Medicine at the Border

The Challenge of Female Genital Mutilations in the Migrant Population

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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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