Genital Mutilation among Female Adolescents Resident in Italy

Grassivaro Gallo P.[1]
Department of General Psychology
Araldi L. and Viviani F.
Faculty of Psychology and Faculty of Medicine
University of Padua

The author discusses the arrival in Italy of Female Genital Mutilation as practiced among various immigrant African populations, notably Somalis, and the absence of any legislation specifically prohibiting this practice in Italy.

Key Words: Female Genital Mutilation, FGM, infibulation, clitoridectomy, African immigrants, Italy

As defined by the World Health Organisation (WHO) Female Genital Mutilation (FGM) comprises "all procedures that involve partial or total removal of the female external genitalia and/or injury to the female genital organs for cultural or any other non-therapeutic reasons" (WHO, 1996: pg. 6).

In fact there are various forms of Female Genital FGM, classified according to their severity from the least to the most destructive forms. However, not all authors agree about how to distinguish them. The WHO recognizes four different types: First, the excision of the prepuce with or without excision of part or all of the clitoris; Second, the excision of the prepuce and clitoris together with partial or total excision of the labia minora; Third, the excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation); Fourth, the complete removal of the clitoris and labia minora, together with the inner surface of the labia majora. The two sides of the vulva are then stitched together with thorns or silk or catgut sutures, so that when the skin of the remaining labia majora heals, a bridge of scar tissue forms over

[1] Address for correspondence: Grassivaro Gallo Pia, Dept. of General Psychology, University of Padua, Via Venezia 8, (35131) Padova, Italy.<

the vagina. A small opening is preserved, by the insertion of a foreign body, to allow the passage of urine and menstrual blood. The fourth type is unclassified.

The mutilated woman does not generally know what type of operation she underwent as a girl, only that she is "open" or "closed" (Grassivaro Gallo, 1986).

FGM is a well-known traditional practice, especially in the area of Africa around the equator. It is carried out throughout the continent from West to East, from the Gulf of Guinea to the Horn of Africa. Within this vast region there are two infibulation enclaves; one is in the east and includes Somalia, Sudan, parts of Egypt, Kenya and Ethiopia. The other is a smaller enclave to the west, comprising Mali and northern Nigeria (Hosken, 1994).

The various types of FGM are carried out in different ways from country to country, but they remain an ethnic characteristic rather than a nationwide custom. In some countries, in Somalia for example, infibulation is never carried out at birth but always before menarche (around 5-10 years of age). It is often the little girl herself who becomes mindful of the matter together with her family, requesting the operation herself. Both at school and at play she would be an object of derision and would be immediately emarginated if she did not comply with this social obligation.

The small girls perceive the operation as a test of their adulthood and their worthiness of taking on the responsibility of marrying and forming a family with a Somalian man. The celebration that follows the operation is organised by the girl's relatives and has serves as a rite of passage to mark the child's admission as a mature person to the extended family and friends. She receives gifts and is praised for her courage in this test. She enjoys more respect from friends and neighbours and usually, from this moment on, starts to dress as an adult. This act gives the whole family an enhanced social dignity (Dualeh R.H.A.,1982; Grassivaro Gallo, 1986; Grassivaro Gallo & Viviani, 1988; Hassan S.S., 1996).

Even though the test is very painful, the child is basically happy for having carried out a social duty. This was established by an analysis carried out on graphic tests administered to young Somalian girls (Grassivaro Gallo & Moro Boscolo, 1984/85).

This, in short, is the situation in Africa. However, in recent times migrants from Africa into Europe have brought this cultural practice into the various European countries which have admitted them, and many not only continue this custom but even going so far as to request that the operation from the health structures of their adopted country (Tanganelli, 1988). This is what has happened in Italy where emigration from East Africa has become very intense as a result of the conflicts in Somalia in 1990.

Western doctors are faced with a moral dilemma and generally refuse to conduct the operation, thus causing the parents or the family of the girl in question to revert to clandestine surgical operations. In this way the underground market, based on a conspiracy of silence, is becoming more and more widespread and commercial transactions are negotiated involving several million lira for each operation.

In these circumstances it is not difficult to imagine extreme cases, even the death of a child, with the relative legal complications and consequences (Smith, 1995:p.153). In Italy there are no specific laws in merit, even if – according to article 5 of the Civil Code and article 583, c2, p3 of the Penal Code – FGM is considered illicit, both for children and women.

The Italian population has become aware of the phenomenon of FGM operations conducted in Italy via newspapers and the mass media, which periodically call attention to instances of FGM (Magdi Allan, 1996) but which are often accompanied by misleading interpretations and inaccurate commentary (Gibelli, 1993).

Bearing all this in mind, in this study it is our intention to indicate the presence of sexually mutilated girls in Italy as a result of immigration at a time when our population is rapidly becoming multi-ethnic and multi-cultural. One of the reasons for doing this is to highlight the seriousness of what is happening and to provoke he relevant health authorities to become concretely aware of the situation with a view to protecting young girls at risk.

Subjects and Methodology

The first epidemiological survey in Italy of obstetricians, to

highlight their impact with FGM in African immigrants was carried out in 1993 (Grassivaro Gallo et al., 1995).

A total of 327 medical staff were surveyed, most of whom were interviewed at the National Conference in Venice and at the Sexology Conference in Modena by means of a questionnaire complimented, when the occasion arose, by an in-depth interview. In particular, several items in the questionnaire asked those obstetricians who had had excised women as patients (47% of the total) for information regarding any mutilated girls they had examined professionally. The obstetricians who answered positively were 18 in number (5.5%) and they refer data relative to 42 mutilated girls. The replies to the items were elaborated using quantitative methods.

During the interviews, those obstetricians who were most interested in collaborating also gave a further in-depth interview. In this specific case it was through these in-depth interviews that we began to note the first descriptions of mutilations carried out on young girls. This gave us the incentive to continue our research on other, new cases collected in quite a different way from the preceding ones.

To the initial data given by the obstetricians we added material collected from various sources of information, for the most part doctors, paramedics, cultural mediators, but also primary school teachers. This material refers to 30 cases in all, involving 71 sexually mutilated young girls. These have been grouped together according to the FGM information given to us, i.e. :

- - 7 cases refer to requests made to medical staff for an excisory operation which, in 2 cases, was refused;
- - 8 cases refer to the presence and/or activity of traditional midwives (or *mammana*);
- - 5 cases refer to mutilation carried out on immigrant children but not in Italy;
- - 10 cases supply other, various information which is not easily grouped together.

These surveys have been analysed by means of a qualitative method which focused on several of the most relevant topics (LIS et al., 1995).

In this study we refer in all to :

A) data relative to 42 mutilated subjects seen in Italy by 18 obstetricians interviewed in 1993;

B) the description of 30 other cases, collected in quite a different way between 1993 and 1997 and which refer to another 71 young mutilated girls.

Results

With all the quantitative and qualitative information at our disposal we have been able to draw a general outline of the presence of FGMEVOL in various Italian regions.

Furthermore we have also drawn up the following results: A) The data, mostly of the quantitative type, collected from the replies to the 18 questionnaires, refer to both the obstetricians themselves and to their patients.

The medical staff were both male and female - 13 and 5 respectively; they work in various Italian regions from north to south, including Sicily, even if most of the mutilated children had been examined in a hospital in Milan.

The number of years the obstetricians in question had been working varied from 0 to 20; the number of excised women seen in all was estimated at "not less than 271".

The 42 evolutive age subjects, can be characterised as follows; they are between 2 and 16 years of age; they are all of African origin with the exception of 2 subjects: one Italian from La Spezia and the other from Sidney, Australia.

The pathological reports concerning these patients as given by the obstetricians refer to: inflammatory reactions and vulvo-vaginitis consequent to infibulation; infections resulting from clitoridectomy; hormonal disorders due to infibulation; fear of mutilation in subjects at risk.

We would like to point out that it was possible to highlight more than one topic from the single cases analysed.

Discussion and Conclusions

We would, first of all, like to make two general comments that explain our opinion on FGMEVOL.

From cultural information already given, it can be seen that if mutilation is put in its context it cannot be considered an act of violence on a minor (in the meaning that is given to the term

in the western world) but, on the contrary, is a sign of the whole family's care of, and attention to, the girl child. In fact, the local belief is that a woman who has not been excised was a child who had nobody to take care of her.

Secondly, in her homeland, the mutilated child has the psychological support of her own community, which makes her feel grown-up and important for the very test that she has passed. In immigrant families excision is more an element causing marginalisation and will further slow down, or even impede, her settling in among non-African children of the same age. On the basis of this fact various psychological disturbances arise and, as we have seen, they are not less important than the more well-known physical ones.

Having said this, we consider that while it would be suitable to let each African country choose whether to keep or put a stop to this custom and maybe even decide the most suitable instruments for its eradication, in the developed countries it must be the Western authorities who take charge of controlling and preventing mutilation on young immigrant women, using the most suitable means, to educate the immigrants against such practices as alien to the societies in which they now live, and if necessary even to punish parents who organise this type of operation for their daughters and to prevents doctors or medical staff from carrying out this kind of operation in Western societies.

To comment on the results of our research, first of all we repute that the analysis carried out on Italian obstetricians can also be considered valid in this case as and when it supplies information on children reaching the age of puberty. This is because even though the children are usually taken to a paediatrician first, they are then usually referred to an obstetrician.

To back up this idea, we can quote from surveys similar to our own, carried out in Switzerland (Beguin-Stockli, 1995) where a total of 82 excised African women were examined by obstetricians. A further enquiry made to paediatricians brought to light only another two young girls who had been seen by the latter alone.

We know of no other data from other epidemiological surveys carried out on girls attaining puberty..

Regarding the number of young, mutilated subjects living in Italy, we may start with the indirect estimation on data regarding immigrant women supplied by the Ministry of the Interior in 1994 which estimates that "not less than 28,000" immigrant African women have undergone FGM (Grassivaro Gallo et al., 1995); the epidemiological survey carried out on 327 obstetricians in 1993 highlighted a number of "not less than 1950 women" (7%), i.e. one woman out of fifteen has needed to turn to a specialist. In particular, excised patients in the evolutive age make up approximately 15% of the total number of excised African women (271) seen by 18 of these obstetricians. To generalise, it can roughly be said that there could be "at least 4/5,000" young excised girls in Italy (15% of 28,000).

However, we cannot completely ignore the number of medical staff who denied having any mutilated girls among their patients. If we also consider these (327-18), it can be seen that the 42 girls are only 2.2% (of 1950 women); that is, out of a total of 28,000 women we can calculate a lower number equal to 900/1,000 mutilated girls.

Therefore, *the number of girls risking mutilation in Italy altogether could be between 1,000 and 5,000 in number.* Personally we would tend to think that the higher number is more probable than the lower one considering the fact that mutilated children/girls generally only present consequences immediately and/or in the medium term, that is, they have fewer reasons to ask for a specialist's visit than a mutilated woman. In fact, the latter are more likely to suffer from long-term consequences among which we can name difficulty in matrimonial relationships, in pregnancy and giving birth, as well as deinfibulation, etc.

Our data, therefore, is in stark contrast with the declaration issued by the Ministero Della Sanita (1988) which denied that any part of the population resident in Italy faced female genital mutilation. Furthermore, our data shows that we can now formulate something more than mere supposition regarding a fact that was officially denied in 1988 (AA VV, 12/1/1988) but

which we had already questioned in 1995 (Grassivaro Gallo et al.): i.e. whether *FGM was also carried out in medical institutions in Italy.* (In England FGM was carried out in private clinics in the eighties - Smith, 1995:p. 175). Obviously, given the illegality of the practice, which is normally carried out clandestinely (Tab.20, pg.74 Hassan S.S., 1996), it would in fact be very difficult to be able to supply sure and more direct proof which could confirm our doubts about the validity of the statement by the Ministero della Sanita..

We shall now attempt to reply to another question: *who could be performing such mutilations in our country ?* Our comments on this point are again based on indirect data. Our investigation brought forth two clues: first, the involvement of *medical professionals* from cases of immediate complications of mutilation in young girls examined at the casualty departments of various hospitals, where the mutilations were technically attributed to professionals. Secondly from requests put forward by parents and relatives to African medical staff working in our hospitals who refused to operate. Moreover there is evidence that *traditional midwives* amongst the immigrant African population conduct these mutilations in various Italian regions.

In the former case, evidently the technician who operates have experience of Italian medical education (e.g. have graduated in Italy or at least have a paramedic diploma which allows them a certain familiarity with the profession and with surgical instruments), but he or she must also be familiar with the traditions of the excisory culture, otherwise the operation could be a failure. The only people who have both these characteristics are *mixed-culture doctors or paramedics (African/Western)* who very often have graduated or are currently working in Italy.

Our survey identified at least three, but there are certainly a higher number, in our country, who conduct FGM. We managed to discover, more or less, the financial background to these operations which can oscillate from one to several million lira according to where (and therefore how) they are carried out, whether at home by the *mammana* or traditional midwives, or a hygienically safer place by a "doctor".

In support of our hypothesis, we refer to the contents of an interview which recently appeared in the national newspaper *La Repubblica* (AA VV, 1/4/1997) given by a lawyer from Rome who is well-known for being professionally interested in the problems of African immigrants. In this interview he confirmed that young girls are operated on in Italy, not only at home but increasingly often in unspecialised private clinics, most often by Italo-Somalian doctors who have qualified in Italy. These are exactly the same conclusions that we have come to!

The data also demonstrates that *these little patients have already begun to make demands* (with their immediate and medium term complications) *on the health institutions*, requesting different forms of assistance as well as emergency aid. We can easily forecast that in coming years they will become young women who will need special health assistance, especially when they marry (deinfibulation) and when they give birth (specific episiotomies, etc.) (Lightfoot-Klein & Shaw, 1991). In Switzerland too, an increase in mutilated patients who will require deinfibulation in particular has also been forecast (Carbo Budri, 1995).

In addition to our data, we would also like to recall other cases collected from bibliography as examples:

- in Florence, in the Infective Illnesses Clinic of the Paediatrics Department, a case of urinary tract infection in an infibulated 13 year old was treated (Franchini et al., 1993);
- in Rome. several cases of Somalian girls with FGM have been reported. Among these, one 14 year old adolescent was admitted hospital with an evident crisis of psychomotory agitation (Iariaet al., 1995).

The latter was a clear case of a psychiatric pathology, but we must not forget the characteristics of an excision which is carried out in an adoptive country, we could say "out of context". Generally it is characterised by an environment without any cultural significance or explanations which justify it. To this we can add the absence of friends and relatives of the same age who are undergoing, or who have undergone, the same operation. This is all then put in a worse light by the clandestine and hurried way in which everything is organised.

Therefore it can be expected that immigrant girls and children suffer from the psychological consequences of the act, resulting in behavioural changes that can occur in the small victims. We cannot even exclude that they can suffer from traumatic shock!

To say nothing of the fear of mutilation in subjects at risk; we would like to make it known that the cases we have quoted above, collected in Italy, have been the subject of requests for political asylum to young immigrant women abroad (Smith,1995); this has happened in France - p.154; as well as in Canada - p.148; and in the USA - p. 179.

These worrying psychological aspects highlight the now inevitable need to inform and update primary school staff on the phenomenon of excision since these could be the first people young girls in difficulty would turn to.

One very new and up-to-the-minute issue for Italy concerns the official statements made out to the magistrates implicating certain parents who have had sexual mutilations carried out on their daughters. *In Italy there is no specific legislation against these acts,* but only laws that prohibit amputations in general. These laws could be extended to cover FGM, but it is necessary to consider more specific legislature, even though these alone may not sufficient to provide social action which will protect all subjects at risk (WHO, 1996).

The two cases in Italy of parents being reported to the magistrates to which we referred in the preceding paragraph had not yet been concluded at the time this article was prepared. ago. If we look at what is happening elsewhere in Europe, we note that France has established a "Commission pour l'Abolition des Mutilations Sexuelles (CAMS)", which numbers among its supporters people like Linda Weil-Curiel, a jurist who, in 1994, was already at her 18th legal defence of genital mutilation on children or trials accusing traditional midwives of circumcision, apprehended while they were operating (personal communication, 1994). There are also legislative instruments, such as Art. 312 of the Penal Code (which concerns acts of violence on citizens under 15 years of age) which makes it possible for legal action to be taken against parents and circumcisers (AA VV, 1984).

Italy, is very behind in this matter because, apart from the absence of any specific legislation, as we have already pointed out, there are only a few very generalized declarations of intent for the future given by political authorities on various levels (AA VV, 1/4/1997). Even Italian medical staff, apart from a few isolated cases (Benassi et al., 1993 -a; -b; -c; Alamin M.M.,1992), do not seem to be fully aware of the seriousness of this problem.

To conclude, we would like to say a few words concerning the mutilations carried out on Italian, non-African, subjects. In fact, the rarity of these would make them appear to be exceptions to which we should not give too much importance, but in the not so distant future this phenomenon could well become more important. To this end, we should not forget that in an up-to-date country like the USA, newborn males continue to be circumcised at birth (60% in urban populations), without any specific therapeutic motives.. The prevalence of male circumcision in the USA is a mystery which has not been satisfactorily explained (Hodges, 1997), and is something that should be borne in mind when we seek to evaluate the potential significance of the introduction of FGM into Italy and Europe by African immigrants.

Summary

In this work we wish to point out that, in Italy too, there is the worrying presence of the excisory culture in young girls due to the immigration phenomenon. According to an indirect estimation there could be 4/5,OOO thousand of these young girls in our territory.

An epidemiological study of FGM was carried out on obstetricians and gynaecologists at the National SIGO Conference in Venice and at the Sexology Conference in Modena in 1993. Out of a total of 327 obstetricians interviewed, 47% declared that they had examined sexually mutilated African patients. Eighteen of these 157 obstetricians had examined, out of 271 women, not less than 42 patients in the evolutive age (from 2 to 16 years), mostly from East African countries and resident in various Italian regions from north to south, Sicily included.

An in-depth discussion, the aim of which was to single out the consequences and complications of mutilation on young girls in Italy, brought to light several cases of children hospitalised (in Milan, Padua, Florence and Rome) due to the immediate complications of infibulation; these subjects had been infibulated in Italy probably by doctors/paramedics of mixed afro/European culture.

Other children, admitted to hospital in Florence, experienced medium-term complications; one young girl in a serious state of psychomotory agitation was treated in Rome.

As far as the means of mutilation are concerned, we also singled out cases of adolescents operated on at home by traditional birth attendants (in Florence, Trieste, Biella and Rome).

Other subjects had been sent by their parents to East African countries, such as Gibuti or to Kenya, to be infibulated or excised.

The results presented are in stark contrast with several official declarations issued by the Ministry of Health.

We would like to underline the fact that FGM, substantially a violation of the body's integrity, not only leads to the well-known medical complications, but can also be the basis for specific psychological pathologies in the country of adoption.

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Application of Nonpregnant and Pregnant Women's Anthropometric Data in Medicine

H. Kaarma, J. Kasmel, J. Peterson, G. Veldre
Centre for Physical Anthropology, University of Tartu, Estonia

The article presents the results of the research on nonpregnant and pregnant women's body structure that was begun at Tartu University as early as in 1974. The sample includes 18–22-year-old nonpregnant women (n=678) and 18–29-year-old pregnant women (primipara, n=3919). By means of multivariate statistical analysis we found that nonpregnant woman's body as a whole is a linear well-correlated system. The leading measurements are height and weight which account for 50% of the variability of all the other measurements. Variations in body height-weight sizes lead to systematic changes in length, breadth and depth measurements, circumferences and body proportions. Comparative changes of body proportions in the general contingent and in the groups of purely pycnic and leptosomic women are based on the corresponding values of their body height and weight.

A well-correlated system of body measurements can be demonstrated during pregnancy as well, when body height and weight account for 45% of the variability of the other measurements. At various gestational ages body weight can be predicted precisely enough by abdominal measurements (R=0.9535).

Combining the 19 simple indices formed from the variables that do not change during pregnancy we formed the pregnant woman's summary body build index. Using this index and gestational age it was possible to predict with sufficient precision the values for every anthropometric characteristic measured (r=0.54–0.91). From the clinical anthropometric characteristics of the parturients we formed the complex body build index, and using this index and body height we created a two-dimensional classification (5 x 5 SD classes) which enabled us to analyse the correlations between labour index and the newborn's weight.

Key Words: anthropometric, nonpregnant, pregnant, parturient, body build index, newborn's weight, health

Health, physical development and body build of nonpregnant and pregnant women are most essential for maintaining and strengthening the health and vitality of every