjected to Female Genital Mutilation (FGM) have you encountered in your professional career?

- None
- between 1 and 5
- between 6 and 10
- between 10 and 20
- between 20 and 30
- between 30 and 40
- between 40 and 50
- more than 50

When affected by the issue of Female Genital Mutilation (FGM) you felt the need to:

- Have a better professional preparation
- Speak to colleagues for cooperation and support
- Do nothing in particular
- Talk with an expert on the subject

From the moment you were affected by the issue of Female Genital Mutilation (FGM):

- I frequently thought about ways to implement prevention
- I hoped for someone to intervene eventually
- I paid particular attention to the information available in regard
- I did not worry/was not interested
- I personally took action to promote prevention and proper patient care

When taking charge of a patient subjected to Female Genital Mutilation (FGM) did you get a cultural-linguistic Mediator involved?

- Yes, in every case
- Yes, only in some cases
- No
- I would have liked to but do not know how to activate the service

How significant and present is the phenomenon in Umbria in your opinion?

- Not at all
- Not much
- Somewhat
- Very
- Extremely

Is it easy to identify Female Genital Mutilation (FGM) in patients?

- Not at all
- Not much
- Somewhat
- Very
- Extremely

Comments or additional suggestions

_____

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Centro Regionale per la Salute Globale (Regional Centre for Global Health), focuses on research, training and analysis around the topic of Global Health. The fields of interest and action are the effects of globalisation on health (Global Health) and the dynamic relationship between people, animals and the environment (One Health), referencing to the determinants of the health model, inequality and justice. Through a joint effort of several professional disciplines, it stimulates the process of participatory planning to promote health in local communities with the involvement of stakeholders in the area, whilst always keeping an eye on the global dimensions and scientific evidence.
Working alongside CERSAG are Regione Umbria, the University of Perugia, the Istituto Zooprofilattico Sperimentale dell' Umbria e delle Marche, the AUSL (Local Health Unit) Umbria 2, the Municipality of Orvieto and the Fondazione per il Centro Studi 'Città di Orvieto'.

A non profit organisation operating at national and European levels to guarantee rights and equal opportunities to the migrant population and sensitise the public opinion to a culture of acceptance.
CIDIS supports the integration of foreigners, stateless people, refugees and asylum seekers into society, on an equal footing with Italian citizens, against any form of racism and discrimination. CIDIS promotes multidimensional and integrated activities paying particular attention to the individual, gender equality and networking.

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