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Female genital cutting: A survey among healthcare professionals in Italy

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This study aims to evaluate the knowledge of female genital cutting (FGC) in a tertiary teaching hospital in Italy. A survey questionnaire on FGC was given to paediatricians, nurses, midwives, gynaecologists and residents in paediatrics and gynaecology in a tertiary teaching hospital in Italy. The results of the survey were then analysed. The results showed that 71.5% (73/102) of healthcare professionals dealt with patients presenting with FGC. Gynaecologists (83%) and paediatric nurses (75%) were the only ones who declared to be aware of Italian law on FGC. In detail, 55% of midwives, 50% of paediatricians, 50% of paediatrician residents and 28.5% of gynaecological residents were aware of this law. The general knowledge of Italian National Guidelines on FGC is even worse: most professionals are not aware of protocols of action. Considering the increasing extension of FGC due to immigration, improvement of care through specialised education of healthcare providers is mandatory.

Keywords: Female genital cutting, female genital mutilation, FGC guidelines, FGC Italian law, professionals survey

Introduction

Female genital cutting (FGC), known as female circumcision or female genital mutilation (FGM), is a culturally determined practice, predominantly performed in parts of Africa and Asia (WHO 1997). There is controversy over the use of the term 'mutilation'. According to a joint WHO/UNICEF/UNFPA statement, the use of the word 'mutilation' reinforces the idea that this practice is a violation of girls' and women's human rights and therefore it helps to promote national and international advocacy towards its abandonment. The statement also acknowledges that, for the community and for the individual, the term can be problematic. Following this, in 1999, the UN Special Reporter on Traditional Practices called for tact when dealing with individual patients and suggested that the term 'cutting' may be more acceptable (RCOG 2009).

Female genital cutting (FGC) constitutes an extreme form of discrimination and violation of the human rights of girls and women, with health consequences acknowledged and documented (Kaplan et al. 2013). FGC has no health benefits and it harms girls and women in many ways. It involves removing and damaging healthy and normal female genital tissue, and interferes with the natural functions of girls' and women's bodies (WHO 2013). In the short term, the practice can result in shock, haemorrhage, infections and psychological consequences, while in the long term, it can lead to chronic pain, infections, keloids, fibrosis, primary infertility, increase in delivery complications and psychological sequelae/trauma. Morbidity increases with the extent and severity of the practice (Behrendt and Moritz 2005; WHO 2006; Alsibiani and Rouzi 2010; Chibber et al. 2011).

Today it is estimated that more than 125 million girls and women have been subjected to FGC in the 29 countries in Africa and the Middle East, where this practice is common. The real extent of this practice, however, remains unknown, since reliable data on the magnitude of the phenomenon are largely unavailable. Due to immigrant, refugee and asylum-seeker communities, European countries and their health services have been increasingly forced to deal with FGC, its medical consequences and the difficulties involved in approaching the issue. Indeed, the problem is not only related to health care, but also to ethics, cultural identity and human rights. The approach to specific problems affecting these women represent a challenge to Western healthcare systems and professionals that need to develop the competence necessary to achieve cross-cultural care (Kripalani et al. 2006; Leye et al. 2006). The European Council and the European Parliament have specifically condemned FGC, and demanded the commitment of the member states to eradicate this practice (European Council 2001; European Parliament 2004). Legislation prohibiting the practice of FGC was passed by the Italian parliament in 2006; it provides an opportunity to think about a social practice that concerns Italy too, and it sets in place measures to prevent, oppose and suppress the practice as a violation of person's fundamental rights to physical and mental integrity and to the health of women and girls (Turillazzi and Fineschi 2007). Different kinds of intervention are considered, starting with the development of informative campaigns (article 3); training of health workers (article 4); institution of a toll-free number (article 5); and international cooperation programmes (article 7). Guidelines have been elaborated addressing FGC in relation to gynaecological/obstetrical care (Ministero Della Salute 2006). All maternity healthcare workers must be familiar with the nature and higher rates of complications related to the extent of FGC and should take this into account when offering advice about antenatal and delivery care, including recommendations about the place of birth.

About 5 million immigrants live in Italy, composing 8.2% of the national population; of those, 22.1% coming from Africa and 18.8% from Asia. Women coming from high-risk FGC countries number about 110,000, and girls <17 years old number about 4,600 (Ministero delle Pari Opportunità 2009).

Despite this epidemiological statement, few data are available regarding the actual dimensions of this phenomenon in Italy,

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1. Sex:
   - ☐ Male
   - ☐ Female
2. Healthcare Professional:
   - ☐ Gynaecologist
   - ☐ Midwife
   - ☐ Paediatrician
   - ☐ Gynaecology Resident
   - ☐ Paediatrics Resident
   - ☐ Paediatrics Nurse
3. Working years:
   - ☐ ≤5 years
   - ☐ >5 years
4. Have you ever heard about FGC?
   - ☐ Yes
   - ☐ No
5. How did you heard about FGC?
   - ☐ Training courses
   - ☐ University education
   - ☐ Scientific literature
   - ☐ Confronting with a patient presenting with FGC
   - ☐ Brochures
   - ☐ Own culture
6. Are you aware about Italian Law about FGC (law n. 7, 09/01/2006)?
   - ☐ Yes
   - ☐ No
7. Have you know Italian Department of Health guidelines on prevention and treatment of FGC?
   - ☐ Yes
   - ☐ No
8. Have you ever attended training courses about FGC?
   - ☐ Yes
   - ☐ No
9. What kind of training course?
   - ☐ Conference
   - ☐ Professional course
   - ☐ Postgraduate course
10. The training course was organized by:
    - ☐ University
    - ☐ Hospital
    - ☐ Trade association
11. The training course was:
    - ☐ Mandatory
    - ☐ Optional
12. Do you need a training course on this topic?
    - ☐ Yes
    - ☐ No
13. Is there in your hospital a guideline for FGC?
    - ☐ Yes
    - ☐ No
    - ☐ I don't know
14. Have you already been confronted with a patient presenting with FGC?
    - ☐ Yes
    - ☐ No
15. Did you correctly identified the types of FGC involved?
    - ☐ Yes
    - ☐ No
    - ☐ I'm not sure
16. Have you already been asked to perform FGC?
    - ☐ Yes
    - ☐ No
17. In cases of infibulation: have you been asked to perform reinfibulation after delivery?
    - ☐ Yes
    - ☐ No
18. Have you been asked to perform deinfibulation?
    - ☐ Yes
    - ☐ No
19. Can you perform the surgical procedure of deinfibulation?
    - ☐ Yes
    - ☐ No

Figure 1. Questionnaire on FGC.

which in most cases remains hidden, but nonetheless, it seems to affect thousands of immigrant women (Bosch 2001). Piedmont is a North-Western Italian region, with a population of about 8,662 immigrants from countries where FGC is practised (8% of Italian migrants). The Italian Ministry of Health has estimated that every year, 67 girls under the age of 17 years living in Piedmont are at risk of FGC.

The aim of this study was to evaluate the knowledge of healthcare professionals about FGC in a single tertiary teaching hospital in Italy.

Materials and methods

A survey was conducted providing a self-administered questionnaire to paediatricians, nurses, midwives, gynaecologists

and residents in paediatrics and gynaecology. A total of 130 questionnaires were sent out in July 2011 and had to be returned by the end of October 2011. The questionnaire collected information on sociodemographic variables (gender, profession and speciality); degree of knowledge on FGC (identification on schematic images of the FGC types); degree of interest elicited (need or desire to know more on the subject, performance of educational activities and knowledge of protocols of guidelines of action); previous experience (care to patients from countries in which FGC is performed) (Figure 1). The professionals who were asked to answer the questionnaire were orally informed about the objectives and the content of it prior to filling it out. Participation was voluntary. Personal details were treated anonymously, making it impossible to identify the participating professionals through the answers provided. Also, those professionals who decided not to participate remained anonymous. No external financial support was required.

Among the 130 questionnaires, 102 were returned (78.46% response rate). This study included 42 midwifes (M); 8 paediatric nurses (N); 18 gynaecologists (G); 6 paediatricians (P); 14 gynaecological residents (GR); and 14 paediatric residents (PR) (Figure 2).

Results

A total of 68.6% of professionals started working in hospital <5 years before (70/102), while 31.4% had been there >5 years (32/102). The professional experience on FGC and correct type identification are shown in Table I.

The health professionals were asked about FGC knowledge and training methods. This study showed that 71.5 % (73/102) of healthcare professionals dealt with patients presenting with evidence of FGC previously performed. In every professional cluster, it was observed that most of the junior professionals knew of FGC issues through professional training (60% of midwives; 100% of gynaecologists and paediatricians), while senior professionals, through clinical experience (77% of midwives; 75% of gynaecologists).

About educational activity on FGC, 55% of health professionals declared not to have received specific training; 32.7% attended at least one specific training; and 12.3% more than one specific training. The training courses were organised: 50% by professional board, 45% by hospital and only 5% by university.

In terms of interest in FGC, 67% of those interviewed believed that specific training should be mandatory; 31% felt that attending a seminar would be sufficient; and only 2% of those surveyed expressed a lack of interest in the subject.

Concerning knowledge of Italian legislation on FGC: 83% of gynaecologists; 75% of paediatric nurses; 55% of midwives; 50% of paediatricians and paediatrics residents; and 28.5% of gynaecology residents were aware of this law.

The situation is worse when dealing with knowledge on Italian national guidelines on FGC: most professionals were not aware of the existence of the protocols of action. Only 9.5% of midwives, 38% of gynaecologists, 33% of paediatric nurses and none of residents or paediatricians declared to know the guidelines. Finally, no gynaecologist, midwife or resident had been asked to perform reinfibulation after delivery.

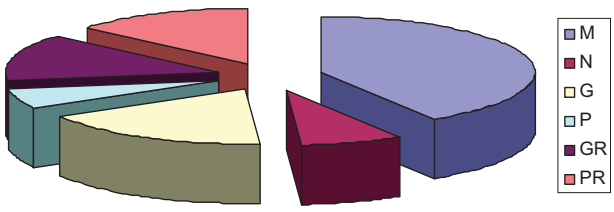

Figure 2. Healthcare professionals included in the study. M, midwifes; N, paediatric nurses; G, gynaecologists; P, paediatricians; GR, gynaecological residents; PR, paediatric residents.

Table I. Professional experience about FGC and correct identification of the FGC type.

Professional group	*n*	≥1 FGC experience (%)	Correctly identified (%)
Midwife	42	73.8	87
Gynaecologist	18	56	100
Gynaecology resident	14	71.4	60
Paediatric nurse	8	100	100
Paediatrician	6	67	75
Paediatric resident	14	64.3	67

Discussion

FGC is a healthcare problem which goes beyond the purely healthcare framework, since it includes the infringement of human rights and the need for a cross-cultural approach to questions closely linked to ethnic identity and gender. FGC is a reality that has radically changed compared with the past, so it is not possible anymore to relegate it to a simplified and distant 'tribal' dimension; FGC has become an issue in developed countries as well. Migration has made European governments concerned, as it is suggested that more than half a million women and girls have undergone the procedure or are at risk within the European Union (European Parliament 2009). Previous studies demonstrated that the problems related to FGC are not rare in primary care consultations, since up to 16% of the participants surveyed declared having detected cases (Kaplan-Marcusan et al. 2009). This study showed that 71.5% (73/102) of healthcare professionals dealt with patients presenting with FGC. Our professionals also demonstrated a great sensitivity towards this subject, asking for more professional training.

The British College of Obstetricians and Gynaecologists recommends that surgery can be performed for purposes connected with labour or birth, but that it is illegal to repair the labia intentionally in such a way that intercourse is difficult or impossible. According to these recommendations, surgery may be performed for mental health reasons, but not as a matter of custom or ritual (Shell-Duncan 2001). This study showed that among Italian gynaecologists who attended women with FGC, none had been asked about the possibility of performing some form of reinfibulation.

When dealing with FGC, physicians not only confront legal and medical issues but also ethical and cultural matters. Dealing with the results of a practice they probably condemn as a mutilation, healthcare workers' reactions may even be a source of added humiliation for the patients (Beine et al. 1995; Chalmers and Omer-Hashi 2003).

It must be kept in mind that these women did not choose mutilation. The procedure is carried out in childhood, when they are too young to give consent. Moreover, they come from societies where such practices are traditional and are viewed as being normal; both patients and family may see it as normal. It should be remembered that, as well as any physical and psychological trauma from the procedure, they may have experienced the emotional turmoil of migration, separation from family and, in some cases, experience of civil war, torture and rape. There is, therefore, no place for expression of disapproval or disgust. All women

must be treated with kindness and sympathy and they and their relatives should not be judged. Not only vaginal examination, but also history-taking, need to be adapted to the needs of such patients in a sensitive and culturally appropriate way (Thierfelder et al. 2005). As management of affected women may be difficult, guidelines for health personnel are needed and specialised training on FGC should be included in medical school curricula (Jäger et al. 2002). Specifically trained health workers should discuss the issue during the prenatal period. Italian law foresees that doctors and nurses of public healthcare facilities will attend courses for the treatment of women and girls who are mutilated, and they will be instructed, also through cultural mediators, on how to relate to people who ask them for infibulation or deinfibulation. In our study, it seems clear that these guidelines are not yet implemented by healthcare professionals. The lack of training of Italian operators is not a surprising result and it is similar to other studies on FGM knowledge among health operators carried out in central and southern Italy (Caroppo et al. 2014). A national committee is mandatory to teach and implement these guidelines in every Italian hospital.

Recent immigration patterns have brought obstetricians and gynaecologists to increasingly deal with women who have experienced FGC. Opportunities to identify FGM are frequently missed, just as stated in a previous study (Abdulcadir et al. 2014). Measures should be taken to improve FGM diagnosis and care. It is imperative that healthcare professionals understand the health and social issues related to FGC so that they can manage it properly.

Strengths and weaknesses

This is an original work evaluating knowledge of Italian law on FGC and Italian clinical guidelines on FGC management.

The main weaknesses of this study are that the questionnaire was given to a single hospital, there was a small sample size and high prevalence of young health operators. Data used in the analysis were collected through a tailor-made specific questionnaire; however, accuracy of answers cannot be guaranteed.

Declaration of interest: The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

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