UNICAMILLUS

UniCamillus Global Health Journal

no. 4 | issue 1 | pages 84 | June 2023

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Editor-in-Chief: Gian Stefano Spoto
Scientific Editors: Alessandro Boccanelli and Laura Elena Pacifici Noja
Registration no.: 103/2021, Ordinary Court of Rome
2 issues per year
ISSN print: 2785-3713
ISBN print: 978-88-9295-749-7
ISSN open access: 2785-4329
ISBN open access: 978-88-9295-750-3
Contributors: Luca Bello, Francesco Cattaneo, Giancarlo Ceccarelli, Massimo Ciccozzi, Monica D'Amato, Valentina De Biasio, Oritseweyinmi Erikowa-Orighoye, Anita Fortunato, Francesco Marchetti, Massimo Papa, Andrea Pettini, Gian Stefano Spoto, Maria Angela Wangui Maina.
No. 4 | issue 1 | June 2023
First edition June 2023

tab edizioni

© 2023 Gruppo editoriale Tab s.r.l.
viale Manzoni 24/c
00185 Roma
www.tabedizioni.it

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UniCamillus Global Health Journal

UGHJ

edited by Alessandro Boccanelli
and Laura Elena Pacifici Noja

no. 4 | issue 1 | June 2023

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The Law that No One Reads

by Gian Stefano Spoto*

UGHJ is a sense of reality. The multilingual platform serves to make the concepts exposed part of everyone's daily life, to combine science and society with the greatest possible concreteness.

The recent conference on female genital mutilation, with the contributions that follow, is a search for solutions, in the awareness of the immense difficulty of opposing centuries-old traditions and tribal intrigues. These often escape façade laws, promulgated by virtue of their form and diplomatic flair, but meant to be ignored. One instance is the law applied in Sudan, which condemns to three years of imprisonment those who practice female circumcision.

On this immense theme, the Islamist Massimo Papa explains what can be attempted and what cannot even be imagined, navigating between law and religion. He ultimately demonstrates the extreme difficulty of extending to all countries the *ubi societas*, *ubi jus* principle, a fundamental one for us. Even more difficult it is to attempt to apply this principle. Infibulation is then seen as a social scourge, but also as a serious health problem, which claims several victims whose numbers are impossible to calculate, mainly due to the code of silence that permeates these practices.

When UGHJ was born, the primary idea was to face and analyze the obstacles that hinder the right to health in the world. This would be possible not only by dealing with health policies, but above all by trying to understand, from time to time, which tools, with the aid of technology, could make up for dramatic shortages.

Nigeria can be taken as an example of a country which is certainly not among the last ones on the African continent, and where 82% of the rural population is excluded from health services. This gives an idea of a situation in which the few operators that are present tend to move to urban centers or emigrate to countries where the work is less tiring, better organized and above all well paid. This generates a health workforce of less than two units per thousand inhabitants, a fact aggravated by strong inequalities in the distribution on the territory.

Brain drain is the result of all this. We see it happening in Nigeria, but also in Ghana and Zimbabwe, just to give two

* Editor-in-chief UGHJ.

DOI: 10.36158/97888929575031

examples. In addition to this, there is a scarcity of economic resources: despite the increase in Western aid, an African country rarely manages to spend 15% of public spending on health care.

Stateless people in the world are another issue not sufficiently addressed: how many there are, how they live and who takes care of them. This fact opens the analysis of other problems, obviously not only of stateless persons. This analysis, indeed, revolves around the mirage of universal health coverage: WHO estimates predict, among other things, a deficit of eighteen million health workers, especially in countries with low-middle income.

Social networks have on occasion the merit of spreading sometimes semi-unknown situations by making them public domain. This would indeed be commendable if the news weren't often taken to extremes, manipulated, enslaved to preconceived theses. Our journal is exactly the opposite: it is intended for those who want to contribute, in any area and measure, to the solution of problems, even if in this magnum sea the term solution already appears dreamlike.

UGHJ's dream is instead a network in which words are always followed by actions.

GLOBAL HEALTH, SYNDEMY AND FEMALE GENITAL MUTILATION

Health meets human rights

Friday, 31st March 2023
h 09 am - 5 pm
UniLabs - Aula Magna and Aula Blu
UniCamillus, Via di Sant'Alessandro 30 - Roma

08.30 - 09.00
PARTICIPANTS' REGISTRATION

09.00 - 09.20
OFFICIAL GREETINGS
Gianni Profita, Rector UniCamillus

FIRST SESSION
Moderator: Massimo Papa

9.20 - 9.40 Oreste Foppiani
MGF: a geopolitical overview of the phenomenon

9.40 - 10.00 Emanuele Caroppo
Mental health as a public asset. Strategies and interventions for protection and implementation

10.00 - 10.20 Giancarlo Ceccarelli
Female Genital Mutilation and Migrants

10.20 - 10.40 Laura E. Pacifici Noja
MGF: ethics and scenarios

10.40 - 11.00 DEBATE

11.00 - 11.20 COFFEE BREAK

SECOND SESSION
Moderator: Alessandro Boccanelli

11.20-11.40 Viola Liberale
The importance of screening. FGM related diseases

11.40-12.00 Anita Fortunato
Reproductive health of the patient in presence of FGM (contraceptive methods, sexuality, diagnostic investigations in pregnancy and the path of accompaniment to childbirth). Focus on: the infibulated patient

12.00-12.20 Luca Bello
The approach to the surgical patient. Different FGM and possible reconstruction. The experience of dedicated clinics

12.20 - 12.40 Marco Trombetti
Technology to help human rights

12.40 - 13.00 DEBATE

13.00 - 14.30 LUNCH

GLOBAL HEALTH, SYNDEMY AND FEMALE GENITAL MUTILATION

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THIRD SESSION
Moderator: Gian Stefano Spoto

14.30 - 14.50 Ugo G. Pacifici Noja
International legislation and the transposition of the Italian legal system

14.50 - 15.10 Valentina De Biasio
The coroner's point of view

15.10 - 15.30 Mario Di Giulio
The protection of women between human rights and constitutional freedoms

15.30 - 15.50 Andrea Pettini
The future: projects and opportunities

15.50- 16.30 Interactive Debate

16.30-17.00 ECM Survey

The event will be simultaneously subtitled in English

Global health and female genital mutilation (FGM) represent a complex and articulated matter with which the healthcare workers, also following the recent migration flows, will have to confront more and more in the next few years.

A conference discussing Global Health together with the drama of FGM testify two dramatic injustices that are encountered where there is the absence of a real right to health, both personal and of the community.

The term FGM refers to all procedures that include partial or total removal of the female genitalia for cultural, religious or other non-therapeutic reasons.

The phenomenon of female genital mutilation, although illegal, does not stop: the estimate of women who have undergone genital mutilation in Europe is 500 thousand.
The FGM is a problem that also affects migrant girls and young women who live in our territory, often at the risk of being to mutilation procedures when they return to their country of origin for visiting relatives.

The conference brings to the attention of the participants the main clinical information on FGM, providing healthcare professionals the tools to deal with a type of patient who needs innovative therapies, psychophysical rehabilitation, and of legal and social protection.

Surgical Repair of FGM

by Luca Bello*

Abstract
The current WHO classification [1] divides FGM into four different types: type I which refers to the removal of the glans of the clitoris and/or the prepuce, type II which refers to the resection of the labia minora and/or glans clitoris with or without resection of the labia majora. Type III refers to infibulation and type IV refers to all other harmful procedures such as punctures, piercings, incisions, scrapings, and cauterizations. type III is further subdivided by WHO into type IIIa (removal and repositioning of the labia minora) and type IIIb (removal and repositioning of the labia majora). However, within this subdivision it is not mentioned whether the clitoris (the glans) has been damaged or left intact. Therefore, although this classification already offers a basis, a further subdivision of type III mutilations would be interesting. This would include information on the integrity of the glans of the clitoris and clitoris, to offer women who undergo defibulation a complete diagnostic overview and the best therapeutic choice to restore the functionality and aesthetics of one's genitals.

Keywords
Clitoral reconstruction, female genital cutting, female genital mutilation, female genital mutilation/cutting, FGM/C, female genital surgery.

1. FGM Type III – "Infibulation"

This type of mutilation involves the possible partial or total excision of the external genitalia with suture of the bloody flaps of the labia majora or minora. A consequence of this is that the vulvar vestibule is covered by a scar that hides both the urethral outlet and the vaginal ostium, often reduced to a small hole of a few millimeters for the emission of urine and menstrual flow [2]. Through the defibulation surgery, performed using the laser or, more frequently, scalpel or scissors [3], the scar is opened and the vulvar vestibule, vaginal orifice and urethral meatus are exposed externally together with the possible re-exposure of the clitoris. Subsequently, it is also possible to partially "reconstruct" the labia majora and minora. Deinfibulation is therefore indicated to reduce

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dyspareunia, increase sexual function (facilitating penetration during sexual intercourse), allow normal urination and a physiological outflow of menstrual blood, decrease obstetric risks and the incidence of caesarean sections, episiotomies and lacerations of the perineum. This operation also allows performing medical and surgical procedures (gynecological examinations, monitoring, urinary catheterization, cervical cancer screening, transvaginal ultrasonography, routine gynecological surgery). The operation is anticipated and followed by appropriate counseling with the patient (and possibly with her partner) [2], to whom recommendations for complete psychosexual and physical rehabilitation are exposed, as well as the enunciation of the national regulations in force on the matter of FGM. This last step is an essential moment of dialogue, crucial in laying the foundations for what, potentially, could prove to be solid prevention for future generations.

In countries where FGM is widespread, the request for defibulation is made mainly for two reasons: after marriage, to allow women to have sexual intercourse and, at the time of delivery, to allow birth. In the first case, it is required that the practice be carried out either by the groom, or by a member of the female family, using a blade or a knife. In some communities, the husband is expected to open the vulva of the newlywed through repeated attempts at penetration. After childbirth, however, a new infibulation is often requested, with the aim of closing the vaginal orifice again: the flaps are sewn together again to recreate a small opening, often the same as the one that existed before the wedding. The Royal College of Obstetricians and Gynecologists (RCOG) and the Society of Obstetricians and Gynecologists (SOCG) recommend that physicians offer defibulation to women living with FGM type III while declining requests for reinfibulation.

Defibulation can be performed at any time in the patient's life, during pregnancy (preferably in the second trimester), during delivery or during a cesarean section [4]. The most recent systematic reviews do not show significant differences in outcome between defibulation performed before delivery and those performed during [6]. Therefore, given the lack of evidence, it is recommended that healthcare professionals evaluate the timing of the intervention based on the local possibility of access to healthcare facilities and the patient's choice of when to perform defibulation.

When the operation is performed during pregnancy, it is recommended to perform defibulation in the second trimester, as there is a higher risk of miscarriage in the first trimester and the patient/family may blame the operation for this event [4].

As far as intra-partum deinfibulation is concerned, the opening of the infibulation is indicated in the first phase of delivery for more effective monitoring and simpler insertion of the bladder catheter.

In order to correctly choose when to perform defibulation, the woman must be fully informed on the benefits of this operation. Difficult urination, recurrent genitourinary infections, the impossibility of having sexual intercourse during pregnancy, are problems that are alleviated if deinfibulation is practiced before delivery, and patients should be informed about this [7].

The collection of patient anamnesis should contain in-

formation regarding the type of mutilation suffered and any related physical and/or psychological complications. Urinary, gynecological, and psychosexual symptoms should be investigated through clear, non-stigmatizing, respectful, and culture-sensitive questions. Not all women are aware of having suffered a mutilation and the consequences it implies. Some girls are unaware of the connection between the symptoms they experience and female circumcision, indeed, some conditions are considered positively. Some ethnic groups, for example, consider obstruction and slow urination to be normal, quiet and feminine, whereas fast urination is loud, gross and masculine.

In some areas, infibulation is practiced after childbirth or after rape to restore the anatomy of a "virgin" woman, in order to avoid social exclusion and preserve the possibility of finding a husband. Experiences, meanings and memories regarding FGM vary considerably and health professionals need to be aware of these differences, so as to avoid generalizing and offer treatment as personalized as possible. Some women have suffered FGM from a very young age, so much so that they do not remember or do not know that they have been mutilated; others were operated in a hospital setting, and did not experience severe pain. Others consider these practices as normal, usual and as rites that serve to make them beautiful, pure and marryable. Some, in contrast, recall a sense of betrayal, fear and pain associated with these rituals, so much so that they can develop depression, anxiety and post-traumatic stress disorder.

Many of the women subjected to FGM experience other traumatic events, such as rape, forced marriage, war and violence during periods of migration. When defibulation surgery is proposed, the healthcare professional should be aware that operative and post-operative pain could lead to the memory of past traumatic events. This is why current guidelines recommend psychological support for patients about to undergo surgical treatment for FGM.

The pre-operative briefing is essential to describe the defibulation surgery and the post-operative follow-up, but also to welcome the expectations, fears and doubts of the patient and her partner. Deinfibulation represents an important cultural, anatomical, physiological and body image change. For this reason it may happen that the woman needs to reflect before accepting the operation.

To carry out a complete briefing it is necessary to:

- Give information on the anatomy and physiology before and after the operation:
- Ask about any beliefs about FGM and any fears/doubts about defibulation.
- Debunk false cultural myths.
- Give information on the concept of "virginity": explain that defibulation does not affect "virginity".
- Explain that defibulation does not widen the vaginal orifice, but only eliminates the scar that covers it, which is the cause of incorrect hygiene due to stagnation of urine and menstrual blood.
- Explain that urine and menstrual blood come out of two different orifices.
- Use understandable drawings and explanations.
- Inform about the physiological color of the vaginal mucosa, which will be clearly visible after defibulation,

since the pink of the mucosa contrasts with the dark color of the skin.

- Inform about the increased speed of urine and menstrual flow after defibulation.
- Explain the anatomy and function of the clitoris before and after defibulation surgery.
- Give information about the procedure.
- Explain the indications and benefits of defibulation.
- Give details of the surgical procedure, follow-up and possible complications.
- Inform the patient on how to perform local hygiene, which painkillers to take, how to avoid spontaneous adhesion of the lips, which post-operative checks she will have to perform, on the presence of sutures/absorbable stitches, how long it is necessary to abstain from sexual activity before full recovery.
- Give information regarding anesthesia, after discussion with the anesthetist.
- Reassure that the intra- and post-operative pain of defibulation is not as severe as that experienced for infibulation.
- During pregnancy, discuss the appropriate time to perform the surgery.
- Give the patient the opportunity to choose whether to perform the operation during pregnancy or during childbirth.
- Give time for reflection before the operation.
- Deliver informed consent.
- Have the informed consent signed.

In case of language barriers, it is necessary to contact an interpreter or a cultural mediator who ensures effective communication and understanding of the information. For cultural reasons, some girls/women may refuse to have an interpreter. The solution is to choose an interpreter selected by the patient or to use alternative means of translation (telephone).

If the girl requests it, her partner or other family members can participate in the debriefing.

Communication between healthcare professionals and women represents a central point for the success of psychophysical rehabilitation: it is important that the woman does not have a traumatic experience of the new reality, and that this does not appear completely different to her, even with respect to the perceptive acquisitions of the past. For these reasons, the explanation of how the vulva will appear post-operatively, how the excretion of urine will vary in terms of jet and sound, of the new sexuality that it will be about to experience, is of fundamental importance. It may be useful to use multimedia databases on the physiological structure of the vulva such as, for example, The Labia Library (www.labialbrary.org.au). Furthermore, always with a view to making the change process as smooth as possible and without difficulties, the support and involvement of the partner plays a primary role.

As already analyzed previously, FGM is accompanied by obstetric risks such as the increased incidence of caesarean sections, post-partum haemorrhages and the use of episiotomies.

A systematic review conducted in 2017 [6] demonstrated that deinfibulation is associated with a reduction in the likelihood of cesarean delivery and post-partum hemorrhage. Compared with uncut women, women who underwent defibulation did not increase the likelihood of prolonged labor, genital tract tears, bleeding, lower Apgar scores, or longer

maternal hospitalization. Taken together, these results highlight the potential benefits of defibulation surgery.

As far as the choice of the best moment to proceed with defibulation in pregnant women is concerned, the literature presents some critical issues in giving an unambiguous answer and, consequently, precise indications. The intervention can take place in the pre-conceptional period, ante-partum or intra-partum.

A literature review aimed at seeking the best indications regarding the timing of deinfibulation concluded that there is currently no evidence of a difference between ante-partum and intra-partum deinfibulation. However, although the results do not show statistically significant differences, if the ante-partum infibulation were performed, the woman would be given the necessary time to heal before giving birth, getting used to her new body image. When the surgery is done during labor, it is usually in the second stage (when the baby's head is moving down the birth canal). The decision regarding the need for a mediolateral episiotomy must be considered after the removal of the adhesions: it is practiced with a view to reducing tension on a tissue with a decidedly reduced degree of distension given the extension of the cicatricial process. For these reasons, sometimes bilateral episiotomies are necessary, proceeding with the foresight to avoid cuts in the midline which could give rise to or worsen pathologies (perhaps already chronicled) such as incontinence or the onset of fistulas due to anorectal trauma. In some cases, defibulation may be necessary in the first stage of labour, or to allow the induction of labor and, in this case, it can be performed with local anesthesia.

However, there are critical factors to be taken into consideration when deciding the timing of the intervention.

1. Woman's Preference: Women should be consulted about their preferences. For example, if a woman places great importance on post-operative cosmetic results, ante-partum deinfibulation should be preferred to allow for adequate healing time and optimal cosmetic results.
2. Access to health facilities: in contexts where women may encounter involuntary delays while reaching healthcare facilities due to difficult access (e.g. in contexts wherethey are alone, without relatives who can accompany them or keep the other children, and in case of barrier linguistic), it should be the ante-partum deinfibulation.
3. Place of birth: given that the intervention must be carried out by a qualified healthcare professional, in contexts where home births are frequent, ante-partum defibulation must be preferred. The same is true for contexts where the healthcare facility has a high patient load and understaffing.
4. Healthcare professional skill level: Anatomical conditions such as tissue edema and sprain during labor can create challenges for inexperienced professionals performing intra-partum de-infibulation. In this case, ante-partum defibulation should be preferred. In environments with experienced and well-trained professionals, intra-partum defibulation may be considered an acceptable procedure.

2. Surgical Techniques

Deinfibulation is the surgical intervention that can be

proposed to women suffering from type III genital mutilation (infibulation).

Type III mutilations vary according to the type of vulvar damage, whether there is excision of the clitoris, apposition of the labia minora (IIIa) and/or labia majora (IIIb). The infibulation scar can be more or less adherent to the deeper tissues: it is therefore useful to inspect and palpate the wound. The clitoris or what remains of it may be more or less visible. Depending on the size of the orifice, a probe or finger is inserted below the scar to evaluate the underlying tissue for adhesions. If the width of the vaginal orifice allows it or if sexual intercourse with vaginal penetration has been carried out, it is possible to carry out the examination with the speculum.[3] The patient's medical record should contain all clinical findings together with a photo of the external genitalia (subject to the patient's consent).

WHO guidelines recommend applying anesthesia during defibulation. It is practiced under local, regional or general anesthesia, depending on the place where it is performed, the resources available and the choice of the woman and the surgeon. In the case of local anesthesia, 1 to 2 ml of 1% lidocaine is injected along the incision scar, a thick layer of 2.5% lidocaine or 2.5% prilocaine cream is applied to the same area by 1 to 5 hours before the injection. General anesthesia is delivered via laryngeal mask.

Deinfibulation can be performed on an outpatient basis with local anesthesia or in day surgery with spinal or general anesthesia.

A complete recovery is obtained in 3-4 weeks, it is therefore necessary to abstain from sexual intercourse during that period. Possible postoperative complications may be minimal bleeding and injury to the urethra and clitoris, infection of the surgical wound, spontaneous adhesion of the labia (especially in the upper part of the surgical incision), and urinary infections. Spontaneous adhesion of the lips generally occurs in the first 7-10 days after the operation. It is therefore necessary to inform the patient on how to perform local hygiene of the vulva and lips (at least 3 times a day) to avoid adhesion. In case of spontaneous adhesion of the lips from the seventh postoperative day, it is necessary to remove the adhesion by applying local anesthesia with the application of a cream based on lidocaine 2.5% and prilocaine 2.5%, or by injection of 1% lidocaine. Prescribe pain relievers (e.g. paracetamol and ibuprofen) if needed. Good hydration and urinating under a stream of water can relieve the burning sensation caused by passing urine over the wound.

Post-operative follow-up visits must be scheduled, one week and one month after surgery, to examine the state of the vulva and discuss the physiological changes (e.g. urination) and the sensations experienced. In intra-partum defibulation, some complications may occur for obstetric reasons and not for the operation itself; these differences should be explained to the patient. Incontinence and other pelvic floor complications must be treated appropriately. The pain also reduces the risk of caesarean sections.

3. Complications

According to recent systematic reviews, women undergoing defibulation experienced minor symptoms, such as wound infections, urinary tract infections, and spontaneous lip adhesions.[9] Other complications may include lesions of

the urethra or residual clitoris, irregularities of the labia after surgery and lesions of the fetal head if the surgery is performed during labor.

If defibulation is performed under local anesthesia, some women report of having experienced the trauma of the mutilation again [10].

4. Clitoral Reconstruction

Clitoral reconstruction (CR) has been the subject of several studies in recent years, mainly in the medical field. Women with female genital mutilation seek clitoral reconstructive surgery to improve their sexual well-being, but also because of the altered body and self-image due to FGM. For some women, performing defibulation alone does not satisfy the need to obtain an improvement in clitoral sensitivity and the restoration of an anatomical appearance as normal as possible. With regard to clitoral reconstruction and the growing demand for this practice, both the WHO guidelines and those of the Royal College of Obstetrics and Gynecologists do not recommend this type of intervention due to the lack of evidence on its real efficacy and potential complications, while other publications have demonstrated an advantage of surgical reconstruction of the clitoris [7-22]. CR consists in removing the cutaneous and periclitoral scar of genital mutilation, re-exposing the body of the clitoris in a more accessible and visible position. CR can be performed for several reasons such as spontaneous or provoked clitoral pain, superficial dyspareunia, cosmetic reasons, psychosocial reasons and sexual dysfunctions related to FGM. CR should, in essence, support women with FGM in rebuilding their body image and improve their relationship with their body and sexuality, but currently there are no solid recommendations in support of CR from major scientific societies.

At present, it is not possible to guarantee to what extent clitoral reconstruction can be considered advantageous for every woman, but it can certainly be offered in appropriate settings to women who request it, after adequate counseling.

In women with chronic vulvar pain pre- and post-defibulation, the possible presence of cysts, neuromas, bridles or adhesions should be considered and these should be treated surgically in case of sexual dysfunction or associated pathologies.

The presence of vulvodynia must also be taken into consideration, and these women must be referred to multidisciplinary centers that can take care of the patient for all areas of the sexual and reproductive sphere [27].

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Female Genital Mutilation

Law, Religion, Anathema and Global Health

by Massimo Papa*

Abstract
This paper addresses the issue of the human rights, their acknowledgment in different contexts and the specific issue of the female genital mutilation, decodified under the lens of tradition and that of universal human rights. The method is that of juridical comparation under a diachronic and synchronic lens, with an analysis of the evolution of the concept inside and outside the Islamic world. The acceptance of the female genital mutilation as a proper Islamic tradition is questioned and denied, together with the effective compliance of many Governments in their commitment to operate towards an effective legal uniformity at a global level.

Keywords
Human rights, female genital mutilation, law, sharia, international cooperation.

1. Introduction

A right qualified as human, or – *rectius* – the category of human rights is a challenge to both jurisprudence and philosophy that crosses human life in a transversal way[1]. Even in a deep past, in the classical era, many have considered how a human being as such is worthy of protection: not only of protection of his goods, of his property, from external usurpations, but worthy of protecting his integrity (both physical and moral), his life, his self-determination[2], as much by other peers as by the action of the State, which is far from always legitimate. Free determination of thought and availability of one's own body are the highest categories in which the concept of human rights can be enclosed. Female genital mutilation is a complex subject, and complexity requires different approaches. Firstly, a clear idea of law in its deepest sense, that of religion, those of concepts such as universality and cogency of the norm and, above all, that of person. These concepts are all very present in everyday talks, in jurisprudential

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production, in contemporary mentality, and in statements and commitments made at international level by various and important actors on the world scene. Yet, the world is far from this unification of norms, and from their uniform application. Lawyers have a clear duty to point out this shortcoming. Several States have recognized their duty to intervene and have made commitments by signing specific declarations. The world needs no further proclamations but an actual and uniform protection of human rights.

2. Human right, divine right?

It is particularly important to underline that the subject of human rights does not concern solely the law of a religion or that of individuals, or that of singular state-level legal systems[3]. Human rights are an issue that has appeared very late in the juridical thought[4]: it has shown to the attention of jurists already in the modernity. Nevertheless, it has been present – in its nature and functions – since the depths of history, given that in its philosophical conception human rights have appeared and have attracted the attention of thinkers much before the modernity. The concept has been unexpressed n the depths of legal thought as well, because (that may perhaps be the only possible case) it leads to the question *par excellence*, the question of questions. Is there law already once the individual exists, or does the law exist only if it is systematized, that is once it is acknowledged by a legal system, thus defining a relationship between several individuals and a system of law? Is law a product of history, as a certain materialistic conception has intended to teach, or does it transcend it? Does it need legitimacy?

3. In the West

It is commonly accepted that *ubi societas, ibi jus*. It has always been an almost introductory motto to the legal reality, an unquestionable mark, a typical conception that originates into the antiquity of legal doctrine or, *rectius*, into the bases of its analytical conception. Santillana said that hermeneutics, therefore interpretation, is not the fruit of knowledge but the search for “the last and most colorful tree in the garden of knowledge”. What do we grasp then if we go to interpret the motto in its deepest root?

In the West, law was born as functional to the relationship between individuals and things, what in a modern civil perspective we could define as goods. Western legal experience has begun to protect relations, especially the economic ones. The first rights were conceived if *in rem*, therefore related to a *res*, precisely to a thing with an economic value.

The object of the right was therefore, as mentioned, the protection of property (including of course the collective one) which became, where possible, the object of greater protection, that of the Gods. We all remember that Jupiter was the guardian of the covenants, and it is no coincidence that we speak of the *sanctity* of contracts. In short, the presence of the divine intervened to protect the given word, and the riches that were transferred, but also suggested the correspondence of the juridical order to something not only human, but superior: the divine order. We will return to this point, an apparently distant one, which instead concerns human rights very closely.

Law has evolved and has evolved in accordance with the development of societies, the sensibilities of the persons

who constituted them, the philosophical conception of existence and having that the different peoples have accepted and produced in the historical becoming. The concept of human rights, on the other hand, seems to be a late one[5]. Philosophically, especially in the classical Greek environment, there was indeed a respect for the person as such. Aristotle spoke of it in the Nicomachean Ethics, but in a context – that of classical Greece – in which in reality a systematic concept of law did not exist. In fact, Aristotle speaks of *the politic correctness*, and not technically of law.

In Christian religious thought, which shares much with Islamic thought, the idea of law coming from nature as an order constituted by God is strong in Thomas Aquinas, in that period mistakenly defined "Middle Ages" in which so much was elaborated. Thomas' position is lucid and clear, and he captures a lot from Christianity but also from those juridical concepts (*first and foremost* that of law itself). In him, rights are principles, they are ethical in nature and are, above all, *generalissimi*[6]. Interestingly enough, this is a reference to a law that discards formalism and specificity, to a law that refers not to a norm made by man but only perceived by the latter as existing in the order structured by God. It is a general concept which transcends and does not need neither the political authority that formalizes it nor the pen of the jurist who elaborates it. Rights have always existed and are not generated but recognized. It is an important leap, perhaps *the* leap that brings to the acknowledgment of human rights.

As mentioned above, it is only the modernity that brings into existence the rights considered "human", that is those rights existing because a human being is *per se* its titular. That would be the end of the conception of law as the regulation of a relationship between things or persons: not only *ubi societas*, but even *ubi homo, ibi jus*: the law is there once a single man is.

And the key to acknowledge human rights lies on Thomas' right of nature, in natural law: it is in this conception the doors are opened to the recognition of human law in the technical sense and in legal orders using modern tools. Law crosses the boundaries of the single legal systems and something common, or – better said – *universal* is recognized: international law is born, the *jus gentium* in the modern sense, and this leads to wonder what sources it acknowledges, a source that can only be common to all. Some of these rights, then, are known as inalienable as well as natural, and find their formulation during the Enlightenment.

That process would then finally lead to recognize human rights in the technical sense, as an actual norm (*jus cogens*).

Human law exists and it exists because a human being is there. Mankind recognizes it, first they see it, then they formalize it.

4. In the East

Islam is a legal system. The whole of creation is subject to God, it is ideed Islam, that is the submission to His laws. The religious norm, the *sharia*, is that behavior due by mankind so that they can be *Muslim*, that is a coherent and integral part of the divine order. This helps us to understand at least two things, both of fundamental importance: the first is that in Islam the only legislator is God, the second is that man has the mere function to interpretate the law.

Islam has expanded into different territories, bringing with it the need to make the multitude a *unicum*. This uniqueness is recognized in the Islamic attitude to recognize a single order of things, a single law, and to conform the action of all to the divine will.

The reference text is, of course, the Koran, which some schools of thought even consider inseparable from God himself. A reference text that is supposed to be not contradictory, not surmountable. An apical and non-surpassable source of law, to which – therefore – every other subordinate source or norm must comply. It would be absurd to try to synthesize in a single article the very rich history of Islamic legal thought, the struggle over sources and their validity, and the legitimacy to lead the Islamic people and to standardize them under a single law. It is necessary, however, to draw attention to how Islamic law elaborated its terminology to designate a specific source of its law, read in two distinct meanings: it is the concept of "tradition", which in Islamic legal language in Arabic is rendered with *Sunnah*.

5. Female genital mutilation: not an Islamic legal institution

At the beginning of Islamic history (around the year '200 of the *Hijra*, or two centuries after the beginning of Muhammad's preaching) the Islamic Community begin to write anecdotes that go back to the life of the Prophet himself[7]. Those would be a further source of inspiration for the Muslims, helping them – following the infallible example of the Prophet and his first companions – to lead a better life and to fill those gaps that, due to their human imperfection, do not allow them to understand the integrity of the Koran and abstract the right path to follow in every occasion of life. A series of scholars will certify if and at what level each *hadith* (this is the name of the story) is authentic and can be referred to. This mechanism is fundamental in the conception of the law of the Islamic way, its reception of human rights and the issue of female genital mutilation.

In fact, when Islam expands it clashes with a series of traditions, i.e. the culture and the identities of the converts. Islam encounters a world already very rich in tradition. Here comes the different interpretation of the law made by the different doctors of the law, called to elaborate a judgment of legitimacy on the customs found all around the newly found territories: the results coming from their interpretation is surprisingly different.

When Islam meets Africa, in some of its lands genital mutilation is already there. There is no evidence or clue that leads us to believe that female genital mutilation was generated by Islam, but rather that the Muslims found that habit and the new converts just kept on using it. That, over time, was just consolidated and perceived as an Islamic habit. In the end, the old law, which is also *sunnah* (as tradition) and the new law became confused and gave the observants the idea that they were simply following Islamic law, without discerning one source from the other, and pre-Islamic habits from the Islamic ones.

The legal basis that should guarantee the conformity of female genital mutilation to the Islamic norm is a *hadith*, one of those that were not considered authentic, which invites those who intervene on the woman to do so "gently" because this would make the woman's face more radiant. A further lin-

guistic note is important in this regard: circumcision is called *tahara*, which refers to a concept of purification. That would therefore involve the removal of part of the genital apparatus as considered "dirty" in the sense of preventing the state of purity in which the *Muslim* must find himself at the moment in which they perform certain acts or lives some moments of particular religious significance. The phenomenon is therefore affected by all that psychological and social conditions that leads a community to become rigid in its defensive practices in the presence of a perceived risk: here, in the era of Covid, after 30 years of continuous decrease a resumption of this practice was witnessed, together with a lowering of the age limits to which girls are subjected (in Mali it even comes to affect two-year-old girls or less). This involves serious difficulties in finding the victims, and even more in developing response tools – or prevention – able to break down a phenomenon that is now considered to have nothing to do with religion but with practices and superstitions rooted in time.

In particular, the phenomenon is probably linked to the rite of passage, typical of the difficult moment of transition between youth and adulthood.

6. Commitments on mutilation: the necessary global response

A turning point of great importance, which concerns both the recognition of human rights and the specific dignity of women and their physical integrity, is the Protocol to the African Charter of human and peoples' rights on the rights of women in Africa (so-called "Maputo Protocol")[8] of the African Union, dated 2003. The document has a profound function and importance, despite the absence among the signatories of major actors of the African continent such as Egypt and Morocco[9].

The Protocol bases its effectiveness and legitimacy on several sources, which are referred to in the preliminary considerations:

- *First of all*, Article 66 of the African Charter on Human and Peoples' Rights, which provides for the adoption of protocols or special agreements in case of need, to implement the provisions of the Charter.
- *Secondly*, the Conference of Heads of State and Government of the Organization of African Unity in Addis Ababa in 1995, which ratified the recommendation of the African Commission on Human and Peoples' Rights to draw up a Protocol on Women's Rights in Africa.
- *In tertiis*, Article 2 of the African Charter on Human and Peoples' Rights, which prohibits all forms of discrimination, therefore also based on gender, or any other discriminatory situation.

This protocol, which has 32 articles, has the fundamental importance of constituting an effective and real obligation towards the ratifying countries: the commitment is to make the various legislations, through the appropriate reforms of domestic law, recognize fundamental rights such as dignity, life, effective consent to the celebration of marriage and especially the elimination of all practices that consist of acts detrimental to physical and mental integrity of women, explicitly mentioning female genital mutilation in Article 5.

This article, entitled "elimination of harmful practices", provides that Member States "prohibit and condemn all forms of harmful practices

that adversely harm women's human rights and are contrary to international standards", and "take all measures, legislative and otherwise, to eradicate these practices", to raise awareness among all sectors of society, to prohibit them by legislative measures combined with sanctions, to protect women who are at risk of being subjected to harmful practices or any other type of violence, abuse and intolerance. The rule therefore provides for both preventive and repressive actions.

In Italy there are about 90,000 women subjected to this practice. A significative number that should make us reflect on the effectiveness of the tools made available, even outside the majority Islamic territories. In 2006, Law no. 7 (so-called "Consolo Law") introduces new cases to strengthen protection against the phenomenon of mutilation. Articles 583*bis*, 583b are added, which provide for a penalty of 4 to 12 years' imprisonment, increased by one third if committed against minors. The material element of the crime is the cause of mutilation in the absence of therapeutic needs: evident, therefore, even if not expressed, the reference to the Maputo Protocol. It is therefore a further form of internationalization and homogenization of law, in this case taken by a European country in imitation of an African legal instrument.

7. Conclusions

The female genital mutilation shall not be recognized as an Islamic legal institution nor as a mandatory practice inside an Islamic community, rather a relic of precedent cultures and praxis spread over a territory that would later become Islamic and keep its ancient traditions. To date, adequate law enforcement policies do not exist because the commitments taken by many States and organizations have found no effect beside solemn declarations. The existing legal instruments are for the most part obligatory, but they proved neither sufficient nor effective: it shall be stressed that what is missing is not the legal instrument – which is manifested in the Maputo protocol and in other various international sources that, being recalled in the protocol itself, can only be recognized by all signatories –. However, they lack ability and will to fulfill obligations. It is worth mentioning the Sudanese legal system, which since 2020 punishes mutilation with a penalty of mere 3 years of imprisonment.

A minimal form of protection against a practice that, far from the norms of faith, constitutes an evident humiliation of the psychological and physical integrity of the girls as well as a disabling practice.

Notes and References

1. Law and social historians have tried to rebuild a human right tradition that would date back up to the early civilizations: among the first samples of this legislative production we would find legislative *corpora* such as the Hammurabi Code (XVIII Century BC) or the Cyrus Cilinder (VI Century BC). This kind of legislative production, despite their absolute historical and social interest, are not to be considered as a proper legislative issue of human rights in the stricter sense. In this sense, see: Hunt L. (2008), *Inventing Human Rights: a history*, W.W. Norton & Company, New York – London.

2. This concept is here expressed according to a very modern terminology. This reference shall therefore be considered as an *ante litteram* one. For an actual explication of this term in its legal-political meaning, see: Fisch J., Mage A. (2015), *The Right of Self-Determination of Peoples The Domestication of an Illusion*, Cambridge University Press, published online December 2015; doi: https://doi.org/10.1017/CBO9781139805698.003.

3. Human rights are in fact acknowledged at an international, ultra-state, universal level.

4. The first sample of a declaration in this sense is the Universal Declaration of Human Rights of 1948, whose text is available online: https://www.ohchr.org/en/universal-declaration-of-human-rights, accessed 15 June 2023.

5. For an in-depth analysis of thid phenomenon see: Hunt L. (2008), *Inventing Human Rights: a history*, W.W. Norton & Company, New York – London.

6. As general as possible. For the idea of the object of justice in Thomas, see: Thomas Aquinas, *Summa Theologiae* II-IIae, q. 57, a. 1.

7. The best reconstruction of the building of the Islamic legal thought, see: Wallaq W.B. (2012), *The origin and evolution of Islamic law*, Cambridge University Press, Cambridge, doi: https://doi.org/10.1017/CBO9780511818783.

8. African Union, Protocol to the African Charter of human and peoples' rights on the rights of women in Africa, available at: https://au.int/en/treaties/1170.

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Medicine at the Border

The Challenge of Female Genital Mutilations in the Migrant Population

by Giancarlo Ceccarelli, Francesco Marchetti, Massimo Ciccozzi*

Abstract
Perhaps better than other health problems, female genital mutilations represent a topic on which migration medicine has found great difficulty in managing the health of migrant women. Particularly in this setting, the encounter/clash between different social and cultural models represents the battlefield on which the game of the migrant's future trust in the health institutions of the host country is played.

Keywords
Border medicine, migration, migrants, female genital mutilations.

1. Opinion Paper

Female genital mutilations remain today a significant problem not only in some geographical areas of the planet where they have traditionally been widely described but also in apparently unexpected contexts.

In fact, in the context of the massive globalization process underway, the migratory flows starting from communities historically practicing female genital mutilation have implemented the probability of meeting with these cultural/religious practices even in countries where they had not been observed or described before.

This occurrence has aroused a strong reaction in an attempt to prevent the continuation of the custom of female genital mutilations in migrant populations culturally prone to this practice, particularly in European countries with multiethnic and multicultural social structures.

The legislative response has followed a parallel path to the social and cultural reaction in the direction of limiting these practices, oscillating between strongly repressive norms of the phenomenon and attempts at mediation between tradition and individual rights.

In particular, the World Health Organization (WHO)

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has taken a line of firm condemnation of female genital mutilations indicating it as a violation of human rights and the right to health, as an extreme form of discrimination and torture. Along the same lines, for example, British legislation has defined female genital mutilations as illegal in the UK, requiring health and social professionals to report such practices.

In the setting of migrant populations, however, this approach has not always represented an effective deterrent for reducing or eliminating the practice of female genital mutilations. In fact, several studies have shown that migrants from countries where female genital mutilations was considered "normal" did not change their opinion regarding this practice despite prolonged contact with non-accepting contexts and integration into societies where the practice was condemned.

In the awareness of the difficulty of eradicating atavistic practices only through prohibition, alternative approaches to the problem have been proposed such as for example a non-judgmental transcultural contact based on dialogue and human rights. Alternatively, community-based "self-help" groups have been proposed to catalyze social progress on the subject through culturally appropriate information.

At the same time, the progressive modification of the legislation of some African countries regarding traditional medicines recognized as an integral part of the right to health, has opened unpredictable scenarios also in relation to traditional religious and cultural practices.

Finally, the process of cultural and legal redefinition of gender identities underway in many Western societies has further highlighted the need for profound reflection and a re-reading of the topic no longer limited to the purely female sphere.

In this context, the management of female genital mutilation in migrant populations is a highly challenging topic in the field of border medicine. In particular, the regulatory context often clashes with hundreds of years old traditions and with social schemes that are difficult to change, especially upon arrival in the destination country of the migratory project. The detection of female genital mutilations is strongly limited to the arrival of migrants, considering that often it is not reported by women to the medical interview and that it is possible to bring out the problem only with a gynecological evaluation. The impact of female genital mutilations on mental and psychological health is also burdened by the use of assessment categories calibrated to Western-style systems.

The essential problem in border medicine is the fact that everything happens rapidly and takes place at the interface between two often non-harmonic visions of life: that of the motherland and that of the land of migration. Social and cultural models, the representation of health and illness often have a strong impact on individual stories, burying them under the traditions of the people to which the migrant belongs.

In this context the priority problem is not how to respond to female genital mutilations but how to bring out the problem, how to engage those who are carriers of these lesions, how to offer them possible solutions in an effective but also non-judgmental way.

Border medicine is a discipline that is still nuanced

and not well defined, but which is interested in one of the most topical moments of migration project: the interaction between the medicine of the country of arrival and the needs of the migrants. Its mission is the correct response to the needs of a person coming from a different social, cultural, and epidemiological system. This response is adequate only if it translates into an effective health protection relationship and an alliance with the patient despite the cultural differences between provider and usufructuary.

However, the barriers encountered still go beyond the sensitivity of the health care worker and the migrant's availability for the doctor-patient relationship. In fact, there are still gross structural barriers that can be easily traced in the lack of availability of elementary tools in the management of patients from distant geographical areas. For example, the non-definition of normal values for common blood tests is frequent in large areas of sub-Saharan Africa; for these populations, specific normal ranges for Caucasian populations (tributed from their colonial past) are still adopted. Similarly, still today a large part of the clinical trials that evaluate the adequacy of diagnostic tools or the efficacy/safety of drugs mainly enroll Caucasian patients with small numbers of Asian and/or African patients. These aspects have a heavy impact on the overall quality of medical assistance provided to migrant populations but above all on arrival when very little information is still available.

Female genital mutilation therefore represents a topic on which migration medicine has found a tough test in relation to the management of migrant women's health. In fact, this setting is one of the battlefields on which the future trust of the migrant in the health institutions of the host country is played out.

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The Reproductive Health of the Patient in the Presence of FGM

Sexuality, Pregnancy, Childbirth. Focus on: The Infibulated Patient

by Anita Fortunato*

Abstract
Women with female genital mutilation (FGM) need personalized and multidisciplinary assistance that takes into account the organic and anatomical aspects of the extent of the damage, depending on the type of excision performed (type I, II, III or IV) but also the psychological, social, cultural and sexual aspects. The first contact with health personnel is essential to provide adequate medical support: women can come into contact with health personnel in various situations, such as emergencies deriving from complications of mutilations or disorders not directly related to them. Taking advantage of the opportunity of first access to address the issue of FGM is crucial, as it is less common to involve these women in prevention and information interventions.
The meaning of FGM varies according to the cultural, relational, and social context the woman lives in, and some studies have shown that women with FGM can still experience sexual pleasure and orgasm: the classification of the type of FGM is not sufficient to fully understand the condition of the patient. It is important to consider that the impact with Western culture and with the extremely medicalized approach of the European context can negatively affect the sexual self-esteem of women with FGM, which is why it is essential to adopt sensitive communication and not excessively problematize the phenomenon.
Taking care of women with FGM from a medical, surgical, psychological and sexological point of view is essential to deal with the consequences of the mutilations. Even when no sexual disorders are present, counselling should be provided to ensure sexual health. There are several tools that can be used in sex therapy, including sex devices that can improve sexual response in all its stages. The complications of FGM vary according to the extent of the organic damage and are divided over time into immediate, medium-term and long-term damage. A particular management concerns pregnant patients with infibulation, for which it is necessary to define the moment of the reparative intervention (deinfibulation) and to plan an awareness and information process for the woman and the family that accompany her during the birth process, as to prevent complications during delivery, such as severe lacerations, bleeding or prolonged labor. Prevention plays a fundamental role, especially in newborn girls, so it is important to establish a structured and authentic dialogue that allows the expectant mother and family to fully understand the dangers and consequences of this practice, in order to independently choose to reiterate it.

Keywords
FGM, sexuality, female circumcision, pregnancy, puerperium.

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1. Sexuality

Sexuality and the protection of sexual health represent one of the fundamental components in the life of an individual and the determinants that characterize them are multifaceted, complex, and related to one another [1]. The main factors that need to be considered in the management of sexual complications in a woman with FGM are:

- The neurophysiological factors.
- The relational factors.
- Cognitive factors (myths, false beliefs, experiences, memories related to FGM).
- Sociocultural factors and context (gender and social identity, social and cultural norms, experiences during migration, other traumatic events).
- Anatomical biological factors (type and method of performing FGM, removal (or not) of the clitoris, complications related to FGM).
- Biochemical factors [2].

The cultural context in which the woman lives, or has lived, can modify the attribution of meaning to the practice of mutilation. The role of FGM is varied and takes on many different meanings depending on the culture of origin (rite of passage into adulthood, guarantee of a good marriage, hygienic and aesthetic standards, control of female sexuality…). When these meanings are perceived positively within the community, the experience of sexual pleasure and orgasm in female victims of FGM is present in a high percentage, as demonstrated by some studies.

This proves the fact that, although there is certainly a directly proportional correlation between the extent of organic damage (based on the type of FGM) and sexual satisfaction (understood as the perception of sexual pleasure and the achievement of orgasm), the mere classification of the type of mutilation is not sufficient to understand and deepen the absolute condition of the patient.

In general, women with mild FGM or who, in any case, have had the excision experience in a positive and indeed functional way for the development of individual and sexual maturity, perceive themselves as healthy, and this is how the healthcare personnel dedicated to their care should perceive them [3].

A second determining factor is the context: women who come from countries with a cutting tradition often become aware of the fact that FGM could have had a negative impact on their lives only through the comparison with Western culture which not only condemns the practice but is even in stark contrast to the theme, often lacking in sensitivity and understanding. The result is sometimes the opposite of the desired one: through the awareness process of the practice, the woman can experience a worsening of the vision of the self (self-body image) with a consequent lowering of sexual self-esteem [4].

In clinical practice, the goal must always be to improve the patient's starting condition; from this point of view it is advisable to allow oneself the dutiful reflections on the best communicative method, avoiding necessarily problematizing the phenomenon and/or excessively medicalizing it.

2. Assistance to the Woman Carrier of FGM

The first contact with the woman victim of female genital mutilation (FGM) is fundamental and decisive for ad-

equate care of the patient. The occasions in which healthcare personnel can come into contact with a woman with FGM are different and often linked to an urgent type of access to the Emergency Department or consulting room. The problems that are treated are not always associated with implications strictly related to female genital mutilation (bleeding abnormalities in pregnancy, miscarriage, vulvovaginal infections, etc.). In other cases and more rarely, access can be specifically linked to a consultation for the complications of FGM or to ordinary preventive visits (pap test, gynecological check-up, etc.).

In most cases, however, patients access for:

- Checkups during pregnancy.
- Request for contraception.
- Request for voluntary termination of pregnancy.

Precisely because it is less frequent and more difficult to involve this user in prevention and information interventions, it is essential to be able to grasp the first access to one of these aforementioned services in order to approach the issue of FGM.

Complicating the management of the excised woman is the difficulty in recognizing, from a clinical point of view, the mutilation and knowing how to classify it, especially if it is a type I or II mutilation (excision of the clitoris, clitoral hood and labia minora), both in women and girls.

A fundamental element in the approach to the female carrier of FGM is the use of a communication method that transmits acceptance, empathy, open and non-stigmatizing dialogue and which does not make the woman feel condemned, victimized or humiliated [5].

Starting from the need to consider the phenomenon of FGM and the women who are its bearers, it is useful to define two welfare objectives:

1. Take charge and treat from a medical, surgical, psychological, sexological point of view, women who have already undergone the mutilation and who report the consequences.
2. Take charge of those who, even if they have undergone mutilation, do not have sexual disorders and therefore need adequate counselling aimed at guaranteeing sexual health (counselling on contraception, adherence to screening programmes, education on menstrual hygiene etc.) [6].

As far as the management of women who report FGM-related damage is concerned, a point must be made. Despite the common-thought understanding that the cutting practice is the incontrovertible cause of permanent and irreversible damage, especially as regards the sexual sphere, the literature on sexual pleasure and orgasm actually refutes this very thought. There is no evidence to support the thesis that “FGM unequivocally destroys sexual pleasure”, just as no significant differences in orgasm perception have been observed between women with FGM and women without [7]. Furthermore, the low incidence of negative consequences on desire, pleasure and the achievement of orgasm in women with FGM was verified, in the absence of complications and with awareness and acceptance of the excision undergone [8].

From an anatomical point of view, in type I and II mutilations, where the excision involves the foreskin, clitoris and labia minora, often the

only portion of the clitoris removed is that of the glans, so all the remaining erectile components, like the clitoral roots and crura, remain intact. The erectile structures of the bulbs of the vestibule and the peri-urethral ones remain intact and for this there is the possibility, in case of sexual dysfunction, to rehabilitate women to a complete and satisfying sexual life [3].

Whenever a sexual dysfunction emerges, regardless of what the triggering factor may be (anatomical, functional, relational, psychological) it is necessary to investigate some points and, if necessary, start a supportive psychosexual therapy. Some of the psychological implications that we can find in excised women are:

- Cultural conflict.
- Stigmatization of women with FGM (especially in a context in which the media, health and awareness campaigns invest heavily in the issue of mutilations).
- Negative expectations about sexuality (fear of being different, of not feeling pleasure, destruction of body image).
- Social non-acceptance (greater sharing and/or contrast with Western culture, as, for example, in the case in which the partner has origins in countries with no cutting tradition) [2].

As regards the codified treatments for the management of female sexual disorders, they include exogenous hormonal therapies, central nervous system (CNS) active drugs and psychological therapy.

Other tools that have proved to be significant in the treatment of sexual disorders are sexual devices (sex toys), both in terms of masturbation and sexual activity as a couple, being functional for increasing the probability of orgasm and for reducing the time latency of orgasm itself [9].

Sexual devices, including vibrators, vaginal and/or anal penetrative devices, clitoral pulsators, share a similar mechanism of action, providing stimulation through vibration, pulsation and penetration by acting on different erogenous areas (anus, vagina, clitoris, perineum, nipples). The objective of sexual devices is to improve, accelerate and/or prolong any phase of sexual response and for this reason they are used for therapeutic purposes on some patients. These patients include those with reduced libido, anorgasmia or conditions that inhibit vaginal penetration (dyspareunia, vulvodynia, pelvic pain chronic, sexual function or pelvic floor disorders, partner's erectile dysfunction, etc.). Pregnant women, before and after childbirth, are also candidates for the use of these devices, as are women in menopause, with disabilities or chronic pathologies.

In order to ensure good adherence to therapy, it is essential to provide suitable information regarding the use, cleaning and storage of sex toys [10].

Another valid support tool for counselling and taking care of women with FGM is the use of images and photographs that portray different genitalia and underline the anatomical variety that sees the dimensions and shapes of the labia minora, labia majora and very different clitoris. These supports, such as the online platform The Labia Library, created by the non-profit Australian foundation Women's Health Victoria, allow health professionals to redefine the meaning of

genital physiology away from the mere aesthetic parameter imbued with social, cultural, and religious present in each geographical area in a given historical context.

Having direct feedback on the multitude of different vulvas that may exist, it is easier for patients and their partners to understand, accept and normalize female genital mutilation.

Considering the complexity of the assistance response, the only model capable of providing an adequate one is the multidisciplinary and multiprofessional one which guarantees, possibly in a single center, the evaluation and management of the patient from every point of view (medical, surgical, psychological, of cultural, rehabilitative, sexological mediation, etc.). This model allows evaluation to be made also in relation to various services in the area: hospital birth points, consultants (screening, contraception, IVG, pregnancy, puerperium), paediatricians and general practitioners.

3. Focus on: the Pregnant Patient with Infibulation

Often FGM carriers do not believe that this condition can negatively affect or even compromise spontaneous childbirth.

The focus of assistance to pregnant women with FGM is based on the prevention of complications of excision that may arise at the time of delivery, thus protecting the health of the woman and the unborn child [11].

While not all types of FGM lead to complications in childbirth, it should be noted that there may be an increase in severe lacerations, cases of post-partum hemorrhage, prolonged labor and fetal distress (Tab. 1) [12].

In particular, in women with type III FGM (infibulation), prevention plays a fundamental role in these situations, for which it is necessary to establish a relationship of trust with the patient throughout the pregnancy in

Tab. 1. FGM and obstetric risks.

OBSTETRIC RISKS	DETAILS
Cesarean section	Increased incidence of Cesarean section and associated surgical complications
Post-partum haemorrhage	Blood loss after delivery greater than or equal to 500 ml
Episiotomy	Performed to reduce the risk of severe spontaneous lacerations
Obstetric lacerations	Scar tissue left over from excision can increase the risk of serious lacerations, making the tissue less elastic
Difficult or dystocic labor	The presence of infibulation may inhibit the newborn progression
Prolonged maternal hospitalization	If severe lacerations or caesarean section are present
Perinatal death/neonatal resuscitation at delivery	Prolonged labor can cause fetal distress

order to be able to address some critical issues:

- The timing and methods of defibulation in view of the birth, specifying the risk factors and the benefits deriving from the intervention.
- The impossibility for the Italian law (legge Consolo n. 7/2006) to proceed with the re-infibulation after the birth and, in the same way, to carry out a genital modification (FGM) on the newborn in case it is female.

Furthermore, during health assessments, in the presence of infibulation, the possibility of carrying out a vaginal birth should always be proposed and discussed with the patient, specifying and taking into account the fact that there may be less perineal competence in the expulsive period and that may need to resort to de-infibulation during labor or, sometimes, episiotomy to avoid severe lacerations and facilitate birth.

As regards women with type III mutilation (infibulation), it is necessary to choose the timing for de-infibulation surgery and this may depend on clinical reasons, cultural factors and psychological motivations [13].

In general, literature and experience agree that the best results are obtained when defibulation is performed before delivery as it decreases the risk of birth complications related to a narrowed vaginal canal. Specifically, the Royal College of Obstetricians and Gynecologists (RCOG) recommends deinfibulation in the preconception period or during labour, as does the WHO. The Swiss Society of Gyneacologists and Obstetricians recommends this intervention during labor and pregnancy only if gynecological visits cannot be performed, while the Italian Guidelines recommend defibulation within the first trimester of pregnancy or before delivery in case of late first access [14].

Regardless of the opinion of scientific societies, it is necessary to consider some fundamental factors to decide the timing of female circumcision, including:

1. Preference of the woman.
2. Access to health facilities: in contexts where women may encounter involuntary delays in reaching health facilities (e.g. single woman, without car, caregiver, language barrier, etc.), defibulation should be guaranteed before delivery, so as to schedule it and thus avoid emergency events.
3. Place of delivery: it is important to ensure ante-partum defibulation especially when delivery is planned at home.
4. Skill level of the healthcare worker: if there are not sufficiently trained resources within the structure for the intervention and management of defibulation, it is preferable to carry out ante-partum intervention [15].

After deinfibulation the appearance of the genitals changes, as well as some of the more daily physiological activities such as urinating or menstruating: it is important to address the subject before the operation, also investigating the reaction of the people around the woman (partner, mother, mother-in-law...) making sure that the management of the intervention is clear.

These issues must be addressed gradually and, if possible, involve the partner or family, in order to raise awareness of FGM as much as possible and allow the woman to be surrounded by people who support her and do not stigmatize her for her decisions. It should

be considered, furthermore, that the prenatal period often represents the first contact with the health service by the woman and/or the couple.

All meetings with the woman or the couple must be accompanied by the presence of a cultural mediator, especially in cases where it is necessary to give informed consent [16].

There are several procedures that complicate the management of women with infibulation, especially during labor:

- Vaginal and speculum examination.
- Labor induction which, if necessary, should only be performed after defibulation.
- Evaluation of the stage of labor, for which a rectal examination may sometimes be necessary.
- Catheterization.

The defibulation surgery is performed under local anesthesia (or by exploiting the epidural anesthesia performed during labor) with episiotomy scissors or a scalpel, from bottom to top, along the midline of the scar up to the urethral meatus, trying to locate it and possibly proceeding with catheterization in order to avoid involuntarily affecting it.

When the surgery is done during labor, it is usually done in the second stage, when the emerged part progresses.

The closing suture of the labia majora is done at the end of the third stage, after birth and expulsion of the placenta [17].

One of the most common risks is that serious vaginal/urethral lacerations occur during childbirth, for which it may be necessary, in order to prevent them, to practice a medio-lateral episiotomy. More rarely, it is necessary to resort to bilateral or median episiotomies, due to a greater risk of incontinence and/or anorectal fistulas.

The adhesions and scar tissue around the vaginal canal cause a reduction in the degree of distension of the perineum. In the event that adhesions are present, it is necessary to divide them and, subsequently, to evaluate the possibility of practicing an episiotomy or not [18].

One of the least considered and most often underestimated aspects is the homogeneous coding of the hospital discharge form after hospitalizations.

In order for the mutilation phenomenon to emerge and for the data to be significant, it is essential that shared diagnostic codes are used and that they refer unequivocally to the type of FGM in question.

4. FGM and Puerperium

During the puerperium, the assistance of the woman must be guaranteed through a weekly follow-up, possibly through home assistance. This attention is necessary to moderate the most recurring risks following defibulation surgery, such as those related to urinary tract infections.

The health personnel involved in supporting these patients and their children hold a fundamental position as regards counseling: the post-partum period is in fact optimal for deepening the woman's experience of excision, trying to understand the maternal wishes and cultural and family dynamics.

The support of specialized personnel assumes further importance in the event that the newborn is female in order to sensitize and inform the mother about the main functional and anatomical notions of the genitals so as to be able, possibly, to make a more informed decision on the excision procedure.

A fundamental aspect of post-partum assistance also concerns support with respect to the perception of

one's body and one's genitals, both in terms of aesthetics and physiology. In addition to this, a fundamental step is represented by the attempt to dispel false myths and discuss women's fears and insecurities.

Finally, one last consideration must always be kept in mind: the patient is not only a deinfibulated or mutilated woman but, in this context, her condition in the puerperium and the resulting needs must first of all be considered, such as the evaluation of the pelvic floor for any incontinence or dysfunction, the evaluation of breastfeeding, contraception, sexual health etc. Also in this process it is essential to involve the partner or family and arrange for the presence of a cultural mediator [15].

In conclusion, taking charge of the female victim of FGM presupposes a multidisciplinary approach and close collaboration between various medical, obstetric, nursing, psychological and intercultural mediation figures.

The training of healthcare personnel is essential to ensure satisfactory levels in each of the areas of interest, whether pertaining to hospitals or the territory.

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Female Genital Mutilations: Medical Legal Aspects

Duty of Information, Consent of the Person Entitled and Certifications

by Valentina De Biasio, Francesco Cattaneo, Monica D'Amato*

Abstract

FGM represents a widespread phenomenon in some areas of the world which, due to migratory flows, also directly affects the so-called Western world. Various measures have been adopted both internationally and nationally to combat these practices, recognized as violations of the fundamental rights of women. These violations involve important repercussions of both a criminal and civil nature. Italy has signed various international conventions, including the Istanbul Convention, which aim to eliminate the phenomenon of FGM, and has implemented measures at the national level to this end. These include the enactment of Law 07/06 which introduces, with Article 583-*bis* of the Criminal Code, the crime of mutilation and the crime of injury (without mutilation) of the female genital organs, with the provision of consequences on parental responsibility and on the professional responsibility of the healthcare professional. Knowledge of the standard becomes fundamental for health professionals who approach this situation for various reasons. First of all, this concerns the Duty of Information towards the Judicial Authority AG with reference to such practices, as a crime that can be prosecuted ex officio. Another important aspect from the medical-legal point of view is undoubtedly the validity of any consent expressed by the woman (or her guardian) to be subjected to FGM, which intertwines the provisions of Articles 50 and 51 of the Criminal Code and Article 5 of the Civil Code In the last decade, both nationally and internationally. These practices have also been recognized as a reason for the recognition of refugee status. Therefore, in some cases, the Healthcare Professional may be required to certify their existence. Finally, for the medical examiner specialist, the important aspect is the assessment for compensation purposes of the damage deriving from such practices.

Keywords

FGM, inviolable rights, informed consent, disclosure obligation, health professional, biological damage.

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1. Introduction [1]

It is estimated that there are more than 200 million girls and women subjected to FGM in the thirty countries of Africa, Asia and the Middle East where such practices are most widespread, with adolescent girls representing the most affected population. At an international level, FGM has been the subject of multiple conventions aimed at eliminating this practice, considered a serious violation of the fundamental rights of women, with the consequent adoption at national level of measures aimed at this direction. The growing migratory flows from countries where such practices are still widespread make FGM a reality with which even health professionals must deal with in the light of current international and national legislation, with its important repercussions both in criminal law and civil law.

2. Regulatory References [2-7]

Italy is a signatory country to a series of international conventions intended to eliminate FGM, including the Universal Declaration of Human Rights (1948), the Convention on the elimination of all forms of discrimination against women (1979), the Convention on the Rights of the Child (1990), the Declaration on Violence Against Women (1993), which includes a particular reference to FGM, the Istanbul Convention of 2011, in which "violence against women is recognized as a form of violation of human rights and discrimination".

According to the Art. 32 of the Constitution "The Republic protects health as a fundamental right of the individual and in the interest of the community. No one can be forced to a certain health treatment except by law. The law cannot in any case violate the limits imposed by respect for the human person".

This article is recalled by Art. 5 of the Civil Code, which regulates the acts of disposing of one's body, which are prohibited "when they cause a permanent decrease in physical integrity or when they are contrary to the law, public order or morality".

2.1. *The Law of 9 January 2006 n. 7 and Art. 583*-bis *of the Criminal Code*

Before the issuance of the c.d. Consolo Law, FGM could be classified among the intentional injuries pursuant to Articles 582 and 583 of the Criminal Code; these, therefore, were punished as serious or very serious personal injury, in relation to the type of alteration produced on the woman and the consequences caused to her.

With the promulgation of the Law of 9 January 2006 n. 7 were dictated "the necessary measures to prevent and repress the practices of female genital mutilation as violations of the fundamental rights to the integrity of the person and to the health of women and girls" (Art. 1). This provision is characterized by its dual character: on the one hand, as a repressive measure of violence against the human rights of every woman and, on the other, as an information-preventive tool.

The most relevant part of the legislative intervention consists of provisions of a penal nature. In fact, with Article 583-*bis*, two new types of crime have been introduced: the crime of mutilation (C1) and the crime of injury (without mutilation) of female genital organs (C2), subject to verification of "actual triggering of a morbid process, producing an appreciable reduction in

the functionality of the organs concerned". It should be noted that, according to the law, the conduct causing the unlawful act can both be active and omissive, therefore there is a crime not only when the parent imposes genital mutilation on the daughter, but also when he/she does not prevent this practice from being carried out by the spouse, or by others.

The article clearly establishes that: "whoever, in the absence of therapeutic needs, practices mutilation of the female genital organs is punished with imprisonment from four to twelve years". The mutilations of the female genital organs to which the Penal Code refers are: clitoridectomy, excision, infibulation, any other practice that reports effects of the same type. It is also specified that whoever, in the absence of therapeutic needs, causes lesions to the female genital organs other than those indicated above with the aim of impairing sexual functions, thereby causing a disease in the body or mind, is punished with imprisonment from three to seven years. The penalty will be more severe if FGM was practiced on a minor or for profit.

With the Law n. 172/2012, implementing the Lanzarote Convention signed by Italy on 25 October 2007, the provision of the accessory penalty of forfeiture of the exercise of parental authority was introduced in Article 583-*bis* of the Criminal Code. This forfeiture is regulated by Articles 330 of the Civil Code (conduct that causes objective damage to children) and 333 of the Civil Code (conduct not such as to give rise to the ruling of forfeiture provided for by Article 330, but in any case prejudicial to the child for which the judge can adopt the appropriate measures and order the removal of one or both parents from the family residence). In 2018, the Court of Turin expressed itself with these provisions on a case of FGM.

It should be specified that the provisions of this law are valid even if FGM is performed abroad, both by an Italian citizen and by a foreign citizen residing in Italy. The law also provides for an accessory penalty for those who practice a health profession (doctors, midwives, nurses), if they are convicted of any of these crimes, or the disqualification from the profession from three to ten years. In view of the prohibition, mutilative medical-surgical interventions are allowed, justified by the need to treat a patient's pathology.

Within the scope of the law, reinfibulative cases are also illicit, in cases where the surgeon (where the suture has been removed for therapeutic reasons) is requested by family members or by the woman to carry out resuturing of the vagina.

Furthermore, the Code of Medical Ethics finally, in Article 52, forbids explicitly to the doctor any form of collaboration, participation, or simple presence, in the implementation of acts of torture, or cruel, inhuman, or degrading treatments and expressly precludes practicing any form of female sexual mutilation.

3. Legal Obligations [2]

With regards to the above, healthcare professionals should be aware of their responsibilities before the law, both with regard to the legitimacy of their conduct and with regard to their duty to inform the AG.

4. Disclosure Duty

Falling within the case referred to in C1 and 2 of Art. 583-*bis* of the Criminal Code in crimes that can be prosecuted

ex officio, the obligation to report to the Judicial Authority is in force for the Healthcare Professional.

This duty of disclosure must be fulfilled in accordance with the law in various ways, depending on the qualification of the operator in the specific case.

The crimes that can be prosecuted ex officio are generally those against life, against individual safety (serious injuries, private violence, kidnapping), against public safety, sexual, abortion (outside of what provided for by Law 194/78), of tampering with a corpse, against individual freedom and against the family (mistreatment, abandonment of minors or the incapable).

Pursuant to Art. 331 c.p.p., public officials and public service officers who, in the exercise or due to their duties or service, have news of a fact that could constitute a crime that can be prosecuted *ex officio*, have the obligation to report it. Therefore, the certainty of the crime is not necessary but the mere suspicion that it has occurred is sufficient.

Those who exercise a public function (activity carried out by a person not in his own interest but in the interest of the community) legislative, judicial or administrative, characterized by authoritative or certification powers hold the qualification of public officials (PU), pursuant to Art. 357 Criminal Code. This is a manifestation of the will of the public administration. Among the figures who hold this qualification are the medical director of a public hospital, hospital doctors in the exercise of authoritative powers (in other cases they hold the position of public service officers), the general practitioner, the resident head of an affiliated laboratory, the doctor who works in a private Nursing Home affiliated with the NHS. Pursuant to Art. 358 of the Criminal Code, those who exercise a public activity, provided in any capacity and governed in the same form as a public function, hold the position of Public Representatives Service (IPS). However they do not hold the typical powers of public officials, i.e. authoritative or certifying powers.

Pursuant to Articles 331 and 332 of the Code of Criminal Procedure, the complaint must contain the exposition of the essential elements of the fact, the sources of evidence already known and the day of the acquisition of the news. The complaint must be presented and sent to the public prosecutor or to a prosecutor's office in writing, without delay, even when the perpetrator is not known. In the event that several people are obliged to report the same fact, a single deed may be drawn up and signed by all the obliged parties.

According to the Art. 334 c.p.p. (Report) and the Art. 365 Criminal Code (Omission of report), the operator of a Health Profession (EPS) who has provided his assistance or operates in cases that may present the characteristics of a crime that can be prosecuted ex officio has the obligation to report, a possibility that must be concrete. The health professions in the Italian legal system are all those professions whose operators, by virtue of a qualifying title issued/recognized by the Italian Republic, work in the health field (pharmacist pursuant to Legislative Decree 258/1991; surgeon pursuant to Legislative Decree 368/1999; dentistry-tra ex l.409/1985; veterinarian ex L. 750/1984; psychologist ex L. 56/1989).

There are also nursing health professions ex L.

905/1980 and obstetricians ex L. 296/1985, as well as pediatric nurse ex d.l. 70/1997; to these are added the rehabilitation health professions, as well as technical-health professions (of the technical-diagnostic and technical-assistance area).

Pursuant to the aforementioned Art. 334 c.p.p., the report must contain the indication of the person to whom assistance was provided, the place, time and circumstances of the intervention, as well as information regarding the fact, the means by which it was committed and the effects that it has caused or may cause. It must be sent in writing to the Judicial Authority within forty-eight hours or, if there is danger in the delay, immediately. As with the report, even if several people are obliged to make a report for the same fact, a single deed may be drawn up and signed by all the obliged parties. Like the provisions for the report, the omission or delay of the report is sanctioned but, unlike the report, there are exemptions from the report obligation (Art. 365 of the Criminal Code): when the presentation would expose the assisted person to criminal proceedings (priority of the Right to Health); if the doctor has failed to submit a report due to having been forced to do so by the need to save himself or a close relative from a serious and inevitable harm to freedom or honor (Article 384 of the Criminal Code).

In summary, the substantial differences between the two cases described above concern the qualification of the obliged subject when he becomes aware of the fact (PU/IPS vs EPS), the ways in which he becomes aware of the fact (news vs pre-stare assistance /work), the timing with which the obligation must be fulfilled (without delay vs < 48 h/immediately), the certainty of the occurrence of an event that can be configured as a crime that can be prosecuted ex officio (suspect vs concrete possibility) and, finally, the presence of any exemptions (envisaged only for the report).

The main differences between the complaint and the report are summarized in Tab. 1.

Since FGM, as mentioned, according to the provisions of Article 583-*bis* of the Criminal Code C1 and C2, types of

Tab. 1. Main differences between the complaint and the report.

	REPORT	MEDICAL REPORT
Qualification of the operator at the moment the subject is aware of the fact	PU/IPS	EPS
Method with which the subject has knowledge of the fact	NEWS	Assistance Provided
Time with which the obligation must be fulfilled without delay	NO DELAY	<48h / immediateley
Exemptions	NOT PROVIDED	

crimes that can be prosecuted ex officio, the obligation to provide information is in force for the Healthcare Professional, according to the methods specified above. The ratio of the report lies not only in the prosecution of the crime already committed, but in a prevention perspective, both to protect current potential victims and future generations.

This fulfilment, however binding, must be carried out by the Healthcare Professional as far as possible in alliance with the assisted, possibly with the support of cultural mediators and Social Services, in order to minimize the risk of her being removed from the network for family and sociocultural reasons.

5. The Problem of Consent [2, 8, 9]

Not insignificant are the problems relating to consent (i.e. the ability of the individual owner of the protected property to self-determination and freely choose) to this practice, taking into account the possibility, far from rare, that it is the victim himself who asks for be subjected to a culturally shared and socially imposed practice. One may consider it intrinsic to one's cultural identity and, consequently, important for maintaining adherence to one's own traditions.

In addition, a healthcare professional may be required to perform FGM on a minor or a disabled person.

Informed Consent is defined and regulated, for the first time in Italy, by Law 219/17 containing "Regulations on informed consent and advance treatment provisions" – also known as the Law on Biotestament. The law is structured in two parts: the first (Articles 1, 2 and 3) deals with informed consent, the second (Article 4) with living wills (the so-called DAT, advance treatment provisions) and planning shared care (Art. 5).

Informed consent represents the very personal right of the patient to self-determination which takes the form of the faculty to choose freely and in full awareness between the various therapeutic treatment options, as well as that of refusing treatment and consciously deciding to interrupt the ongoing therapy.

The choice follows the presentation of a specific series of information, made understandable to him by the doctor or medical team.

Anyone who is directly involved in a medical act, if of age, conscious and capable, must give their consent to the health personnel so that they can act legitimately.

Given that it is a free and conscious manifestation of will, some subjects may not be in a position to meet these requirements. No distinction is made between minors, interdicted and incapacitated, we generally speak of incapable patients. The incapable patient "must receive information on the choices relating to his health in a manner consistent with his abilities to be put in a position to express his will", as stated in the Art. 3 paragraph 1 of Law 219 of 22 December 2017. In such cases, the consent is expressed by the tutor or by the same disabled person.

Informed consent is used to make a certain health act lawful, in the absence of which the crime is committed again.

In the case of FGM we are faced with an act that has no therapeutic value (to which the assisted person may or may not give his/her consent), since, in particular as regards the provisions of C1, these are actions aimed at producing a disability of the psycho-physical integrity of the person and, as such, liable to prosecution by law.

Therefore, specifically, in addition to the Penal Law and

the Deontological Code (Art. 52), the provisions of Art. 5 c.c. ("Acts of disposing of one's body", which are prohibited when they cause a permanent decrease in physical integrity, or when they are otherwise contrary to the law, public order or morality), except in cases expressly provided for by the law (L. 458/67: living kidney transplantation; L. 164/82: rectification and attribution of sex; L. 107/90: blood transfusions; L. 30/93: sampling and grafts of corneas; L. 91/99: removal and transplantation of organs and tissues; Law 483/99: partial liver transplantation).

Can the woman therefore (or the guardian in the case of minors or disabled persons) express valid consent to these procedures? Are they specifically the holders of the existing right?

With regard to C1 of Article 583-*bis* of the Criminal Code, considering that these practices always result in a permanent decrease in psychophysical integrity (a right constitutionally guaranteed by Article 32), they cannot in fact express this consent.

Then, with regard to the crime of injury referred to in C2, there is no doubt that some types of FGM (e.g. practices which involve piercing, perforation, incision of the clitoris and labia) do not necessarily produce a permanent decrease in the psychophysical integrity which must be documented if necessary. Therefore, in this case it is possible to express consent to these practices pursuant to Law 219/17, and here, for example, the woman can legally request that a genital piercing be affixed to her.

As regards the discriminating factor referred to in Art. 51 of the Criminal Code, the right referred to could consist in the right to religious freedom, or in that arising from custom, or provided for by a foreign law. However, it should be noted that no religious denomination compulsorily prescribes FGM and, even if this were the case, the exercise of freedom of religion cannot lead to the infringement of higher-ranking constitutional rights, such as personal dignity (Articles 2 and 3 Const.), physical integrity and psycho-sexual health (Art. 32 Const.); therefore, in the case of FGM, not even the disclaimer pursuant to Art. 51 Criminal Code.

Finally, please note that Law 219/17 in Art. 1 paragraph 6 specifically states that the patient cannot demand health treatments contrary to the law, professional ethics or good clinical-assistance practices and that, in the face of such requests, the doctor has no professional obligations.

As far as defibulation is concerned, however, it does not integrate the crime set out in Art. 583-*bis* of the Criminal Code since it is connected to a therapeutic need, aimed at repairing a serious violation of the physical integrity of the woman and of her right to health. Like other medical acts, it always requires the acquisition of a valid informed consent, also with the help of a cultural mediator where there is a need. In the case of minors, the persons exercising parental responsibility must be involved in the decision-making process, bearing in mind however that, in any case, the subject of protection is the right of the minor to see a serious violation of her physical integrity and her right to health. This must be in harmony with the provisions of Art. 3 of the aforementioned Law 219/17 as well as in the case of the adult and incapable subject.

6. International Protection [9-31]

A person who is at risk of being subjected to female gen-

ital mutilation (FGM) can ask the Italian State for recognition of international protection, a set of fundamental rights recognized by Italy for refugees.

Refugees are people who have a well-founded fear of being persecuted in their country for reasons of race, religion, nationality, political opinion, belonging to a certain social group and who cannot receive protection from their country of origin. From this point of view, FGM is considered persecution that confers the right to the condition of refugee. This condition provides, in fact, for subjects to receive international protection and first of all to have guaranteed the right not to be repatriated and to stay in Italy.

Asylum applications for reasons of FGM can fall under Legislative Decree 251/2007 Art. 7 and 8, which consider physical or psychological violence or acts specifically directed against a specific gender or against children as relevant for the purpose of granting refugee status. On the basis of the principles set out in the 1951 Geneva Convention, these acts of violence amount to a serious violation of fundamental human rights. Nonetheless, even having removed oneself or having removed one's daughter from such practices may be considered for the purposes of requesting asylum applications, potentially implying a persecution of a political nature in countries where FGM represents a practice strongly rooted in the religious political order. This reason for persecution is specifically provided for by the aforementioned Legislative Decree. The same applies to those who have already undergone FGM, as they may have legitimated and well-founded fear of future persecution and the same can be repeated and/or re-inflicted in different forms. The law includes, in fact, both hypotheses of past and future persecutions (Articles 2, 3 and 4). The inclusion of FGM among the reasons for accepting asylum applications has also been reiterated in the context of European Union law and by the UNHCR. On this point, it should be noted that as early as the 1990s, the jurisprudence of various European countries, such as France, the United Kingdom, Austria, Germany, Belgium and Spain, and non-European countries, such as Canada, the United States and Australia, identified FGM as a precondition for the recognition of refugee status.

In 2016, Italy recorded an increase in migratory flows, especially from countries at risk of FGM, estimated at around 181,500 people, with a parallel increase in the number of asylum requests, for which it was the third EU country with 123,000 questions. Although the exact number of women who seek asylum for reasons related to FGM and who obtain it for this reason is not known, these data make it likely that in this population there is a high percentage of women who have suffered or are at risk of suffering FGM, considerations strengthened by the evidence of the high number of women asylum seekers from countries where the practice of FGM is still widespread: high numbers both in absolute terms, as in the case of Nigeria and Eritrea (which had an incidence of FGM equal to 27% and 89% respectively), and relative terms, as in the case of Somalia where the incidence of FGM was equal to 98% (Fig. 1). It is estimated that in Italy there are between 60,000 and 81,000 women subjected to a form of FGM in childhood.

The burden of proof is on the applicant and it is suffi-

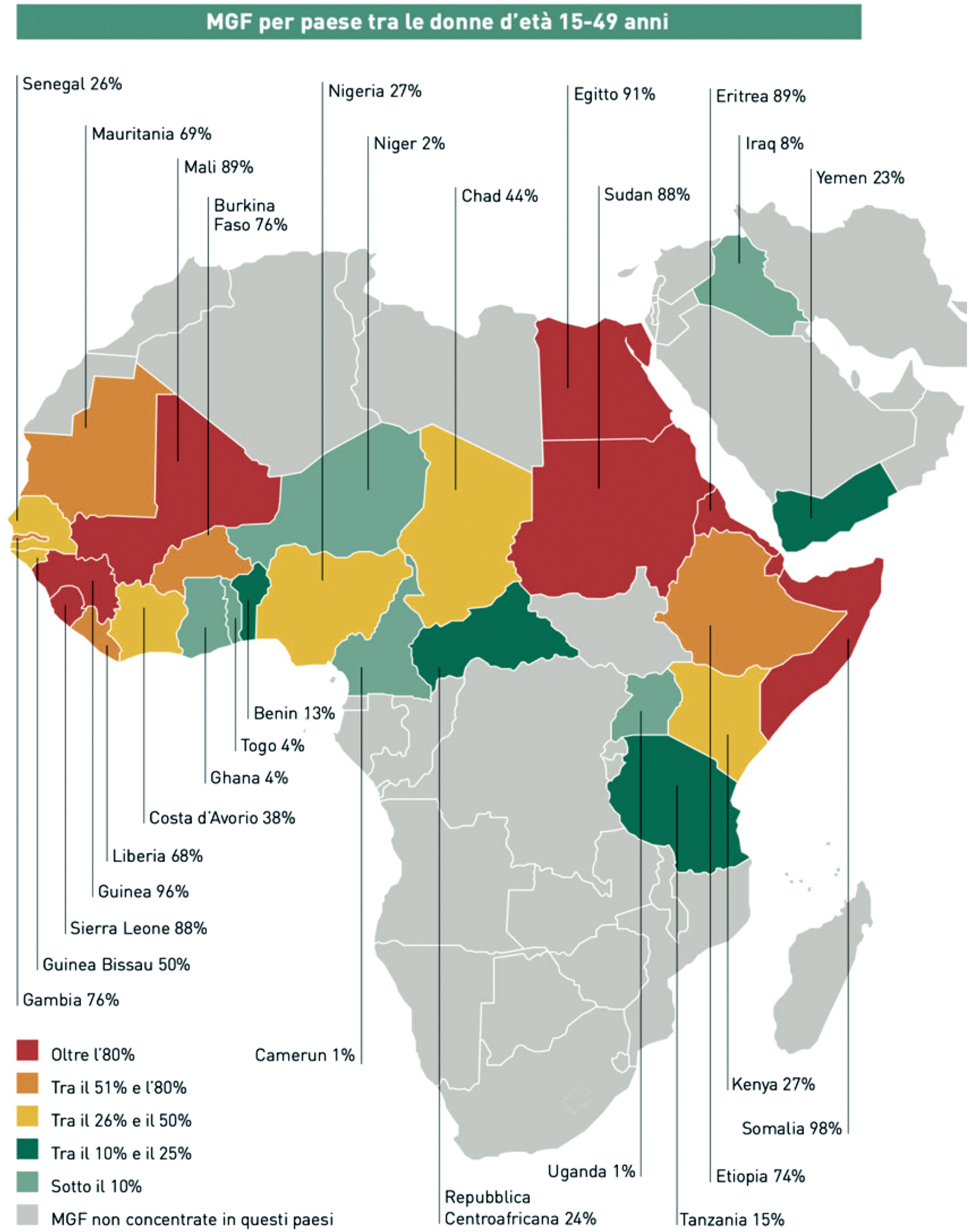

Fig. 1. FGM by country among women aged 15-49 [31].

cient to prove the credibility of the facts even circumstantially (C.C. sentences n. 18353/06, 10177/11 and 6880/11).

As regards the healthcare professional (mainly specialists in Gynecology and Obstetrics and Forensic Medicine), they may be required to certify the existence of the mutilation, its typology and extent in order to correctly process the application.

7. Compensation for Damages [9, 32-36]

In civil law, the protection of victims of FGM raises the question of the possibility of compensation for the biological damage caused to them by such practices.

This cannot be separated from a medical-legal assessment concerning not only the assessment of the existence of a legally relevant causal link between the aforementioned practices and the residual injury at a psycho-somatic level but, above all, the transience or permanence of the outcomes themselves. Furthermore, it is advisable to consider the existence of disabling outcomes not only from a physical point of view, but also from a psychic point of view, as these practices are recognized to be very effective in terms of psycho-traumatic outcomes. The repercussions on the functioning of the victim are so considerable that they can configure a framework of Post-traumatic Stress Disorder. An example is given of a sentence condemning compensation for damages in a case of FGM issued by the Court of Appeal of Turin on 26.02.2020 and subsequently confirmed in Cassation in 2021.

Having understood the damage as "the injury to the psychophysical integrity of the person, susceptible to medical-legal assessment, which is compensable regardless of its impact on the income-producing capacity of the injured party" (Art. 5 paragraph 3, Law 57/01), the medical-legal assessment must be undertaken. It is done possibly in collegial action with a specialist of merit in cases that present the profiles of medical professional responsibility as provided for by Law 24/17, and it will have to verify the existence of the impairment, its extent and any functional repercussions on the patient's psycho-physical health.

8. Conclusions

FGM is recognized as a serious violation of the fundamental rights of women and girls and, for this reason, condemned by a series of international conventions which aim to eliminate such practices. In these conventions Italy is also a signatory. In the light of this, in the Italian legal system the practice of FGM, in violation of constitutionally guaranteed rights, entails a series of consequences both in the criminal sphere, in particular the cases referred to in 583-*bis* of the Criminal Code introduced by L. 07/06, and in the civil sphere relating to parental responsibility, international protection and, last but not least, compensation for the damage suffered.

As far as healthcare personnel are concerned, the law provides for an accessory penalty in the event of the practice of FGM, which are also expressly prohibited by the Code of Medical Deontology. Furthermore, since these are crimes that can be prosecuted ex officio, the duty of informing the Public Administration is in force for the doctor or the health professional, a duty defined differently according to the qualification held by the health professional.

Another critical element

is the issue of consent. In the case of FGM we are faced with an act that has no therapeutic value (to which the assisted person may or may not give his consent). This is due to the fact that, in particular as regards the provisions of C1, it concerns actions aimed at producing an impairment of psycho-physical integrity of the person and, as such, liable to prosecution by law. Therefore, in addition to the Penal Law and the Code of Conduct, the provisions of Art. 5 c.c. apply. Finally, please note that Law 219/17 in Art. 1 paragraph 6 specifically states that the patient cannot demand health treatments contrary to the law, professional ethics or good clinical-assistance practices and that, in the face of such requests, the doctor has no professional obligations.

The case of deinfibulation is different, as it responds to a therapeutic need aimed at repairing a serious violation of women's rights, thus not integrating the crime pursuant to Art. 583-*bis* but remaining in any case bound by the provisions of Law 219/17 both for the capable adult and in the case of minors or incapable subjects.

Regarding the recognition of refugee status, the reasons contemplated by Legislative Decree 251/07 may include FGM as serious violations of fundamental rights directed against a gender or social group. This is also stated by subsequent European directives and guidelines of the UNHCR as well as by some judgments at the Italian level.

Finally, with regard to the aspect of the biological damage resulting from FGM and its recovery, the coroner will have to consider for the purposes of the assessment not only the residual physical damage but also the psychic one, since FGM has an important psycho-traumatic efficiency.

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Clash of Law, Social Norms and Cultural Beliefs

Challenges in Eradicating Female Genital Mutilation (FGM) in Kenya

by Maria Angela Wangui Maina*

Abstract
More than 200 million girls and women alive today have undergone FGM worldwide [1]. Kenya is one of the FGM-practicing countries and has 4 million girls and women as FGM victims [2]. The objective of this journal article is to show the link between the following issues as challenging factors hindering the complete eradication of FGM in Kenya: a. The ongoing underground FGM operations despite Kenya's anti-FGM law; and b. The harmful social norms, beliefs and misconceptions directly linked to FGM in Kenya. This study begins by dissecting these issues to show that laws alone cannot eradicate FGM, which has been a practice for centuries. The conclusion herein reveals that law, social norms and cultural beliefs truly clash, and there is no single remedy to eradicating FGM in Kenya. The Kenyan government must make more intentional and localized efforts to tackle these interlinked factors.

Keywords
Female genital mutilation, FGM, girls, women, Kenya, SDGs.

1. Introduction

Female genital mutilation (FGM) refers to a procedure that involves removing partial or whole of the external female genitalia or altering/injuring the female genitalia for cultural or other non-medical reasons [3]. The term FGM is a specific annotation of the fact that it is a procedure with no medical benefit in comparison with male circumcision – which medical experts encourage to reduce the transmission of HIV and sexually transmitted infections [4]. Thus, the international human rights community does not condone using the term "female circumcision" because FGM also leads to immediate health risks as well as long-term complications to physical, mental and sexual health, and overall well-being [5].

Despite the above, FGM is still an ongoing practice. The World Health Organization (WHO) reports that more than 200 million girls and women alive today have undergone FGM in 30 countries in Africa,

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the Middle East and Asia [2]. Kenya is one of the FGM-practicing countries and has 4 million girls and women as FGM victims (21% who are aged 15 to 49 years) [1]. Fortunately, the prevalence of FGM has decreased in Kenya from 38% in 1998 to 15% in 2022 [6]. There is still more to do in FGM eradication. For instance, some identifiable factors challenging FGM eradication include:

a. The ongoing underground FGM operations despite Kenya's anti-FGM law.
b. The harmful social norms, beliefs and misconceptions directly linked to FGM in Kenya.

This journal article shows the link between the above issues as challenging factors hindering the complete eradication of FGM in Kenya. The author is a Kenyan, hence the focus on Kenya as the jurisdiction of focus.

This study begins by dissecting the two main factors to show that laws alone cannot eradicate FGM, which has been a practice for centuries. The conclusion is that the Kenyan government must make more intentional and localized efforts to tackle these factors – which are interlinked in the fight against FGM.

2. Anti-FGM Law in Kenya: Its Interconnection with the Status of Girls and Women, Challenging Beliefs and Misconceptions of FGM

FGM is currently an illegal practice in Kenya owing to the Prohibition of Female Genital Mutilation Act (2011) that has been in force since 4 October 2011. Notwithstanding, reports of FGM incidents often appear in the Kenyan news [7]. From a deeper perspective, it appears relatively difficult to eradicate FGM by this law alone, especially since there are underlying factors that are directly linked to its existence and perpetuation. These interconnected, underlying factors are analyzed herein within the Kenyan context.

2.1. *Prohibition of Female Genital Mutilation Act (2011): Key Provisions and Relating Statutes*

The Prohibition of Female Genital Mutilation Act (hereafter referred to as "the Act") criminalizes FGM in all its forms (mainly clitoridectomy, excision and infibulation). Furthermore, it identifies the parties who can be held criminally liable. The Act is a step towards achieving Sustainable Development Goal (SDG) 5 (gender equality) as it explicitly addresses Target 5.3 of the SDGs (to eliminate FGM) by imposing a life imprisonment penalty for those who directly perform FGM or undergo training to do so, notwithstanding consent given. The Act equally addresses Target 5.2 of the SDGs by acknowledging FGM as an act of physical violence against girls and women, similar to the United Nations (UN).

Section 2 of the Act distinguishes the acts of FGM from sexual reassignment procedures or medical procedures with a genuine therapeutic purpose. The definition of "sexual reassignment procedure" is provided "as any surgical procedure that is performed to alter (wholly or partially) the genital appearance of a person to the genital appearance (as nearly as practicable) of a person of the opposite sex" [8]. The provision intentionally and explicitly distinguishes this procedure from FGM.

Section 3 of the Act further establishes the Anti-Female Genital Mutilation Board as a body corporate with the duty

to conduct and design public-awareness programmes, and generally advise the government on FGM matters and implementing the Act, among other functions. So far, the Board is living up to its expectations and heavily works with local communities to achieve its objectives.

Most importantly, FGM is made an offence under Part IV of the Act, where the offences include:

1. Principal offence: "Any person who performs FGM (including persons undergoing training to become a midwife or medical practitioner (under the supervision of a midwife or medical practitioner) to perform FGM; and causing the death of another by FGM". This is an offence punishable by imprisonment for life upon conviction [9].
   There have been increasing instances of FGM medicalization – legitimizing FGM practice as safe and appropriate because it is conducted by a healthcare provider. As reinforced by the WHO, medicalized FGM is on the rise because these healthcare professionals believe in FGM social norms and may be given financial incentives to conduct the procedure [1]. The *2021 High Court Constitutional Petition case brought by Dr. Tatu Kamau* is proof that there are medical practitioners that conduct FGM based on perpetuating social norms and cultural beliefs. In the aforementioned case, the Petitioner (Dr. Tatu Kamau) challenged the constitutionality of the Prohibition of Female Genital Mutilation Act since FGM is a cultural practice and Article 11 (1) of the Constitution of Kenya recognizes culture as the foundation of the nation [10]. In this sense, the drafters of the Act had commendable foresight to combat ongoing and future medicalization of FGM practices, without the exclusion of the old traditional FGM "circumcisers".
2. Aiding and abetting offences: These have been included to punish additional persons who "procure or assist persons to conduct FGM on another in Kenya, take a person outside Kenya to conduct FGM, allow FGM to be knowingly conducted on their premises, possess tools for FGM, fails to report the commission of FGM and persons who use derogatory or abusive language towards FGM victims or shame a woman who has not undergone FGM" [11].
   Privatized FGM procedures are conducted in personal homes or premises, which have become common after the criminalization of FGM. In such instances, the Act puts great effort to capture each actor that may partake in encouraging FGM practices privately to circumvent legal punishment. For example, parents are well-known to collude with "circumcisers" to cut girls in private homes [12].

Indeed the greatest risk of implementing the Prohibition Against Female Genital Mutilation Act has been the rise of underground FGM operations by communities that refuse to eradicate this belief due to deep-seated traditions and beliefs passed down intergenerationally. Thus, it may take longer to achieve SDG 5 (Gender Equality) in Kenya. Inversely, the benefit of the Act is that it indicates a strong will to deconstruct these traditional

beliefs that have no place in modern society.

Additional legal instruments in Kenya work alongside the Prohibition of Female Genital Mutilation Act to eradicate FGM.

1. International legal instruments ratified by Kenya and forming part of national law by Article 2 of the Constitution of Kenya:
   - *Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)*: Ratified by Kenya in 1984, this convention addresses the rights of women and girls, including the elimination of harmful practices such as FGM.
   - *African Charter on Human and Peoples' Rights*: Kenya ratified this charter in 1992 to emphasize the protection of human rights, including the rights of women and children.
   - *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol)*: Ratified by Kenya in 2010, this protocol specifically addresses women's rights in Africa and seeks to eliminate FGM and other harmful practices.
   - *United Nations Convention on the Rights of the Child (UNCRC)*: Kenya ratified the UNCRC in 1990, which protects the rights of children, including protection from harmful practices like FGM.
   - *Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime (Palermo Protocol)*: Kenya ratified this protocol in 2010, which addresses human trafficking, including trafficking for purposes of conducting FGM.
   - *International Covenant on Civil and Political Rights (ICCPR)*: Ratified by Kenya in 1972, this covenant promotes and protects civil and political rights, including the rights of women and girls to be free from harmful practices like FGM.
2. The Children Act (No. 29 of 2022): Section 23 makes it an offence to subject a child to harmful cultural practices, including FGM, forced male circumcision, and child marriage, *inter alia*.
3. Protection Against Domestic Violence Act (No. 2 of 2015): Section 3 classifies FGM as an act of domestic violence. Part II also provides protective order measures for survivors and victims of such domestic violence acts.

From the list of the above legal instruments and their objects, it is clear that FGM practice is linked to other acts of Gender Based Violence (GBV) acts such as early child marriage. Ergo, the transition into the succeeding sub-section.

2.2. *Harmful Social Norms, Beliefs and Misconceptions Directly Linked to FGM in Kenya*

From studies, the perception of the female gender and social norms greatly inform the beliefs and misconceptions that fuel FGM occurrences today. Occurrences of GBV will become more difficult to tackle as long as the root belief is that the female gender is the "weaker sex". The next few paragraphs explore the main harmful social norms, beliefs

and misconceptions present in FGM-practising communities in Kenya, citing testimonies and case studies conducted on the same.

The main aim of this sub-section is to show that while the law exists to protect us from ourselves, it does not directly do away with the harmful mentality and traditions that have permeated our society for centuries.

2.2.1. Child Marriage

The rationale for practising FGM varies from community to community in Kenya, but the foundational reasons seem to be marriageability and controlling girls'/women's sexual desires. The Defence Witness in the *2021 High Court Constitutional Petition case brought by Dr. Tatu Kamau* testified that FGM is usually performed on girls between ages 4 to 14 either as a rite of passage, to preserve virginity for marriage, upon being married, during the first pregnancy or labour [10]. According to UNICEF, FGM is performed at different ages around Kenya, including after the age of 15 in some ethnic groups [2], but other studies show it may be conducted as early as ages 7 to 12 [13]. Many different traditions exist, but the prevalent reason for FGM is a traditional rite of passage to mark a girl's coming of age and prepare her for marriage [13], as a sign of her marriageability [14], sexual chastity and other traditional beliefs [15]. As such, once a girl is subjected to FGM, she is expected to be subjected to marriage shortly after.

The correlation between FGM and child marriage is so strong that anecdotal evidence suggests that uncut girls are less likely to be desirable for marriage and often excluded from wider social events within a community [14]. Consequently, child marriage leads to teenage pregnancies, thus disrupting any ambitions to resume education in most cases [16].

2.2.2. Tribal Community Traditions, Parental Attitudes and Stigma

Parents come from a community with traditional practices and beliefs passed down from generation to generation. Parents then form an attitude that is difficult to deconstruct, passing it down to their children. This is often how FGM practice passes on trans-generationally.

A 2020 academic study concludes that there is an association between daughters' cutting and favourable parental opinions towards the practice [17]. As narrated by an FGM activist, parents still pass on the mentality that they should stigmatise those who refuse to undergo FGM as a rite of passage [16]. In other areas, where the link to traditional rites of passage does not exist or is in decline, girls are reported to be cut with little or no celebration; and the procedure is increasingly carried out by medical personnel [13].

2.2.3. Low Literacy Levels

Another main factor that leads to the continuation of FGM is the low literacy levels on its dangers, especially at the grassroots level, for both parents and children within the practising communities. Additionally, we have also explored the link between FGM practices and the ability of girls to continue their education – an ambition that appears impossible since girls are married off after FGM.

An FGM activist testify that many of their parents did not attend school, so they are not aware of the dangers of

FGM [16]. However, uncut girls are considered less likely to be subjected to early marriage (as they are considered unsuitable for marriage and sexually unchaste), thus are more likely to be able to stay in school [14]. Inversely, one can imply that protecting girls from FGM gives them a better chance to access school education.

A 2020 case study in Kenya concluded that providing FGM to communities, particularly young men coupled with keeping girls in school appeared to be an effective method [18]. Moreover, supporting education and targeted training are recommended to enable all stakeholders to sensitively and respectfully address FGM as a complex and long-standing practice [19].

2.2.4. Cross-Border Migration

In Kenya, FGM practice is relatively high in some communities, specifically among the Somali (94%), Samburu (86%), Kisii (84%) and Maasai (78%) [20]. Kenya ranks number 19 rank in the worldwide FGM index and Somalia ranks number 1 – a country with strong relations and presence in Kenya because of migration (forming approximately 2,780,502 of the total 47,564,296 Kenyan population) [21]. Therefore their traditions remain even after migration to Kenya, making it a little more different to eradicate as the FGM practice is also linked to the practice of Islam. A local religious leader in the North-Eastern Somali community tells UNICEF that "Islam is a religion of mercy but FGM is merciless to the girl child and therefore negates our belief. It is a harmful and unnecessary evil" [22].

3. Conclusion: Need for a More Localized FGM Eradication Regime

A more localized FGM eradication regime is necessary for Kenya to effectively address the cultural, social, and regional nuances that perpetuate the practice. By tailoring interventions to specific communities, engaging local stakeholders, and allocating resources strategically, we can make significant progress in eradicating FGM and safeguarding the rights and well-being of women and girls in Kenya. Such an approach is necessary to address the unique challenges and dynamics present at the regional and community levels.

One of the primary reasons for a localized approach is the significant cultural variation within Kenya. The country is home to various ethnic groups, each with its traditions and beliefs. These differences affect the prevalence and acceptance of FGM in different communities. Therefore, a blanket approach to eradication may not effectively tackle the issue across the entire nation. Instead, targeted interventions tailored to the specific cultural contexts and sensitivities of different regions are crucial.

A localized regime enables a more comprehensive understanding of the factors contributing to the persistence of FGM within specific communities. It allows for in-depth research into the underlying beliefs, social norms, and economic factors that perpetuate the practice. This knowledge is essential for designing effective interventions that challenge the misconceptions surrounding FGM and promote alternative, healthier rites of passage.

Furthermore, a localized approach encourages community ownership and participation in eradicating FGM. It recognizes the importance of engaging local leaders, religious institutions, and influential community members in promoting change. By involving these stakeholders,

interventions can be designed to respect and preserve cultural values while simultaneously challenging harmful practices. This participatory approach fosters a sense of empowerment and ownership within the community, leading to sustainable change and a greater likelihood of long-term success.

Additionally, a localized regime allows for the allocation of resources in a targeted and efficient manner. By focusing efforts on specific regions with higher prevalence rates, resources such as funding, healthcare services, education programs, and awareness campaigns can be concentrated where they are most needed. This approach maximizes the impact of limited resources, ensuring that interventions reach the most vulnerable populations and make a tangible difference.

However, while a localized approach is crucial, it is important to maintain a national framework that sets clear legal guidelines and standards for eradicating FGM. National legislation acts as a powerful tool to enforce prohibition, protect victims, and hold perpetrators accountable. Localized efforts should work in tandem with national policies to create a comprehensive and coordinated approach to eradicating FGM in Kenya. The 2010 UNICEF Innocenti report highlights local interventions and national programmes at different stages of implementation. Each, in different ways, provides evidence and insights that contribute in varying degrees to understanding the complex social dynamics of abandonment of FGM/C. Legislation is only part of a broader transformative process to complement and uplift local-level efforts [13].

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Elementary Tools of a Riverine and Rural Health Worker in Southern Nigeria

Lessons from the Field

by Oritseweyinmi Erikowa-Orighoye*

Abstract

This article explores the essential tools and practices employed by health workers operating in riverine and rural areas of the Niger Delta. The article aimed to understand the roles, challenges, and experiences of these workers and derive valuable lessons from their fieldwork.

The article highlighted the primary tools utilized by riverine and rural health workers, shedding light on their crucial roles in delivering healthcare services to underserved communities. It included the importance of leveraging locally available resources and adopting culturally appropriate practices.

Furthermore, the article explored strategies to address the challenges faced by riverine and rural health workers. It emphasized the need for tailored support, improved infrastructure, and enhanced training programs to strengthen the healthcare system in the region.

Keywords

Universal health coverage, health worker, coastal areas, Niger Delta.

"Universal health coverage depicts the availability and ease of access to healthcare services for all individuals without suffering the risk of financial bankruptcy, while health systems strengthening involves the amalgamation of various practices, instruments and policies to improve the quality of a country's healthcare system" as stated by Dr. Tedros, the WHO director general, when speaking on Health systems strengthening, Universal health coverage, and Global health security [1]. The World Health Organization (WHO) estimated a projected shortfall of 18 million health workers by 2030, mostly in low- and lower-middle-income countries. However, many countries irrespective of the socioeconomic development they face, to varying degrees, difficulties in the education, employment, deployment, retention, and performance of their health workforce [2].

Despite the increased funding from donors like the UK, many countries still require support to supplement low resources in their health sectors, this is highlighted in several African

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countries which are unable to meet the target of committing about 15% of their government's expenditure to healthcare due to chronic underinvestment and poor quality of healthcare systems [2, 3]. Owing to a wide range of economic and political factors, this has further worsened as African health professionals have been leaving for destinations within the region and abroad, searching for better living standards countries with better employment opportunities [4]. This is reported as the current brain drain, happening in countries like Nigeria, Ghana, Zimbabwe, with reports showing that, from Nigeria, the health workforce density is about 1.95 per 1000 population, which is complicated by inequities in the health workforce distribution, due to the lack of national policies guiding the posting and transfers of health workers, with the Covid-19 pandemic bringing this to the fore [4, 5].

In developed countries like Australia, Italy, and the UK, where healthcare workers from Africa are in high demand, especially with their aging population and the impact of Covid-19, the wages are higher [6]. The loss of staff through migration is leaving knowledge gaps in already fragile health systems, but global health security specialists believe that amid the trauma of the pandemic lies the opportunity to create policies that protect health staff and incentivize them to stay [7, 8].

The United Nations has proposed the Sustainable Development Goals to improve universal health coverage for all people and ensure quality of health coverage at all places including rural areas, although this is difficult, due to the inability of rural areas to attract and retain healthcare professionals (HCP) by reason of several factors [9]. Therefore, the search for innovative strategies that involve communities is very important for ensuring health. Like other African countries, Nigeria (alongside the exodus of health professional to developed countries), it is still faced with the poor distribution of the available healthcare workforce positioning in most areas of the country, especially the rural, riverine, and other underserved areas and, therefore, the primary care health facilities are facing a disadvantage. [10, 11] The deployment to and retention of health workers in the rural and riverine areas remains a challenge [11]. In Nigeria, for example, more than 82% of the rural population is excluded from health-care services due to insufficient numbers of health workers compared to 37% in urban areas, according to the International Labor Organisation [12].

Research has shown that low staff-to-patient ratio has been recorded in rural areas, the hospitals and clinics in the rural and riverine areas are often short-staffed because many healthcare professionals tend to seek better opportunities in the urban regions [13, 14]. In addition, there are inadequate facilities and equipment for effective diagnosing and treatment, untrained and inexperienced staff, as well as inappropriate diagnostic tools [13, 15]. There is also evidence of the government's neglect as there are inadequate policies in place and poor partnerships with various stakeholders [13-15].

The Niger Delta region is rated as one of the most oil spill vulnerable areas in the world, with about 123 gas-flaring sites [16]. Several oil facilities are located close to the homes, farmlands, and water sources of host communities in this region. Environmental pollutants, such as volatile organic compounds (VOCs), heavy metals, polycyclic aromatic hydrocarbons (PAHs), are released when oil is spilt, and gas flared with several reports

showing that living in areas polluted by oil have adverse effects on human health [16-18]. Studies have reported that oil pollution in the Niger Delta affects men and women disproportionately, with women being more exposed and vulnerable due to some cultural and socio-economic factors [19, 20]. With reports showing that women tend to bear the highest burden of environmental degradation, especially women of childbearing age who are often considered as a vulnerable group [21].

Reports of corruption, ethnicity and conflicts in the Niger Delta constitute serious barriers to the development of the Niger Delta region [13]. These factors tend to affect the collaboration of stakeholders (state and local government official, health boards, local leaders, and community members) and continuity towards healthcare delivery, with reports showing an increase in death rates, from preventable causes such as severe malaria, anemia, meningitis, tetanus, all due to unavailable emergency healthcare services, travel distance to available and functioning health centers and high cost of services [13, 21-23]. Water transport is the major mode of transportation for most of the communities and issues such as long travel distances, high cost of transportation, and lack of quick and ready means of transportation have posed challenges to acquiring necessary health treatment. Transport services are poor in the rural and riverine areas and not readily available, thus affecting access and schedules or planned movement [24, 25]. Owing to the barriers being experienced in accessing good healthcare services, such as emergency care, maternal and child healthcare; there is an increase in the patronage of traditional health centers that are not medically certified in the rural and riverine areas [26,27]. There is a limitation of a sustainable health care financing scheme in these areas and, thus, a high rate of out-of-pocket payments system for health care services exists. The people financially contribute or pay more for health care services than official care and funding programs [28,29].

How can sustainable support systems improve delivery of healthcare and quality of living in rural, riverine, and underserved communities? Countries in Africa, like Sierra Leone and Ghana, have implemented several strategies such as compulsory postings and incentives (20-30% increase in salary, staff vehicle hire) as motivators for health workers to accept rural practice [30, 31]. However, neither of these has yielded the desired results in addressing the lack of health professionals in rural areas [30,31]. A review of the literature on the attraction of health staff to rural areas in middle- and low-income countries and their retention points to poor working conditions, such as a lack of safe and clean water, poor sanitation of health facilities, limited career progression prospects, show a lack of management and community support and the absence of proper equipment and infrastructure at the health facility level, as reasons deterring health workers from practicing to rural and riverine areas [30-33]. Other reported varied factors influencing health workers' willingness to practice these settings, are socioeconomic status, rural background, gender, culture, and individual and curriculum characteristics [31, 32].

The local and state government and the problems of imbalances in the distribution of these health workers persist, with certain local government areas in the rural and riverine communities remaining at a disadvantage, as they slowly implement these ideas and many more. There is a need to

adopt sustained and innovative actions at an individual and community level to address the current health workforce problems in primary health centers located in rural and riverine communities. Studies have shown the important factors that are required for rural practice based on recruitment and retention, which includes understanding the setting, community engagement and leadership; yet, several health workers feel unprepared for some aspects of rural or riverine practice [34]. This paper sought to capture the breadth of possible strategies based on the experiences of a health worker in a riverine and rural area in Southern Nigeria.

1. Community engagement and tailored solutions: Every rural and riverine community is unique, facing peculiar challenges, and must shape its own solutions. It is helpful to work with a logic model that suits a community itself rather than working with a rigid pre-designed model that might not be effective. Some reports argue that a rural or riverine upbringing or some lived experiences might be a key requirement to practice in rural/riverine areas [22] although it is helpful for healthcare workers to identify and understand the value of a rural/riverine health career, what it means to them as it will determine how well they engage with communities and offer tailored healthcare delivery. It is helpful to be community centered, irrespective of the size of the community as communities can be clustered when it comes to healthcare services in rural/riverine areas and the spectrum of care might differ across communities.
A rural inland community might engage with the health center, promoting door-to-door health visits for immobile patients with an attempt to bridge the gap and ease the burden of transportation, while a riverine community with road access might opt for a different form of health promotion.
A health worker would need to consider the wider social determinants of the patients that have an impact on their health and wellbeing. To engage with communities, health workers need to lead and advocate, which includes finding champions in each community and helping them develop the skills they need to facilitate behavioral change. A health worker, in a rural/riverine area, needs to be aware of the vulnerable population, as those represent the people who need the most. As in the case of working in the Niger Delta, a health worker needs to be aware of the environment and its impact on vulnerable groups in the community. For example, mothers bringing in infants under 5 years with severe undernutrition, should trigger conversations not only about nutrition but water sources too, as most water sources are contaminated from the oil spills.
2. Building and empowering primary healthcare teams: Due to the shortage of healthcare workers performing in rural and riverine areas, various government and non-governmental organizations engage with communities to deliver healthcare. Such organizations work with local primary health centers by designing and delivering programs that seek the improvement of the utilization of PHCs in some of the riverine and rural areas of the Niger Delta. Being a health worker, it is important to know that con-

fidence and competence are developed through exposure in rural settings and skills building in rural competencies to fully engage with the communities and building strong teams, one must invest in understanding the political, socio and economic dynamics that involve the delivery of healthcare in these settings. For example, to carry out immunization in a community, a health worker would need to inform the stakeholders of the development and get the relevant approval from the leaders. The commitment and success of such program in these areas is dependent on teamwork and how the information is delivered.

3. Resilience and accepting uncertainty: Uncertainty is an accepted component of medicine; however, this is usually described within the context of a diagnostic dilemma and the clinical reasoning processes used to manage it [35]. In this context, as a health professional, uncertainty points to how often and to what extent one's own clinical skills will be stretched. For instance, having clinical courage on a midnight call with an obstructed labor on an island without the availability of boat transport to the nearest hospital, requires taking not only the initiative and pushing boundaries on acute care skills, but also these skills are required to appropriately manage patients with complex, less acute, problems, such as mental health, complications of diabetes and maternal cases. There is also a need to identify, understand and adapt the expertise of transferring skills used in different situations to a new situation, as well as figuring out what to do in real time in a life-threatening situation.
4. Managing technology innovations and current reality: There is a clear sense of not having the personnel and equipment that might be available in better resourced areas when managing patients in rural/riverine communities. Familiarity with the context of practice and relationships with the local leaders of a community, local team members and the available and accessible distance support and retrieval systems, will enable a health professional to maximize the available local resources for the benefit of their patients. Being unfamiliar with this context, such as managing a child with cerebral malaria and severe anemia, who needs to be referred to – but there's no Internet connection to make a direct call – might cause serious concerns with increased anxiety for the health workers as they might be less aware of the resources they could call on in challenging clinical circumstances. As much as we are in the times of smart phones, a simple phone without Internet might be effective in delivery healthcare as its battery might say long. There might be a need to use radio transmitters for emergencies. Currently, mobile phones are used as tools to improve and speed up access to healthcare systems in rural areas, and have been used in healthcare workers' training, prevention and access to health information, remote consultations, and patient monitoring. We can affirm that the adoption and use of mobile phones has obvious benefits for improving the health literacy of populations living in rural areas [36, 37]. One major challenge with this development is that the Internet quality available is

very poor and under political control. Poor Internet quality seriously hampers the success of the use of mobile phones in rural/riverine settings for a health worker. One might mitigate the above challenge if there's a provision of infrastructure; however, the equipment supporting connectivity (electricity) is not readily available, or unreliable when it exists. Apart from being an under electrified continent, untimely, frequent, and long periods of electricity cause cuts in health delivery both in urban and rural areas. As a health worker in the rural and riverine area, one needs to have alternative measures to manage and work with technology and the delivery of healthcare.

5. Literacy levels and language of the population: Although educational attainment is not an isolated factor in health literacy, the type of education system in which individuals are included plays a very important role. Reports reveal the differences between health literacy levels in urban and rural settings, showing that rurality alone is not a risk factor for low literacy; yet, when accompanied by the aforementioned factors and a health system that does not prioritize easy access to health care in rural areas, important disparities in health literacy may occur between urban, suburban, and rural areas [38, 39]. Thus, health workers in rural and riverine areas need to understand the literacy levels of the communities, as it requires plugging in and living there. There is a need to prepare for confidentiality issues that arise for a village doctor, nurse or community health worker who is aware of the patients with STIs, alcohol and substance abuse, mental health issues and how to interact with them outside care settings. It is helpful to understand the power and intimacy with patient, staff, and the community.
6. Lessons Learned: The self-assessment literature cautions of overconfident self-judgements are not uncommon, and that experience can increase confidence and, thereby, increase the risk of overestimating one's own skills [35]. Humility is not a passive process. These health workers, including doctors, working in low resource settings at a distance from tertiary care and, often, secondary care centers, do not conflict confidence with competence. Limits are sought through deliberate practice and testing, self-reflection and critical discourse with experts and peers, patients, and community members. As a society, we are into quick solutions. That approach will not work for most rural and riverine communities.

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Advocating the Minimum Health Care Policy for Those Who Are Invisible

The Stateless

by Andrea Pettini*

Abstract
Fighting for global health care means fighting for civil (and *minimum*) rights for those who are "legally invisible". Stateless people face the risk of rights violations every day, from destitution and denial of basic services to immigration detention. Many are forced to be separated from their families. The cause for this is that most European states have yet to put in place procedures to identify stateless people and provide them with a route out of limbo and the chance to rebuild their lives[1].

Keywords
Worldwide policies, minimum rights, citizenship, National Governments, State(less) and Settler, minimum and global health assistance.

1. Definition and Extent of Statelessness

A stateless individual is someone who is not "recognised" as a national by any country. Just to make it short, these people are not entitled not only to have a passport, ma even to ask for it! The number of stateless people globally is – at this time – still unknown. UNHCR data received from circa 96 countries indicates that, at the end of 2021, there were an estimated 4.3 million stateless people or persons of undetermined nationality. Based on these figures, the largest known populations of those who are stateless or of undetermined nationality can be found in Côte d'Ivoire (931,166), Bangladesh (918,841), Myanmar (600,000), Thailand (561,527) and Latvia (195,190)[2].

1.1. *International legal framework for protection from statelessness*

There is an international legal framework to protect stateless persons and to prevent and reduce statelessness. The 1954 Convention Relating to the Status of Stateless Persons (1954 Convention)[3] sets out the international legal definition of a *stateless person* as someone "who is not considered as a national by any State under the operation of its law" and extends to these persons *specific rights* such as the right to education, employment and housing as well as the right to identity, travel documents and administrative assistance. In this definition,

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nothing has been mentioned about access to health care service or the right to have a *minimum* standard health care protection.

The 1961 Convention on the Reduction of Statelessness (1961 Convention[4]) requires that States establish safeguards in legislation to prevent statelessness at birth or later in life, for example due to loss or renunciation of nationality or State succession.

The right to a nationality is also set out in several international human rights instruments and statement, such as the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, the International Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the Elimination of All Forms of Discrimination Against Women, the Convention on the Rights of the Child, the Convention on the Rights of Persons with Disabilities, and the Migrant Workers Convention.

Furthermore, customary international law reinforces the statelessness conventions through key norms such as the prohibition on racial discrimination, which applies to both the acquisition and loss of nationality and the treatment of stateless persons.

However, although almost all European states have signed up to international law standards on the protection of stateless people, most internal legislation based on National's *Magna Charta* of different country, have to face the non-existence of effective national frameworks to put these commitments into practice. This has left many people facing discrimination and rights violations daily.

The solution to this problem is a strong national-based "political will". States need to set up statelessness determination procedures as a regularisation route for stateless people who would otherwise be stuck in indefinite limbo. The limbo in which the risk to be put *at-the-border* on any health care protection policy is realistically concrete.

Encouragingly some countries have recently taken positive steps towards this goal. The Statelessness Index web page[5] provides in-depth information and analysis on how countries within Europe are performing against their international commitments in this area (and others). The Index compares what countries are doing to identify and protect stateless people, including whether they have a dedicated procedure in place and how it stands up to scrutiny against international norms and good practice in areas such as procedural safeguards, evidentiary assessment, appeal rights, protection status, and acquisition of nationality. The Index highlights some good practice, but it also demonstrates that there is much still to be done. By the way, even in this circumstance, the minimum standard for Health care protection is vaguely mentioned.

"First and foremost, it has become clear stateless people are among those most adversely affected by the pandemic..." says Mr. Chris Nash, director of the ENS*. "They are also often the first to react on the ground and support their communities. It is critical that stateless people and affected communities are heard and better resourced. Working together with stateless people, we seek to address the protection gaps exposed by the pandemic"[6]. It is interesting to notice that in the ENS's strategic plan 2019-23, Solving Statelessness in Europe – among different priority issues the ENS Advisory has identified four broad priority – the "health" themes is sufficiently "mentioned".

Nevertheless, later the onset of Covid-19, the NGO's representing the stateless community have stressed local authorities across Europe to ensure that healthcare systems meet the needs of the entire population, including the marginalised and disadvantaged and – over all – those who are not "present" in the territory based on paper-documentation. In most countries, legal status and formal documentation in fact are prerequisites for accessing quality and *minimum* standard healthcare. They are also prerequisites for gaining access to important social determinants of health, including employment, social protection, and adequate housing. Over 500,000 stateless persons in Europe, many belonging to minorities, do not enjoy the fundamental human right to recognition everywhere as a person before the law[7]. In a recent Report, provide by European Network on Stateless (ENS) in the 2021, Miss Dunja Mijatović as Council of Europe Commissioner for Human Rights as quoted as "Covid-19 has demonstrated that the right to health cannot be protected at an individual level. It requires effective systems that provide for inclusive prevention, treatment, and rehabilitation for all, leaving no one behind and ensuring that structural inequalities are not magnified over time but disrupted and addressed"[8].

Delving into some aspects of the ENS report *Situation Assessment of Statelessness, Health, and Covid-19 in Europe*[9], might also be useful to get a more global view on the state of the art of "needs". The sociological survey was based on strict data collection mechanisms. Moreover, in the end it produced a set of recommendation that it might be useful to know a little more in depth.

In a broader context in terms of "rights," the ESN Report clearly identifies some needs related to the "right to health" and suggests some "political" initiatives for states in the form of Recommendations.

Let us have look at the most relevant ones:

- States must guarantee the right to health of all on their territory, including stateless persons during and after Covid-19.
- States should consider regularising all stateless people during public health emergencies in order to guarantee the right to health. In the longer-term and where they have not yet done so, States should introduce mechanisms to identify and resolve cases of statelessness on their territory as well as statelessness determination procedures to guarantee stateless migrants the protection they are due under the 1954 Convention.
- States must uphold the protection of life and health for all stateless persons via appropriate disease mitigation and support measures in camps, shelters, settlements, social housing and immigration detention settings; and including those who are homeless. Stateless people and their communities no matter what setting (spanning community, accommodation centres, and immigration detention settings) must be provided with personal protective equipment (masks) and other basic necessities (handwash, soap, hot and clean water, towels).
- States must not detain stateless people under the pretext of disease prevention or containment. States are obliged to take steps to prevent the arbitrary detention of stateless people and ensure full access to rights and services whilst pro-

Fig. 1. Palestine is perhaps the most famous of all modern cases of "statelessness". What does it mean to be a national of a state without formal recognition, especially over the course of many decades and generations? This issue is considered in the bottom of the international political discussion, due to the long-time struggles in the Gaza's area.

viding sufficient housing, health, and social care (including childcare) support on release from immigration detention.

It would be also interesting to have a look about the Statelessness Community in Europe. In December the 14th, 2015 the *Conclusions of the Council and the Representatives of the Governments of the Member States on Statelessness* was adopted. As consequences of the Conclusion, within the debate in the Justice and Home Affairs Council[10] arrive the Conclusions to give the mandated to the European Migration Network[11] (EMN) to establish a platform for exchange of information and goods practices. The Steering Board of EMN established the EMN Platform on Statelessness on 20 May 2016. The aim of the EMN Platform on Statelessness is based on the intention to raise awareness in regards with statelessness and to bring all the relevant stakeholders in the field together: representatives of Member States, European Commission, European Parliament, European agencies, international organisations, and NGOs. The first practical objective of this platform was to determine the state of play of statelessness in the European Union.

In addition, the platform collects and analyses information on statelessness via the EMN ad-hoc query system. The most recent report *EMN INFORM Statelessness in the EU, update version 4.0 in November 2016* is available on line at this address/:/ https://home-affairs.ec.europa.eu/[12]. Is a very interesting Report as it delves into the legal situation of each European country in relation to statelessness. For each individual member state of the Union, a whole range of issues is covered, in terms of the lack of rights and the weakness of each country's protection system.

In conclusion, it is evident that the *status* of stateless often

Regional Bureau for West and Central Africa
FORCIBLY DISPLACED AND STATELESS POPULATION
as of 31 January 2023

13.0 MILLION FORCIBLY DISPLACED POPULATION

The total forcibly displaced and stateless population to UNHCR in West and Central Africa (WCA) relates to the people UNHCR is mandated to protect and assist. It includes those who have been forcibly displaced; those who have returned home within recent years; those who are stateless or at risk of statelessness; and other groups to whom UNHCR has extended its protection or assisted on a humanitarian basis.

- 1.6 MILLION REFUGEES & ASYLUM-SEEKERS
- 7.7 MILLION INTERNALLY DISPLACED PERSONS
- 1.6 MILLION STATELESS & AT RISK OF STATELESSNESS
- 1.7 MILLION RETURNED INTERNALLY DISPLACED
- 0.1 MILLION REFUGEES RETURNEES
- 0.1 MILLION OTHERS OF CONCERN

The total of 1.6 million refugees represents an 4% increase from January 2022. Chad hosts the largest number of refugees in the region with 37%. Cameroon is the second largest refugee-hosting country in the region with 30%. CAR, Sudan, and Nigeria are the main countries of origin (together 76%) of the region's refugees with a contribution of 30%, 25%, and 21% respectively.

The number of internally displaced rose to an estimated 7.7 million. Nigeria hosts 41% of IDPs in the region. Burkina Faso is the second largest country in terms of IDPs (24%).

The Lake Chad Basin hosts 34% of forcibly displaced population in West and Central Africa. Central Sahel hosts the second largest number (32%) with the majority being Internally Displaced Persons in Burkina Faso (61%).

MAIN COUNTRIES OF ORIGIN

CAR 486,290; SUDAN 411,675; NIGERIA 350,074; CAMEROON 131,369; MALI 101,551; BURKINA FASO 57,561; MAURITANIA 26,477

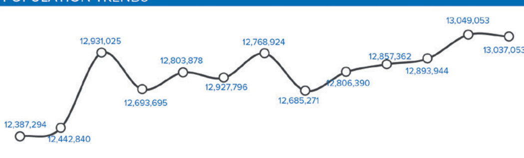
MAIN COUNTRIES OF ASYLUM

CHAD 599,211; CAMEROON 483,857; NIGER 302,056; NIGERIA 93,405; MALI 64,015; BURKINA FASO 35,175; SENEGAL 12,062

INTERNAL DISPLACEMENTS

NIGERIA 3,167,581; BURKINA FASO 1,882,391; CAMEROON 983,281; CAR 515,665; MALI 440,436; CHAD 381,289; NIGER 361,593

POPULATION TRENDS



PERSONS OF CONCERN BY COUNTRY

MALI 1.3M; NIGER 701K; CHAD 1.1M; SENEGAL 12K; CAPE VERDE 115; GAMBIA 4K; GUINEA BISSAU 69; GUINEA 2K; SIERRA LEONE 10; LIBERIA 2K; COTE D'IVOIRE 1.7M; BURKINA FASO 1.9M; GHANA 8K; TOGO 10K; BENIN 3K; NIGERIA 3.3M; CAMEROON 2M; CAR 1M; E.G.; GABON 290

The boundaries and names shown, and the designations used on this map do not imply official endorsement or acceptance by the United Nations.

	REFUGEES	ASYLUM SEEKERS	REFUGEES RETURNEES	IDPs	RETURNED IDP	STATELESS	OTHERS	TOTAL
BENIN	1,885	1,499						3,384
BURKINA FASO	34,622	553		1,882,391				1,917,566
CAMEROON	474,474	9,383		983,281	555,668			2,022,806
CAPE VERDE						115		115
CAR	11,260	485	31,662	515,665	499,430			1,058,502
CHAD	594,235	4,976		381,289			101,551	1,082,051
COTE D'IVOIRE	5,633	205				1,656,330		1,662,168
GABON	213	77						290
GAMBIA	3,691	209						3,900
GHANA	6,243	1,955						8,198
GUINEA	2,204	266						2,470
GUINEA BISSAU	32	37						69
LIBERIA	1,680	839						2,519
MALI	63,127	888	84,898	440,436	695,598			1,284,947
NIGER	255,367	46,689		361,593			37,606	701,255
NIGERIA	91,766	1,639	3,880	3,167,581				3,264,866
SENEGAL	11,799	263						12,062
SIERRA LEONE	10							10
TOGO	9,097	778						9,875
GRAND TOTAL	1,567,338	70,741	120,440	7,734,687	1,750,696	1,656,445	139,157	13,037,053

REFUGEE POPULATION PROFILE

CHILDREN 53%; WOMEN & CHILDREN 79%

REFUGEES WITH SPECIFIC NEEDS: LEGAL & PHYSICAL NEEDS 131,739; CHILD AT RISK 129,381; WOMAN AT RISK 76,919; SINGLE PARENT 56,752; OLDER PERSON AT RISK 46,423; PERSONS WITH DISABILITY 43,299; SERIOUS MED. CONDITION 24,922

REFUGEES IN CAMPS 46%; REFUGEES IN URBAN AREA 9%

DEMOGRAPHICS (Female / Male): 60+ 2% / 2%; 18-59 24% / 19%; 12-17 8% / 8%; 5-11 12% / 12%; 0-4 6% / 7%

SITUATIONS

CAR SITUATION: 747,578 REFUGEES AND ASYLUM-SEEKERS; 515,665 INTERNALLY DISPLACED PERSONS

These figures represent refugees from Central African Republic in neighboring countries (Cameroon, Chad, Congo, the Democratic Republic of Congo, Sudan, South Sudan) and IDP in Central African Republic.

FAR NORTH CAMEROON: 42,607 REFUGEES AND ASYLUM-SEEKERS; 36,276 INTERNALLY DISPLACED PERSONS

These figures represent Cameroonian refugees in Chad and forcibly displaces people following the outbreak of violence in the Far North region of Cameroon in December 2021.

SAHEL SITUATION: 1,111,618 REFUGEES AND ASYLUM-SEEKERS; 3,065,709 INTERNALLY DISPLACED PERSONS

These figures represent all refugees and IDPs in Central Sahel (Burkina Faso, Mali, Niger), Chad and Mauritania. Refugees from Central Sahel in neighboring coastal countries (Benin, Cote d'Ivoire, Ghana, Togo) are also included.

Creation date: 15.02.2023, Sources: Geographic data: UNCS. Population statistics: UNHCR Monthly Statistical Reports or latest available, IDP statistics from OCHA, IOM. Statistics should be considered provisional and subject to change. For more information, please contact UNHCR RBWCA DIMA <rbwcadima@unhcr.org>

Fig. 2. 13.0 Million Forcibly Displaced Population. The total forcibly displaced and stateless population to UNHCR in West and Central Africa (WCA) relates to the people UNHCR is mandated to protect and assist. It includes those who have been forcibly displaced; those who have returned home within recent years; those who are stateless or at risk of statelessness; and other groups to whom UNHCR has extended its protection or assisted on a humanitarian basis. [https://reliefweb.int/report/nigeria/unhcr-rbwca-forcibly-displaced-and-stateless-population-31-january-2023].

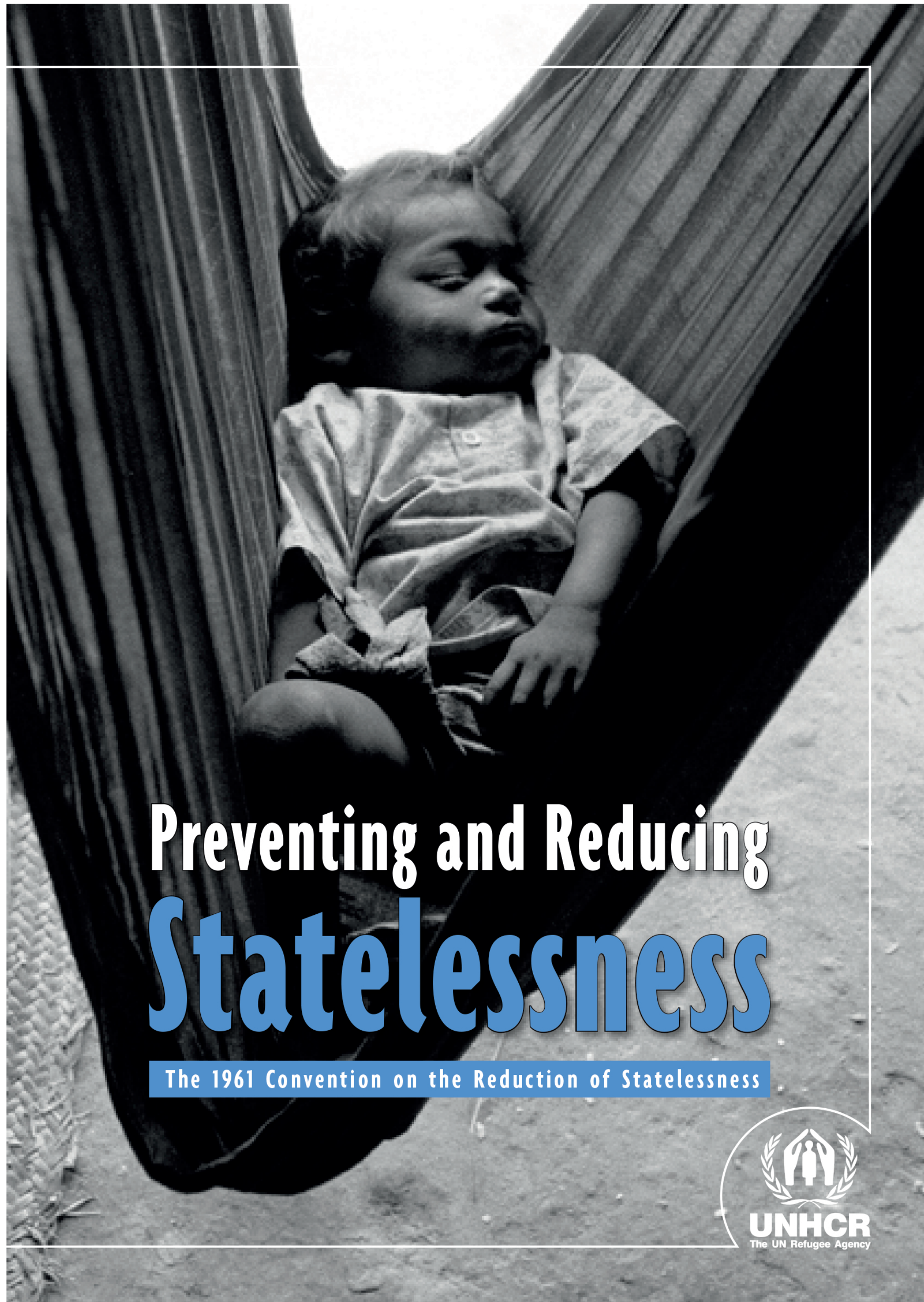


Fig. 3. "Millions of people around the world are stateless. This is a matter of concern. The Convention on the Reduction of Statelessness is an important tool for tackling the problem. Many States already have legislation that is compliant with the provisions of the Convention and implementing it costs very little. Yet few States are parties to this instrument. We need to change that. I pledge the full support of my Office to governments wishing to become parties". António Guterres, secretary-general of the United Nations, https://www.refworld.org/docid/4cad866e2.html.

coincides with that of "undocumented" migrants. A condition of administrative irregularity that pushes to the bottom of civil society these figures deprived of any a guarantee of legality. In addition, it is increasingly difficult to address the issue of fundamental rights if this is strongly linked – inevitably – to the "bureaucratic" issue of a "simple" documents.

Any action to protect the vulnerabilities faced by those in a stateless condition in a country must necessarily start with a clear definition of the legal body of the stateless condition and that should be done at the level of *Magna Charta* for states.

Without a strong relevant philosophy and legal action and despite strong advocacy by civil society and international organisations including UNHCR during the pandemic, the data collected in the ENS, *Situation Assessment of Statelessness, Health, and Covid-19 in Europe* shows that stateless people experience extraordinary vulnerabilities and rights violations in relation to health, but not only. It draws attention to their invisible nature in communities, policies, countries, and at the European level. It reveals a clear absence of specific empirical evidence and attention, by States, on the implications of statelessness for effectively addressing Covid-19.

So, the main question is... what are the consequences that stateless people encounter today worldwide? Without citizenship or a *minimum* process of "National recognition" based on the "territory", stateless people have no legal protection at all and no right to vote and they often lack access to education, employment, and health care, registration of birth, marriage or death, and property rights.

They have no access to life. Just survive to themselves, without past or future, and an uncertain present.

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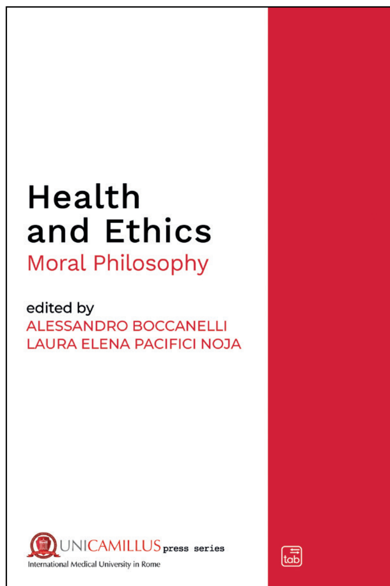
Books Reviews

Health and Ethics

Moral Philosophy

edited by Alessandro Boccanelli & Laura Elena Pacifici Noja



ISBN print: 978-88-9295-012-2
Paperback, 280 pp.
€ 23,00

e-ISBN: 978-88-9295-013-9
€ 12,00

Publication date: Dec. 2020

The book *Health and Ethics* stems from the need to divulge the knowledge and emotions shared by students and professors during the first lessons of Moral Philosophy, led by professors Pacifici Noja and Boccanelli. A spontaneous bond which had arisen amongst the two counterparts, led to an innovative model of creative interaction. The students, divided into 17 groups, had to choose among different themes suggested by the professors, according to their preferences and personal interests. The themes range among many fields, but they have one purpose in common: highlighting and studying the different relationships bonded between the physician and the patient. Therefore, the book was designed to be an important resource for the comprehension and the understanding of both the difficulties and the duties a physician needs to face, but also of the satisfaction and happiness which can arise from them.

Ripartire con la cultura. Ripartire con la sanità

edited by Ugo Giorgio Pacifici Noja

ISBN print: 978-88-9295-293-5
Paperback, 284 pp.
€ 24,00

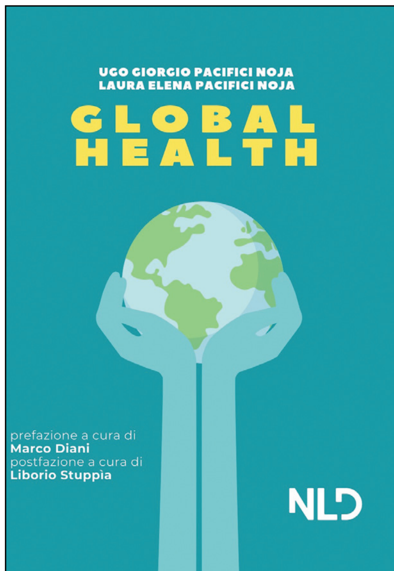
e-ISBN: 978-88-9295-307-9
€ 14,00

Publication date: Nov. 2021

The first annual report of the CIRS – International Center for Social Research in Health Science, established at the UniCamillus University of Rome in 2020, focuses on the concepts of health and culture to encourage a restart. Healthcare and culture, normally united in the commonly used syntagm of "health culture", are here shown and investigated in and from a new perspective, with the aim of creating a permanent debate on the subject, as society and healthcare are in permanent transformation. Professionals from different fields were called upon to contribute to the report, such as the academic, journalistic-scientific, medical management and freelance sectors. However, the first CIRS report is not a white paper, rather it takes the form of a series of interdisciplinary ideas useful for addressing extremely topical topics.

Global Health

by Ugo Giorgio Pacifici Noja & Laura Elena Pacifici Noja



ISBN print: 978-88-3358-831-5
Paperback, 416 pp.
€ 28,00

Publication date: Aug. 2022

Talking about global health means, as has been said, taking a broad look and above all not limited to the concept of health, but at the same time juridical, sociological, and certainly philosophical. The volume that is presented here fits into the wake of a vast foreign and Italian literature in the sector. The new element is described by a multi-perspective representation, which allows global health to be framed with a plurality of focuses instead of from a single angle as usual. The book intends to refer to a multiplicity of possible readers: students, and the academic world in general; those who, for information or in-depth study, need reference texts; those who have to take an exam or an institutional interview in the global health sector. Preface by Marco Diani. Afterword by Liborio Stuppìa.

Authors

Luca Bello

Specialized in Gynecology and Obstetrics, he is the medical director in charge at the service for the prevention and treatment of FGM of the ASL City of Turin. Adjunct professor of Obstetrics and Gynecology at the Department of Public Health and Pediatric Sciences of the Faculty of Medicine of Turin. Since 2015, he has been responsible for the post-graduate training course for Military Doctors at the ASL-City of Turin. Member of the Equal Opportunities Commission of the Turin Medical Association, he is an expert and technical consultant of the judge of the Court of Turin.

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Dr. Oritseweyinmi Erikowa-Orighoye, popularly called Dr. Weyoms is an environmental and public health practitioner, researcher, and coach. She's the director of Programs for Coastal and Marine Areas Development Initiative, and the vice chair of the Institute of Mangrove Ecology and Environmental Technology, Delta State, Nigeria.

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Anita Fortunato is a midwife and sexual educator specialized in Global Health in 2021. Alongside Dr. Luca Bello, she works at the MGF clinic in the comprehensive care, counseling, treatment, and prevention of genital mutilation at the multidisciplinary center for sexual health of the City Health Authority (ASL) of Turin.

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Andrea Pettini

Former International Humanitarian Law's legal adviser, was head of the Italian Red Cross Protection Division and qualified "expert" in the context of the 6th International Course on the Management of the Dead in armed conflicts and catastrophes by the Cameron Forensic Medical Sciences and School of Medicine and Dentistry in London and the International Committee of the Red Cross (ICRC). Author of the first sea arrivals management manual *Ten Steps on Lampedusa. Guideline and Tools in an emergency context caused by international migratory flow in the Mediterranean*. Graduated in Philosophy, currently works at the "Farnesina" and is dealing with the area of judicial cooperation in Europe.

Gian Stefano Spoto

Born in Bologna became a professional journalist in 1983. He wrote for numerous newspapers including «la Repubblica», «Il Resto del Carlino», «Corriere medico». In 1988 he joined the italian television corporation (Rai) where he was special correspondent, editor-in-chief Tg2, vice-director Raidue and Rai International, correspondent from Middle East in Jerusalem. He has conducted several programs including *Linea verde* and *Futura City* on new technologies. Author of numerous publications and five books, the last two about the war in Gaza.

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She is a Kenyan lawyer focusing on policy research and analysis in sustainability, human rights and gender equality. She is currently a legal intern at Pavia e Ansaldo and the chief research coordinator-Africa at The Thinking Watermill Society. She has contributed to 4 books worldwide focusing on policy and advocacy, including *Asylum Rights: Gender as a Protected Social Group in the Asylum Determination Process* (CNR-IRISS). Her top 2 SDGs are SDG 5 (Gender equality) and SDG 10 (Reduced Inequalities).

Refugee camps are considered as extraterritorial units. In some, the right to health is respected, while in others it isn't. After all, this is a reflection of a world in which most countries, if not too many, are not able or willing to take care of the less fortunate.

euro 16,00
issn: 2785-3713
isbn: 978-88-9295-749-7

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