FGM in Italy: healthcare professionals as agents of change?

A study ten years after the adoption of law 7/2006 on targeted training as dialogical tool

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Title and subtitle
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Abstract:

Due to migration fluxes, modern societies are increasingly more characterized by a plurality of cultural groups, each one with its specific behavioural norms and cultural practices. Particularly, "female genital mutilation" (FGM) represents a challenge not only for multiculturalism but also for healthcare systems and for professionals working within: women with FGM have in fact specific medical and psychological needs that doctors, nurses, social assistants, etc., without specific training, will not be able to manage. In this regard, in 2006 Italy adopted an *ad hoc* law – law January 2006, n.7 – which, in addition to prevent and prohibit the practice, entails guidelines addressing the training of professionals working in direct contact with immigrants coming from those countries where FGM is traditionally performed. The purpose of this study is to verify whether educational activities have been implemented by Italian institutions and how this intervention has affected workers' knowledge in terms of FGM and their approach towards it, and, consequently, their role in launching a significant intercultural interaction with immigrants. To this end, a survey was conducted by means of a supervised self-completion questionnaire and the findings revealed the importance of targeted training inasmuch as a tool to establish intercultural dialogue with immigrant women and their communities. Significantly, this research conveys the need for an equal dialogical process between institutions and immigrant women, which are not anymore conceived as passive bearers of traditions but as active protagonists of change.

Key words:
Female genital mutilation, FGM, cultural practices, human rights, multiculturalism, feminism, healthcare setting, targeted training, understanding, equality, dialogue, change

Number of words: 22.652 (text only)

DECLARATION

I certify that this is all my own work. Any material quoted or paraphrased from reference books, journals, www. etc. has been identified as such and duly acknowledged in the text or foot/end notes. Such sources are also listed in the bibliography. I have read the College's policy on plagiarism and am aware of the penalties for plagiarism.

I have retained a copy of my work.

Signed:..... Emma Belli ..... Name: .....Emma Belli.....

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LIST OF ABBREVIATIONS

AIDOS = Associazione Italiana Donne per lo Sviluppo

CARA = Centri di Accoglienza per Richiedenti Asilo

CEDAW = UN Convention on the Elimination of All Forms of Discrimination against Women

CRC = Convention of the Rights of the Child

FGM = Female Genital Mutilation(s)

ECOSOC = Economic and Social Council of the United Nations

EIGE = European Institute for Gender Equality

IAC = Inter African Committee on Traditional Practices Affecting the Health of Women and Children

ISTAT = Istituto Nazionale di Statistica

NSD = Norwegian Centre for Research Data

UDHR = Universal Declaration of Human Rights

UN = United Nations

UNESCO = United Nations Educational, Scientific and Cultural Organization

UNFPA = United Nations Population Fund

UNICEF = United Nations Children's Fund

VAW = Violence Against Women

WHO = World Health Organization

INTRODUCTION

RESEARCH MOTIVATIONS

The reasons for choosing the topic of this thesis are linked to my study experience, in particular to a bachelor program lecture in cultural anthropology in Rome. I still distinctly remember it: some years ago, the topic was "Female Genital Mutilations" and the class was silent and attentive. As the professor mentioned it, my stomach screamed "that's horrible!". When she illustrated how, my chest held back "that's barbaric". When she explained why, my mouth kept quiet. It might appear banal, but since that day I have started to learn how to (try to) hold my feelings and to not be judgmental when dealing with issues that easily enrol emotions. Few years later in Norway, attending the master in human rights and multiculturalism, I understood the importance of adopting that attitude towards certain issues, especially when culture and individuals' identity are involved. Therefore, "to acknowledge" and "to understand" have become to me necessary conditions in approaching subjects – particularly if sensitive - as the one I chose to investigate. As a consequence, later I asked myself what was an efficient tool to acquire knowledge. The answer was "educational activities", and from there I got an idea: what if I analysed knowledge in terms of FGM of those professionals working closely with immigrant women in Italy? Could this contribute in activating a change towards the abandonment of the practice?

SETTING THE SCENE

In recent decades, due to migration fluxes, societies are increasingly made up of persons coming or having origins from a multiplicity of realities, characterized by different ethnical and cultural patterns. Inasmuch as fundamental in shaping individuals' identity, their values and behavioural norms are generally embedded in specific cultural practices which, inserted in Western contexts, have arisen several challenges whether from a legal or an ethical point of view. In particular, the practice of "female genital mutilation" - mainly conceptualized as a violation of human rights and specifically of women's and children's

rights - has come under intense international scrutiny within communities of scholars, lawyers and doctors. Accordingly to the typology, FGM may indeed entail severe health, sexual and psychological consequences on women's lives. In 2016, UNICEF estimated 200 million women in 30 countries of Africa, Asia and Middle East had undergone the procedures and the number of girls at risk seems indicating that such a phenomenon is far to be eradicated (UNICEF, 2016). To this end, ad hoc legislations have been developed worldwide, nevertheless they have easily obtained the opposite outcome, namely increasing the number of FGM cases performed illegally (Basile, 2013; Fusaschi, 2015). Having said that, a question could naturally raise: which strategy should thus be used in order to activate a change towards female genital mutilation's abandonment? As Gruenbaum points out, if behavioural change is to be accomplished, the goal of abolishing FGM requires that the socio-cultural dynamics of the practice be well understood (Gruenbaum, 2005). In fact, deprived of its social value, female genital mutilation is too often perceived by Western societies as a mere abuse without taking into account the variety of meanings attributed to the practice by the women themselves. For most Westerners – generally en-cultured in a society where bodies are managed by medicine and where pain is considered something to be avoided - the descriptions of the various FGM operations, usually performed in non-medical settings, evoke strong feelings of horror with no space for further considerations (Gosselin, 2000). As a consequence, this simplistic attitude has brought to pay minor attention to the consequences of condemning without examining in depth the issue and the effects this could have in interacting with immigrant women (Fusaschi, 2003). Therefore, in order to acknowledge the phenomenon, its nature and nuances, some governments have considered as necessary specific training of those professionals working closely with immigrants, coming from countries where the practice is traditionally performed. In this regard, since 2006, in Italy a specific law - law January 2006, n.7 – exists and, in addition to prevent and prohibit FGM, it envisages specific guidelines addressed to healthcare operators. Inasmuch as "front men", first main actors in direct contact with immigrant women, their familiarity with the subject could lead them to adopt a "cultural-neutral" approach towards the practice and, as a consequence, towards those who represent it. In this way, professionals would be able to provide adequate care to patients who have undergone FGM and, at the same time, would be appointed as key agents in establishing a significant contact with immigrant women and their communities. In other words, they could both adequately manage patients' special needs and meet the conditions for a positive intercultural dialogue. In view of this, this thesis attempts to

contribute reflecting on the impact that targeted educational activities may have on healthcare professionals' attitude and, consequently, on establishing intercultural dialogue with immigrants women, with the ultimate aim of activating change towards the abandonment of FGM.

RESEARCH OBJECTIVE

Bearing in mind the previous foreword, my research is mainly concerned with verifying, after ten years from the adoption of law January 2006, n.7 and related guidelines, *if* and *how* the Italian government has abided by its obligations to train health professional figures and which kind of impact this has had in the establishment of an intercultural dialogue with the immigrants' community. Significantly, this study could help in assessing Italian conduct and could be useful as a guide to any future attempts to investigate female genital mutilation training in relation to dialogical processes in multicultural frameworks.

RESEARCH QUESTIONS

Having pinpointed the research purpose, I formulated the following research questions:

- *Since the adoption of the law 9 January 2006, n. 7 and the related guidelines, has the Italian government provided training of healthcare operators? If yes, how has this affected their knowledge in terms of Female Genital Mutilation?*
- *After ten years, has the intervention had a positive impact on healthcare operators' approach with regard to FGM and, consequently, on the establishment of an intercultural dialogue with immigrant women?*

THEORETICAL FRAMEWORK

Being FGM a practice which engages legal, cultural, social and sexual dimensions of women's and girls' lives, in this paper I drew on a variety of interpretations from various disciplinary and theoretical perspectives. This research thus includes references to sociologists and anthropologists as Bourdieu for describing the practice and its meanings,

as well as authors who tackled female genital mutilation from a legal point of view. Furthermore, I found it fundamental to refer to the political philosopher Will Kymlicka and its contribution to cultural groups issues in multicultural settings, in addition to the "multiculturalism vs. feminism" debate, represented by the liberal feminist Susan Moller Okin. Finally, relevant contributions as Parekh's dialogical principles have set the frame to discuss intercultural dialogue and its establishment in multicultural societies.

METHODOLOGY

As a first step, I reviewed targeted investigations and literature making connections to theoretical perspectives within feminist and medical discourses on FGM and healthcare settings in Europe and particularly in Italy. On the other hand, I adopted a quantitative method of research: I elaborated a questionnaire which allowed me to collect data from healthcare professionals working in two Italian healthcare centres; their answers in terms of knowledge of the theme, the law and regarding their training, could give indications on Italian government's modus operandi in the fight against FGM first, and successively on the impact it may have in establishing intercultural interactions. At a later time, I established specific criteria of sample selection and I proceeded starting the recruitment phase of the research process.

THESIS OUTLINE

In this introductive part of the paper, I intended to provide the broad as well as the specific contextual background of my research indicating the relevance of its contribution to the FGM debate.

In chapter one, I will introduce to the reader the delicate topic of female genital mutilation starting from historically presenting the many attempts to define and categorize it. Later, some of the main research carried out on this issue will be illustrated with a special focus on Italian studies.

Chapter two retraces the history of the practice and explains its social meanings, particularly through an anthropological point of view. Furthermore, it creates a theoretical

framework re-contextualising FGM in the migration context and discusses the challenges this arises both in multicultural and healthcare settings.

Chapter three describes the main steps undertaken by the international community in targeting female genital mutilation as an infringement of fundamental rights. Successively, it presents specific legal tools developed worldwide to address the practice and later introduces the Italian framework, illustrating law 9 January 2006, n. 7 and the related guidelines addressed to healthcare operators.

In chapter four, the research design and methodology applied in this study will be traced and reflected upon. Moreover, the questionnaire used to collect data will be presented and its content explained. Lastly, relevant ethical considerations will be highlighted.

In chapter five, my findings will be presented according to three main areas of interest - healthcare operators' training, knowledge in terms of FGM and healthcare operators' approach - and illustrated through percentages and tables. Finally, the results will be thematically analysed and discussed together with relevant theories.

In the Conclusions, I will attempt to answer my research questions and reflect on the limitations encountered while conducting the investigation. Finally, I will present some suggestions on possible further research.

CHAPTER ONE

"The state of art"

INTRODUCTION

The chapter aims introducing to the reader the sensitive topic of female genital mutilation. Starting from its first descriptions, I will historically retrace the many attempts to define and categorize FGM. Later, some of the main research carried out on this issue sequentially by the United Nations, Europe and Italy, will be presented. Finally, the discussion will narrow down to some specific existing Italian studies regarding healthcare operators and FGM - which are clearly relevant for this paper – to conclude with some considerations concerning the areas that need further research.

FEMALE GENITAL MUTILATION

Female genital mutilation is a worldwide debated phenomenon that, despite its "popularity" within the media and humanitarian campaigns aimed to fight against it, still exists in various forms. Before tackling the different types of FGM, it is important first of all to retrace, chronologically, the attempts of the international community in acknowledging and defining it.

DEFINITIONS

Except for ethnographic diaries of explorers, missionaries and colonial officials, the earliest definition of FGM dates back in the mid-nineteenth century and sees as protagonist the medical community: in 1847 the English doctor Daniell tried to make a first classification of an African phenomenon that, in the London Medical Gazette, he described as "female circumcision" (Daniell, 1847). For almost a century this expression was used and gradually updated on the basis of the typologies observed in different countries, in particular in those of Africa (Fusaschi, 2003). The World Health Organization (WHO) acknowledged the practice in 1958 and, after being solicited by the Economic and Social Council of the United Nations (ECOSOC) to undertake a study on FGM, replied that the ritual practices in question were not within its jurisdiction, inasmuch as results of social and cultural conceptions proper of certain countries (Aldeeb Abu-Sahlieh, 1997). Only

twenty years later, with the publication of the first statistical overview made by means of the feminist journalist Fran P. Hosken, the WHO began to develop the first official FGM classifications (which were very similar to the ones presented below). Afterwards, the concept of FGM was officially shifted from the cultural level to the medical level: in 1979, during an international meeting with the United Nations Children's Fund (UNICEF) and some delegates of African countries, female genital mutilation was explicitly condemned and targeted as a public health matter (Fusaschi, 2003). Despite the significance of the issue, approximately twenty more years passed before an explicative and detailed notion of the practice was given. Finally, the most known definition of FGM was agreed in 1997, the year of the Joint Statement announced by the WHO, the UNICEF and United Nations Population Fund (UNFPA). According to it, "female genital mutilation comprises all procedures involving partial or total removal of the external female genitalia or other injury to female genital organs whether for cultural or other non-therapeutic reasons" (WHO, 1997). Therefore, a tentative categorization of FGM in four types was made, bringing to light some ambiguities in terms of its nature and forms (WHO, 1997). Finally, only in 2008, with the new interagency statement *"Eliminating Female Genital Mutilation"*, a definitive classification was internationally agreed:

- ***Clitoridectomy**: partial or total removal of the clitoris and/or the prepuce;*
- ***Excision:** partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora;*
- ***Infibulation:** narrowing of the vaginal orifice with the creation of a covering seal by cutting and repositioning the labia minora and/or the labia majora, with or without excision of the clitoris;*
- ***Other:** all other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterizing (WHO, 2008).*

Despite a classification which at first sight could seem clear and detailed, the attempt to draw distinct contours of such a varied phenomenon presents some flaws that are reflected in the quantity and quality of the data collected. It should be thus evident that, because of the obvious and significant variety – in terms of health, sexual and psychological consequences – among the four types of FGM, diversification and specification become necessary during the investigation. For this reason, it appears surprising that international

organizations' reports and institutional research seem not taking into account this important aspect of the issue, thus resulting incomplete and limited outcomes, as will be pointed out in the next subsection.

EXISTING RESEARCH

With the purpose of portraying the phenomenon in the clearest possible way, I decided to present some of the existing research on FGM starting from the international level with some UN material, passing through the regional level, represented by Europe, to conclude with a special focus on the work conducted at the local level that is, in the case of this paper, the Italian one.

INTERNATIONAL LEVEL - UNITED NATIONS

The most recent data on female genital mutilation is available on UNICEF's website and is dated 2016. According to it, until today at least 200 million girls and women have experienced the practice in 30 countries across three continents that are Africa, Asia and South America (UNICEF, 2016). What is interesting here is the absence of the above described categories when presenting the percentages: FGM are "simply FGM", showing that a lack of more precise distinctions within the typologies of the practice contributes to create a confused picture of the phenomenon, hence generating an ambiguous data collection (Fusaschi, 2013). In fact, only three years before, in 2013, the same UN agency published *"Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change"*, a study on FGM in 29 countries which revealed that more than 125 million girls and women have undergone it. Once again, even though the increasing number of FGM cases is impressive, the report does not inform us about the nature and the kind of female genital mutilation in question, thus limiting the quality of the information and consequently the development of specific strategies to fight it. Furthermore, the data collection presents a limitation in terms of geographical areas: FGM are also common among migrants from Africa or the Middle East where the practices are more concentrated (UNICEF, 2013), but no data are available for Europe and Northern America; in this way the risk is to offer a conception of the practice as a reality existing only in certain parts of the world, confined within territorial borders and performed among some "primitive" ethnical groups.

REGIONAL LEVEL – EUROPE

On the contrary, at European level, the latest reports *"Study to map the current situation and trends of FGM"* and *"Estimation of girls at risk of female genital mutilation in the European Union"* (EIGE, 2013, 2015) shift the attention on the EU Member States tearing down the idea of "uncivilized practice in uncivilized countries". Published respectively in 2013 and in 2015 and commissioned by the European Institute for Gender Equality (EIGE), both investigations consist in a study to map and estimate the number of girls at risk of FGM by analysing and assessing the current situation of the phenomenon in the 28 EU countries. The research justifies mixed methodological approaches, recommends legal and policy frameworks for combatting female genital mutilation (EIGE, 2013a, 2015), but does not mention the practice's differentiations as well as the related implications. Once more, FGM is labelled and investigated as a form of violence against women without taking into account its fundamental nuances, which are, in practice, ignored. Despite that, it is undeniable that both studies contribute to reveal the incidence of a practice sometimes still wrongly conceived as far from "western" countries. In fact, the findings show that approximately 98.000 girls are at risk of FGM and that this risk varies among the Member States according to the total number of first generation migrants originating from a country with high FGM prevalence (EIGE, 2015). In addition, in order to investigate the phenomenon more in detail, in 2013 EIGE conducted a qualitative in-depth research in nine European states and made available online a fact sheet on FGM for each of those countries, including Italy.

LOCAL LEVEL - ITALY

The EIGE document (EIGE, 2013) offers some key information about the Italian legal framework in terms of protection from FGM and in terms of national studies concerning the issue. According to it, the estimated number of women who have undergone the practice is 35.000 while the estimation of girls at risk amounts to 1000 (EIGE, 2013b). The latter data matches with the more detailed "Country Report" (part of the abovementioned study to map the current situation and trends of FGM), but only partially. Indeed, "concerning the girls at risk, the estimates calculated by diverse actors are as follows: 400, according to the commission of the Ministry of Health; 500, according to AIDOS; 1000, according to a study by Piepoli" (EIGE, 2013a, p.252). What it is remarkable here is the discrepancy of data at the institutional level. In fact, each actor represents Italian ministerial offices: the first is an ad hoc national commission of the Ministry of Health

composed by experts (Ministero della Salute, 2007); AIDOS is an Italian non-governmental organization who was authorized to manage public funds for the implementation of development and cooperation projects in 1992 by the Ministry of Foreign Affairs (AIDOS, website); the third is Institute Piepoli SpA, a private company specialised in market analysis in charge of investigating FGM on behalf of the Ministry of Equal Opportunities (EIGE, 2013a). Is this tri-partition showing an intention to approach the topic from multiple angles – health, development and gender equality - or is it only an evidence of a confused investigative strategy?

At national level, the main retrievable document is to be found at the Ministry of Equal Opportunities' website with the title of *"Qualitative and quantitative evaluation of the female genital mutilation phenomenon in Italy"* (my translation); I decided to focus my attention on this specific study because it should contribute to describe the national situation on FGM which is relevant for this research, but I am aware that other works have been published at a regional level by some Italian regions that can be consulted for a local understanding of the practice's prevalence. Going back to the study, available only in Italian, it was published online in 2009 and conducted by the above-cited Institute Piepoli SpA. Astonishing is the fact that it consists in a PowerPoint presentation and it is the only source of information on FGM held by the ministry; even Maria Sangiuliano, the researcher in charge of preparing the above-presented country report for the EIGE's investigation, highlights that an e-mail was written to the technical secretariat of the FGM national commission asking if a full report of the same research was available. The answer was negative, the same secretariat "stressed that the PowerPoint file itself was the final product of the research which the Ministry of Equal Opportunities commissioned from Institute Piepoli SpA" (EIGE, 2013a, p. 233). In addition, once again, it is possible to notice the absence of a clear distinction with regards to the kinds of female genital mutilation; brief mention is made on infibulation and excision, but not in terms of diversification of the collected data. As mentioned in the title, both quantitative and qualitative methods are used in the study: a quantitative one, through desk research on available statistical data and some interviews with informed actors in order to come to a realistic estimation; another one, presented as "motivational" approach, with in-depth interviews carried out by psychologists in order to grasp sensitive qualitative data that key informants may share (Istituto Piepoli SpA, 2009). Few lines superficially explain which figures have been involved in the qualitative part of the research, without justifying the

methodological choices: medical doctors, cultural mediators, researchers, political actors, women's NGO activists (Istituto Piepoli SpA, 2009, p. 22). Regarding the quantitative aspect, FGM prevalence is calculated by applying WHO/DHS prevalence indices, for those African countries classified as having FGM tradition, to the number of legal immigrant women in Italy from the same countries (EIGE, 2013a). Nevertheless, the relationship between the quantitative and the qualitative part of the study results unclear, therefore the presented numbers and percentages appear ambiguous and inconclusive. Moreover, no bibliography is included at the end of the work, with the consequence of leaving the reader with possible doubts about its content and credibility.

In order to create an adequate framework for my research, I decided to illustrate the above-mentioned studies to firstly tackle in general terms the phenomenon of female genital mutilation, introducing to the reader the difficulties encountered in investigating this subject. Specifically, narrowing down the discussion to the topic of my investigation, I will now present relevant research conducted during years with the participation of those professional figures working with immigrants.

HEALTHCARE PROFESSIONALS AND FGM IN ITALY

One of the first investigations on female genital mutilation involving Italian healthcare settings dates back to the end of the 1980s. At that time, precisely in 1988, Professor Pia Grassivaro Gallo set up a working group at the Department of General Psychology of the University of Padua, bringing together several Italian scholars interested in studying the immigration situation in Italy with regards to FGM. Particularly, because of the suspicion - raised by the press and denied by the government - that the practice might be performed in Italian public health units, the group initialised a first research project through interviewing Italian and African healthcare professionals working in close contact with families of immigrants coming from those countries where FGM is traditionally performed (Grassivaro Gallo et al., 1997). No direct evidences of a "medicalization" of the practice were found in Italian hospitals, but according to the interviewees' answers FGM was likely to be performed also in Italy, especially among Egyptians and Somalis (Grassivaro Gallo & Livio, 1991). To map FGM presence and incidence in the country, in 1993 the same working group conducted a survey among obstetricians and gynaecologists working with immigrant women in healthcare structures of various Italian regions: 318 professionals

were interviewed and 46% of them declared to have been involved with FGM at work. Moreover, an estimation of African excised women living in Italy was quantified in 27.000 cases and distributed over the whole country, to a lesser degree in the northern regions and in the internal areas of the main islands (Grassivaro Gallo et al., 1995). In the wake of the previous investigation, in 1994 and in 1995 two more surveys were made with a specific focus on de-infibulation. Interviews with Somali immigrant women were gathered in addition to the data collected in 1993 and revealed that the delicate operation of de-infibulation was performed only exceptionally and because of health problems caused by female genital mutilation (Grassivaro Gallo et al., 1997). Another study carried out by Grassivaro Gallo and her team centred on the cases of young immigrant girls who were treated for immediate and medium consequences of infibulation at public Italian hospitals, namely in Trieste, Milan, Padua, Florence, Rome. The episodes showed that some of the girls were operated in medical settings, some at home by traditional birth attendants and some others had undergone the practice in their countries of origin during holidays (Grassivaro Gallo & Sirad Salad Hassan, 1996).

More pertinent to this study, "*Health care for immigrant women in Italy: are we really ready? A survey on knowledge about female genital mutilation*" is the title of a research conducted in 2012 by Università Cattolica del Sacro Cuore and the Italian Red Cross of Rome. The purpose of the survey was to estimate the knowledge of the FGM practice among social and health care assistants working in Italian shelters (CARA) for refugees and asylum seekers (Caroppo et al., 2014, p. 49). From October to December 2012, a questionnaire was sent out to forty-one operators in structures of central and southern Italy where refugees were received after their arrival in the country (*ibid.*). The questionnaires were composed of fourteen questions to be answered quickly (3-5 minutes) and anonymously (apart from gender and profession): 100% of them returned with a high responding rate and out of the total number of participants 31.7% were males, 68.3% were females (Caroppo et al., 2014, p. 51). Regarding their occupation, 36.6% were doctors, 24.4% social assistants, 17.1% psychologists, 12.2% nurses, 7.3% health assistants, and 2.4% educators (*ibid.*). According to the results, only 7.3% of respondents stated to well know FGM, 4.9% did not know it at all and 70.7% declared to have never met or assisted a woman with FGM, nevertheless all respondents worked with asylum seekers coming from those countries where FGM is practised (Caroppo et al., 2014, p. 49). Furthermore, 56% of

the participants ignored that since 2006 a national law - Law 9 January 2006, n. 7 – exists and is intended to prevent and prohibit FGM in Italy (Caroppo et al., 2014, p. 52).

Thus far, the most relevant study aimed to evaluate the knowledge of healthcare professionals about FGM is titled "*Female genital cutting: A survey among healthcare professionals in Italy*" and was published in 2015 by a group of scholars of the Department of Obstetrics and Gynaecology at the University of Eastern Piedmont. The investigation was conducted from July to October 2011 providing a self-administered questionnaire to the healthcare staff operating at the departments of paediatrics and gynaecology in a tertiary teaching hospital in Italy, the Novara and San Bassiano Hospital. Among the 130 questionnaires, 102 were returned, and the population was composed of 42 midwifes, 8 paediatric nurses, 18 gynaecologists, 6 paediatricians, 14 gynaecological residents and 14 paediatric residents (Surico et al., 2015, p. 395). Informants were asked to answer a nineteen questions-questionnaire concerning FGM knowledge, training, previous experience and knowledge of Italian legislation and related guidelines (*ibid.*). The results of the survey showed that 71.5% (73/102) of healthcare professionals dealt with patients presenting with evidence of FGM previously performed, and it was observed that most of the junior professionals knew of female genital mutilation issues through professional training, while senior professionals through clinical experience (*ibid.*). With regard to educational activities on FGM, 55% of healthcare operators declared not to have received any specific training, 32.7% attended at least one and 12.3% more than one (*ibid.*). About the knowledge of Law 9 January 2006, n. 7, and its related guidelines, the percentages of aware informants were as follows: 83% of gynaecologists, 75% of paediatric nurses, 55% of midwives, 50% of paediatricians and paediatrics residents, and 28.5% of gynaecology residents declared to be familiar with the Italian legislation, while only 9.5% of midwives, 38% of gynaecologists, 33% of paediatric nurses and none of residents or paediatricians declared to know the guidelines (*ibid*).

Having said that, those surveys could be used to create a specific framework where to collocate my study. Undoubtedly, the most relevant investigations adopted a typical approach of the scientific community, thus analysing female genital mutilation principally through medical lenses. However, it is clear that the examination of the phenomenon entails the contribution of different disciplines, including social sciences. For this reason, I think that the area of healthcare professionals knowledge on FGM in Italy needs to be "socially" further investigated, with a major focus on the operators' awareness and attitude

towards the practice. Moreover, it could be interesting to evaluate the current situation in 2016, not only because since the last questionnaires' submission (Surico et al., 2015) five years have passed, but also because the ad hoc law and its guidelines were adopted exactly ten years ago. Plus, to include a bigger number of hospitals/structures/centres in a study could be more representative thus useful in depicting the national situation.

At this point, it should be evident to what extent mapping and quantifying FGM cases, as well as evaluating knowledge of the practice, represents a challenge for both international organizations and scholars. Nevertheless, the research made worldwide during years has contributed to develop specific legislation to fight FGM. Before inserting female genital mutilation in legal contexts, in the next chapter the phenomenon will be re-contextualised in migration framework and later the challenges FGM arises both in multicultural and healthcare settings will be tackled.

CHAPTER TWO

"Theoretical framework"

INTRODUCTION

In the first part of the chapter, I will retrace the history of female genital mutilation and explain the social meaning attributed to the practice. Thereafter, FGM will be inserted and re-contextualised in the migration context and later the phenomenon will be discussed inasmuch as challenge to "western" multicultural societies. Finally, the attention will be shifted to healthcare settings where a "medicalization" of the practice has been discussed and deserves here to be explored. To conclude, the role played by healthcare professionals, possible key agents in preventing and managing FGM, will be described.

FGM BETWEEN NATURE AND CULTURE

From intentional harm to religious traditions, from Africa to Middle East, a lot has been affirmed about where, why and how the practice originated, with the result of alimenting the confusion around this phenomenon. Through the anthropological point of view - that is the main perspective characterizing female genital mutilation investigation worldwide and throughout centuries - the next section will clarify these fundamental aspects which are still debated and, sometimes, misinterpreted.

ORIGINS

The first traces of FGM seem to date back to Pharaohs' Egypt, as transcribed by the two Greek historians Herodotus and Strabo: in the 5th century B.C. Herodotus described mutilation practices among Egyptians and Ethiopians as well as within Syrians and Palestinians who later might have taken the custom from Egyptians themselves, while Strabo mentioned Greeks and the habit of mutilating boys' genitalia and excising girls as in the Jewish manner (Erlich, 1986, cited in Fusaschi, 2003). These testimonies are thus evidences that circumcision and excision were known in the ancient Egypt before Christ and that both practices remained even after the conversion of those populations to Christianity and Islam (Fusaschi, 2003). Therefore, FGM is not proper of religions and, in

particular, it is not mandated by the Quran: in fact, as stressed by Delafosse, "[excision] has undoubtedly not origins in Islam and some Muslim population practise it only exceptionally" (Delafosse, 1972, p. 176). From that time, the following acknowledgment took place in the European era of colonization and expansion, during which excision and other similar practices were mostly observed through the lens of weirdness, deformity and monstrosity (Fusaschi, 2003). At this point, the reader should keep in mind that, for a long historical period, the look towards certain issues – FGM included – has been "masculine" and "European" (Fusaschi, 2003, p. 52), therefore the products of its ethnography have been characterized by a strong positionality and, specifically, a pre-conceptual framework built on the "civilized-uncivilized" relation. That said, a first sign of "detached" approach comes from the French philosopher Montaigne, who in the sixteenth century wrote about a non-specified location "where man and women are circumcised and baptized at the same time" (Montaigne, 2002, p.147 cited in Fusaschi, 2003). In 1686, with his *"Description de l'Afrique"*, a Dutch doctor named Olfert Dapper described in detail some African practices on female genitalia and firstly introduced their social importance (Dapper, 1970). At a later time, during the 18th century, Leclerc found it interesting to study the practices according to age – for example, in the Middle-East girls were excised after puberty, in Benin between the 8th and the 15th day after birth, exactly as usual for boys – and the motivations behind them: while boys were circumcised for sanitary reasons, for the infibulated girls the motivation needed to be found in a form of obsessive jealousy (Leclerc, 1984). On the other hand, according to Diderot and d'Alembert, Abyssinian women were circumcised as a sign of nobility and men had their genitals pierced by rings in order to preserve their health (Diderot & d'Alembert, 1988). With the Scottish explorer Bruce's mission in eastern Africa a tentative justification was found in the "dimension" of the genitalia: regarding the excision, he wrote that the women of that region used to undergo the practice before marriage and because of the peculiar aspect - due to an excrescence - of their external genitalia (Bruce, 1790-92). This hypertrophy, labial and/or clitoral, has been described at the end of the 18th century especially after the French mission by means of Napoleon in Egypt, during which many scientists observed the phenomenon (Sonnini de Mannoncour, 1798; Fauvelle-Aymar, 2002) and attributed it to the hot temperatures of the region, where the warm weather could have provoked a relaxation of muscles and flesh (Virey, 1800). Until that period, the collected information was the result of non-professional anthropologists as colonial administrators and missionaries; only at the end of the 19th century the first anthropological societies arose and the attention shifted from the

mere description to the analysis of the phenomenon, thus leading to the concept of "rite of passage" first (Van Gennep, 1985) and of "rites of institution" later (Bourdieu, 1990).

In anthropology, traditional practices as clitoridectomy and infibulation are interpreted as rituals/acts of gender institution and/or of belonging to a given group, as well as ways to control women's sexuality (Fusaschi, 2003, in Belli, 2014). In any case, the goal of female genital mutilation is not thus to harm intentionally female genitalia, as a harried point of view could suggest. Let's now explore it.

CULTURE OVER NATURE

In every society, on different levels, it is believed that the body at birth is a "natural object" still imperfect, which needs to be shaped and made perfect through external interventions in order to become compliant with the idea a given society has of it (Fusaschi, 2003, p. 74-75). The human body continuously produces "meaning", therefore its marking make it able to communicate and transmit social values among the members of a specific group (*ibid.*). Throughout history, corporeality has been culturally and socially built, and the "marks" have brought strong identity significances, as in the case of FGM (Fusaschi, 2003, p. 78). Anthropologically speaking, it can be affirmed that "the Culture intervenes on the Nature" (Fusaschi, 2003, p. 75, *my translation*) and for this reason, since ancient times, women's body has always been considered as a wax board, a surface on which signs and symbols can be written, read, interpreted and decoded (Du Bois, 1988). In 1909, Arnold Van Gennep firstly defined as "rites of passage" those rites characterizing every modification – including definitive corporal modifications - in terms of social position, role and status (Van Gennep, 1985). According to Van Gennep, both male and female mutilations are to be conceived as fundamental parts of transition rites, where the individual passes from a specific status to another one through a corporal mark, namely the sign of a "new" social identity (*ibid.*). At a later time, the sociologist Pierre Bourdieu completed Van Gennep's definition by introducing the expression "act of institution". Using it as an example, Bourdieu describes the ritual of male circumcision as an act aimed to sanction not the difference between circumcised and non-circumcised boys, but the difference between man and woman, between masculinity and femininity (Bourdieu, 1990, p. 146). In other words, even with regard to excision or infibulation, the objective of the act is to assign "properties of a social nature in a way that makes them seem like properties of natural nature" (*ibid.*). In this way, the rite socially appoints the difference by instituting the man inasmuch as

man (*ibid.*) and, concerning FGM, the woman inasmuch as woman (Fusaschi, 2003, p. 80). Through a "formalisation" of the differences, the gender is explicitly conveyed thus establishing identity: on the one hand, the protagonist of the act will be aware of his/her nature and will behave accordingly (Bourdieu, 1990, p.148); on the other hand, the whole community will be able to acknowledge what he or she is, namely man and woman, and the related social responsibilities (Fusaschi, 2013, p. 81). Moreover, male/female genital modifications, inasmuch as acts of institution, become a veritable "investiture" which, due to its symbolic effectiveness, can transform the protagonists: after circumcision, the man is considered stronger and more virile; after excision, the woman is seen as cleaner and ready to get married (*ibid.*). For instance, the purpose of the act is to confer the appropriate gender, even if it consists of brutal actions. To become a woman, the first step is to interiorize these practices to such an extent that the individuals involved can get to desire the operation, in order to finally obtain the key of the door of that world they will be able to enter only thanks to such a physical modification (Belli, 2014). Relevant social prerogatives as marriage and maternity will be then gained throughout the progressive incorporation of a symbolic wound - that is a definitive modification - realizing a "grammar" by which the feminine body becomes legible as integrant part of a particular socio-cultural context, marked by a deep masculine domination (Fusaschi, 2003).

Concerning the context, it should be emphasized that it is an aspect of the phenomenon that can change and can be modified. On the contrary, the symbolic value attributed to the practices is firmly kept, but due to migration fluxes it is also re-contextualised. In the next section of the chapter, the re-contextualisation of female genital mutilation in "western" societies will be tackled, together with the challenges arisen from it.

FGM IN MIGRATION CONTEXTS

Female genital mutilations are practices which take place on women's body not only in their countries of origins, but also in "host" countries. In these new settings, FGM does not lose its social meaning but preserves it, despite laws and interventions aimed to eradicate the phenomenon. The following part of the paper will focus on its re-contextualisation.

The context - in which female genital mutilations are traditionally performed – can first of all modify geographically, secondly in relation to the type of operation and lastly based on the participants involved (Fusaschi, 2003, p. 86). From anthropological literature, the ethnographies describing the nature of the ceremonies are various. According to Paulme, in Upper Guinea operations as excision and clitoridectomy were performed in collective settings, with celebrations, music and dances (Paulme, 1952). On the other hand, de Villeneuve and Tauzin depicted respectively excision and infibulation in Somalia and clitoridectomy in Mauritania as practices taking place in private circumstances, without celebrations and with the participation of few members of the community (de Villeneuve, 1937; Tauzin, 1988). The latest investigations on the subject revealed that FGM in urban contexts has progressively lost its collective feature, becoming an individual practice, principally performed in private settings – kitchen, bathroom, yard - either of the girl's mother's house or of the ritual midwives' (Fusaschi, 2003, p. 94). Therefore, as above-mentioned, the context changes, as well as the ritual's features, while the symbolic value attributed to the practice itself is maintained (*ibid.*). Especially in migration contexts, female genital mutilation has turned from being private to "secrete", and the age of performance has decreased (Raulin, 1987, in *ibid.*). Both aspects could be the consequences of the adoption, in European and extra-European countries, of specific laws to fight the phenomenon. In fact, as stated by Fusaschi, FGM legislation has certainly contributed to shift the practice from a "private" level to an "illegal" one; moreover, it has influenced the age of the girls who undergo the mutilation, because to perform it on younger girls would constitute a lesser risk – for both parents and midwives - to be reported from their daughters (*ibid*). In addition, regarding the age, some women stressed the intention to "mark" their children as soon as possible, in order to avoid leaving in their minds any kind of memory related to painful feelings; the memories are thus built onto what the mothers, grandmothers, aunts, etc., who participated at the rite tell, and not connected to the mutilation itself (Lefeuvre-Déotte, 1997). That said, one could now state that FGM taking place nowadays and in the realities where women emigrated are somehow subjected to a transformation, strictly depending on the new context. In fact, the phenomenon acquires a "binding" characteristic: since it is often easy to experience marginalisation in the country of arrival, for many women the preservation of certain practices could become a way to maintain bonds with their country of origin (Fusaschi,

2003, p. 109). In addition, whether integration would not be perceived as achievable, to be "marked" would allow and guarantee the acceptation among those group members coming from the same land of the women/girls involved in the act (*ibid.*).

As above-illustrated, female genital mutilation is not a phenomenon confined to a certain area of the world but, together with persons, it crosses borders without losing its relevance in women's life. The following section will present some of the relevant theories concerning cultural practices, as FGM has been defined, and the related challenges arisen in multicultural contexts.

FGM AND MULTICULTURALISM

By ethnographers and more generally by scholars, female genital mutilation has been generally depicted as "cultural practice". For instance, it could fall under the UNESCO definition of "folklore", describing the traditional and popular culture as

> *"the totality of tradition-based creations of a cultural community, expressed by a group or individuals and recognized as reflecting the expectations of a community in so far as they reflect its cultural and social identity[...]; its forms are, among others, language, literature, music, dance, games, mythology, rituals, customs, handicrafts, architecture and other arts"* (UNESCO, 1989).

That pinpointed, some questions could spontaneously arise: what happens when a cultural community, as a consequence of migration, becomes a cultural minority community in a given society? Being cultural practices so fundamental for a group's social identity, how could they be handled in a multicultural context? Multiculturalism literature is mainly focused on addressing this kind of issues, and particularly "multiculturalism advocates policies which seek to accommodate the different identities, values and practices of both dominant and non-dominant cultural groups in culturally diverse society" (Murphy, 2012, p. 6). The political philosopher Will Kymlicka argues that cultural groups have their own "societal cultures" which provide members with meaningful ways of life - encompassing both public and private spheres – and, because such cultures risk to be threatened with extinction, special group rights should be granted (Kymlicka, 1995). The situation gets complicated when social and cultural practices entail women's involvement, with risk of consequences on their personal, sexual, and reproductive life. With regards to FGM, as

above-presented, gender and culture are deeply interrelated, meaning that in most existing contexts, to defend such "cultural practices" is likely to have much more impact on the lives of women and girls rather than on those of men and boys (Okin, 1998, p. 667). The liberal feminist Susan Okin addresses the connections between gender and culture simultaneously with feminism and multiculturalism using, together with other examples, female genital mutilations. The author takes a stand expressing the idea that certain customs proper of culture or traditions – as clitoridectomy, coerced marriages, polygamy – are so closely linked with the control of women that they could be virtually equated (Okin, 1999, pp. 14-16). For this reason, in *Is Multiculturalism Bad for Women?,* she raises an interesting question: "what should be done when the claims of minority cultures or religions clash with the norm of gender equality that is at least formally endorsed by liberal states [...] ?" (Okin, 1999, p. 9). Kymlicka proposes to deny education, the right to vote or to hold office, to those cultures that openly and formally discriminate women, clearly labelling those groups as not deserving special rights (Kymlicka, 1995, p. 153). Plus, he suggests a "no sex discrimination" test which, however, could easily lose its reliability: because the subordination of women is often far less formal and public than it is informal and private, no culture in the world today, whether minority or majority, could pass the test if it was applied in the private sphere (Kymlicka, 1990, in Okin, 1998, p. 679). Indeed, it is at home where much of culture is practiced, preserved, and transmitted to the young (Okin, 1998, p. 667). Recalling FGM re-contextualisation, private homes are in fact the main settings where girls undergo the practice, therefore the phenomenon is never likely to emerge in public, remaining hidden. As an attempt towards a solution, Okin highlights the importance of taking special care to look at within-group inequalities and emphasizes the necessity of guaranteeing adequate representation to the less powerful members of cultural groups, because "unless women [...] are fully represented in negotiations about group rights, their interests may be harmed rather than promoted by the granting of such rights" (Okin, 1999, p. 23, 24).

After having re-contextualised FGM into migration context and having presented some of the challenges this poses to multicultural societies, I will now narrow the discussion to the healthcare settings, where healthcare operators are the main figures in contact with immigrant women and could potentially be key actors in managing and preventing female genital mutilations.

FGM AND HEALTHCARE SETTINGS

Approaching female genital mutilation, particular attention has been paid to its negative consequences on women's health. For this reason, over the last five decades, international medical associations have made an attempt to improve its safety by proposing a "medicalization" of the practice. Let's explore it.

FGM MEDICALIZATION: HARM REDUCTION OR PROMOTION?

The medicalization of FGM has become increasingly common across African countries as Egypt, Sudan and Somalia (Shell-Duncan & Hernlund, 2000) and it basically consists in performing the practice through the use of sterile instruments and local anaesthetic, in order to reduce pain and minimize health risks for girls and women (Shell-Duncan, 2001). Since 1990s, some proposals for medicalization have been developed in the West as well, raising controversies between medical communities (Shell-Duncan, 2001). In Europe, particularly in the Netherlands, in Germany and in Italy, a medically performed symbolic FGM was proposed inasmuch as safer alternative, provoking public debates and oppositions from associations and non-governmental organisations (Bartels & Haaijer, 1992; Groh, 1999; Turone, 2004). Conceived as a step towards the eradication of the practice, these new strategies entailed a milder version of female genital mutilation - namely an incision of the clitoral hood - performed in healthcare settings and by medically skilled personnel, without entailing any removal of genital tissue and any long-term damages (Leye et al., 2006). The proposes were firmly rejected, becoming objects of a debate which, until now, poses a moral dilemma: "to protect women's health at the expense of legitimating a destructive practice, or to hasten the elimination of a dangerous practice while allowing women to die from preventable conditions?" (Shell-Duncan, 2001). The main arguments against FGM medicalization make it a matter of medical ethics, of wrong conceptualization of the practice, as well as of promotion of the latter. Concerning healthcare workers, it is argued that to perform the practice could be seen as unethical, especially because FGM is not performed for medical reasons, but for cultural ones. Therefore, to execute it would result as against medical deontology (Leye et al., 2006). Moreover, an incision is anyway a violation of women's and girl's fundamental rights, thus violating the right of bodily integrity that healthcare professionals should protect (*ibid.*). In addition, the practice could be accepted and perceived as normal, in other words there is a risk that female genital mutilations could be officially promoted (*ibid.*). Furthermore, it has been argued that since the cause of harm is a human behaviour, efforts

should be made in changing it, and not in legitimizing or even in encouraging it (Toubia & Izette, 1998). On the other hand, Shell-Duncan highlights the difficulties in changing this specific human behaviour. Inasmuch as connected with complex social meanings including sexuality, personhood, identity, a veritable change may take decades to take hold (Shell-Duncan, 2001). On the contrary, a harm reduction approach could promote an intermediate step towards the elimination of female genital mutilation, offering culturally acceptable alternatives in a delicate process of change. "Rather than taking a moral stand on the practice (female "circumcision" is immoral and illegal and therefore punishable), the focus is on the degree to which any form of behaviour is harmful to the individual or the community" (*ibid.*): FGM medicalization could thus reduce the negative consequences on women's health, while culturally sensitive strategies for FGM elimination are developed. In addition, every woman involved faces a personal dilemma: on the one hand, her health and wellbeing, on the other hand the acceptance and support within her cultural group (*ibid.*). In this case, medicalization – "by minimizing the relatively avoidable health risks of adhering to the tradition" – could help in dispelling doubts (Obiora, 1997), and may represent a solution to reduce risk and promote health among those who currently view the abandonment of the practice as an unacceptable option (Shell-Duncan, 2001).

As above-presented, those professionals working in healthcare settings can face several difficulties while dealing with patients who are at risk of female genital mutilation, and more in general terms with women who have undergone the practice. Plus, with regards to the medicalization debate, the stand they take may have considerable consequences on women's life. The following section will focus on the role played by healthcare operators in managing FGM cases.

HEALTHCARE PROFESSIONALS AND FGM

Despite discrepancy of opinions concerning FGM medicalization, activists and scholars worldwide have agreed that it is vital for healthcare workers to "understand factual and ethical arguments and counter-arguments, as well as motivations, of both purchasers and providers of FGM, so they can provide sensitive care for patients [...]" (Pearce & Bewely, 2013). In case of female genital mutilation, "care" for patients should not be limited to the mere clinical aspect of it but, to be adequate, it should include a culturally sensitive professional counselling (Leye et al., 2006). Taking as relevant examples the experiences of five European countries, namely Belgium, the Netherlands, Sweden, Denmark and

United Kingdom, it has been argued that due to the increasing number of immigrant women practising FGM, the following instruments should be developed and introduced in healthcare settings: first of all, technical guidelines for clinical management of the practice; secondly, codes of conduct on quality of care; lastly, ad hoc services for medical and psychological support (*ibid.*). In order to be properly prepared to manage FGM cases, one of the first steps should be providing healthcare operators with specific educational training for the acquisition of FGM knowledge, from health complications to social meanings. For example, a physician who may not be aware of the cultural and social implications of a given practice, risks to merely condemn it as a mutilation, thus adding humiliation for the patients (Beine et al. 1995; Chalmers & Omer-Hashi, 2003). Plus, all women must be treated with respect, kindness and sympathy, with an approach freed from prejudices: the patients and their relatives should not be judged and feel judged, and their needs may be listened in a sensitive and cultural appropriate way (Thierfelder et al., 2005). Concerning health risks, a lack of technical guidance to care appropriately for women who have already undergone female genital mutilation may result detrimental in addressing the psychological and physical consequences of the practice (Widmark & Ahlberg, 2002). Moreover, situations that may hamper the provision of adequate care could arise also from workers' emotions and feelings. In fact, some healthcare professionals may feel powerless in the management of procedures that are irreversible, even angry, thus generating tension and anxiety among her/his colleagues and with patients (Nienhuis & Haaijer, 1995). Therefore, a multidisciplinary team composed also of psychologists – in addition to plastic surgeons, gynaecologists, obstetricians, paediatricians, nurses, etc. – should be considered (Caroppo et al., 2014). Finally, incoherent strategies within health services, social services, immigration services, etc., implemented by national institutions could prevent healthcare operators from offering qualitative care to women affected by the practice (Leye et al., 2006).

In the previous pages, an attempt to shed some light around the origins and meanings of female genital mutilation has been made, followed by a re-contextualisation of the practice, both in migration and in multicultural societies. Later, in the field of public health, FGM medicalization has been proposed as safer alternative to reduce harm but, at the same time, it has been charged as a way to legitimise the practice. In healthcare settings, important role is played by healthcare professionals, who need a proper training to be able to manage FGM cases. Concerning this educational aspect, in the next chapter the Italian guidelines

establishing specific protocols of action with FGM cases will be presented in detail, after having inserted the phenomenon in the international legal context and having presented the Italian *ad hoc* legislation, namely law 7/2006.

CHAPTER THREE

"Background: protection and prevention"

INTRODUCTION

The chapter will begin with the description of the main steps undertaken during years by the international community in targeting female genital mutilation as an infringement of fundamental rights. Successively, the violated rights will be tackled and, at a later time, specific legal tools developed to address the practice worldwide will be presented in order to introduce the Italian framework. Finally, after having illustrated its specific law, the related guidelines for the prevention of FGM established by Italy and implemented at regional level will be described.

HUMAN RIGHTS AND FGM

Referring to chapter one, what appears clear while investigating or more generally dealing with FGM is to what extent this phenomenon is internationally considered as a violation of human rights, as well as of women's and children's rights. For instance, the next section will present the main steps undertaken during years by the international community in targeting the practice as an infringement of rights.

FGM AS VIOLATION OF HUMAN RIGHTS

Initially, global attention was paid on the adverse health consequences of female genital mutilation. Progressively, this emphasis began to fall from favour primarily because campaigns did not obtain significant results in terms of prevalence reduction, but also because of the inadvertent promotion of a "medicalization" of the practice, that means to perform and undergo FGM in healthcare settings (Shell-Duncan, 2008, cited in UNICEF, 2013). In the early 80s, the practice was publically recognized as rights' violation, in particular in 1984: with the institution of the Inter African Committee on Traditional Practices Affecting the Health of Women and Children, FGM was identified not only as an harmful act for women's lives, but first and foremost as an attack to their rights (Fusaschi, 2013). Later, two important developments occurred during the Vienna World Conference on Human Rights in 1993, the link with human rights was thus created: "first, "female

genital mutilation" became classified as a form of violence against women (VAW); second, the issue of VAW was for the first time acknowledged to fall under the purview of international human rights law" (Shell-Duncan, 2008, p. 227). Moreover, some years later with the Maputo protocol and the Conference of Beijing, the practice was equated with sexual violence (Héritier, 2002, p. 170). Through the mid-1990s the conceptualization of FGM as a human rights violation became a hot subject of debate in the international law scene, especially because none of the existing human rights instruments specifically addressed the practice (UNICEF, 2013). Therefore, since female genital mutilation is considered as a form of VAW, both the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment can be invoked (UNICEF, 2013). In addition, because in most of the cases it is performed on minors, FGM also violates the Convention of the Rights of the Child (UNICEF, 2013). Referring explicitly to the Universal Declaration of Human Rights (UDHR), to perform the practice is a violation of three universal human rights: the right to health (Article 25); the right to life liberty and the security of personhood (Article 3); the right to an adequate education that includes proper knowledge of the cultural practice (Article 26) (Danial, 2013). Overall, it has been argued that female genital mutilation breaches the rights of women, the right to freedom from torture, the right to health and bodily integrity and the rights of the child (UNICEF, 2013).

Women's rights and gender equality

What has been stressed worldwide in the FGM discourse is its discriminatory nature in terms of equality: in fact, "female genital mutilation has been recognized as discrimination based on sex because it is rooted in gender inequalities and power imbalances between men and women and inhibits women's full and equal enjoyment of their human rights" (WHO, 2008). Plus, the association of the practice with a form of violence against women makes possible to invoke the CEDAW, strong tool entered into force in 1981 which obliges the states party of the Convention to modify the social and cultural patterns of conduct of men and women, in order to achieve the elimination of prejudices and customary and all other practices which are based on the idea of gender inequality (UN, 1979, cited in Shell-Duncan, 2008, p. 228). However, the main obstacle to the efficiency of this instrument is to be found in the volunteer aspect of the act, because women are not simply victims but also protagonists of it: the decision to perform FGM is indeed often in

the women's control, thus weakening the claim of gender discrimination (Shell-Duncan, 2008).

Freedom from torture

According to Article 1 of the Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment, a torture is

> *"any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person [...] for reasons based on discrimination of any kind"; plus, it requires the act to be inflicted with the "acquiescence of a public official or other person acting in an official capacity" (UN, 1984).*

The first problem with this approach regards the private dimension of FGM. Shell-Duncan stresses that the practice is most often performed in private settings beyond the view of public officials (Shell-Duncan, 2008, p. 228), therefore that definition presents some limitations. On the other hand, the aspect of consensus seems very complicated to be discussed here because, as explained in the previous chapter, women can get to desire to undergo the practice, thus making the attempt s of labelling female genital mutilation inasmuch as "torture" even harder.

Health and bodily integrity

From the UDHR, Article 25 states that "everyone has the right to a standard of living adequate for the health and well-being of himself" (UDHR, 1948). With regards to FGM, several immediate and long-term harmful consequences on health and dangers for childbirth have been documented (WHO, 2008). Despite that, the main problem with this approach is that "a narrow focus on health complications does not exclude various forms of medicalization as solutions", which have been objects of controversial debates within the international community in the last decades (Shell-Duncan, 2008, p. 228). Moreover, some scholars have pointed out that, in countries dealing with more acute health issues and epidemics, a preventive health approach concerning female genital mutilation would be economically unaffordable (Breitung, 1996; Boulware-Miller, 1985).

Rights of the child

As documented, FGM are mainly practiced on children, figures primarily not autonomous in making decisions independently (WHO, 2008). Their inability, below a certain age, to provide informed consent, has been used as solid base to denounce female genital mutilation as a practice against their rights. As vulnerable and care needy, the CRC aims to grant to children's rights special protection in the human rights context, firstly considering their best interests (Convention on the Rights of the Child, 1990), strongly determined by parents or guardians. The problem here is rooted in the concept of "best interests" itself, which leads parents to choose to perform FGM on their daughters. As Shell-Duncan notes, parents who value the cultural, economic, and social benefits of female genital mutilation may conceive it as in the best interest of their children, specifically in terms of social acceptance (Shell-Duncan, 2008). In other words, parents may perceive as most important the social "benefits" from submitting their children to FGM and consider secondary everything else, pain and health consequences included.

What should be evident at this point is the multidimensionality of the issue, which entangles the concepts of equality, freedom from torture and health integrity with women's and children's rights. For this reasons, in order to protect them, many are the instruments around the world that have been developed and that could be labelled as constituting a "FGM legislation". Let's now explore them.

LEGAL TOOLS

Before narrowing the discussion to the Italian reality with its specific law and national strategy to prohibit and prevent female genital mutilation, the following section will illustrate the main legal tools adopted by several countries worldwide to specifically address the practice.

INTERNATIONALLY AGAINST FGM

Generally, legal provisions that apply to FGM can be found both in criminal laws and child protection laws. With regards to Africa, many states have approved national laws to fight the phenomenon inasmuch as "traditional practice" to firmly oppose to: from Egypt to Uganda, almost half of the African countries have publicly condemned FGM and declared the importance of developing efficient means to eradicate it (Ministero della Salute, 2006).

On the other hand, as a consequence of migratory fluxes, countries as Australia, Canada, New Zealand and United States have instituted normative apparatus to contrast female genital mutilation on their territories. Concerning the EU member states, in the vast majority, FGM has been mainly prosecutable under general criminal legislation: provisions and articles in their penal codes dealing with bodily injury, voluntary corporal lesions and sometimes also mutilation are in fact applicable to the practice and can be used to prosecute it (Leye & Sabbe, 2009). In the past decade, thanks to solicitations from both the European Parliament and the Council of Europe, some European countries have developed specific FGM legislation, namely Austria, Belgium, Cyprus, Denmark, Italy, Norway, Portugal, Spain, Sweden and the UK (Leye & Sabbe, 2009). With a view to strengthening the fight against female genital mutilation, the large majority of EU members includes the principle of extraterritoriality in their criminal dispositions, which makes it possible to prosecute the practice even if it happens elsewhere, because

> *"Most frequently, girls and young women undergo FGM when they are "on holiday" visiting relatives in their country of origin. The principle of extraterritoriality renders it possible to prosecute the practice of FGM when it is committed outside the borders of one of the European countries. Conditions for the application of this principle differ: often, either the offender or victim - or both - must be a citizen or at least a resident of the European country, and sometimes FGM must also be considered an offence in the country where the crime was committed (double incrimination)".* (Leye & Sabbe, 2009)

Moreover, in all member states professional secrecy provisions have been foreseen for those figures – health professionals, social workers and teachers - operating with immigrant communities. In some countries, these professionals have the "right to report" cases of FGM and in others the right becomes a "duty to report" (Leye & Sabbe, 2009). Among those EU states where the duty to report FGM cases applies there is Italy which, since 2006, possesses precise dispositions regarding health and social professionals working in close contact with immigrant women and an *ad hoc* law to prohibit and prevent the practice, the 7/2006 law.

ITALY: LAW 9 JANUARY 2006, N.7

Following the European request of commitment to eradicate the practice, Italy decided to promulgate a law to openly contrast female genital mutilation, namely law 9 January 2006, n.7, "*Dispositions concerning the prevention and prohibition of female genital mutilation*

practices" (my translation) passed by the Italian Parliament in 2006. The law is composed of nine articles:

- article 1 highlights the objectives, that are to prevent and ban the practice inasmuch as violation of women's and girls' fundamental rights;
- article 2 attributes to the Ministry of Equal Opportunities the role of promoter and coordinator of activities aimed to assist the victims of FGM and eradicate the phenomenon;
- article 3 appoints the Ministry of Equal Opportunities, of Health, of Education, of Research, of Work and Social policies, of Foreign Affairs and of Home Office together with the Italian regions and the two autonomous provinces – Trento and Bolzano -, responsible for: 1) the organization of informative campaigns in Italy, on its borders and in Italian consulates, with the purpose of sensitizing women and girls on their rights and on the FGM ban (art. 3a.); 2) through the participation of NGOs, voluntary associations and healthcare settings, the promotion of initiatives for the development of a socio-cultural integration of immigrant communities coming from those countries where FGM is performed (art. 3b);
- article 4 announces the adoption of specific guidelines addressed to health professional figures dealing with communities of immigrants, aimed to realize activities of prevention, assistance and rehabilitation of women and girls who have undergone the practice;
- article 5 institutes a toll-free number where cases of FGM can be reported and information regarding voluntary associations and NGOs helping immigrants can be retrieved;
- article 6 envisages imprisonment from 4 to 12 years for those who, in the absence of therapeutic requirements, perform the practice, and up to 7 years for those responsible for other kinds of lesions to female genitalia, which in any way can cause impairment of sexual functions and physical and mental illnesses; if the act is performed by a healthcare professionals, he/she will be debarred from his/her profession – with an official communication to the National medical board – for 3 to 10 years; whether the victim who undergoes FGM is under-age, the terms of imprisonment are increased; plus, recalling the principle of extraterritoriality, the practice is prosecutable also when it is committed outside national borders by Italian citizens or by foreigners residing in Italy;

- article 7 establishes international cooperation programmes - consisting of training and informative courses to fight the practice - to be carried out by the Ministry of Foreign Affairs in those countries where FGM is traditionally performed;
- article 8 states that the institution where a case of FGM is committed will have to pay a penalty;
- article 9 provides an overview of the financial coverage – several millions of euro – allocated for the activities to be implemented (Parlamento Italiano, 2006).

In addition to this legal tool, as presented with article 4, the training of professional figures working in health care settings and closely to immigrant women and children is one of the main strategy developed to prevent the phenomenon. For this reason, the next section of the chapter will describe the above-mentioned guidelines and their implementation in the Italian public health system.

THE ITALIAN GUIDELINES

Law 7/2006 and, in particular, article 4, attributes to the Italian Ministry of Health the duty to emanate specific guidelines in order to realize activities of prevention, assistance and rehabilitation of women and girls who have already undergone female genital mutilation (Parlamento Italiano, 2006). The guidelines are largely addressed to medical personnel – paediatricians, gynaecologists, obstetricians, nurses – but also to those other professional figures – teachers, psychologists, cultural mediators, social workers, volunteers - which operate with communities of immigrants coming from countries where FGM is traditionally performed (Parlamento Italiano, 2006). Specifically, these "instructions" have been conceived for the training of healthcare workers with the purpose of firstly becoming familiar with the practice, its nature and its types, and secondly of offering the proper assistance when dealing with FGM cases, especially in relation to gynaecological/obstetrical care whether health complications might occur; in other words, "healthcare operators of the National Health Service should have a basic knowledge of FGM and of the medical, anthropological and sociological aspects linked to it" (Ministero della salute, 2006, p. 22).

The guidelines have been elaborated according to criteria and methods proper of the methodological manual "*How to produce, spread and update recommendations for the clinical practice*" (my translation) published in 2002 by the Italian National Institute of

Health and the National Agency for Health Services (ASSR & ISS, 2012). The dispositions are classified with letters, from A to E, which indicate, in decreasing order, the recommendations' strength compared to the quality of the scientific evidences supporting their application and use:

A = the execution of a particular procedure or action is highly recommended;

B = some doubts concerning the recommendation of a particular practice or action exist, but the execution should be carefully considered;

C = substantial uncertainty exists, both in favour and against the recommendation of executing the procedure or action;

D = the execution of the procedure it is not recommended;

E = it is strongly advised against executing the procedure;

√ = "good clinical practice" behaviour, based on the experience of the group of professionals who developed the guidelines (Ministero della Salute, 2006, p. 21).

In total, the recommendations are twenty-four – seventeen for healthcare operators, four for cultural mediators and social workers, three for teachers - and are mainly targeted with A, B and √:

Health care operators

A, highly recommended:

1) Specialized personnel should be envisaged to face at risk situations as, for example, surgical intervention of de-infibulation;
2) operators should possess sufficient cultural and scientific information on FGM, in order to avoid an embarrassing and untrustworthy relationship between doctor and patient;
3) in that relationship, interpersonal communication should be prioritized;
4) the clinical and psychological contact with a women who have experienced FGM should be conducted by a female operator;
5) healthcare professionals should acknowledge the different types of FGM;
6) pregnancy and childbirth assistance should be particularly curated with women with FGM;
7) the first gynaecological exam has a particular importance;
8) de-infibulation should be executed for FGM type III cases;
9) de-infibulation can be partial or total and has to be undergone in local anaesthetic;

10) for those women hospitalized at Obstetrical and Gynaecological departments it should be suitable to include specific FGM information in their medical records;
11) de-infibulation physically cancels FGM effects (totally or partially), but does not delete psychological damages that should be treated adequately;

B, to be considered:

12) Healthcare operators should be aware of the geographical, ethnical, social and cultural aspects involved while dealing with FGM, in order to guarantee the best prevention and assistance;
13) the approach towards a women who has undergone FGM should be multidisciplinary;
14) if necessary, it would be adequate and respectful to collaborate with interpreters and cultural mediators;
15) due to the difficulties that might occur, healthcare workers should carry out gynaecological exams delicately and should not insist whether it might result painful;

√, *"good clinical practice:*

16) Every healthcare operators working with women's health should be able to meet the needs of women who have undergone FGM;
17) it should be suitable to acknowledge the number of de-infibulation cases carried out in Italian hospitals and to homogenously codify such intervention in the medical reports.

Cultural mediators and social workers

√, *"good clinical practice:*

1) It should be suitable that the cultural mediator manifests, in his/her work, discretion, sensibility and knowledge of the FGM phenomenon;
2) the role of cultural mediators, as well as the one of social workers, should favour the relationship between institutions and families, also with the purpose of revealing the attitude towards FGM;
3) social workers could actively promote social and medical services offered territorially, in order to spread correct behaviours for women's and girls' health protection;
4) to include men in an awareness process could help more efficiently in the change of attitude towards FGM.

Teachers

√, *"good clinical practice:*

1) It is important that teachers know how to recognize certain behaviours, characterized by fear or anxiety, among girls that could reveal possible FGM cases;
2) it is important for teachers to establish a trustworthy relationship and dialogue with families;
3) it is important for teachers to observe eventual changes of behaviours that could be caused by a FGM episode (Ministero della Salute, 2006, p. 22-37).

In order to realize a national strategic plan, in 2012 an agreement on the activities to be developed for the prevention and fight of the female genital mutilation phenomenon, as stated in article 3, law 7/2006, was made between state, regions and the two autonomous provinces Trento and Bolzano. The agreement highlighted the national objectives in prohibiting and preventing the practice and established a budget destined to implement them at regional level. In fact, it is here important to remind that in Italy a National Health System exists, but each region autonomously manages funds and determines policies in terms of health care. With regards to FGM, as retrievable from Attachment 1 of the guidelines, information concerning the activities of healthcare workers' training, counselling, de-infibulation and research, together with the description of specific regional structures, represented the Italian situation, region by region. According to it, ten regions – Valle d'Aosta, Veneto, Marche, Abruzzo, Molise, Campania, Basilicata, Calabria, Sicilia and the province of Trento - resulted lacking of any of those activities and structures, three regions – Piedmont, Friuli Venezia Giulia and Umbria - missing only the structures, and eight – Lombardy, Liguria, Emilia-Romagna, Toscana, Lazio, Puglia, Sardinia and the province of Bolzano - being adequately organised with both activities and structures (Ministero della Salute, 2006, p. 40).

Due to the vast number of regions and to the limitations, in terms of time and resources, of this study, I had to narrow my investigation to some parts of Italy. In order to answer to my research questions, I needed to identify the areas and the structures where to look for participants because, as indicated by the content of the guidelines, healthcare workers are

the main addresses of the recommendations. For this reason, the next chapter will focus on the methodology chosen to conduct the study and on the criteria adopted to select the sample.

CHAPTER FOUR

"Methodology: from here to there"

INTRODUCTION

The purpose of this chapter is to describe the steps characterizing the research process of this study while providing the reader with a better understanding of the related research choices. Starting from an introduction on research topic, objective and questions, I will present a comprehensive overview of my research design, the criteria set for sampling and the recruitment stage. The chapter will then focus on the data collection method and its instrument. Later, a brief foretaste of the descriptive analysis that will constitute the successive chapter will be given. To conclude, relevant ethical principles taken into account during my research path will be presented.

RESEARCH TOPIC, OBJECTIVE AND QUESTIONS

The research topic of this paper is Female Genital Mutilation in Italy. Initially, I wanted to approach the issue by discussing it with the individuals concerned - women subjects/objects of such a discussed practice - among immigrants' communities living in Italy. At the time, the purpose was to analyse the impact of the law 9 January 2006, n. 7, on the establishment of an intercultural dialogue between the Italian government and African immigrant women by giving voice to the latters: do those women feel attacked or protected by that law? Do they recognize the practices described in it? Do they believe that law could respect their rights? Those were some of the questions I had in mind at the beginning of the research process and to interview some of those protagonists seemed to be an interesting way to find proper answers. Then, I started to contact some of the relevant communities via email, Facebook and phone. However, I did not have any success. It was then that I realized the difficulties I would have faced: who would have accepted to talk, face to face, with an "outsider" about such a delicate, intimate, and besides, illegal practice? At best, whether I would have found someone to interview, how long would it have taken to establish a trustworthy connection with the participants, key factor to freely discuss certain issues? A plan B occurred, therefore I considered to switch perspective by reformulating

my research questions and looking for answers through the analysis of the "other side of the coin", the other Italian addressees of the law and its guidelines: the healthcare workers.

Knowing this, the objective of the project is still to investigate the phenomenon of Female Genital Mutilation in Italy. After ten years from the adoption of a national law to prevent and prohibit FGM and its related guidelines issued by the Health Ministry, the research aims to verify *if* and *how* the Italian government has abided by its obligations to train health professional figures and which kind of impact this has had in the establishment of an intercultural dialogue with the immigrants' community.

Having pointed out the purpose, I have formulated the following research questions:

- *Since the adoption of the law 9 January 2006, n. 7 and the related guidelines, has the Italian government provided (a) training of healthcare operators? If yes, how has this affected their knowledge in terms (b) of Female Genital Mutilation?*
- *After ten years, has the intervention had a positive impact (c) on healthcare operators' approach with regard to FGM and, consequently, on the establishment of an intercultural dialogue with immigrant women?*

Being the first question a "yes or no" question, I had to consider the possibility of a negative response. In this case, this study could anyway contribute to give an insight of the Italian situation and reveal healthcare professionals' knowledge in terms of FGM. Therefore, whether the answer would be "no", the second part of the question will become: "*are healthcare operators familiar with the subject?*". As a consequence, their level of knowledge could still be useful in determining its impact on healthcare operators' approach towards female genital mutilation and on the establishment of an intercultural dialogue with immigrant women. Therefore, the second question could be reformulated as follows: "*which kind of impact training of healthcare professionals could have on the establishment of an intercultural dialogue with immigrant women?*".

Before explaining the process of the research questions' formulation, I will now present to the reader the "blueprint" of the project.

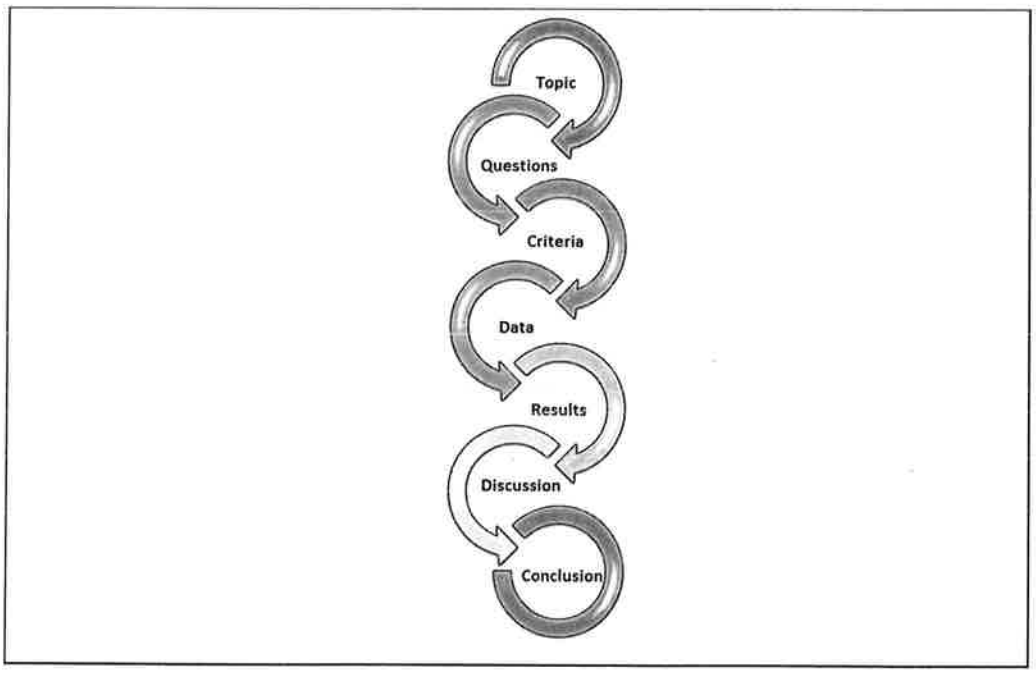
RESEARCH DESIGN

To be able to answer the abovementioned research questions, preparing an effective action plan for the collection and analysis of data becomes fundamental. In other words, a research design is needed. In social science research, as Robert K. Yin explains,

> "[…] a research design is *a logical plan for getting from here to there*, where *here* may be defined as the initial set of questions to be answered, and *there* is some set of conclusions (answers) about these questions. Between "here" and "there" may be found a number of major steps, including the collection and analysis of relevant data." (Yin, 2009, p. 26)

According to this description, I imagined my research design as a colourful sequence made up of curved arrows. As illustrated in figure 1, the arrows represent the steps of my "research path": chosen the *topic*, I refined it into *questions*, which led me to set specific *criteria*, necessary to identify sampling for the collection of *data*, that once analysed constituted the *results*, later interpreted through a *discussion* and finally summarized as a *conclusion*. In order to give to the reader an exhaustive picture, I will now tackle, more in depth, each step which, to use Yin's expression, "got me from here to there".

Figure 1. My research "path"



TOPIC

Since the choice of the topic and its evolution has already been amply justified, it would be here unnecessary mentioning it once more.

QUESTIONS

As Bryman suggests, "research questions can provide students with important guidance when they may have difficulty 'seeing the wood for the trees'" (Bryman, 2012, p. 91), therefore to formulate the "right" research questions could be considered as one of the most important aspect of a successful research. Probably due to the shift of perspective - the plan B I adopted regarding the investigation of FGM in Italy - the questions' formulation has not been so easy for me. A stratagem that helped in simplifying this process was to think about the analysis phase right after the construction of my research questions; this way, I could elaborate precise questions by dividing the research objective in specific areas of interest:

a) healthcare operators' training;

b) knowledge in terms of FGM;

c) healthcare operators' approach.

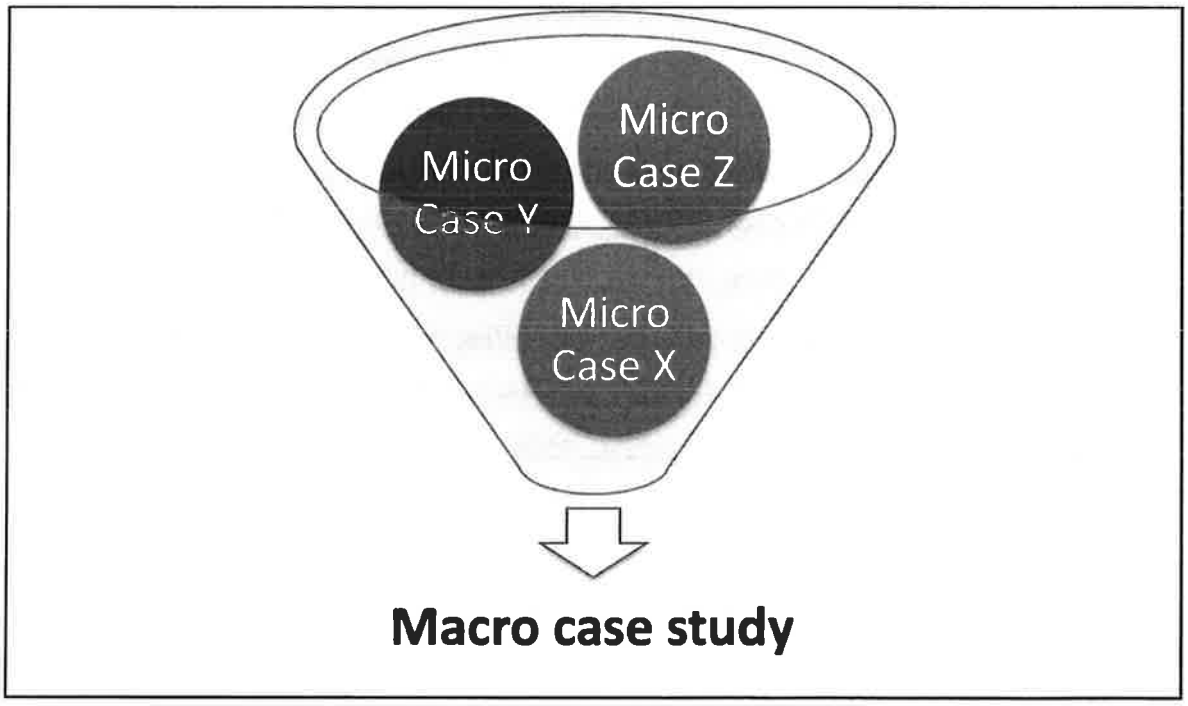
Having pinpointed those, I "transformed" the areas into interrogative sentences which constitute my research questions; I used this tri-partition also to develop the questionnaire, as I will later illustrate. Converted into words, each question finally begun to direct light to the right direction and to address attention to something that should be examined within the scope of the study (Yin, 2009, p. 28). Furthermore, since the form of the question provides clue regarding the most relevant research method to be used (Yin, 2009, p. 27), a term as "how", contained in one of the questions, initially led me to pick the case study design as appropriate method (Yin, 2009, 28), but not without difficulties. Indeed, the case study design appeared as the most adequate: according to Yin, a classic case study is an individual, but "the case" can be as well an event, a program, a decision, an organizational change, an implementation process (Yin, 2009, p. 24). Honestly, I found it hard to *not* depict a study as a case study and, consequently, as a design: in fact, as Bryman stresses, "unless a distinction of this or some other kind is drawn, it becomes impossible to distinguish the case study as a special research design, because almost any kind of research can be construed as a case study" (Bryman, 2012, p. 69). Therefore, even "Female Genital

Mutilation in Italy: healthcare operators as agents of change? A study ten years after the adoption of law January 2006, n.7 on targeted training as dialogical tool" could be labelled as a case study.

At a later stage, while reflecting on where to start seeking answers and collecting my data, a problem occurred due to the number of selected elements: as will be introduced in the next subsection, I included more than *one* group of healthcare operators, more than *one* healthcare centre and more than *one* Italian region. Could it still be considered *a* case study?

Yin affirms that "the same study may contain more than a single case. When this occurs, the study has used a multiple-case design, and such designs have increased in frequency in recent years [...]" (Yin, 2009, p. 53). Single and multiple-case designs are thus considered to be variants within the same methodological framework and the choice to be between research designs, because both are included under a case study method (*ibid.*). Considering that, as shown in figure 2, I opted for a multiple case design where groups of healthcare operators working in different healthcare centres represent a the same time "micro" cases - X, Y, Z, etc. - and compose a single unique illustration, that could more generally be described as "FGM in Italy" "macro" case study.

Figure 2. Example of multiple-case design



According to this logic, each case must be carefully selected so that it could predict similar results (example: if healthcare operators have been trained, they all should possess an equivalent knowledge in terms of FGM) and, successively, attest replication (Yin, 2009, p. 54). Yin compares the replication logic to that used in multiple experiments (*ibid.*), which recall experimental designs and quasi-experimental designs that, according to Bryman, have been particularly prominent in evaluation research studies as evaluation of social and organizational programmes or interventions (Bryman, 2012, p. 57). At this point, I believe this study could contribute not only to verify the Italian conduct in training healthcare operators about FGM but also to evaluate it, thus earning it the title of evaluation research. In addition, in support of this "label", I think that timing could be considered as a useful variable of evaluation, precisely because the research was conducted exactly ten years after (2006-2016) the adoption of the law 7/2006 and its guidelines.

The methodological approach adopted for this goal is quantitative and, in this kind of research, to set clear parameters for sampling recruitment becomes fundamental. Let's explore it.

CRITERIA FOR SAMPLING AND RECRUITMENT

Once traced the contours of my study, a fundamental step has been to set specific criteria to recruit proper sampling, namely to define the units of analysis; units of analysis could be a small group of persons or a given service offered in a specific geographic area (Yin, 2009, p. 32). Initially, I selected immigrant women as units of analysis but then, after "having turned upside down the coin", I decided to identify healthcare operators as more appropriate. Healthcare operators work in healthcare centres, therefore to establish precise selection standards became essential:

1) Immigrants population

In the first place, I browsed the Italian National Institute of Statistics (ISTAT) website and retrieved the official number of foreign citizens living in Italy to the date 31st of December 2015, which is the most updated fact. To narrow the number, I chose Nigerian population as research criterion for two reasons: first of all, because Nigeria is one of those countries where FGM is traditionally performed, and secondly because on the 31st of March 2006 a Nigerian woman was arrested in Verona, a city located in Northern Italy, intent on "the

practice of female clitoridectomy of a Nigerian new-born" (Polizia di Stato, 2006). The episode was the first case of FGM Italy had to deal with right after the adoption of the law 7/2006 and which introduced the expression "Culturally Motivated Crimes" to describe those crimes committed by male and female immigrants, questioning the concept of "mutilation" and the effectiveness of the law itself (Fusaschi, 2015, p. 19). Having said that and obtained Nigerians' regional distribution, I located the three first regions of Italy - respectively Veneto, Emilia-Romagna and Lombardy - where Nigerians reside and the related three first districts: in Veneto Padua, Verona, Venice, in Emilia-Romagna Modena, Parma, Reggio Emilia, and in Lombardy Brescia, Bergamo, Milan. Finally, in those areas, I identified healthcare centres which offer specific services to immigrants.

2) Type of structure and services

After having localized the regions and the related districts, I fixed the following parameters: *a) the healthcare centres must be localized to those areas*, this standard has been justified in the previous paragraph about immigrants population; *b) the healthcare centres must not be private but public structures*, with regards to the private/public aspect, in the guidelines it is explicitly stressed that the addresses of these recommendations are the operators of the National Health Service, therefore to be coherent to my research questions I selected only public healthcare centres; *c) the healthcare centres must offer services to immigrants and/or specific services to immigrant women*, regarding the nature of the services, I "filtered" my research by considering ad hoc services offered to immigrants, known as "immigrant women room" and "health counselling for immigrant families" (*my translation*).

After having determined those research parameters, the participants' selection process started and, alas, it has not been that easy. First of all, identified and selected some of those centres satisfying the abovementioned criteria - three structures for each region, for a total of nine healthcare centres -, I prepared a one-page project description (research purpose, sampling and implications in terms of participation), I then asked for a formal thesis research confirmation from my university and I looked for telephone numbers on the regional health department websites. Before sending out the material to the official email addresses, I tried to reach the directors of the centres with vocal calls through Skype: in this way, I could have presented the study or given further explications and I could have sent, if interested, all the information via email. Few answered, many did not; telephonically, I managed to talk and immediately get a positive feedback from only one

centre, the Verona one, therefore I proceeded to send the informative material via email to the other centres but, once again, just one of the directors replied. At that point, a bit demoralized, I decided to play my last card and go directly to knock their office's doors. Being the centres distributed in different regions of Northern Italy, I managed to physically reach only two of the three centres of Emilia-Romagna, respectively one in the city of Reggio Emilia and one in Sassuolo. In Reggio Emilia, I met the operators and I illustrated to their team leader the project. All of them were willing to participate, but due to the centre's hierarchy, their consent was not enough: inasmuch as parts of a team managed by a director, his/her approval was needed. After some negotiations and many meeting attempts, the director agreed and let the operators collaborate with me. On the contrary, in Sassuolo I had the chance to "catch" the director in the office, present the study and obtain an agreement. The overall recruitment process took more or less four months, fifteen phone calls, twenty-five emails and three journeys to Italy. All things considered, I can affirm that the phase has been very excited: I was a researcher, in the field, and I really enjoyed it.

Because the characteristics of each healthcare centre and related operators will be presented in details in the analysis chapter, it is now time to describe the method chosen to collect data.

DATA COLLECTION

In this study, data has been collected by means of a survey, namely a supervised self-completion questionnaire in Italian. In social surveys, self-completion questionnaires or self-administered questionnaires entail respondents answering questions by completing the questionnaires themselves (Bryman, 2012, p. 232). Prominent forms are postal or mail questionnaire but, as for this case, "the term "self-completion questionnaires" also covers forms of administration, such as when a researcher hands out questionnaires to all students in a class and collects them back after they have been completed" (*ibid.*). In social research, this kind of instrument has been labelled as very similar to structured interview method, with a main, obvious, difference, that is the absence of the interviewer to ask the questions (Bryman, 2012, p. 233). As a result, self-completion questionnaires generally tend to present some disadvantages: no prompts can be given in case questions are found difficult to understand hence to answer; respondents can easily become tired of answering, therefore questions must be salient to them and must not be too many; the use of open questions should be limited because participants frequently do not want to write a lot;

questionnaire can be read as a whole, thus questions could be answered without following the structural order; with postal questionnaires, the researcher cannot know for sure who answered (Bryman, 2012, p. 234, 235). To prevent these situations arising, I chose to supervise the interviewees during the self-completion phase, to develop a questionnaire (see Attachment) characterized by an easy-to-follow design, a clear layout, different fonts - for questions and answers - and, in order to reduce "respondent fatigue" *(ibid.)*, I prepared sixteen multiple choice questions, three of which provided of some space for further elaboration in the answer. In addition, to be able to estimate an indicative completion time (resulted in less than five minutes) and to avoid biased questions/answers, I pre-tested the questionnaire sending it out to some friends, colleagues and a professor who is a female genital mutilation expert. Being aware that "if possible, it is best to find a small set of respondents who are comparable to members of the population from which the sample for the full study will be taken" (Bryman, 2012, p. 264), the difficulties faced for the sampling recruitment made impossible to achieve such a condition, therefore I decided to take into account friends', colleagues' and professors' feedbacks, which allowed me to determine, at least partially, the adequacy of instructions, the questions understanding and the related flow. Regarding the latter, I followed some rules about questions order: early questions should be directly related to the research topic; questions that may be source of anxiety should be left at the end of the survey; questions should be grouped into sections; general questions should precede specific ones (Bryman, 2012, p. 221). Having said that, to be able to "measure" what I wanted - training, knowledge in terms of FGM, healthcare operators' approach - I had to determine some indicators that would stand for the concepts; an indicator is in fact something that is employed as though it were a measure of a concept (Bryman, 2012, p. 164). Therefore, especially in the light of the analysis, I devised indicators through four series of questions that designate a given concept, similarly to the strategy used to transform the research objective into research questions. Before presenting it, it is here important to highlight that the following order does not reflect the questions' disposition in the questionnaire but rather illustrates a functional grouping finalized to define the indicators:

a. Training on FGM.

The table (table 1) contains five questions that have been formulated to answer to the first of my research question, a "yes or no question", that is: *"since the adoption of the law*

7/2006 and the related guidelines, has the Italian government provided to train healthcare operators on FGM?". As a consequence, the questions of this group possess a simple interrogative form and only a yes/no answer option. Two of these questions (Q3, Q4) are directly concerned to show whether a specific FGM training has taken place at the healthcare centres, here referred to as workplace, during healthcare operators' working experience; operators' background in terms of professional role and working experience in public healthcare centres will be exhaustively presented in the analytical chapter. Two more general questions (Q1, Q2) about operators' direct contact with FGM cases at their workplace have been included to indicate their familiarity with the issue. Moreover, a question (Q5) regarding the knowledge of the law 7/2006 has been considered as an indicative element to reveal operators' training experience due to the direct link between law and guidelines.

Table 1. Questions about healthcare professionals' training

TRAINING	Question	Measure
Q1	Have you ever heard about FGM at your workplace?	1= Yes; 2= No
Q2	Have you ever dealt with cases of FGM at your workplace?	1= Yes; 2= No
Q3	Have you ever been trained on FGM at your workplace?	1= Yes; 2= No
Q4	During your working experience in healthcare centres, have you ever been trained about FGM?	1= Yes; 2= No
Q5	Do you know that in Italy, since 2006, there is a law (law 7/2006) to fight FGM?	1= Yes; 2= No

b. Knowledge in terms of FGM.

This group of questions (table 2) constitutes a tool to measure healthcare operators' knowledge by answering to the consequent part of the previous research question: *"how has the training affected their knowledge in terms of Female Genital Mutilation?"*. Here, respondents could choose more than one answer for each questions, except for one

question (Q1), that is a "yes or no question" and aims to verify familiarity with female genital mutilation in general terms. In terms of typologies, age of performance, geographical spread and motivations, four questions (Q2, Q3, Q4, Q5) have been thought to test operators' FGM knowledge. The majority of these questions (Q3, Q4, Q5) has not been formulated as interrogative but as a sentence to be completed and, among the answer options, it presents the voice "Other", which entails the possibility for respondents to be more specific by writing some lines of words, thus enabling a collection of more detailed data.

Table 2. Questions about healthcare professionals' knowledge

FGM KNOWLEDGE	Question	Measure
Q1	Have you ever heard about FGM?	1= Yes; 2= No
Q2	Which kind of FGM do you know?	1= Clitoridectomy; 2= Escission; 3– Infibulation; 4– Other
Q3	FGM is performed on:	1= New-borns; 2= Girls; 3= Adolescents, 4= Adults
Q4	FGM is widespread in:	1=Americas; 2= Africa; 3= Europe; 4= Asia; 5= Oceania
Q5	FGM is motivated by:	1= Culture; 2= Religion; 3= Social norms; 4= Other

c. Healthcare operators' approach.

The last table of questions (table 3) refers to the following research question: *"has the intervention had a positive impact on healthcare operators' approach with regard to FGM?"*. It is here important to specify that, due to the strong connection of this question to its second part concerning the establishment of an intercultural dialogue with immigrant women, the meaning attributed to the term "positive" will be properly explained later in the conclusive part of the paper. With regards to the indicator, this group is composed by four (Q1, Q2, Q4, Q5) particular "yes or no questions" which present a third option, namely "I do not know"; this answer has been conceived to let respondents express absence of opinion alias of interest towards a given issue. Two of these questions (Q1, Q2) have been formulated to expressly ask operators' point of view in terms of FGM training,

whether they consider important to get trained and to learn more about the practice. Of the same typology, I decided to include a question (Q5) to acquire some information concerning respondents' perception of the law 7/2006 effectiveness. Plus, a question (Q4) has been used to probe participants' stand with regards to the internationally discussed adoption of the term "mutilation"; here some space for further comments is provided, with the purpose of encouraging respondents to elaborate the answer. The remaining two questions have been formulated as sentences to be completed which entail the interviewees to express a judgment (Q3) on the practice and an opinion (Q6) on the possible results achieved by reporting cases of FGM to competent authorities.

Table 3. Questions about healthcare professionals' approach

APPROACH	Question	Measure
Q1	In your opinion, should healthcare workers be trained on FGM?	1= Yes; 2= No 3= I do not know
Q2	Would you like to participate to ad hoc courses to learn more about FGM?	1= Yes; 2= No; 3= I do not know
Q3	In your opinion, FGM is a practice to be:	1= Condemned; 2= Understood; 3= Supported; 4= Ignored
Q4	Do you believe that the term "mutilation" is appropriate to define those practices?	1= Yes; 2= No; 3= I do not know
Q5	Do you believe that, since the adoption of the above-mentioned law, in Italy the number of cases of FGM has decreased?	1= Yes; 2= No; 3= I do not know
Q6	"The possible evidence of FGM case performed in Italy entails the duty to report it to the competent authorities" (law 7/2006, art. 6). In this case, do you believe to report a case of FGM can lead to	1= Decrease the number of FGM cases; 2= Impede an intercultural dialogue between Italian government and those who perform FGM; 3= Increase the number of FGM cases performed illegally; 4= Protect immigrant women and their children

ETHICAL CONSIDERATIONS

In the course of conducting research, ethical issues might arise at a variety of stages. The individual who enters the researcher role should thus adhere to ethical principles in order to avoid the transgression of some of them, as for example causing harm to participants, lacking informed consent or invading privacy (Diener & Crandall, 1978). For this reason, during the recruitment process, I first of all send out to healthcare centers' directors a one-page project description via email; in this way, put on "electronic paper", the email recipients had a chance to carefully read the information, understand the research objectives and decide whether or not they wanted to participate (NESH, 2006). At a later stage, all the professionals who were asked to answer the questionnaire were informed again – this time orally – about the purpose and the content of it prior to filling it out. Furthermore, healthcare operators were asked to sign a consensus form demonstrating their intentions to voluntarily participate to the survey. According to the standard procedure, the study was notified to the Norwegian Centre for Research Data (NSD) and the data collection phase began only after having obtained approval. Moving back to interviewees, their participation was voluntary and personal details were treated anonymously, making it impossible to identify them through the answers provided (Kvale, 2007). Through questionnaire, information on socio-demographic variables (gender, profession, years of professional experience, etc.) were collected, therefore to ensure their anonymity I attributed fictitious identities (for example informant A, B, C, etc.) when presenting their quotes. Finally, participants were previously informed regarding the possibility of this study to be published.

RESULTS, DISCUSSION AND CONCLUSION

To evaluate the Italian conduct ten years after the adoption of the law 7/2006 and related guidelines, I firstly collected data by means of the above-presented questionnaire, then I entered and descriptively analysed it by using SPSS Statistics. Thanks to this instrument, I could quantify and transform the gathered information into tables and percentages, which will be later illustrated in the analysis chapter. Later, in the same chapter, the findings will be thematically analysed according to the above-illustrated three main categories – targeted training, knowledge in terms of FGM and healthcare professionals' approach – and linked to relevant theories. Finally, in the conclusive chapter the results will be summarized and used to answer to my research questions.

In conclusion, some of the methodological choices I could have made but did not deserve here to be mentioned. For instance, I could have adopted a qualitative method using semi-structured interviews. Probably, that strategy could have allowed me to investigate more in depth the Italian reality especially in revealing healthcare operators' attitude towards female genital mutilation through "elaborated" questions, which entail engagement of more time and concentration. On the other hand, due to the faced difficulties in recruiting participants for a 5 minutes-questionnaire, I believe that method could have arisen even more difficulties in including healthcare workers in the study. Therefore, I think the chosen method could be considered as more efficient in collecting relevant information to address my research questions, enabling me in any way to draw conclusions about my research topic.

With this chapter, my goal was to provide the reader with an overall overview of the research process, starting from the choice of the topic to conclude with a brief description of data analysis method. To avoid repetitions, I believe it is now time to discover *if* and *how* has it been possible to answer my research questions; it is thus now time to discover and analyse the collected information.

CHAPTER FIVE

"Analysis and findings"

INTRODUCTION

In this chapter, I will present and analyse the data collected from healthcare workers who participated to this survey. Firstly, I will provide some background information about my informants and the centres where I had the opportunity to submit my questionnaire. Later, the results of the survey will be thematically presented according to the three main areas of interest - healthcare operators' training, knowledge in terms of FGM and healthcare operators' approach - and described through percentages and tables. Finally, the findings will be analysed and discussed together with relevant theories.

SAMPLING DESCRIPTION

Before describing the sample, it is here important to illustrate the characteristics of the healthcare centres included in this survey.

HEALTHCARE CENTRES

As explained in the previous chapter, before starting the recruitment process first of all I identified and selected some of those centres satisfying my research criteria. At the beginning of that phase, my intention was to include three structures per region – three in Lombardy, three in Veneto, three in Emilia-Romagna - for a total of nine structures. Unfortunately, due to the insurmountable difficulties, I managed to obtain the participation of only two healthcare centres, the first located in Reggio Emilia, Emilia-Romagna, and the second in Verona, Veneto.

a. Centre X.

As the reader would notice, I intentionally made the centre's name anonymous. This choice was the consequence of a specific request: few days after the data collection in Emilia-Romagna, I received a communication on behalf of the centre's director who explicitly asked me to hide the identity of the structure. For this reason, I decided to label the latter with the letter "X" and to partially reveal its location (only the city). With regards

to the features, this centre is in Reggio Emilia and offers ad hoc services to immigrants, both regular and irregular, namely "health counselling for immigrant families" and "immigrant women room". Particularly, the team of professionals provides gynaecological examinations, meetings with obstetricians and special assistance during pregnancy for women, as well as medical care for their children.

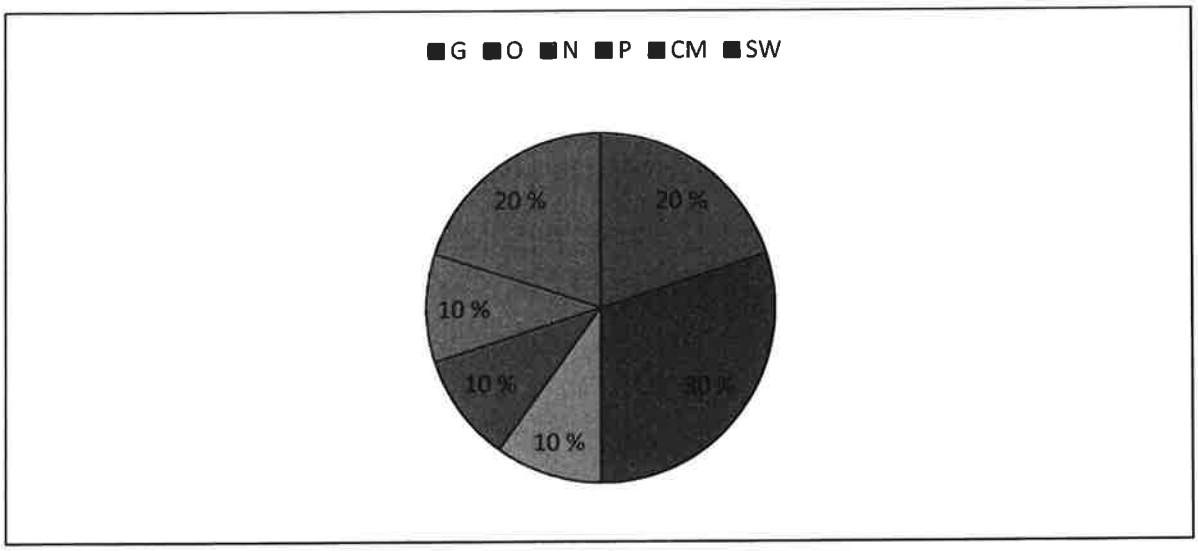
b. Centre ULSS 20.

The second centre is called ULSS 20 (to avoid confusion, due to the importance acquired from numbers in this chapter from now on I will substitute the centre's name with the expression "centre Y"). Centre Y is a structure located in Via Poloni 1, in Verona, where patients can go and benefit from the "immigrant women room" service. There, healthcare operators offer gynaecological and obstetrical consultations. In addition, social and psychological support is provided to those immigrant women experiencing particular difficulties and exclusion.

HEALTHCARE PROFESSIONALS

As illustrated in Figure 1, this study included 10 participants: 2 gynaecologists (G), 3 obstetricians (O), 1 nurse (N), 1 paediatrician (P), 1 cultural mediator (CW) and 2 social workers (SW).

Figure 3. Healthcare professionals included in the study



Five work in centre X and 5 in centre Y. Respectively, 1 gynaecologist, 2 obstetricians, 1 nurse and 1 paediatrician in the first structure; 1 gynaecologist, 1 obstetrician, 1 cultural mediator and 2 social workers in the second (Figure 2).

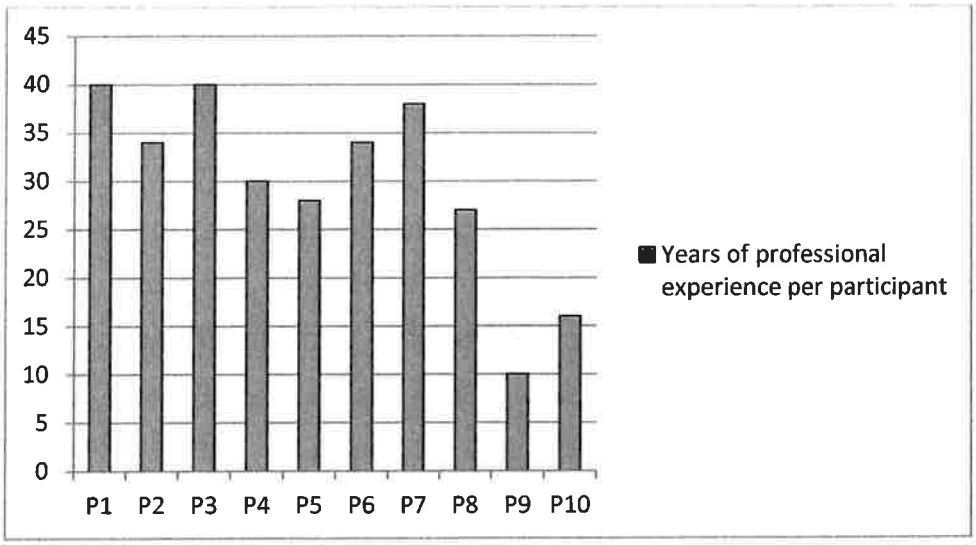
Table 4. Workers' distribution per occupation and centre

OCCUPATION/CENTRE	Centre X	Centre Y
Gynaecologist	1	1
Obstetrician	2	1
Nurse	1	0
Paediatrician	1	0
Cultural mediator	0	1
Social worker	0	2
Tot.	5	5

With regards to their sex, 80% of the sample is composed by women and 20% by men. Specifically, 2 men work at centre X, while centre Y is entirely composed of a female team of professionals.

As highlighted in the previous chapter, timing can be considered a variable for evaluation. Therefore, I asked my informants to indicate years of professional experience in order to be able to establish whether their participation to this survey would have been useful in evaluating the Italian intervention. From the questionnaire, it resulted that the minimum amount of years is 10, the maximum is 40, with an average of about 30 years of working experience per professional (Figure 3).

Figure 4. Participants' working experience



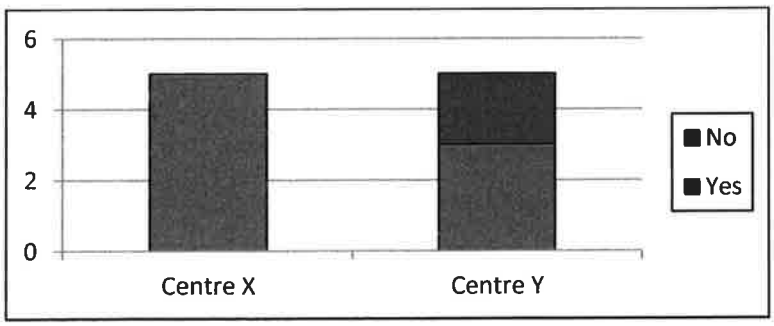
RESULTS

After having illustrated the sample characteristics, in this section the findings will be presented on the basis of the above-mentioned categorization.

TRAINING ON FGM

About educational activities, 90% of interviewees declared to have been trained on FGM during their working experience in healthcare centres. At centre X, all the healthcare operators specified having attended a course at their workplace, while at centre Y 2 workers did not (Figure 4).

Figure 5. Participants' answers to the question "Have you ever been trained on FGM at your workplace?"



Overall, more than half of participants (7/10) dealt with cases of FGM at workplace and the totality confirmed having heard about FGM there. In addition, the whole sample is aware that in Italy, since 2006, there is a law (law 7/2006) to fight the phenomenon.

KNOWLEDGE IN TERMS OF FGM

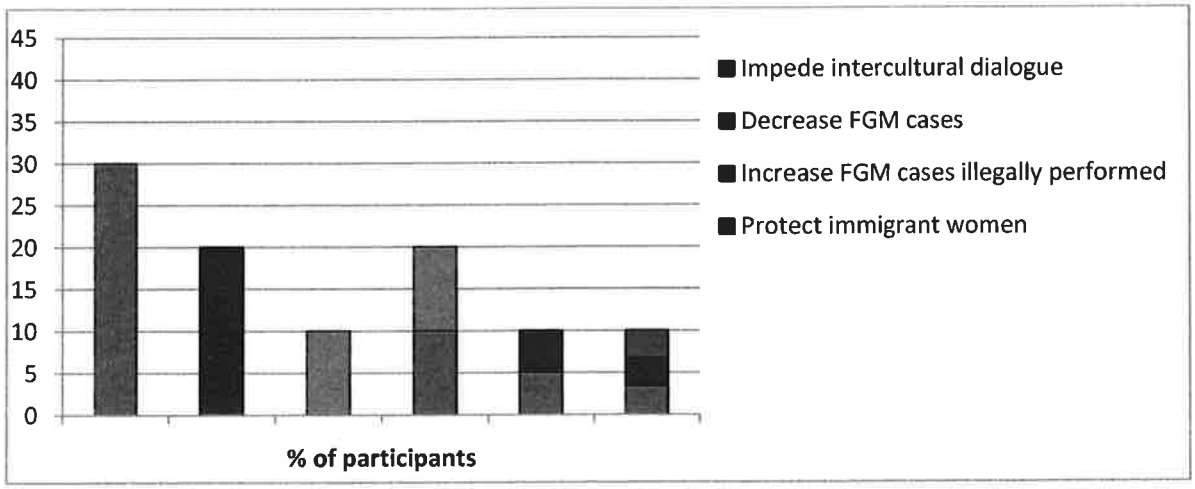
Concerning the knowledge of the practice, the totality of informants has heard about FGM in general terms. With regards to FGM differentiation, 90% recognized three main types of FGM – clitoridectomy, excision and infibulation – and 1 informant declared to ignore excision. About the age of performance, 20% sustained that FGM is practiced on new-borns, girls, adolescents and adults, 40% on new-borns and girls, 10% on girls and adolescents, and 30% only on girls. Shifting the focus to its geographical distribution, 7 participants out of 10 stated that FGM is widespread in Africa, 1 informant included Americas, another added Europe, Asia and Oceania, while only 1 chose all the options. Regarding the motivations behind FGM, all healthcare professionals stressed that the practice is motivated by culture and social habits, and among them 40% included also religion as relevant factor. The following table shows the percentages of correct answers per professional group to Q2, Q3, Q4, Q5 (see "FGM knowledge" questions in methodology chapter).

Table 5. Interviewees' correct answers

Professional group	n	Correct answers (%)
Gynaecologist	2	82
Obstetrician	3	73
Nurse	1	51
Paediatrician	1	68
Cultural mediator	1	68
Social worker	2	53

In terms of interest in female genital mutilation, 100% of interviewees believed that healthcare workers should be trained on this subject, but only 30% showed interest in participating to ad hoc courses to learn more about the practice. About personal perception of the latter, almost the totality (8/10) declared to consider FGM as a practice to be condemned, among them 3 informants thought that it also has to be understood, while 2 highlighted "understood" as the only option. Concerning the terminology, 6 participants out of 10 sustained that the term "mutilation" is appropriate to define the phenomenon, 3 interviewees stressed the opposite, while 1 ticked the option "I do not know". With regards to the efficiency of law 7/2006, 60% of healthcare professionals admitted to be unable to express an opinion, 20% thought that since 2006 in Italy the number of cases of FGM has decreased and 20% expressed that it has not. Finally, about the duty to report a case of FGM, 30% of participants believe that it could only lead to protect immigrant women and their children, 20% only to increase the number of FGM cases performed illegally, and 10% only to decrease the number of FGM cases. The remaining 40% includes 2 operators who chose both the protection and reduction option, 1 worker who stressed that to report could protect immigrant women but also increase the number of FGM cases performed illegally, and 1 informant who in addition selected the risk of impeding an intercultural dialogue between Italian government and those who perform female genital mutilation (Figure 6).

Figure 6. Differentiation of answers concerning duty to report FGM cases



After having illustrated the results, in the next section of the chapter the collected data will be analysed and discussed together with relevant theories.

DISCUSSION

Even though this survey was limited by its small sample, I believe it could provide some insight into the Italian situation with regards to female genital mutilation. Having said that, in the following pages I will thematically analyse the gathered information and discuss it referring to relevant literature.

TRAINING

As a starting point, this study aimed to verify whether Italian government - in compliance with law 2006/7 and the related guidelines - has provided training on FGM for those healthcare professionals working with immigrant women. According to the findings, the vast majority of participants received specific training, both during their professional experience in healthcare centres and in the selected structures, while an informant did not. Remarkable here it is the fact that the latter is the only interviewee who started working exactly ten years ago, namely when the FGM legislation was introduced. Therefore, this could demonstrate that the training received by the participants was not only prior to the law/guidelines, but also exclusively a healthcare centres' responsibility. In other words, the data revealed that, since 2006, not at all Italian institutions have fulfilled their obligations in terms of healthcare professionals' training.

KNOWLEDGE IN TERMS OF FGM

As Leye and colleagues state, "there are several factors that may hamper the provision of adequate clinical care for women with FGM, [...] including the unfamiliarity of health care professionals with FGM and their deficient knowledge" (Leye et al., 2006, p. 372). Despite the findings having shown a lack in educational activities over the last decade, overall it can be affirmed that healthcare workers included in this study possess a good knowledge in terms of female genital mutilation. However, concerning the practice's geographical prevalence, from the results it seems clear that the interviewees tend to conceive the phenomenon as still circumscribed to Africa. Although half of participants have directly dealt with FGM cases at their workplace, just 20% of informants chose also "Europe" as

valid answer, thus showing resistance in eradicating the conception of the practice inasmuch as far from Western contexts.

Shifting the attention to FGM differentiation, in addition to the three main typologies several informants suggested "symbolic incision of the clitoral hood" - namely medicalization - demonstrating to be up to date on FGM on-going debates. Furthermore, interesting is the choice of one of the interviewees to add "piercings" to the standard FGM categories. Recalling WHO's classification, since "pricking" of female genitalia falls under the label of "female genital mutilation", the participant's suggestion could easily arise a licit question: how can it be that piercing female genitalia – a practice on women's body that can freely be performed in Western countries– is condoned, and a clitoral incision, that is basically the same intervention, is considered as a form of mutilation to be banned?

Minor and maius?

Several scholars (for example Fusaschi, 2011; Johnsdotter & Essén, 2010) have addressed a similar issue, specifically with regards to female genital cosmetic surgery. Johnsdotter and Essén stress that if we disregard context and only focus on what is anatomically removed, the practices are for all intents and purposes comparable (Johnsdotter & Essén, 2010). In fact,

> *"Female genital cutting covers everything from the most extensive procedures, such as infibulation, to the mildest of only "pricking" the genitals to draw a drop of blood. Genital cosmetic surgery, on the other hand, may entail removal of labia, but also removal of clitoral tissue (in so-called "clitoris lifts")". (ibid.)*

Therefore, although both practices leave an irreversible mark on women's bodies, they are not treated with the same political and juridical approach: in practice, the prohibition against genital modifications in Western countries concerns only African groups, hence discriminating between European and African genitals (*ibid.*). Indeed, according to Fusaschi, the problem is to be found in the double standards used to evaluate the cases: on the one hand, female genital mutilation as a *minus,* a mere attempt on women's health which needs to be overcome; on the other hand, cosmetic genital surgery as a *maius*, a way for women to reach more well-being (Fusaschi, 2011 in Belli, 2014). As a result, such an evaluative discrepancy seems reflecting, still to this day, an idea of "African primitive

nature" in clear opposition with "Western modernity". Bringing into discussion the element of consent, at the same time it could be argued that female genital mutilation and genital cosmetic surgery cannot be compared, principally because the first is generally performed on infants and girls, while the second implies consenting adult women. FGM legislations worldwide is mainly aimed to protect children and their right to bodily integrity until they have reached an age where they may give consent (Johnsdotter & Essén, 2010), but at the same time, as above-mentioned, those laws risk to discriminate women for their ethnic background. If child protection is the major concern both in legal and medical field, it should be stated that a woman above a specific age may choose to have her genitalia modified: "that would protect children while placing adult women, of Western and non-Western origin alike, in the same category – that is, that they have the right to make decisions about their own bodies" (*ibid.*).

The subjectivity of the individuals involved is often underestimated when discussing female genital mutilation issues and even the terms we use to refer to the practice might influence it. For this reason, in the questionnaire a specific question regarding the terminology was included to investigate healthcare professionals' approach. In the next section, collected data related to the latter will be discussed, starting exactly from presenting to what extent terminology matters.

HEALTHCARE OPERATORS' APPROACH

In order to investigate healthcare professionals' attitude towards FGM, one of the questions was specifically conceived in relation to the expression "mutilation". Although more than half of participants expressed agreement in adopting this term, the information gathered from those who explained the reasons why it might not be appropriate deserves here to be mentioned.

Terminology matters!

Above some impressive numbers and brutal descriptions, in the majority of the existing research conducted worldwide none or very little attention is paid to the expression used to refer to FGM. Recalling WHO's definition, "female genital mutilation comprises all procedures involving partial or total removal of the external female genitalia or other injury to female genital organs whether for cultural or other non-therapeutic reasons" (WHO, 1997). Generally, the practice is depicted with the expression "female genital

mutilation", although this terminology has been subject of on-going debate because of its potentially offensive connotations. Initially, the international community referred to the phenomenon by using the term female "circumcision", which erroneously equated it to male circumcision. Due to the evident differences among the two practices - especially in terms of nature and health and sexual consequences - many activists objected proposing the expression "mutilation". In the 1990s, "female genital mutilation" was thus adopted firstly by the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) and later by the UN and its agencies. Particular attention must be here paid to this term: as stated in the WHO's document, "the word "mutilation" emphasizes the gravity of the act" (WHO, 2008), but it results clear that, even though "female genital mutilation" creates a linguistic distinction, it implies a strong negative connotation. In fact, the word itself profoundly confers a moralizing tone to the expression "FGM" that hastily concludes negative implications before an explanation is offered (Danial, 2013, in Belli, 2014). In an effort to become more culturally sensitive, UNICEF and UNFPA have used the term "cutting" or "FGC" in order to reflect the importance of using non-judgmental terminology with practicing communities (WHO, 2008, in *ibid*). Currently, UNICEF and UNFPA use a hybrid expression that is "female genital mutilation/cutting" or FGM/FGC, meant to highlight at the same time to what extent the practice is to be considered as a human rights' violation, but also the importance of approaching the issue in a less biased way (UNICEF, 2013). Even the European Institute for Gender Equality spends few lines to tackle the problem, however it firmly advocates the use of the term "female genital mutilation" to emphasize the violating nature of the procedures without further space for discussion (EIGE, 2015). On the other hand, the risk is that this terminology could result in being too negative and even offensive to the women involved. As Fusaschi affirms, "female genital mutilation" is basically an ethnocentric expression based on western criteria that, despite what was suggested by the IAC, is burdened with a heavily negative judgment, which entails the consideration of the "Other" as inferior (Fusaschi, 2003, p. 32) and consequently does not fulfil the necessary condition – the equality - for a positive dialogue (Parekh, 1996).

Having pinpointed this, the unsuitability of using the expression "mutilation" was expressed by several informants and from different points of view. For example, participant A. purely focused on the anatomical inaccuracy of that term, highlighting that

"not every practice produces mutilation effects."

On the other hand, interviewee B. was concerned with women's subjectivity and stressed that the expression "female genital mutilation"

"does not matches with the experience and the language proper of those African women I have met during my professional experience."

As a solution, participant C. proposed to adopt *"modification"* as less judgemental and more culturally sensitive term. Similarly, informant D. suggested the same expression pointing out its importance in terms of communication. He/she wrote

"to use "genital modifications" is more appropriate, the expression "mutilation" has a negative connotation which obstacles a dialogue with those women who practise FGM."

In other words, healthcare workers' suggestion could constitute a valid alternative, useful to create a "neutral" space in which trying to elaborate an intercultural comprehension path with the women involved (Fusaschi, 2003, p. 141).

Establishing intercultural dialogue

Recalling the discussion concerning female genital mutilation in multicultural contexts (see "FGM and multiculturalism" in chapter two), it has been shown that in every modern society including minorities, the latters' cultural practices can pose considerable challenges with the possibility of offending society's own values. To this regard, on the one hand the political theorist Parekh asserts that when a minority practice offends the society's operative public values, that specific cultural practice merits disapproval (Parekh, 1996, p. 261). However, on the other hand, he recommends dialogue inasmuch as essential tool to resolve these kind of deep moral and cultural disagreements (Parekh, 1996, p. 258). Being those minority practices embedded in specific ways of life, fundamental part of cultural identity, according to Parekh' principle of moral universalism, every society should enshrine these values and at the same time every society should have the right and the duty to disallow practices considered as offensive (Parekh, 1996, p. 254). To be able to decide what should be allowed and what should not, a given society should engage in an open-minded and morally serious dialogue with the minority and act on the resulting consensus, which may eventually involve compromises (Parekh, 1996, p. 255). Within this process of communication, Parekh highlights the necessity of all parties to recognize each other as equal participants (Parekh, 1996). With regard to female genital mutilation, unless immigrant women who practise it will be conceived as "subjects" and active protagonists

of change, the condition of equality will not be satisfied, thus jeopardising a positive dialogue to take place. In other words, this principle of "dialogical consensus" would first of all show respect for the minorities by including them in decisions affecting their interests, and secondly it would deepen mutual understanding while reaching a broadly acceptable decision (Parekh, 2006, p. 255). Moreover, such an intercultural interaction would lead the minority to explore what the cultural practice means to it and what place it occupies in its way of life (Parekh, 1996, p. 261), becoming an occasion to question, explain and understand. Concerning the latter, Starosta and Chen advise that, in order to reciprocally deepen understanding, a focus on mutual listening should constitute the core of intercultural dialogue (Chen & Starosta, 2005). Moreover, they stress that a process of intercultural listening should be characterized by openness, curiosity and empathy; without these elements, the whole procedure would not result fruitful (*ibid.*). Therefore, a "cultural-neutral" approach is needed. About it, Purdy and Manning explain that an unbiased approach entails firstly knowledge of our own culture, and subsequently some knowledge/experience of other cultures, or at least ability to be open-minded and consciousness that we have biases that could be set aside if we are aware of them (Purdy& Manning, 2015). Certainly, as they pinpoint, it is almost impossible to shed our culture. However, through dialogue and intercultural interactions we could become more aware, and listening to how culture is expressed could result in a strategy being more respectful of cultural differences (*ibid*).

To condemn?

To understand their personal stands, in the questionnaire I included a question regarding healthcare professionals' point of view on FGM. According to findings, almost the totality of interviewees declared to consider female genital mutilation as a practice to be mainly condemned. To "condemn" implies a legal procedure, therefore it is interesting the fact that with regards to the question concerning the efficiency of law 7/2006, more than half of participants admitted to be unable to express an opinion. This could reveal that, despite the intention of labelling such a phenomenon as a crime, serious uncertainty is shown towards the results of a law that prohibits it. As an evidence, because law 7/2006, art. 6, establishes that "the possible evidence of FGM case performed in Italy entails the duty to report it to the competent authorities", the answers given by healthcare workers are not unexpected: in fact, the number of interviewees who believed that this duty could decrease the number of FGM cases is inferior to those who thought it would increase the number of cases

performed illegally. In this regard, Basile questions the Italian *ad hoc* legislation and expresses perplexity in considering this legal instrument inasmuch as efficient contribution to FGM eradication (Basile, 2013). On the contrary, according to him, not only the FGM cases performed illegally have increased, but also those episodes where the practice is executed during vacation in the countries of origin (*ibid.*). Consequently, the risk is to strengthen bonds of complicity and conspiracy of silence among immigrants groups, with the inevitable consequence of limiting interactions with the Italian society and culture (*ibid.*). To conclude, it is also fundamental to not confuse female genital mutilation consequences with its goals. Indeed, establishing a specific crime could only result in a discriminatory measure: in this way, Italian legislation would impose its judgment, impeding situations of dialogue and mutual understanding to arise. In other words, it would lose its pedagogical function (Fusaschi, 2003), namely what should be its main feature which could concretely contribute to launch a change towards the abandonment of the practice.

In this chapter, the sample and the collected data have been presented and illustrated with percentages and tables. At a later stage, gathered information has been thematically analysed following the tri-partition characterizing the questionnaire. In light of this, in the next and last part of the paper I will make an attempt to answer to my research questions – which I had to re-formulate, as hypothesized in chapter four – and finally draw my conclusions. In addition, limitations and suggestions for further research will be pinpointed.

CONCLUSIONS

Over the past decades, migration fluxes worldwide have contributed to create "new" realities that are increasingly more varying and diverse. Together with cultural groups, certain cultural practices, implemented in Western contexts, have arisen remarkable challenges to multicultural societies. Particularly, female genital mutilation represents a challenge for healthcare systems and for professionals working within: women with FGM have in fact specific medical and psychological needs that doctors, nurses, social assistants, etc., without specific training, would not be able to manage. Furthermore, healthcare professionals' attitude towards the practice could be significant in establishing an intercultural dialogue with those immigrant women who still perform female genital mutilations. In this regard, in Italy an *ad hoc* law to prevent and prohibit this practice entails guidelines addressing the training of professionals working in healthcare setting. This study was set up to verify whether educational activities have been implemented by Italian institutions and how this intervention has affected workers' knowledge in terms of FGM and, consequently, their approach towards the latter. The main weakness of this research is that the questionnaire was given to only two healthcare centres, resulting in a small sample size. In fact, data presented and analysed in the previous chapter was collected through the participation of ten healthcare professionals. For this reason, they cannot be considered as representative sample: statistical significance cannot be attributed to collected data. However, I believe that the information gathered in this study could contribute to address the problem of female genital mutilation from a different point of view, so as to highlight the importance of training of healthcare operators' and their significant role in managing the issue.

Recalling the first of my research questions, in light of the results shown in the previous chapter, it is now time to try to explicitly answer it:

Since the adoption of the law 9 January 2006, n. 7 and the related guidelines, has the Italian government provided training of healthcare operators? **No, it seems not.**

On the basis of what explained above, to answer "no" after having analysed a small sample would be an hazard, therefore I think that "it seems not" is a more appropriate answer and

enough supported by collected data. Moving back to the latter, the findings indicate that healthcare operators have attended specific courses – probably independently organised by the directors of the centres included in the survey - at least ten years ago, namely before FGM legislation was adopted. Therefore, I argue that Italy has ignored its obligations. To support this affirmation, the need for training was believed to be imperative by the majority of interviewees, highlighting the necessity of providing adequate educational activities on the phenomenon.

Being the response to the first research question negative, I found that the data collected could anyway be useful in verify healthcare professionals' knowledge in terms of female genital mutilation. For this reason and aware of the fact that research questions might change during the investigation process (see chapter four), I re-formulated my questions and used gathered information to answer to the following interrogative:

Are healthcare operators familiar with the subject? **Yes, they are.**

As revealed by results, overall participants demonstrated to be familiar with FGM characteristics and motivations behind them. However, it must be verified whether their knowledge has been acquired by means of training or through direct experience with immigrant women. The majority of the interviewees indeed possess more than thirty years of professional experience, therefore one could assume that the credit for their FGM knowledge is not to be associated with institutional educational strategies. In any event, inasmuch as main workers in direct contact with immigrants, it can be affirmed that healthcare professionals' knowledge in terms of female genital mutilation can shape their approach towards the practice and, consequently, towards those individuals representing it. Therefore, to acknowledge and understand the phenomenon become basic conditions for a fruitful interaction, and FGM training a necessary requirement to establish intercultural dialogue with those who consider the practice as fundamental element in building their identity, whether ethnical, cultural or sexual. Undertaking such a process of communication implies being open-minded and being conscious that we have biases we need to dismantle. For this purpose, I believe that these abilities can be acquired by means of specific training, which can lead to adopt a "cultural-neutral" approach. A first step towards this direction could consist in *subjectivizing* immigrant women, namely considering them as active subjects and decision-makers, responsible and able to choose. Concerning female genital mutilation issues, it is undeniable that African women are

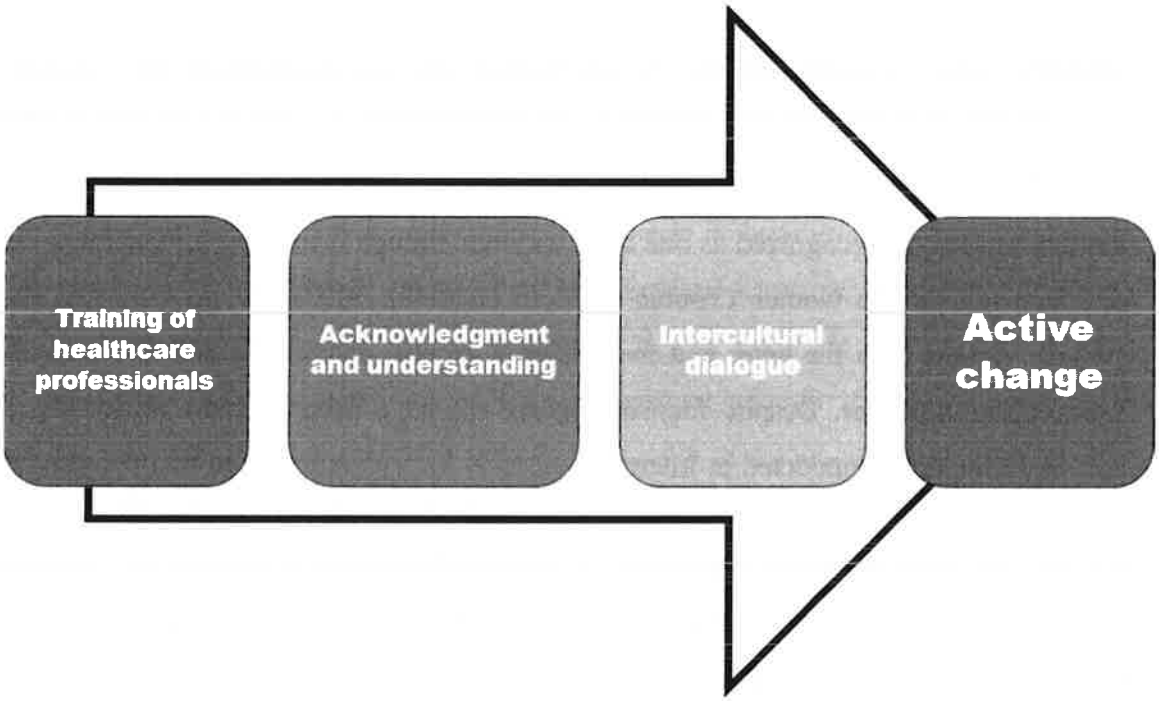
basically seen as victims per se. As Jhonsdotter and Essén point out, this has influenced legislation and policies in many Western countries, where those women are openly mirrored as passive "bearers of tradition", mere prisoners of rituals (Jhonsdotter & Essén, 2010). The imagine obtained is that of "sexually mutilated African women" or "Third World women", whose life is constrained both by their gender and by being "ignorant, poor, uneducated, tradition-bound, domestic, family-oriented, victimized, etc.,", in sharp contrast to Western women inasmuch as "educated, modern, having control over their own bodies and sexualities, and the freedom to make their own decisions" (Mohanty, 1991, in Gosselin, 2000). Unless equality in considering and conceptualizing the "Others" is achieved, this victimization will impede to those individuals we tend to conceive as passive "objects" to become "subjects" and activate a real change. Obviously, female genital mutilation must be recognized as one form, extreme though it may be, among many forms of social injustice to women (Toubia, 1995 in Gosselin, 2000), but governments should actively engage with the latter and their cultural groups, elaborating and driving specific interventions together. Despite focused legislations have been adopted worldwide, until now investigations conducted at international level have demonstrated that the number of FGM cases has not decreased. Consequently, I deduce that this rules' imposition from the top has not been effective. Therefore, I believe that what is needed is a bottom-up approach, which entails intercultural dialogue and inclusion of interested communities and their members, not anymore pre-judged or labelled as "victims and perpetrators", but finally seen as capable of facilitating meaningful change.

Furthermore, it is important to reflect on healthcare operators' role inasmuch as "bridges" in terms of communication. In fact, working in healthcare settings, it could be stressed that these professionals speak a "universal" language, which unites individuals independently of cultures and values: the language of healing people and their pains, concretely. Especially with regard to immigrants, men, women and children generally come from countries where medical care is not only hardly accessible to the vast majority of the population, but also often not guaranteed. For these reasons, healthcare operators could play a significant role in breaking barriers, firstly of communication and, as a consequence, culturally speaking. In order words, they could be seen as active agents of change.

To this end, I argue that the implementation of specific training for those professionals operating closely with immigrant women - in addition to provide them with adequate clinical care - could provide in depth-knowledge of their communities, their cultural values

and practices, raise awareness and promote a cultural-neutral attitude: namely, it could be used as an efficient tool to establish a positive intercultural dialogue (Figure 7).

Figure 7. Process throughout change



In light of what has been presented, the last research question deserves an answer:

Which kind of impact training of healthcare professionals could have on the establishment of an intercultural dialogue with immigrant women? ***A positive impact.***

LIMITATIONS AND SUGGESTIONS

At the end of my "research path", I can affirm that this study is an original work evaluating knowledge in terms of female genital mutilation among healthcare professionals working in Italian healthcare settings and the impact it can have on the establishment of an intercultural dialogue with immigrant women.

In this research, an evident limitation is to be found in the poor quality of information available at Italian level with regards to female genital mutilation. Particularly, Italian institutions seem having shirked their responsibilities revealing a lack in conducting and coordinating investigations, and consequently in collecting relevant information. To get a clearer and coherent image of the issue, further research is thus required. Mapping and identifying the true prevalence and distribution of female genital mutilation in Italy could help in addressing more comprehensive and targeted FGM training to healthcare operators working in the areas characterised by high prevalence of immigrants coming from those countries where the practice is still performed. Furthermore, another limitation has been faced during the recruitment process. As illustrated in the methodological chapter, originally my research plan was to include nine healthcare centres in the survey; in that way the study might have been characterized by a certain statistical relevance. Unfortunately, seven centres' directors out of ten showed considerable reluctance in participating to a five-minutes questionnaire survey: could this be perceived as reticence to reveal lack of FGM knowledge, thus constituting an evidence of institutional non-compliance with law 7/2006?

Certainly, this study cannot fill the gaps originated by Italian inefficient or inexistent investigations and/or policies. However, it could represent – within its limits – an evidence of the importance of implementing FGM training for healthcare professionals, and it may help in developing *ad hoc* strategies to establish intercultural dialogue, with the purpose of activating a positive change in multicultural societies which deal with female genital mutilation issues.

Finally, I would like to conclude this paper by stressing that I totally embrace my interviewees' suggestion to adopt the expression "modification" to refer to this sensitive topic. Inasmuch as little step towards a cultural-neutral approach, the term "modification" could help in pushing away judgments which, if "fuelled", could only lead to obtain another kind of mutilation, namely a "cultural" mutilation.

BIBLIOGRAPHY

AIDOS, information retrieved from the official website http://www.aidos.it/lang/en/pagine/index.php?idPagina=1.

Aldeeb Abu-Sahlieh, S.A. (1997). In *Sexual Mutilations: A Human Tragedy*, edited by Denniston G. C. and Fayre Milos M., Springer Science+Business Media New York.

ASSR & ISS, (2002). *Manuale metodologico, Come produrre, diffondere e aggiornare raccomandazioni per la pratica clinica.* Retrievable at: http://www.iss.it/binary/lgmr2/cont/Manuale_PNLG.1234439852.pdf.

Bartels, K. & Haaijer, I. (1992). *'s Lands wijs, 's lands eer? Vrouwenbesnijdenisen Somalische vrouwen in Nederland.* Centrum Gezondheidszorg Vluchtelingen , Rijswijk.

Basile, F. (2013). *Stato, Chiese e pluralismo confessionale*. Rivista telematica, n. 24, retrievable at www.statoechiese.it.

Beine, K. & Fullerton, J. & Palinkas, L. & Anders, B. (1995). *Conceptions of prenatal care among Somali women in San Diego*. Journal of Nurse-Midwifery, vol. 40, pp. 376 -381

Belli, E. (2014). *Universality vs. particularity: FGM and the Rwandese "Gukuna" practice*. Unpublished, Faculty of Humanities and Education, HBV, Drammen.

Boulware-Miller, K. (1985). *Female Circumcision: Challenges to the Practice as a Human Rights Violation*, Harvard Women's Law Journal, p. 155–177.

Bourdieu, P, (1990). *I riti come atti di istituzione*, in *Problemi del Socialismo*, n. 6, pp. 145-154.

Breitung, B. A. (1996). *Interpretation and Eradication: National and International Responses to Female Circumcision*, Emory International Law Review, p. 657–693.

Bryman, A. (2012).*Social Research Methods*. Fourth Edition, Oxford University Press, published by Oxford University Press Inc., New York

Bruce, J. (1790-92). *Voyage aux sources du Nil en Nubie et en Abyssinie, 1768-1772*, London.

Caroppo, E. & Almadori, A. & Giannuzzi, V. & Brogna, P. & Diodati, A. & Bria, P. (2014). *Health care for immigrant women in Italy: are we really ready? A survey on knowledge about female genital mutilation.* Ann. Ist. Super Sanità, Vol. 50, No. 1, pp. 49-53.

Chalmers, B. & Omer-Hashi, K. (2003). *Female genital mutilation and obstetric care.* Bloomington, Trafford Publishing.

Chen, G. M. & Starosta, W. J. (2005). *Foundations of Intercultural Communication.* Lanham, MD: University Press of America.

Danial, S. (2013). *Cultural Relativism vs. Universalism: Female Genital Mutilation, Pragmatic Remedies*, Prandium - The Journal of Historical Studies, Vol. 2, No. 1, pp. 1-10.

Dapper, O. (1970). *Description de l'Afrique*, Johnson Reprint Corporation, New York.

Delafosse, M. (1972). *Haut-Sénégal-Niger*, Maissoneuve et Larose, Paris, 3 vol.

Diderot, D. & d'Alembert, L. (1988). *Circoncision, Femme, Fibula*, in Encyclopédie raisonnè de Sciences, des Arts et des Métiers, Bad Cannstatt, Stuttgart.

Diener, E. & Crandall, R. (1978). *Ethics in Social and Behavioral Research.* University of Chicago Press, Chicago.

Du Bois, P. (1988). *Sowing the Body. Psychoanalysis and Ancient Representations of Women.* University of Chicago Press, Chicago.

EIGE, (2013) (a). *Study to map the current situation and trends of FGM,* Luxembourg: Publications Office of the European Union.

EIGE, (2013) (b). *La situazione attuale delle mutilazioni genitali femminili in Italia,* Available online at http://bookshop.europa.eu/it/la-situazione-attuale-delle-mutilazioni-genitali-femminili-in-in-italia-pbMH3112938/.

EIGE, (2015). *Estimation of girls at risk of female genital mutilation in the European Unio,.* Luxembourg: Publications Office of the European Union.

Erlich, M. (1986). *La femme blessée: essai sur les mutilations sexuelles féminines*, L'Harmattan, Paris.

Fauvelle-Aymar, F.-X. (2002). *L'invention du Hottentot. Histoire du regard occidental sur les Khoisan*, Publications de la Sorbonne, Paris.

Fusaschi, M. (2003). I segni sul corpo, Bollati Boringhieri, Torino.

Fusaschi, M. (2011). *Quando il corpo è delle altre*. Bollati Boringhieri.

Fusaschi, M. (2015). *Humanitarian Bodies: Gender, Moral Economy and Genitals Modifications in Italian Immigration Policy*. Cahiers d'Études africaines, LV (1), 217, pp. 11-28.

Gosselin, C. (2000). *Feminism, anthropology and the politics of excision in Mali: Global and local debates in a postcolonial world.* Anthropologica, 42(1), pp. 43-60. Retrieved from http://search.proquest.com/docview/214177924?accountid=43239.

Grassivaro Gallo, P. & Livio, M. (1991). *Italy faces problem of excision by African immigrants*. Win News, pp. 17-37.

Grassivaro Gallo, P. & Livio, M. & Viviani, F. (1995). *Survey on Italian obstetricians and gynaecologists: FGM in African immigrants* in *FGM: a Public Health Issue Also in Italy*. Unipress, Padova.

Grassivaro Gallo, P. & Sirad Salad Hassan, (1996). *Preliminary Report, FGM in evolutive age in Italy*. European Congres Europeen de Psychopatologie de l'Enfant et de l'Adolescent. Venezia.

Grassivaro Gallo, P. & Viviani, F. & Livio, M. & Corsaro, R. & De Cordova, F. & Fortunato, G. & Beccaccini, S. & Sirad Salad Hassan (1997). *Epidemiological surveys on FGM in Italy* in *Sexual Mutilations, a Human Tragedy*. Springer US, pp. 153-157.

Groh, A. (1999). *Manual for the new strategy against female genital mutilation.* IP, Berlin.

Gruenbaum, E. (2005). *Socio-cultural dynamics of female genital cutting: Research findings, gaps, and directions.* Culture, Health & Sexuality, 7:5, pp. 429-441, DOI: 10.1080/13691050500262953.

Héritier, F. (2002). *Masculin/Féminin II. Dessoudre la hiérarchie*, Odile Jacob, Paris.

Istituto Piepoli SpA, (2009). *Valutazione quantitativa e qualitativa del fenomeno delle mutilazioni genitali in Italia*, available online at the Ministry of Equal Opportunities:

http://www.pariopportunita.gov.it/images/stories/documenti_vari/UserFiles/Il_Dipartimento/report_mgf_piepoli.pdf.

Johnsdotter, S. & Essén, B. (2010). *Genitals and ethnicity: the politics of genital modifications*. Reproductive Health Matters, vol. 18, pp. 29-37.

Kvale, S. (2007*). Doing interviews.* London: SAGE.

Kymlicka, W. (1990). *Contemporary Political Philosophy: An Introduction.* Clarendon, Oxford, pp. 239 - 262.

Kymlicka, W. (1995). *Multicultural Citizenship: A Liberal Theory of Minority Rights.* Oxford University Press.

Leclerc, G.L. (1984). *Histoire naturelle*, J. Varlot, Gallimard, Paris.

Lefeufre-Déotte M., (1997). *L'Excision en process: un different culturel?.* L'Harmattan, Paris.

Leye, E. & Powell, R. A. & Nienhuis, G. & Claeys, P. & Temmerman, M. (2006). *Health Care in Europe for Women with Genital Mutilation.* Routledge, pp. 362-378.

Leye, E. & Sabbe, A. (2009). *Overview of legislation in Europe to address Female Genital Mutilation. Expert paper prepared for UN expert to address meeting Female Genital Mutilation*, International Centre for Reproductive Health, Ghent University, Belgium.

Ministero della Salute, (2006). *Linee guida destinate alle figure professionali sanitarie nonché ad altre figure professionali che operano con le comunità di immigrati provenienti da paesi dove sono effettuate le pratiche di mutilazione genitale femminile per realizzare una attività di prevenzione, assistenza e riabilitazione delle donne e delle bambine già sottoposte a tali pratiche* (Art. 4 – Legge n. 7 del 2006). Ministry of Health, Rome, Italy. Retrievable at: www.salute.gov.it/ imgs/C_17_pubblicazioni_769_allegato.pdf.

Ministry della Salute, (2007). Information retrievable from the ministerial archive at the following website: http://www.salute.gov.it/imgs/c_17_pubblicazioni_769_allegato.pdf.

Mohanty, C. T. (1991). *Under Western Eyes: Feminist Scholarship and Colonial Discourses*. Mohanty, A. Russo and L. Torres (eds.), Bloomington and Indianapolis: Indiana University Press, pp. 51-80.

Montaigne de, M. (2002). *Saggi*. F. Garavini, Adelphi, Milano (or. ed. *Essais* [1580], Gallimard, Paris, 1962).

Murphy, M. (2012). *Multiculturalism, a critical introduction*. Routledge contemporary political philosophy, London.

NESH, The National Committee for Research Ethics in the Social Sciences and the Humanities (2006). *Guidelines for research ethics in the social sciences, law and the humanities*. Oslo: The Norwegian National Research Ethics Committees.

Nienhuis, G. & Haaijer, I. *Ignorance of female circumcision may hamper adequate care.* Werkgroep Interculturele Verpeging, Intercultureel Verplegen. De Tijdstroo, Utrecht.

Obiora, L. A. (1997). *Bridges and barricades: Rethinking polemics and intransigence in the campaign against female circumcision.* Case Western Law Review 4, pp. 275-378.

Okin, SM. (1998). *Feminism and Multiculturalism: Some Tensions.* The University of Chicago Press, Ethics, Vol. 108, No. 4, pp. 661-684.

Okin, SM. (1999). *Is Multiculturalism Bad for Women?* Princeton University Press.

Paulme, D. (1952). *L'initiation des filles en Pays Kissi (Haute-Guinée)* in *Atti della II Conferencia internacional dos africanistos ocidentais em Bissau*, Ministério das Colonias, vol. 5, pp. 303-331.

Parlamento Italiano, (2006). Legge 9 gennaio 2006, n. 7, *Disposizioni concernenti la prevenzione e il divieto delle pratiche di mutilazione genitale femminile*. Gazzetta Ufficiale n. 14, January 2006. Retrievable at: http://www.camera.it/parlam/leggi/060071.htm.

Pearce, A. J. & Bewley, S. (2013). *Medicalization of female genital mutilation. Harm reduction or unethical?*

Parekh, B. (1996). *Minority Practices and Principles of Toleration.* International Migration Review, 30(1), pp. 251-284.

Polizia di Stato, (2006). *Verona: arrestata nigeriana per mutilazioni organi genitali.* Article retrievable at http://www.poliziadistato.it/articolo/13089Verona_arrestata_nigeriana_per_mutilazioni_organi_genitali/.

Purdy, M. & Manning, L. (2015). *Listening in the Multicultural Workplace: A Dialogue of Theory and Practice.* International Journal of Listening, 29(1), pp. 1-11.

Rausin, T. (1987). *Femme en cause: mutilations sexuelles des fillettes africaines en France aujourd'hui.* Centre Fédérale FEN, Paris.

Shell-Duncan, B. & Hernlund, Y. (2000). *Female "circumcision" in Africa: Culture, controversy and change*. Boulder, CO, Lynne Reinner Publishers.

Shell-Duncan, B. (2001). *"The medicalization of female ''circumcision'': harm reduction or promotion of a dangerous practice?"*. Social Science & Medicine 52, pp. 1013-1028.

Shell-Duncan, B. (2008). *From Health to Human Rights: Female genital cutting and the politics of intervention*, American Anthropologist, vol. 110, no. 2, pp. 225-236.

Sonnini de Mannoncour, C.S. (1798). *Voyage dans la Haute et Basse Egypte fait par l'ordre de l'ancien Gouvernement*, F. Buisson, Paris.

Surico, D. & Amadori, R. & Gastaldo, L. B. & Tinelli, R. & Surico, N. (2015). *Female genital cutting: A survey among healthcare professionals in Italy*. Journal of Obstetrics and Gynaecology, Informa UK, pp. 393-396.

Tauzin, A. (1988). *Excision et identité féminine: l'exemple mauritanien* in *Anthropologie et Société*, XII, n.1, pp. 29-37.

Thierfelder, C. & Tanner, M. & Kessler Bodiang, C.M. (2005). *Female genital mutilation in the context of migration: experience of African women with the Swiss health care system*. European Journal of Public Health, vol. 15, pp. 6-90.

Toubia, N. (1995). *Female Genital Mutilation: A Call for Global Action.* Rainbow and Women Ink. Turrittin, Jane, 2nd ed., New York.

Toubia, N., & Izette, S. (1998). *Female genital mutilation: An overview*. World Health Organization, online edition.

Turone, F. (2004). *Doctor proposes alternative to female genital mutilation.* British Medical Journal, pp. 247-328.

UN, (1979). *Convention on the Elimination of All Forms of Discrimination against Women,* (CEDAW).

UN, (1984). *Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment.*

UN, (1990). *Convention on the Rights of the Child.*

UNESCO, (1989). *Recommendation on the Safeguarding of Traditional Culture and Folklore.*

UNESCO, (2003). *Convention for the Safeguarding of the Intangible Cultural Heritage.* Retrievable at http://www.unesco.org/culture/ich/en/convention

UNICEF, (2013). *Female Genital Mutilation/Cutting: a statistical overview and exploration of the dynamics of change*, New York.

UNICEF, (2016). *FEMALE GENITAL MUTILATION/CUTTING: A GLOBAL CONCERN.* Brochure available at http://www.unicef.org/media/files/FGMC_2016_brochure_final_UNICEF_SPREAD(2).pdf.

Van Gennep, A. (1985). *I riti di passaggio*, Boringhieri, Torino.

Villeneuve, A. de (1937). *Etude sur une coutume somalie: les femmes cousues* in *Journal de la Société des Africanistes*, VII, n.1, pp. 15-32.

Virey, J.-J. (1800). *Histoire naturelle du genre humain*, F. Dufait, Paris.

Widmark, C. & Ahlberg, B. M. (2002). *A study of Swedish midwives' encounters with infibulated African women in Sweden.* Midwifery, vol. 18, pp. 113-125.

WHO, (1997). *Female Genital Mutilation, A joint WHO/UNICEF/UNFPA Statement.*

WHO, (2008). *Eliminating Female genital mutilation, an interagency statement.*

WHO, (2014). *Female genital mutilation,* fact sheet N°241, retrieved from http://www.who.int/mediacentre/factsheets/fs241/en/.

Yin, R. K. (2009). *Case Study Research: Design and methods.* Fourth Edition, Sage Publications.

Zaborowski, S. (1894). *De la circoncision des garçons et de l'excision des filles comme pratiques d'initiation* in *Bulletin de la Société d'Anthropologie de Paris*, IV s., vol. V.

University College of Southeast Norway

QUESTIONARIO

"Mutilazioni Genitali Femminili in Italia: operatori sanitari come agenti di cambiamento? Uno studio a dieci anni dall'adozione della legge n. 7 del 9 gennaio 2006"

Nome struttura _____

Indirizzo _____

_____

_____

Genere M ☐ F ☐

Nazionalità _____

Professione _____

Anni di esperienza lavorativa _____

Istruzioni

Leggere attentamente ogni domanda e barrare la lettera corrispondente alla risposta scelta.

N.B.: E' possibile scegliere più di una risposta per domanda. Se ha dubbi non esiti a chiedere chiarimenti. La sua partecipazione è estremamente preziosa, grazie mille per il suo contributo!

---

1. Ha mai sentito parlare di Mutilazioni Genitali Femminili (MGF)?

Sì

No

2. Che tipo di Mutilazioni Genitali Femminili conosce?

Clitoridectomia

Escissione

Infibulazione

Altro: per favore specificare _____

3. Le Mutilazioni Genitali Femminili sono praticate su

Neonate (0-12 mesi)

Bambine (età prepuberale)

Adolescenti

Adulte (22+)

4. Le Mutilazioni Genitali Femminili sono diffuse in

Americhe
Africa
Europa
Asia
Oceania

5. Sapeva che in Italia, dal 2006, esiste una legge (Legge 9 gennaio 2006, n. 7) per combattere le Mutilazioni Genitali Femminili?

Sì
No

6. Nel suo luogo di lavoro, ha mai sentito parlare di Mutilazioni Genitali Femminili?

a) Sì
b) No

7. Ha mai avuto a che fare con casi di Mutilazioni Genitali Femminili nel suo luogo di lavoro?

Sì
No

8. Nel suo luogo di lavoro, ha mai preso parte a corsi di formazione riguardo le Mutilazioni Genitali Femminili?

a) Sì
b) No

9. Nella sua esperienza lavorativa in strutture come quella in cui lavora, ha mai partecipato a corsi di formazione riguardo le Mutilazioni Genitali Femminili?

a) Sì
b) No

10. Secondo lei, chi svolge una professione come la sua dovrebbe essere formato nel luogo di lavoro riguardo le Mutilazioni Genitali Femminili?

a) Sì
b) No
c) Non lo so

11. Sareste interessato/a a prendere parte a corsi di formazione nel centro dove lavora per saperne di più sulle Mutilazioni Genitali Femminili?

a) Sì
b) No
c) Non lo so

12. Ritiene che le Mutilazioni Genitali Femminili siano motivate da

a) Cultura
b) Religione
c) Convenzioni sociali
d) Altro: per favore specificare _____

13. Secondo lei, le Mutilazioni Genitali Femminili sono pratiche da

a) Condannare
b) Comprendere
c) Sostenere
d) Ignorare

14. Crede che l'espressione "*mutilazione*" sia adatta a definire tali pratiche?

a) Non lo so
b) Sì
c) No

- Se ha scelto "no", spieghi perché "mutilazione" non è l'espressione adatta:

_____
_____
_____
_____

15. Pensa che in Italia, dall'entrata in vigore della legge succitata, i casi di Mutilazioni Genitali Femminili siano diminuiti?

a) Sì
b) No
c) Non lo so

16. *"L'eventuale riscontro di una MGF avvenuta durante la permanenza in Italia comporta l'obbligo di denuncia alle Autorità competenti" (Legge 9 gennaio 2006, n. 7, art. 6).* In questo caso pensa che denunciare possa portare a

a) Ridurre il numero di casi di MGF
b) Ostacolare un dialogo interculturale tra l'Italia e chi pratica le MGF
c) Incrementare il numero di casi di MGF praticate in clandestinità
d) Proteggere le donne immigrate e le loro figlie

HSN University College of Southeast Norway

Dichiarazione di consenso per l'acquisizione dei dati forniti al progetto

Può partecipare al progetto volontariamente e decidere di ritirarsi in qualsiasi momento e senza dover fornire alcuna spiegazione. Se decide di ritirarsi, ogni dato da lei fornito verrà eliminato.

N.B.: La sua partecipazione non avrà alcuna ripercussione sul suo lavoro e sui rapporti con pazienti, colleghi, direttori, ecc. Ricordi: è libero di ritirarsi quando vuole e durante qualsiasi fase del progetto.

Se è interessato/a a partecipare o se ha domande o curiosità riguardo il progetto non esiti a contattare: **Emma Belli**, tel. **320 11 80 316**, email: emmabelliemma@gmail.com.

Questo progetto di ricerca è stato notificato al Data Protection Official for Research, NSD - Norwegian Centre for Research Data (Centro norvegese per ricerca dati).

Dichiaro di aver letto le informazioni riguardo il progetto di ricerca "Mutilazioni Genitali Femminili in Italia: operatori sanitati come agenti di cambiamento? Uno studio a dieci anni dall'entrata in vigore della legge n. 7 del 9 gennaio 2006" e desidero partecipare.

(Firma e data)