Migration effect on the future of female genital mutilation: the case of African women in Italy

Patrizia Farina – University Milano – Bicocca
Livia Ortensi – University Milano – Bicocca

Background

Female genital mutilation (FGM) defined by WHO and the United Nations agencies as “the partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons” is common mainly in African countries and to a lesser extent in Asia and the Middle East. FGM includes a range of operations that varies from a symbolic nicking of the clitoris to excision of tissue and partial closure of the vaginal area (infibulation). The practice - mostly carried out on girls sometime between infancy and early teens - causes severe pain and has several health consequences. Moreover, it interferes also with the natural function of girls' and women's bodies.

International community recognized FGM as a violation of the human rights of girls and women. Since it is nearly always carried out on minors it is also as a violation of the rights of children. The practice violates a person's rights to health, security and physical integrity, the right to be free from torture and cruel, inhuman or degrading treatment, and the right to life when the procedure results in death.

According to recent estimates 100 to 140 million girls and women worldwide are currently living with the consequences of FGM. In Africa an estimated 92 million girls from 10 years of age and above have undergone FGM.

The causes of female genital mutilation include a mix of cultural, religious and social factors within families and communities. The root of those factors is inequality between the sexes and discrimination against women. In fact FGM is often considered a way to prepare girls for adulthood and marriage linking this practice to premarital virginity (and marital fidelity afterwards). Moreover, in many countries it is believed that FGM will reduce a woman's libido, and thereby is further believed to help her resist to “misbehavior”. Again, FGM is associated with cultural ideals that girls are “clean” and "beautiful" after removal of body parts that are considered as “penis” or unclean.

Tab. 1 Estimated prevalence of female genital mutilation (FGM) in girls and women (15-49 years, %) according to country of residence

Country	Year	FGM prevalence
Somalia	2006	97.9
Guinea	2005	95.6
Eritrea	2002	88.7
Djibouti	2006	93.1
Sierra Leone	2006	94.0
Egypt	2008	91.1
Sudan (Northern)	2000	90.0
Mali	2006	85.2
Gambia	2006	78.3
Burkina Faso	2005	72.5
Ethiopia	2005	74.3
Mauritania	2007	72.2
Liberia	2007	58.2
The Gambia	2007	55.0
Chad	2004	44.9
Côte d'Ivoire	2006	36.4
Yemen	2003	38.2
Guinea Bissau	2007	35.0
Nigeria	2008	29.6
Central African Republic	2008	25.7
Senegal	2005	28.2
Kenya	2009	27.1
Benin	2006	12.9
Tanzania	2004	14.6
Togo	2006	5.8
Ghana	2006	3.8
Uganda	2006	0.8
Cameroon	2004	1.4
Niger	2006	2.2

Source: MICS, DHS and other national surveys, 1997-2009. Published also on http://www.who.int/reproductivehealth/topics/fgm/prevalence/en/index.html

Aims

The growing interest of international community on FGM practice and the political actions to stop it is also related to their spread within cultural environments that is both not willing to accept and hardly understand them. In fact last decades the feminization of migration flow from Africa to Europe, North America, and the Gulf States countries and the stabilization of migrant families has increased the prevalence of FGM and made them to come out as a issues. The first consequence of the awareness of FGM has been the increase of the need to know how many migrant mutilated women live abroad also in order to realize appropriate policies. In Italy as like as in many other countries, the number of women living with the consequences of FGM has been guessed (at worst) or derived applying the same proportion estimates in home countries (at best). Usually estimation of the prevalence among immigrant women is based on the application of the national

level or on expert's hypothesis to the number of women present or on case signaling and reporting by medical professionals (Gallard 1995, Leye et al. 2006). The first methods is clearly not a good approximation because as the prevalence changes between areas and group and fails to consider the process of migrant selection. In other words this procedure is based on the wrong assumption that migration is not-selective and that migrant population behaviors are always the same in time and space. On the contrary researches underline that African female migration is more and more made up of a significant share of women who move independently to fulfill their own economic needs, not simply joining a husband or other family members. Recent studies tell also that such an increase in independent female migration is not confined by national borders: professional women from Nigeria and Ghana now engage in international migration. Female nurses and doctors have been recruited from Nigeria to work abroad, while their counterparts in Ghana are taking advantage of the better pay packages in English speaking countries (Adepoju, 2004). Social selection, existence of migration chains or the existence different migration models can imply a selection also in the prevalence of FGM that can be different from the general national level. Estimation based on medical professionals have been tried in Italian setting (Menonna e Ortensi, 2007) but have proved to be unreliable especially in the cases of excisions that don't cause any problem during pregnancy and delivery and can remain unnoticed to professional that is not been previously trained about FGM.

Giving this premise the contribute has different purposes. The first aim is to provide a reliable estimates of FGM among African women living in Italy as well as the the amount of Second generations at risk to be mutilated. The second aim is to evaluate the factors that reinforce or undermine the practice in migration. The comparison of women characteristics in migration and in home country - education, autonomy, personal experience and so on - may allow evaluating the power of migration itself on the continuation of the practice.

Data

To provide a reliable estimation an FGM module has been added to a general survey about sexual and reproductive health conducted in 2010 in Italy in the region of Lombardy, the first Italian region for number of immigrants that accounts for ¼ of the total international migration. The survey is based on a representative sample of 2.000 women of age 15-49, 1.020 are women from African countries. The quota sampling has been based on data about the general presence of foreign women present in Lombardy coming from the annual regional survey made by the Regional Observatory on Migration that encloses also the irregular component of migration. As one of the aim was the estimation of the prevalence of women with MGF some nationality had a higher sampling fraction. For example the 2011 women interviewed represented 4,9‰ of the target population as estimated at 1 July 2010, but this level was higher for some provenances like Somalia (212,7‰), Eritrea (98,7‰) or Ethiopia (92,1‰). A procedure of data weighting followed the gathering of data. Every interview has therefore a weight inversely proportional to the ratio, distinct by country, between national sample size by age and the general female population by age and nationality. The final weight is therefore the result of three partial multiplier systems.

The questionnaire followed the suggested standard for all country surveys defined by DHS to enable comparison with migrant's home countries. As in DHS module the questions about FGM in

the Italian survey can be divided into four categories: 1) whether the respondent is circumcised or not; 2) what she remembers of her own experience of circumcision; 3) what she recalls of the experience of one of her daughters; and 4) the respondent's opinion about various aspects of FGM (benefits and drawbacks, how and why FGM should continue or not, etc.).

Main results

The estimation of FGM prevalence in Lombardy is 17.2% among African women of age 0-49 (about 21.000 cases) and less than 5% counting all migrants. The number of young girl at high risk of being mutilated is about 1500.

Tab. 2 Estimation of prevalence of FGM between migrants and population of age 0-14 at risk of FGM in Lombardy, 2010

	Age 15-49	***% over total African women of age 15-49***	***% over total foreign women of age 15-49***
African women with FGM	19.920	20,9	4,7
Total African women	95.495		
Total foreign women	419.705		
	Age 0-14	***% over total African women of age* 0-14**	***% over total foreign women of age* 0-14**
African women with FGM	1.410	4,9	1,3
African women at high risk of FGM	1.515	5,3	1,4
Total African women	28.690		
Total foreign women	105.285		
	Age 0-49	***% over total African women of age* 0-49**	***% over total foreign women of age* 0-49**
African women with FGM	21.330	17,2	4,1
African women at high risk of FGM	1.515	1,2	0,3
Total African women	124.185		
Total foreign women	*524.990*		

This result puts FGM back in its right perspective, often lost due to strong stereotypes that cross the Italian social body as well as political arena. No less interesting is the comparison between prevalence of FGM in Italy and in each home country: the prevalence is lower than the one assessed in countries of origin (Nigeria being the only exception). Since the practice is mostly carried out on girls sometime between infancy and early teens such a difference confirms that migration is a process that involves a selection of people - in this case less mutilated. The same selection process is at work for Nigerian women but implies an opposite trend. Most of Nigerian female comes from Benin City area. There the prevalence of mutilated women is over 50% and prevalence rise among urban, wealthy and skilled women (National Population Commission (NPC) Nigeria and ICF Macro, 2009). This process of selection of migration flow turns out to a prevalence of over 70% among Nigerian women in Lombardy. In the end while in the other African countries whose immigrant are present in Lombardy characteristics like urban settling, higher education and

to a lesser extent higher income are associated to a lower prevalence in FGM, for Nigeria they are associated to a higher prevalence of FCG.

Women with FGM reported they have been submitted to this practice in home country during infancy, most by traditional circumcision practitioners. Percentage below 50% of traditional circumcision practitioners are found only for Somalia and Egypt. The type of cutting is obviously related to the country of origin. The most common type of cutting between African migrants in Lombardy is the removal of clitoris while 30% of Somali had a complete infibulations.

Tab. 3 Estimation for migrants with FGM and population of age 0-14 at risk in Lombardy (Italy) for main nationalities, 2010

Country	Women of age 15-49 with FGM	Girls of age 0-14 with FGM	Girls 0-14 at risk of FGM	% 0-49 with FGM Lombardy	% 0-49 with FGM country origin	Difference Lombardy- Home Country
Senegal	525	--	25	6.7	28.2	-21.5
Eritrea	1,160	170	40	67.5	88.7	-21.2
Egypt	11,555	605	1,005	70.7	91.1	-20.4
Ethiopia	530	45	--	56.5	74.3	-17.8
Côte d'Ivoire	805	45	55	21.7	36.4	-14.7
Burkina Faso	850	80	25	64.5	72.5	-8.0
Somalia	405	30	40	88.8	97.9	-9.1
Ghana	160	--	--	3.4	5.4	-2.0
Nigeria	3,085	285	225	74.3	29.6	+44.7
Other Countries	845	150	100			
Total	19,920	1,410	1,515			

Migration changes also the risks to be mutilated of younger generations since the proportion of women supporting the practice and willing to submit their daughters to FGM is very low, with partial exceptions for Nigerian and for Somali. The first have higher rates of support of the practice than other nationalities and the latter would better like in a quite high percentage a symbolic ceremony.

Tab. 4 Opinion about the continuation of FGM by country of origin (%)

	Support							
	yes without condition	if less aggressive	In hospital	symbolic	Total support	Disagree	Don't know	Total
Côte d'Ivoire		2.1	2.1		4.2	83.5	12.3	100
Burkina Faso		3.1		0.9	4	85.8	10.2	100
Egypt	1.9	6.2	4.8	0.9	13.8	73.7	12.5	100
Ethiopia						97.8	2.2	100
Nigeria	23.2	5.8	12.8		41.8	43.2	15	100

Senegal				0.9	0.9	94.1	5	100
Somalia	1		2.2	15.9	19.1	57.2	23.7	100
Eritrea			2.3	2.4	4.7	86.8	8.5	100
Total	4	3.4	3.5	0.8	11.7	75	13.3	100

What is most interesting is that reason for support produced by are mostly related to social and public membership and to community sense of belonging (the first fifth reasons in Tab. 5) while benefits about not being circumcised are mostly related to the personal wellbeing (around 73%, first fifth reasons in Tab. 6.)

Tab. 5 Benefits to be mutilated by reason indicated by women (%)

Benefits	%
No benefit	40.2
Benefit	59.8
Total	100
Reason:	% within benefits
Respect for tradition	32.9
To preserve virginity	15.1
Approval of family	12.8
Social appreciation	10.3
Approval of religion	9.1
Cleanliness	10.1
Better marriage conditions	6.8
Greater male pleasure	2.9
Total benefits	100

Tab. 6 Benefits to be non-mutilated by reason indicated by women (%)

Reasons	%
Her greater pleasure	24.9
Avoid pain	24.8
Less gynecological problems	12.8
Less embarrassing during physical examination	6.1
Feeling like the other Italian girls	5.0
Greater male pleasure	9.8
Other	0.8
No benefit	3.8
Don't know	12.1
Total	100

Personal experience is the most important factor in driving attitudes and intention about FCG: women who are not circumcised are unwilling to submit their daughter to FGM, but also mutilated women reduce the attitudes about FGM. For example in Egypt only 21% of mutilated women

haven't intention to submit their daughters to FGM and the same can be assessed in the field of for autonomy.

Tab 7 Mothers intentions on daughters according to their age, origin, autonomy

	Mother condition	Intentions for their daughters	
All sample		Yes	No
	Mutilated	21	79
	Non-mutilated	-	100
Origin		Yes	No
Egypt	Mutilated	22	78
	Non-mutilated	-	100
Nigeria	Mutilated	47	53
	Non-mutilated	-	100
Age		Yes	No
15-24	Mutilated	33	67
	Non-mutilated	-	100
40-49	Mutilated	15	85
	Non-mutilated	-	100
Autonomy		Yes	No
Low	Mutilated	33	67
	Non-mutilated		100
High	Mutilated	16	84
	Non-mutilated		100

Finally, it is really important to underline that characteristics of migrants like generations or education attained haven't been found as crucial as in home countries probably because migrants are socially and economically more homogeneous and the difference among them are less meaningful. Greater support for discontinuation of circumcision among immigrant women than in home countries suggests that the practice is likely to decline sharply in the future at least in receiving countries.

Bibliography

Adepoju, A., (2004) *Trends in international migration in and from Africa* in Massey, D. S. and J. E. Taylor (Eds). International Migration Prospects and Policies in a Global Market. Oxford: Oxford University Press.

Central Statistical Agency [Ethiopia] and ORC Macro (2006). Ethiopia *Demographic and Health Survey 2005*.Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Agency and ORC Macro.

El-Zanaty, Fatma and Ann Way (2009) *Egypt Demographic and Health Survey 2008*. Cairo, Egypt: Ministry of Health, El-Zanaty and Associates, and Macro International.

P.Farina (2010) (cur.) *Indagine sulla presenza nel territorio lombardo di popolazione a rischio in relazione alla salute sessuale e riproduttiva e alle mutilazioni genitali femminili* 2010 Irer

Gallard C. *Female genital mutilation in France* BMJ: British Medical Journal, (1995) June 17; 310(6994): 1592–1593.

Institut National de la Statistique [Côte d'Ivoire] et ORC Macro (2001) *Enquête Démographique et de Santé, Côte d'Ivoire 1998-1999*. Calverton, Maryland USA : Institut National de la Statistique et ORC Macro.

Institut National de la Statistique et de la Démographie (INSD) et ORC Macro. 2004. *Enquête Démographique et de Santé du Burkina Faso 2003*. Calverton, Maryland, USA : INSD et ORC Macro

Menonna A., Ortensi L.E. (2007) *(Ri)conoscere le Mgf. Riflessioni sulle possibilità di quantificare un fenomeno elusivo*",Nicola Pasini (cur.), *Mutilazioni genitali femminili: riflessioni teoriche e pratiche: Il caso della regione Lombardia*, Milano, Regione Lombardia- Fondazione ISMU,

National Population Commission (NPC) Nigeria and ICF Macro (2009) *Nigeria Demographic and Health Survey 2008*. Abuja, Nigeria: National Population Commission and ICF Macro.

National Statistics and Evaluation Office (NSEO) [Eritrea] and ORC Macro (2003) *Eritrea Demographic and Health Survey 2002*. Calverton, Maryland, USA: National Statistics and Evaluation Office and ORC Macro.

Leye E., Powell R. A., Nienhius G., Claeys P., Temmermann M. (2006) *Health Care in Europe for Women with Genital Mutilation Health Care for Women International*, 27: 362–378, 2006 Taylor & Francis Group, LLC

Yoder P. S., Khan S. (2008) *Numbers of women circumcised in Africa: The Production of a Total* DHS Working Papers series 2008/39 Macro International Inc. Calverton, Maryland, USA

WHO (2011) *An update on WHO's work on female genital mutilation* (FGM) Progress report, 2011WHO/RHR/11.18