LAW, ETHICS AND MEDICINE

Female genital mutilation: the ethical impact of the new Italian law

E Turillazzi, V Fineschi

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Despite global and local attempts to end female genital mutilation (FGM), the practice persists in some parts of the world and has spread to non-traditional countries through immigration. FGM is of varying degrees of invasiveness, but all forms raise health-related concerns that can be of considerable physical or psychological severity. FGM is becoming increasingly prohibited by law, both in countries where it is traditionally practised and in countries of immigration. Medical practice prohibits FGM. The Italian parliament passed a law prohibiting FGM, which has put in place a set of measures to prevent, to oppose and to suppress the practice of FGM as a violation of a person's fundamental rights to physical and mental integrity and to the health of women and girls. The Italian law not only treats new offences but also wants to deal with the problem in its entirety, providing important intervention in all the sectors. Different kinds of interventions are considered, starting with the development of informative campaigns, training of health workers, institution of a tollfree number, international cooperation programmes and the responsibility of the institution where the crime is committed. Particularly, the law recognises that doctors have a role in eliminating FGM by educating patients and communities.

The law prohibiting the practice of female genital mutilation (FGM) was passed by the Italian Parliament (law 7/2006), providing the opportunity to reflect on a social practice that by now also concerns countries of immigration in ever greater measure.

The practice of FGM is actually widespread in many geographical regions. Although the strictly clinical aspects of FGM are well known, with particular reference to the clear and inevitable consequences on the health of women subjected to these procedures,[1 2] data on the actual numerical dimensions of this phenomenon are not clear.

On the basis of the limited amount of available information, it is estimated that between 100 and 140 million girls and women worldwide[3] have been subjected to FGM and that each year about 2 million girls will be subjected to some form of FGM. FGM is practised in about 28 African countries and in some Asian countries, but this phenomenon is widespread also among immigrant population groups in Europe, North America, Australia and New Zealand.

This suggests, as a first consideration, that FGM is a reality that has radically changed with respect to the past, so that it is not possible to relegate it to a simplifying and distant ''tribal'' dimension anymore: FGM has become an issue also in developed countries.[4]

THE CLASSIFICATION OF FGM BY THE WORLD HEALTH ORGANIZATION

It seems appropriate to briefly and preliminarily consider the classification of FGM by the WHO[5]: FGM, often referred to as female circumcision, comprises all procedures entailing partial or total removal of the external female genitalia or other injury to the female genital organs for cultural, religious or other non-therapeutic reasons. Different types of FGM practised today include:

- Type I—excision of the prepuce, with or without excision of part or all of the clitoris;
- Type II—excision of the clitoris with partial or total excision of the labia minora;
- Type III—excision of part or all of the external genitalia and stitching or narrowing of the vaginal opening (infibulation);
- Type IV—pricking, piercing or incising of the clitoris or labia; stretching of the clitoris or labia; cauterisation by burning of the clitoris and surrounding tissue;
- Scraping of tissue surrounding the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts);
- Introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purpose of tightening or narrowing it; and any other procedure that falls under the definition given above.

The unquestionable psychophysical ''harmfulness'' of FGM is a certain and fundamental acquisition of medical science and has been documented in several studies in medical literature.[6] The ethical dimension of this phenomenon has caused great interest, raising,[7–10] at the international level, strong and unanimous expressions of condemnation towards a practice that is harmful both to the physical and psychological health of the girls and the women who have undergone these procedures and also to their dignity and sexual freedom.

Abbreviation: FGM, female genital mutilation

See end of article for authors' affiliations

Correspondence to: V Fineschi, Department of Legal Medicine, University of Foggia, Policlinico Ospedali Riuniti, Via Luigi Pinto 1, 71100 Foggia, Italy; vfinesc@tin.it

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REASONS FOR INTRODUCING THE LAW IN ITALY

The European Council[11] and the European Parliament[12] have specifically condemned FGM, and demanded the commitment of the member states to eradicate this practice. After admonitions of the European supranational organizations, many countries, made aware of the practice also by the strong immigration flows, perceived the necessity for official interventions against genital mutilation.

Of these countries, Italy was one that decided to promulgate a law. Despite the presence of about 30 000 women coming from countries where FGM is practised,[4] few data are available regarding the actual dimensions of this phenomenon, which in most cases remains hidden, but none the less seems to affect thousands of immigrant women.

A survey conducted in 1993 by the Department of General Psychology of the University of Padua, Padua, Italy, on a sample of 318 obstetricans and gynaecologists working in hospitals and in university and private clinics of different regions,[13] showed that

> 147 practitioners admitted having treated women or girls who have been circumcised or infibulated. Almost all had examined up to 10 circumcised women, but seven of them have counted up to 100 for each. Of these seven practitioners, five were working in Milan in specialised structures for the assistance to immigrated women, and two of them, of African origin, were working in the hospital in Florence and Padua. The medical examinations had taken place mostly at the hospital or in university clinics (57% of cases) and have been increasing since 1990, in coincidence with the war in Somalia. The patients, average age 25 years (with the alarming presence of about 40 girls between 2 and 16 years of age) had sought medical treatment for the consequences and the problems caused by the mutilations they had experienced. Only one quarter of these women had asked for de-fibulation to ''conform to western life style''. Finally, only two obstetrics had been asked to perform infibulation and had actually performed it. Women, in some cases girls, had gone to hospitals and clinics for the immediate consequences of the mutilations they had undergone. A stitch made with a silk suture thread or a little vaginal drainage tube were the evident proof that those mutilations had been done here in Italy, perhaps in some public structure and anyway by expert hands and with surgical techniques sometimes perfect.

Moreover, the same epidemiological survey reported:

> We found the traditional midgan (midwives), descending from bon (ethnic group of hunters/collectors who inhabited the African savannah before the Somali tribes). They work at home, in Florence as well as in Trieste and probably also in the area between Milan and Bergamo. Their presence was reported also in the Somali community in Aprilia (Lazio).

Sirad Salad Hassan, a Somali physician who, between 1991 and 1993, has conducted an epidemiological–statistical survey on 34 Somali women aged 11–48 years living in Tuscany,[14] comes to the same conclusion:

> Also in some Italian cities, the girls are mutilated on the kitchen table, in their own dwellings, by expert people whom are expressly sent for from the countries of origin.

Clearly, the results of the study carried out in Padua show only a small part of a reality that is much more widespread. On the basis of statistics from the Ministry of Internal Affairs, it is possible to reasonably estimate that Italy has about 27 000–30 000 infibulated and circumcised women.

Data from the Tuscan Regional Referral Centre for the prevention and treatment of complications due to FGM show that in 1 year ''about 40 interventions connected to female genital mutilations'' have been executed (treatment of infections, defibulation interventions and vaginal plastic surgery).

These are the epidemiological data that, even in their absolute numerical vagueness, show a reality, which is for the most part hidden and with which the Italian healthcare providers must necessarily deal.

The law passed by the Italian Parliament appears in the cultural and juridical contexts of the strong condemnation of FGM, which has been recently animated by disputes regarding the proposal of a ''harmless and symbolic'' alternative to FGM to be practised on African women at a public hospital in Florence, Italy.

It is an alternative ''ritual'', consisting of a puncture of the clitoris under local anaesthesia that would let a few drops of blood out, and was proposed by a Somali gynaecologist who graduated in Florence about 25 years ago and now heads the centre for the prevention and treatment of FGM. Negative reactions have been very strong at both political and cultural levels.[15]

On the other hand, the Italian Code of Medical Ethics (article 50) expressly forbids a doctor to ''… perform any kind of female sexual mutilation''. Also, in a document regarding this issue, the National Bioethics Committee[16] has strongly criticised these practices, stating that

> even in the due respect of the plurality of cultures, also when they manifest themselves in forms which are extremely far from those of western tradition … believes that no respect is due to practices, even if ancestral, whose only purpose is to irreversibly mutilate the individual and above all to violently alter his psycho-physical identity … when this does not find an unequivocal justification in the strict interest of the individual health ….

The absence, until the very recent promulgation of the law, of an autonomous instance of offence in the Italian regulative order, none the less allowed the penal defence of the individual psychophysical integrity, which was certainly violated by the practices at issue. Already, before the issue of the law, a lawsuit was filed in Milan: an Italian woman, the separated wife of an Egyptian man, denounced her ex-husband for subjecting their two children, a 5-year-old boy and a 10-year-old girl, to genital mutilations during a holiday with his relatives in Egypt. For personal reasons, the woman had to remain in Milan, but on their return, she became suspicious on observing the poor health conditions of the girl (haemorrhage, infections and fever) and realised what had happened. The woman immediately filed a complaint and on 25 November 1999, in Milan, the lawsuit took place, in which the father was accused of serious personal injuries to the children. The man was sentenced to 2 years' imprisonment.

A brief inquiry at the public prosecutor's office and at the juvenile court in Rome and research in some Italian public prosecutors' offices did not yield any other similar case. But, if the estimates made by some researchers are reliable, the number of girls living in Italy who have been mutilated is large and the number of girls at risk of being mutilated would be even greater. It seems that the girls are subjected to mutilation during their stay in the countries of origin or by itinerant

''traditional female operators''. The involvement of Italian doctors or health facilities has not been reported, even if there are rumours about private clinics where Somali or Italian–Somali doctors operate.

PRINCIPLES OF THE ITALIAN LAW ON FGM

On this normative and cultural basis, it was deemed appropriate to proceed to the issue of a specific law whose main purpose (article 1) is that of laying down ''the necessary measures to prevent, to contrast and to suppress female genital mutilation practices as violations of the individual's fundamental rights to physical and mental integrity and to the health of women and girls''. This is perceived as necessary to safeguard fundamental rights confirmed by the Italian Constitution, such as the right of a person to freedom and health (articles 13 and 32).

The law provides for a term of imprisonment from 4 to 12 years for practising clitoridectomy, excisions, infibulations and other mutilations in the absence of therapeutic requirements, and up to 7 years for those responsible for lesions of other kinds, which in any way cause impairment of sexual function and physical and mental illnesses (article 6). The terms of imprisonment are increased if the victim is under-age, although there are extenuating circumstances in case of a minor lesion.

Physicians practising genital mutilations will be debarred from the profession (with communication to the medical board) for 3–10 years. The institution where the offence was committed will have to pay a penalty; in the case of an accredited private clinic, it will lose the accreditation.

The law will also punish Italian citizens or foreigners residing in Italy who commit the offence while abroad.

At the time of the issue of the final text of the law, the article allowing refugee status to women who escape from their country to save themselves or their daughters from genital mutilation was suppressed.

The Italian political oppositions have reacted strongly; there is, however, a proposal to consider the issue of refugee status for immigrant women who have opposed genital mutilation practices in the law regarding the right to asylum, which is soon expected to be examined by the Italian Parliament.

The Italian law not only treats new offences but also wants to deal with the problem in its entirety, providing important interventions in all the sectors concerned in eradicating this phenomenon, given that, to be effective, the approach to FGM cannot be limited to repression.

In fact, genital mutilations are the expression of a cultural practice based on deeply rooted social and anthropological strategies,[17] which render it difficult to eradicate by using repression through legislation as the only instrument.

Therefore, different kinds of intervention are considered, starting with the development of informative campaigns (article 3), training of health workers (article 4), institution of a tollfree number (article 5), international cooperation programmes (article 7) and the responsibility of the institution where the crime is committed (article 8).

The issue of foreign citizens coming from countries where genital mutilations are practised will be dealt with by massive informative campaigns from the moment they ask for an entry visa for Italy. Health education courses in primary and secondary schools and childbirth education classes for infibulated women will also be provided. Doctors and nurses of public healthcare facilities will attend courses for the treatment of women and girls who are mutilated, and they will be instructed, also through cultural mediators, on how to relate to people who ask them for that kind of intervention.

The legislator's will to punish a specific behaviour means that our country has become aware of the problem and, through this regulation, wants to deal with it seriously by means of interventions that are not generic and vague but have a specific aim and are rational.

This commitment offers the possibility of producing greater awareness among women who are mutilated and also of fighting the distrust and ignorance of citizens, which can result in exclusion of a specific group of people.

At present, the legislator's intervention seems well reasoned and carefully thought out: it does not seem to aim only at punishing the criminal conduct but also at helping all the people participating in the execution of these practices to understand the devastation caused to the female body.

In the light of this, the creation of a specific instance of offence seems an appropriate intervention, which shows how seriously the legislators have considered the problem, how they want to confirm, through their intervention, that such practices will not be tolerated within the territory, and that they intend to fight them with all possible means.

It seems appropriate to make one last observation regarding the fact that the text approved by the parliament lacks any explicit reference to the victim's consent not being operative as extenuating; such a reference was present in the projects that preceded the final drafting of the law.

In fact, the original formulation of the legislative text was the following:

> Anyone who, in the absence of therapeutic necessities, causes a mutilation to female genital organs, even with the victim's consent, is punished ….

From the analysis of parliamentary works, it is possible to infer that one of the causes leading to the cancellation of any reference regarding consent not being operative was just to dispel every possible doubt about the availability of such a right for the passive subject.

The exclusion from the final formulation of the law of the phrase ''even with the victim's consent'' calls for a few remarks.

It is necessary to consider that in the practice of FGM, values and motivations (of a social, cultural, economic and anthropological nature) come into play which, even if incomprehensible and unacceptable to us, are deeply rooted in some cultures, where they are a sign of belonging to a community. According to some cultures, it is through the mutilation of her own genitals that every woman recognises herself and is recognised as a member of her community. Not undergoing these practices means condemning herself to exclusion and rejection and thus to a loss of the sense of belonging to a community. We could even arrive at hypothesising a presumed ''right'' of the woman to assert her own identity, not only sexual but also personal.

Thus, the hypothesis of two conflicting rights—namely, the right to psychophysical integrity (which unquestionably is damaged by genital mutilation) and the right to play an active and socially appreciated part in the social structures of the woman's everyday life (this right is protected by the constitution just like the right to health)—does not appear odd at all.

We believe that it will not be completely unlikely that the occurrence of cases in which the consent given by an adult woman to be subjected to genital mutilation (and especially, for the reasons we have already examined, to refibulation after delivery) will be, if not granted, at least taken into consideration as an assertion of the woman's right to have an active and socially appreciated part in the social structures of her everyday life (this right is protected by the constitution just like the right

to health), with the potentiality to assume a greater value than the right to physical integrity.

As such, perhaps it would have been better to keep in the final text a clear and explicit reference to the absolute and indisputable lack of effectiveness of the woman's consent to genital mutilation practices.

The different political parties came to a substantial agreement on the law. The main reason for opposing the law was that, for financial reasons, the request to acknowledge the right to asylum and refugee status of women who oppose mutilation, as has been recommended by the European Parliament, was not granted. Some senators from opposition parties attempted to introduce an article regarding this issue and proposed the following article (article 4 bis): ''The refugee status is granted to women who want to save themselves and their minor daughters from the risk of genital mutilations since their Country of origin or of provenance allows these practices''. This amendment, like similar ones presented by other parliamentary groups, was rejected.

Likewise, for financial reasons, an amendment (article 9 bis) regarding the institution of an observatory against FGM and with the function of gathering data related to the victims of FGM, of evaluating the effectiveness of prevention and contrast measures as well as of monitoring the results of the law was rejected. This rejection has resulted in strong objections from the opposition.

The position of women immigrants in Italy on the issue of FGM has been thoroughly analysed in anthropological studies that underlined its strict dependence on the complex interaction with the society receiving them. This is a variable that can influence, in a decisive way, the position of immigrant women with regard to FGM, determining two opposite attitudes. It can either favour an attitude of gradual refusal of this practice or provoke an attitude of closure, which ends up radicalising FGM as a means to reaffirm their own diversity.

The new regulation has been defined ''A gift strongly desired'', by the president and founder of Aidos, the Italian women's association for development. As acknowledged also by this association, which has devoted years in fighting against FGM, one strong point of the law is to be the first and only example of a law that does not limit the preventive action just to the ''deterrent factor'' but provides for and finances the realisation of campaigns that inform and sensitise communities, allocating 5 million Euros a year for the prevention of FGM. As it has been emphasised, ''The law has been strongly demanded precisely by the African women who work within the communities''. Also, the Italian Section of Amnesty International has expressed today its appreciation for the approval of the law stating that: ''This law was one of the goals of the campaign 'Never again violence on women', launched worldwide by Amnesty International in 2004'', and also underlining ''the emphasis given by the law to the activities of sensitization, information, research, cooperation, appreciation and involvement of all operators''.

CONCLUSIONS

Apart from the ethical and deontological principles prohibiting the doctor from performing ''treatments'' that are not compatible with the legitimacy of the professional condition (neminem laedere), the constitutional principle regarding the limitation of the effectiveness of individual acts that are directed to allow the medical activity must be in force (unless the intervention of a provision of the law is in conformity with the principles on the basis of human dignity and freedom). Let alone that the doctor is, anyway, the fundamental instrument when trusted with health protection, which, however intended, is never satisfied by treatments that have no relationship with any concept of treatment.

Authors' affiliations

E Turillazzi, V Fineschi, Department of Legal Medicine, University of Foggia, Foggia, Italy

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