



FEMALE CIRCUMCISION IN FINLAND

*The recommendations
of an expert group for the personnel
in social and health care*



Finnish League for Human Rights

Edited by
Marja Tiilikainen

Illustrated by
Hanna-Leena Aromaa
and Outi Kaasinen
(Stadia Helsinki Polytechnic)

Layout
Taru Koskinen

Translation
Katri Blomster and
Elli Vanhakartano

Further information:
Finnish League for Human Rights
Döbelninkatu 2, 8th floor
00260 Helsinki, Finland
Tel. +358 9 4155 2500
Fax. +358 9 4155 2520

info@ihmisoikeusliitto.fi
www.ihmisoikeusliitto.fi

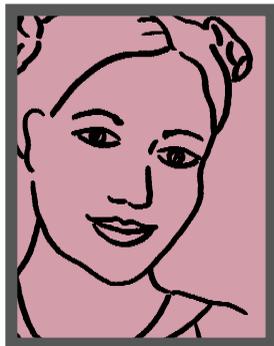
Printing
Kainuun Sanomat,
Kajaani 2007

ISBN 978-99667-3-8

***FEMALE CIRCUMCISION
IN FINLAND***

Finnish League for Human Rights • KokoNainen project Helsinki 2007

CONTENTS



1.	INTRODUCTION	5
2.	BACKGROUND INFORMATION ON FEMALE CIRCUMCISION	6
2.1	What is meant by female circumcision?	6
2.2	Terminology	7
2.3	Why are girls and women circumcised?	9
	• Cultural reasons	9
	• Religious reasons	10
2.4	Prevalence of the tradition	11
2.5	How is a girl circumcised?	14
3.	THE HEALTH HAZARDS OF FEMALE CIRCUMCISION	14
4.	STARTING POINTS IN FINLAND	15
4.1	Are girls circumcised in Finland?	15
4.2	Female circumcision as a violation of human rights	17
4.3	Finnish legislation	19



5.	PREVENTING FEMALE CIRCUMCISION	21
5.1	Detecting and registering the circumcision status	21
5.2	Pregnancy and labour	22
5.3	Babyhood and pre-school age	23
	• Child welfare clinic	23
	• Day-care centre	26
5.4	School age	27
	• School health care	27
	• Class	29

6.	CIRCUMCISED GIRLS AND WOMEN	30	
6.1	How to regard a circumcised girl and woman?	30	
6.2	Babyhood and pre-school age	30	
6.3	Puberty	31	
	▪ School health care	31	
	▪ Class	32	
6.4	Dating and marriage	32	
6.5	Pregnancy and labour	33	
	▪ Maternity clinic	31	
	▪ Hospital	33	
	▪ House calls	33	
6.6	Protecting the newly born daughter from circumcision		35
6.7	Menopausal age		35
7.	DE-INFIBULATION		36
	8. FEMALE CIRCUMCISION WITH REGARD TO SOCIAL AND CHILD WELFARE		38
	8.1 Prevention		38
	8.2 Co-operation		39
	8.3 Threat and suspicion		40
	8.4 Performed circumcision		41
	9. INSTRUCTIONS IN A NUTSHELL		44
	REFERENCES		46
	SOURCES AND LITERATURE		48
	FURTHER INFORMATION AND MATERIAL		50



PREFACE

Female circumcision or female genital mutilation (FGM) is an ancient cultural tradition, which is practised in many African countries, but also in some areas of the Middle-East and Asia. During the past twenty years it has become topical even in the Nordic countries as a consequence of increased mobility and migration. The tradition violates the rights of both children and women. Nowadays, work against female circumcision is carried out all over the world with the purpose of ending the tradition.

The recommendations provided in this publication have been drafted as a part of the KokoNainen (Whole Woman) project at Finnish League for Human Rights. Although the guidelines are based on the situation and conditions in Finland, they may well be usable also elsewhere. It is important to combine research results with knowledge of good practices to have an influence on the preventive work. Translating the originally Finnish language recommendations into English also gives the KokoNainen project an opportunity to take actively part in the international discussion on female circumcision and furthermore, to highlight current policies regarding female circumcision in Finland. At the same time, translating the booklet enabled the KokoNainen project to update some of the information.

The recommendations were translated into English for the 4th FOKO Conference – Female Genital Cutting in the Past and Today, taking place in Espoo, Finland, on September 7–8, 2007. The conference is the fourth gather-



I. INTRODUCTION

ing of The Nordic Network for Research on Female Circumcision (FOKO). Researchers in the Nordic countries have met every second year since 2001 to share findings and questions related to research projects on female circumcision. The conference, arranged in Finland for the first time, is organised by the KokoNainen project in cooperation with Hanasaari – Swedish-Finnish Cultural Centre (Finland) and Stiftelsen Kvinnoforum (Sweden). The translation work was financed by Stiftelsen 7de Mars Fonden. The KokoNainen project would like to give special thanks to **Marja Tiilikainen**, who worked as the first Project Manager of the KokoNainen project and edited the original Finnish recommendations, for her valuable comments and active involvement in the translation process. Warm thanks also belong to the translators **Katri Blomster** and **Elli Vanhakartano** for a job well done, as well as to **Milla Aaltonen**, **Maria Mölsä** and **Tuija Sarvi**, who proofread the draft translation and gave useful suggestions.

As James P. Grant (Executive Director of UNICEF 1980-1995) once said:

“The right of the child is the responsibility of adults.”

Helsinki, August 1st, 2007

Janneke Johansson

Project Manager

KokoNainen project

Female circumcision became a subject of general interest in Finland in the 1990s, when refugees started arriving into the country from areas where circumcisions are performed. In practice, social and health care personnel have had to familiarise themselves with female circumcision issues by learning from experience, since no consistent, practical guidelines on the issue have been published in Finland before. Therefore, the documenting procedures, for example, have been diverse, and female circumcisions have not been systematically followed. In addition, employees are often uncertain of how to deal with circumcision issues with the clients. Whose responsibility is it to introduce the subject? How to act if suspicions arise that a girl of a client family is threatened by circumcision? What if there are suspicions that a girl has been circumcised during a trip abroad?

These guidelines are a part of the KokoNainen (Whole Woman) project of Finnish League for Human Rights, which is the widest project against female circumcision that has been carried out in Finland. KokoNainen project has been in operation since August 2002 with the funding of RAY (Finland's Slot Machine Association). The studies, which were conducted in the framework of the KokoNainen project, form the basis for these guidelines. One of the studies concerned immigrants that come from a country where female circumcisions are performed (Mölsä 2004), and the other concerns public health nurses in the Helsinki region, most of which worked in maternity and child welfare clinics as well as in school health care during the research period (Tiilikainen 2004). The researches clearly indicate that questions regarding female circumcision are topical in Finland.

The answers to the inquiry sent to the public health nurses reflect the lack of information, material and clear instructions as well as the difficulty of discussing circumcision. Many of the respondents brought out that the shortage of time and staff hindered them from examining circumcision issues or dealing with them with the clients. Out of the 97 respondents that returned the inquiry, the majority (93%) stated that they did not know for sure, whether or not the daughters in their client families had been circumcised, and 73% of the respondents announced that they did not systematically observe the situation of uncircumcised girls. Over a half of the public health nurses (52%) had never discussed female circumcision for preventive purposes with the mother or other guardian. The current situation is challenging. The circumcision of girls can be compared to domestic violence, which is also experienced as a difficult matter to discuss with clients. Nevertheless, it is crucial to open the discussion and broach the issue professionally.

The aim of these guidelines is to enhance prevention of the circumcision of girls and promote the good treatment of girls and women that have already been circumcised. These guidelines can be considered as a recommendation and it is primarily aimed at public health nurses, midwives, doctors, social workers and child welfare workers. In addition, the guidelines are also useful to day-care centre workers and teachers, who meet children and young people with immigrant backgrounds in their work. The guidelines have been made for nationwide use, and it can work as a basis for creating more specific strategies in terms of municipalities, regions, and work communities. The development of the preven-

tion of female circumcision should be started in one's own work community. In the shared meetings, it is important to discuss whether there has been any circumcision cases in the region, what actions were taken regarding those cases and what actions will be taken in the future. The development of local networks is essential in dealing with such a complex phenomenon as female circumcision

The guidelines concentrate on female circumcision in particular. Therefore, general questions related to the health care of refugees and immigrants, such as the use of an interpreter, have mainly been excluded. These guidelines have been written according to the periods of life of both circumcised and uncircumcised girls and women. Therefore, it is easy to study at first the chapters that are central to one's own work. As a result, certain issues and recommendations are repeated in the text. However, reading the entire text is recommended in order to receive a general view on the topic.

The writers of the guidelines have considered it important that the points of view of both social and health care to female circumcision are in the same booklet. It is good for social and child welfare workers to be informed on how and under which circumstances health care workers deal with female circumcision. The health care workers, on the other hand, have often only little information on the course of child welfare processes. Common recommendations emphasise the importance of co-operation between social and health care workers and the authorities in stopping female circumcision.

The steering committee of the KokoNainen project has represented the Ministry of Social Affairs and Health, the State Provincial Office of Southern Finland, the Association of Finnish Local and Regional Authorities, the al-Huda mosque as well as the municipalities of Helsinki, Espoo and Vantaa. For the preparation of the guidelines, a multi-professional expert group with an open principle was assembled, which started to create and work on the material in June 2003. The participants of the working group have years of experience on immigrant work and issues related to female circumcision. In addition, the guidelines have made use of the international guidelines and recommendations, which have been adapted to the circumstances in Finland. The core of the group has included the following people and actors:

The specialists on gynaecological diseases and labour **Helena Laasonen** (Jorvi Hospital) and **Anna Sariola** (Kätilöopisto Maternity Hospital), and licentiate in medicine, researcher **Mulki Mölsä** (University of Helsinki); midwife **Synnöve Salonen** (Jorvi Hospital) and the midwifery students **Hanna-Leena Aromaa** and **Outi Kaasinen** (Stadia Helsinki Polytechnic); public health nurses (in maternity and child welfare clinics as well as in school health care) **Iris Johansson** (Helsinki), **Marita Kerola** (Espoo), **Helena Kivelä** (Espoo), **Raili Peltonen** (Helsinki), **Auli Rinne** (Espoo), **Riitta Savolainen** (Espoo), **Anne Sujamo** (Vantaa) and **Kaija Virtanen** (Vantaa) and consultant **Janneke Johansson** (Immigration unit, Helsinki) and public health nurse **Hannele Rauha** (Multi-Service Office for Immigrants, Vantaa); social worker **Paula Karjalainen** (Helsinki), child welfare social workers **Pihla Salemaa** (Helsinki) and **Sarianne Tanjas-**

Kuusisto (Helsinki), and the leading social worker **Pirkko Turpeinen** (Helsinki), development consultant **Irma Maikkula** (Helsinki) and lawyer **Karri Välimäki** (Helsinki). In addition, the working group has included the consultant on immigrant issues **Said Aden** (Helsinki) and the lecturers of Stadia Helsinki Polytechnic **Pirjo Koski** and **Sirkka Pietiläinen**.

Iwould like to give warm thanks to all the above-mentioned persons and parties, who have contributed their skills and time for the creation of these guidelines. I would also like to thank everyone else, who have discussed the content of the material, but who were not separately mentioned here. I would like to especially thank development consultant **Irma Maikkula**, who took the responsibility for the preparation of the social work and child welfare perspective, as well as **Helena Laasonen** and **Anna Sariola**, who have many times commented on the text with their expertise as medical doctors. Special thanks also belong to the child neurology specialist **Marja Koivusalo**, who had valuable comments on the section regarding school health care. I would like to thank Stadia Helsinki Polytechnic for the rewarding co-operation: the students of Stadia **Hanna-Leena Aromaa** and **Outi Kaasinen** illustrated the booklet as a part of their final paper. In addition, I would like to give warm thanks to **Taru Koskinen**, who has created the visual look for the booklet. Funding for the layout and printing expenses was received from the Funds for Health Promotion of the Ministry of Social Affairs and Health.

Helsinki, August 17th, 2004

Marja Tiilikainen
Project Manager, PhD
KokoNainen project

2. BACKGROUND INFORMATION ON FEMALE CIRCUMCISION

2.1 What is meant by female circumcision?

Female circumcision is primarily an African tradition, and it was practised already before Christianity and Islam over 2000 years ago. The historical origin of female circumcision is not known with certainty, but it is often said to originate from the ancient Egypt and Sudan. The custom has spread to several African countries and the Arabian Peninsula. In addition, female circumcision is practiced, for example, in some Asian countries.

Female circumcision refers to all procedures including partial or total removal of female genitalia or other injury to the genitals due to cultural or other non-medical reasons.



According to the World Health Organisation (WHO), female circumcision can be divided into four different types¹:

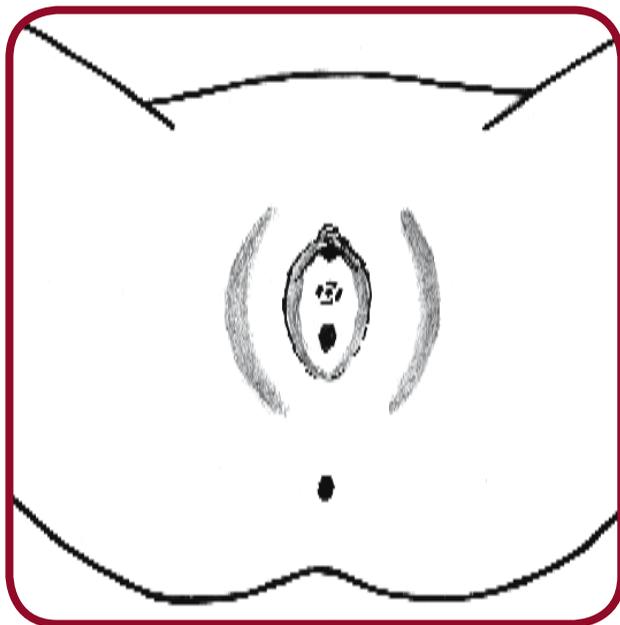
Type I: excision of the prepuce, with or without excision of part or the entire clitoris.

Type II: excision of the clitoris with partial or total excision of the labia minora (sometimes referred to as *excisio*).

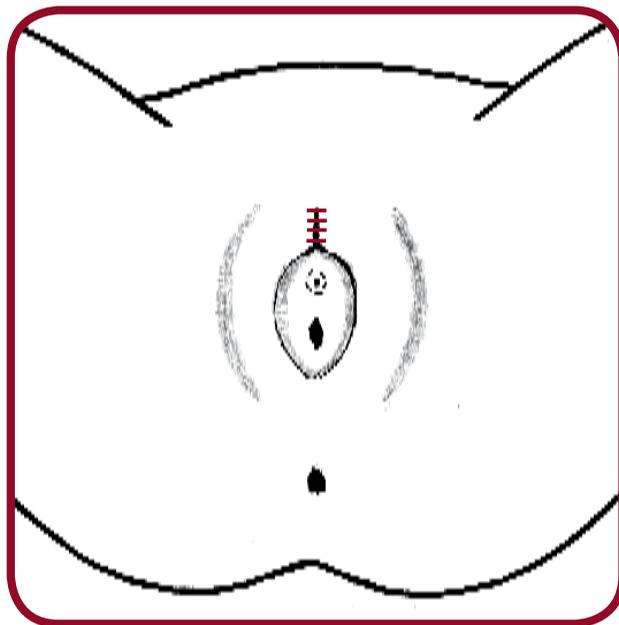
Type III: excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening, leaving only a tiny opening to allow the passage of urine and menstrual blood (infibulation or pharaonic circumcision).

Type IV: Several unclassified customs: pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization 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 most common types of female circumcision are Type I and II (accounting up to 80% of all female circumcisions). Infibulations (Type III) account to some 15% of all procedures. In practice, however, it may be difficult to distinguish the type of operation in question. Circumcisions including many different features are common,



Normal anatomy



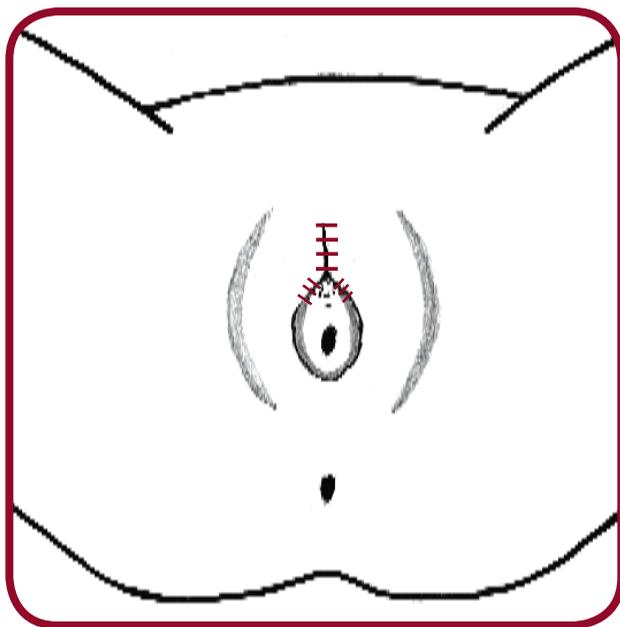
Type I: excision of the prepuce and clitoris

and the above-mentioned classification can only be considered as suggestive. For example, sometimes in the *de-infibulation* of a closed vulva, it has been noted that although a circumcision has extrinsically looked like an *infibulation*, the clitoris may still have been there. On the other hand, it has been unclear what the excision of the prepuce in the Type I circumcision signifies: in order to perform the operation, one would actually require a microscope, which is hardly available

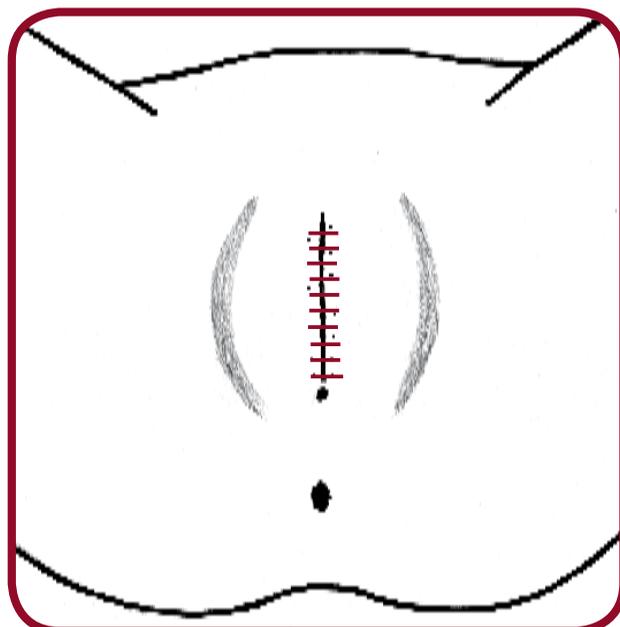
to the circumcisers. In practice, therefore, Type I always stands for the excision of part or the entire clitoris.

2.2 Terminology

In the prevention work on female circumcision, in Finland as well as internationally, the term FGM (*female genital mutilation*) is generally



Type II: excision of the clitoris with partial excision of the labia *minora*



Type III: excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening

used. Also in the 6th general assembly in the spring of 2005 on the *Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC)*, an appeal was made to use the term FGM (6th IAC General Assembly, 4–7 April, 2005, Bamako/Mali). There is nevertheless ongoing discussion on the appropriate terminology. For example, in the international conference on female genital mutilation held in Addis Ababa in February 2003, it was discussed whether the term female genital cutting (*FGC*) is better suited for prevention work. In this booklet,

the term female circumcision is used, which has been recommended for use in projects against circumcision carried out in Norway and Denmark, for example. The term female circumcision better reflects the cultural significance of the operation as compared with the term mutilation, which is very emotionally and politically charged as a term. In Finland, the term female circumcision has been found to provide a better basis for prevention work and discussion on the issue among the communities who practice the tradition. It is important that also women and girls that have



undergone circumcision are able to accept the terminology. “Mutilation” also seems to be unsuitable to describe minor forms of circumcision, such as different kinds of pricks or incisions.²

The communities that practice circumcision have their own terms for it. For example in Arabic, both the circumcision of girls and boys can be referred to with the terms *khitaan* or *tahara*, which mean purification. Also *gudniin* in Somali stands for the circumcision of both girls and boys. The so called sunna circumcision is a term that is used by some of the Muslims coming from cultures where circumcisions are practiced, and the term is often described as standing for pricking or shedding a few drops of blood from the clitoris, or mainly as circumcision Type I. However, the “*sunna* circumcision” is very non-specific. Although it is often understood as a “small” operation, it can in practice stand for an operation as extensive as infibulation.³

2.3 Why are girls and women circumcised?

Cultural reasons

Female circumcision is justified with cultural, religious, moral, social, economic and sexual reasons, as well as reasons related to aesthetics and purity. The reasons for female circumcision vary according to country, region and cultural background. The circumcision age of girls varies in different regions and different ethnic groups.

The operation can be performed already to babies, in childhood years, before marriage, during the first pregnancy or after childbirth. Most often the operation is performed between the ages of 4 and 10. Similarly, the operation method can vary even in the same region, depending on the local tradition, the routines of the circumcisers, the wishes of the relatives, education or social class. The continuation of the tradition guarantees the living of the circumcisers. Therefore, in some programmes against female circumcision that have been carried out in Africa, there have been attempts to find alternative sources of living for the circumcisers, so that they can give up their profession as circumcisers.

The circumcision of girls is related to questions of tradition and cultural continuity. Through circumcision, the cultural and ethnic identity of a community is renewed by defining the characteristics of a community with the help of symbols and meanings related to the body. Female circumcision has also been justified with religious reasons, although it is not a part of the key principles of any religion. The circumcision of girls is often related to social acceptance. Circumcision is a sign of sexual maturity, and it signifies the turning of a girl into a woman. In Kenya, for example, circumcision is an important rite of transition from the world of girls to the world of women.

By circumcision, girls are made into women by excising the parts of the body that are considered masculine in some communities. In other words, circumcision is a symbol of female identity. Circumcision is also an indication of a decent,

respectable and marriageable woman, and it is often a requisite for getting married. In Somalia, for example, circumcision has been thought to guarantee the virginity of a girl before marriage. A circumcised girl is valuable for the family, since she will bring a high bride price to the family, when she gets married.

The necessity of circumcision has also been explained by the assumption that it reduces the over-sexuality of a woman or, respectively, increases the sexual pleasure of the husband. In many areas, circumcision is seen as an operation of purification, by which the ritually impure genitals are excised. The circumcision of girls can be seen as an operation that increases fertility and hygiene, preventing the contagion of certain diseases. Circumcision is also connected to aesthetic values. There may, for example, be fears that the clitoris starts to grow extremely or hang. Conceptions of beauty are culture-bound and a circumcised woman is not only normal but also beautiful in her own community.

In some communities, for example in Sudan, the importance of *re-infibulation* is emphasised, which stands for re-stitching the opened vulva and closing the vagina after child birth or when a divorced woman remarries. According to the Sudanese women interviewed by Mulki Mölsä (2004), *re-infibulation* is often considered so important that even women living in Europe may travel to Sudan for the operation. By stitching, virginity is artificially created over and over again. Being “open” is considered as a health

risk, because “dirt” will freely enter the vagina. The interviewed women justified re-stitching as improving the sexual life of both men and women.

Many beliefs uphold the tradition. However, pharaonic circumcision does not guarantee the virginity of a girl, and the moral value of a person cannot depend on circumcision. Usually, female circumcision hardly increases the sexual satisfaction of the man. On the contrary, it often makes the intimate relationship between wife and husband more difficult. The *de-infibulation* of a *pharaonically* circumcised woman in a traditional way by the first sexual intercourse is a distressing situation for both the man and the woman. Female circumcision does not improve the hygiene of a woman; on the contrary, it can cause severe health problems. Due to lack of communication, men and women may be unaware of each other’s opinions. Women may assume that men do not marry uncircumcised women, although men may already have changed their opinions in reality.

Religious reasons

The circumcision of girls is often associated with Islam, despite the fact that the tradition is older than Islam. However, many of the circumcised women in the world are Muslims. On the other hand, the custom is unfamiliar in many Muslim countries, and a great proportion of Muslim women have not been circumcised. In Algeria, Morocco and Tunisia, for example, girls are not circumcised. In addition, circumcision is

practiced also among Christians (e.g. in Egypt and Ethiopia) and Jews (e.g. in Ethiopia), as well as among animists in such regions, where female circumcision is a common practice. Female circumcision is not a part of the key principles of any religion.

Female circumcision is not mentioned in the Koran, but interpretations that justify female circumcision, and especially the so called *sunna* circumcision, can nevertheless be found in the Islamic world. In Islam, *sunna* stands for the right way, being based on the example of Prophet Mohammed. In addition, *sunna* refers to an action that is recommendable, but neglecting the action does not lead to punishment. The sunna circumcision of girls, however, is not a generally known concept in Islam and among Muslims. In Finland, discussion on the *sunna* circumcision is nevertheless important as regards the Muslim immigrants who come from countries where circumcisions are performed.

Uncertainty about the stand of Islam stems from the fact that female circumcision is only mentioned in oral tradition, and the scholars of Islam disagree on the authenticity and the interpretation of these specific *hadiths*. According to one of the most cited *hadiths*, the Prophet said to a woman performing a circumcision: “Do not cut severely, since it is better for a woman and more desirable for a husband.” Disagreement is particularly related to the minor forms of circumcision. The stands of the scholars of Islam, according to which extensive circumcisions on girls are

anti-Islamic, have significantly affected on the decrease of at least pharaonic circumcisions in the last decade.⁴

2.4 Prevalence of the tradition

According to WHO estimates, there are 100-140 million circumcised women in the world, and annually approximately 3 million girls belong to the risk group of being circumcised.⁵ The girls who have been or are under the threat of being circumcised live in 28 different African countries, as well as in some countries of the Middle East and South and Southeast Asia. As far as is known, the circumcision of girls is practiced or has been practiced also among some indigenous peoples, for example in Central and South America. Currently, girls and women who have been or who are under the threat of being circumcised increasingly live among immigrants in Europe, Canada, the United States, Australia and New Zealand.

The statistics and research on the prevalence of female circumcision and the different operation types in different countries are only suggestive. It has to be taken into account that there may be great differences regionally or in different ethnic groups in many countries: female circumcision may be very common in a part of the country, whereas it may not be practiced at all elsewhere. Therefore, the following map can only be considered as suggestive.

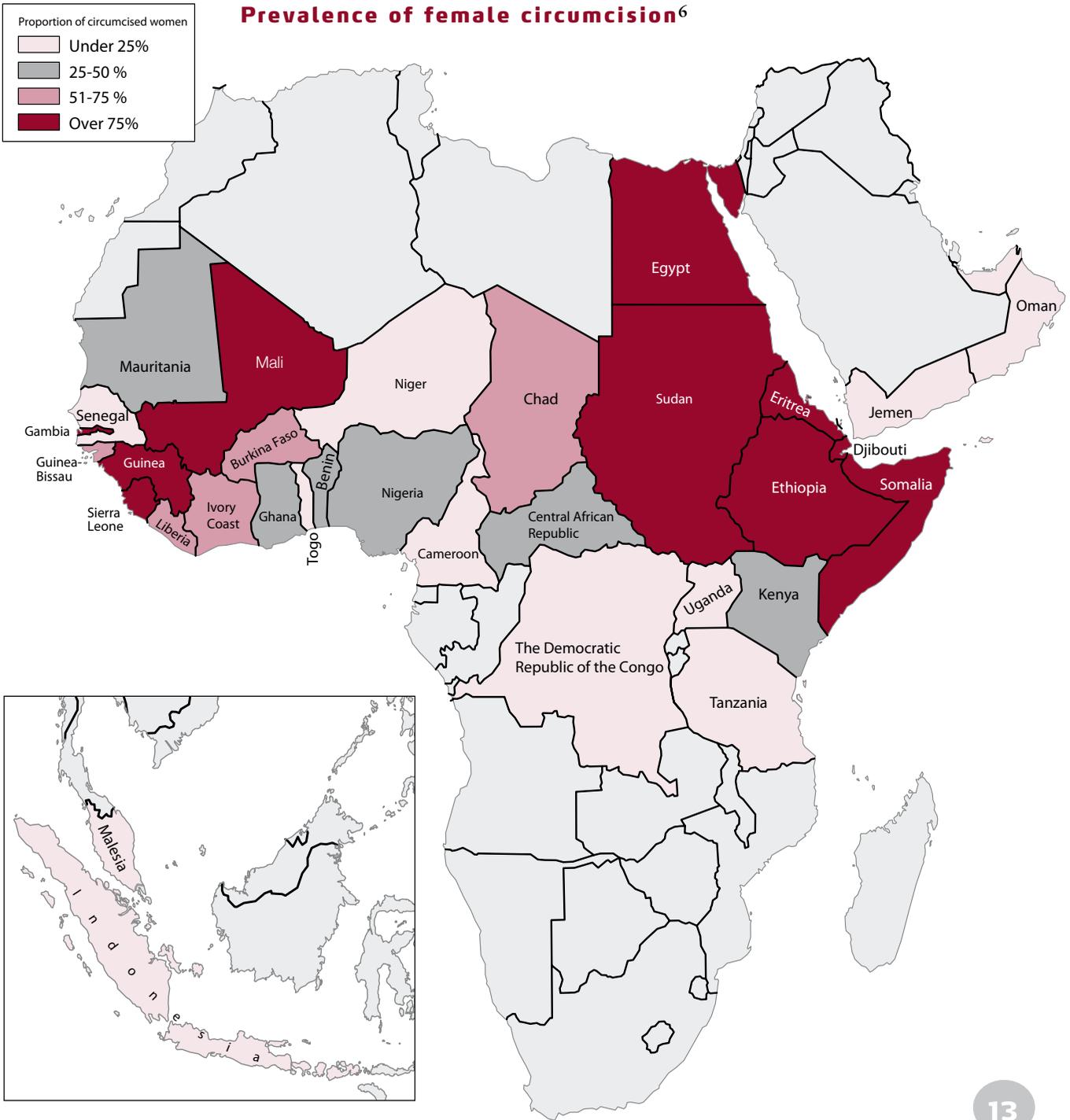
Proportion of circumcised women in different African countries⁷

Country	Percentage share
Benin	50
Burkina Faso	70
Djibouti	90–98
Egypt	78–97
Eritrea	90
Ethiopia	73–90
Gambia	60–90
Ghana	9–30
Guinea	70–90
Guinea-Bissau	50
Cameroon	5–20
Kenya	38–50
Central African Republic	50
The Democratic Republic of the Congo (previously Zaire)	5
Liberia	50
Mali	90–94
Mauritania	25
Niger	5–20
Nigeria	25–50
Ivory Coast	45–60
Senegal	5–20
Sierra Leone	80–90
Somalia	90–98
Sudan (esp. Northern Sudan)	89
Tanzania	10–18
Togo	12
Chad	60
Uganda	5

Female circumcision is most common in Somalia, Djibouti, Egypt, Mali, Sierra Leone, Ethiopia, Eritrea, Sudan (especially in the northern part of the country), Guinea, Burkina Faso, Chad, Ivory Coast and Gambia. Out of the different kinds of circumcision types, *infibulation* is the most common in Somalia, Djibouti, eastern Chad, Mali, Northern Sudan, and Southern Egypt near the border to Sudan, as well as in Eritrea and Ethiopia, especially in the areas bordering on Sudan, Somalia and Djibouti.

Female circumcision is also practiced in the Arabian Peninsula. In Yemen, approximately 23 per cent of the women – and in some areas over 96 per cent – are circumcised. In addition, female circumcisions are performed, for example, in Oman and the United Arab Emirates, although detailed information on the occurrence of the operations is not available. It is often argued that girls are not circumcised in Saudi Arabia. However, it has sometimes been claimed that girls are circumcised there too, but there has just not been any research on the occurrence of circumcisions in the areas. Circumcisions of girls are also performed to some extent especially among the Muslim population in the Indian Peninsula (the Muslim community of *Daudi Bohra*), Malaysia and Indonesia. In the case of Indonesia, Type I and IV have been reported to occur in the islands of Java and Sumatra, for example.⁸

Prevalence of female circumcision⁶



2.5 How is a girl circumcised?

The circumcision of a girl can be performed by using special knives, scissors, pieces of glass or razor blades. In rural villages, elderly women or traditional midwives work as circumcisers. In an operation that is performed in the traditional way, there are usually no anaesthetics or sterile instruments available.

The persons assisting in the circumcision hold to the child during the operation, which lasts for approximately 15 minutes. In order to stop the bleeding, the wound may be treated with herb mixtures, porridge or ash. In *infibulation*, the mutilated labia are stitched with thick thread or thorns from acacia trees. The girl's legs are bound together in order for the wound to heal faster. After circumcision, the girl is given only little drinking water in order to reduce the need to urinate. However, in cities, wealthier families can take their daughters to trained nurses, midwives or doctors who perform the operation in hospital settings.

The consequences of female circumcision vary according to the extent of the operation, the used instruments, the skills of the circumciser, as well as other circumstances related to the operation as well as after the operation. There is relatively little research information on the complications.

In literary sources, the possible consequences of circumcision are usually referred to only when the operation is performed by the traditional circumcisers in unhygienic circumstances. The risk of complications also increases, if the woman is always re-infibulated after each childbirth. If the circumcision is performed in hospital conditions, health hazards and risks are most likely smaller. A performed pharaonic operation does not harm the pregnancy or childbirth, if *de-infibulation* has been performed under appropriate circumstances before the pregnancy. When evaluating the consequences of circumcision, it should be remembered that, for example, the treatment conditions of an infibulated woman in labour are significantly better in Finland than for example in the African countryside. Therefore, many of the problems related to childbirth in the following listing, for example, do not necessarily occur under hospital conditions in Finland.⁹

4. STARTING POINTS IN FINLAND

4.1 Are girls circumcised in Finland?

Female circumcision in Finland became a subject of general interest in the beginning of the 1990's, when the number of immigrants started to increase substantially. The first information on the tradition of female circumcision came from asylum seekers arriving from Somalia. The topic became current in Finnish municipalities in 1993–1995, when the numbers of women and girls amongst the Somali population increased due to family reunification.

The Somali population is currently the largest, but not the only group that practises female circumcision in Finland. There are also other immigrant groups in whose respective countries of origin female circumcision is practised at least to some degree. These countries include, among others, Ethiopia, Eritrea, Egypt, Sudan, Kenya, Ghana and Nigeria. Female circumcision can also be practised in some surprising regions, such as in the Kurdish regions – a factor which has come up at the training events organised by the *KokoNainen* project. The question on female circumcision can also come up in a mixed marriage, where one of the spouses comes from a community that practices circumcision. Therefore, it is very important to remember that the possibility of a girl having undergone circumcision is taken into account also when dealing with other client groups than the Somalis or Muslims.

I Immediate consequences

- pain and psychological consequences
- haemorrhage (excessive bleeding)
 - anemia
 - decrease in blood pressure
 - rapid blood loss
 - death
- infections
 - wound infection, wound rupture
 - blood poisoning
 - tetanus
 - viral infections (HIV, hepatitis B and C)
 - septic shock and death
- difficulties with urination
 - urine retention
 - urethral damage
 - urinary tract infection
- fractures due to holding down during the operation
- injury to the surrounding tissue

II Long-term consequences

- pain
 - menstrual pain
 - painful sexual intercourse
- effects of scarring
 - external cysts and abscesses
 - neuroma (tumour of cells in the nervous system)
 - inelastic scar tissue
 - accumulation of menstrual blood in the vagina

- fistulas in the bladder or the intestine
- gynaecological examination and catheterisation may be painful or impossible
- problems with urination
 - urinary tract infections
 - incontinence
 - urolith
- effect on fertility and sex life
 - painful sexual intercourse
 - vaginal intercourse might be impossible
 - difficulties in experiencing orgasms
 - infertility
- other consequences
 - psychological problems (post-traumatic stress, nightmares, anxiety, depression)
 - chronic viral infections (HIV, Hepatitis B and C)

III Problems related to childbirth

- fears of childbirth
- prolonged pushing stage
- problems in monitoring childbirth and the welfare of the foetus
- ruptures
 - bleeding
 - inflammations
 - tetanus and blood poisoning under primitive circumstances
- unnecessary Caesarean sections
- transmission of chronic infections from mother to child

So far in Finland, the question on the circumcision of girls has been discussed in a few theses and in studies especially targeted at Somali women.¹⁰ Mulki Mölsä, a Somali born medical doctor herself, has conducted two studies on circumcision in Finland. The first one, *Tyttöjen ympärileikkauksen hoito ja ehkäisy Suomessa (Treatment and prevention of female circumcision in Finland)*, was published by Stakes (the Finnish National Research and Development Centre for Welfare and Health) in 1994. For the study, Mölsä interviewed 130 Somali women living in the *Uusimaa* region. At the time, the Somali mothers were quite certain that they were going to have their daughters circumcised and over a half of the single women were uncertain of the matter. Amongst the interviewed women, there were supporters of *infibulation* and Type II circumcisions. However, many were in favour of the minor types of female circumcision.

In 2004, Mölsä conducted her second study for the KokoNainen project. The study was titled *Ajat ovat muuttuneet: Selvitys tyttöjen ja naisten ympärileikkaukseen liittyvistä asenteista ja aikeista pääkaupunkiseudulla asuvien maahanmuuttajien keskuudessa (Times have changed: an account of the attitudes and intentions on the circumcision of women and girls amongst immigrants living at the Helsinki Metropolitan Area)*. Mölsä interviewed 18 women and 12 men for the study. The interviewees were originally from Somalia, Sudan, Ethiopia, Eritrea and Nigeria and they were 15–60 years of age. Things had changed in ten years, because none of the interviewees wanted their daughters or future daughters to be infibulated. However, many of the

mothers and fathers as well as of the young were unsure of the necessity of the circumcision of girls and their future plans regarding the operation. In terms of circumcision of girls living in Finland, an important factor was that it is not only a question of the parents' wishes, but also of the desires and identity seeking of young teenage girls. The uncertainty was especially related to the smaller operations, which the interviewed Somali and Sudanese referred to as the *sunna* circumcision, and which they justified with religious reasons. It may be possible that circumcision will be given up in Europe, but if a girl returns to her country of origin, circumcision may become important again. The interviewed mothers told that they had been pressured by their relatives to have their daughters circumcised during visits in the country of origin. Not all of the interviewees were aware of the Finnish legislation or considered it important in terms of making a decision on the matter.

Mölsä states that talking about female circumcision is difficult at many levels. It is difficult in one's own community, where women and men are not used to communicating with each other on matters related to sex, and it is also difficult in Finnish society, where female circumcision is an unfamiliar tradition and an illegal operation. Based on the studies conducted for the KokoNainen project and on the training events and discussions at the grass roots level, it seems that the possibility of female circumcision can still not be excluded. It is most likely that operations are performed during trips abroad. In order

to completely dismantle female circumcision, extensive and long-term co-operation is needed between the key persons with immigrant backgrounds, workers in social and health care and with the school system and other authorities.

4.2 Female circumcision as a violation of human rights

Nowadays female circumcision has been globally recognised as a practice that violates human rights, and like other forms of violence, it is an attack on the dignity, equality and integrity of girls and women. The tradition of circumcision violates for example the right to life and integrity, right to live without violence, the right to health, the right to life without discrimination and, in general, several children's rights. Even though the majority of the agreements on human rights do not refer to traditional harmful practices specifically, they are customarily regarded as prohibiting female circumcision.

With regard to female circumcision, important agreements on human rights include the UN Convention on the Rights of the Child, the Convention on Discrimination Against Women, the International Covenant on Civil and Political Rights as well as the convention against torture. Central regional agreements include the European Convention on Human Rights as well as the agreements drafted within the Organization of African Unity (OAU), the African Charter on Human and People's

Rights and the African Charter on the Rights and Welfare of the Child. In addition, the 1995 Beijing Plan of Action advises states to particularly act for the abolishment of female genital mutilation. International agreements on human rights provide a framework, on which the national legal systems and plans of action on female circumcision should be based. In practice, however, this has not been realised.¹¹

Article 24 of *the UN Convention on the Right of the Child* enacts that a child has the right to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. It is also stated that the States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children. In addition, article 19 enacts that States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child. Thus the states that have signed the Convention, including Finland, have committed themselves to the abolishment of female circumcision and to protecting girls from being circumcised. The obligation of the Finnish authorities is to act for preventing the circumcision of girls.

In some cases, circumcision may be performed on an adult, for example on a woman about to get married. Thus *the UN Convention of the Elimination of All Forms of Discrimination Against Women* from 1979 is important with regard to circumcision. The fifth article of the convention states that the States Parties shall take all appropriate measures to “modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women” (113a).

In the plan of action of the 1995 Beijing World Conference on Women, female genital mutilation is specifically mentioned as a form of violence against women (113a). In addition, it is stated in the plan of action that governments should “enact and enforce legislation against the perpetrators of practices and acts of violence against women, such as female genital mutilation...and give vigorous support to the efforts of non-governmental and community organizations to eliminate such practices” (124i).

Female circumcision also violates sexual rights, which are based on the Charter of Sexual and Reproductive Rights, published by the **International Planned Parenthood Federation (IPPF)** in 1995.¹²

According to the Convention relating to the Status of Refugees (the so-called Geneva Treaty from 1951) a refugee is a person, who has a

“well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion”. Recently, more and more attention has been paid to the particular problems of female refugees and it has been recognised that sexual violence against women is a form of persecution. The threat of female circumcision has been used as a justification for granting an asylum in the United States. Thus far there is no precedent of the matter in Finland, but in principle, the Finnish legislation makes it possible to protect someone from persecution because of their sex and the threat of circumcision.

In the Western world, female circumcision is usually prohibited by a particular law (at least in Sweden, the UK and Norway) or an already existing criminal law is applied to it. Numerous NGOs and other official organs act against female circumcision. During the past few years, several projects against female circumcision have been started all over Europe and, at the same time, the inner networking of the European Union has been made more effective.

Furthermore, several African countries fight female circumcision. Several countries have striven towards developing legislation and plans of action against it. However, in Sudan, for example, the law only prohibits infibulations and not the minor forms of circumcision. In Egypt, there has been an ongoing debate for years on whether female circumcision is, according to the Egyptian law, prohibited in all circumstances or whether

the custom could be medicalised and accepted when performed by doctors. In addition, the religious leaders of Egypt disagree on whether the circumcision of girls is a part of Islam or not. By themselves, the laws have not proved to be efficient enough to cut off the tradition of female circumcision.

4.3 Finnish legislation

In Finland, there is no separate law that would prohibit female circumcision. However, female circumcision is, by the Finnish Penal Code, a punishable act in all its forms. This also applies to *re-infibulation* i.e. re-stitching the labia *majora* to close the vagina. Altogether three bills have been drafted in Finland to prohibit the female circumcision; the first one in 1992 and the latest in 2003. So far the Ministry of Justice has taken a negative stand against enacting a separate law.

As far as is known, there has not been a single case related to the circumcision of girls, but most likely it would be judged as aggravated assault and battery. By the Penal Code, an assault is defined as aggravated, if in the assault grievous bodily harm or serious illness is caused or the offence is aggravated also when assessed as a whole. The right to institute criminal proceedings expires after 20 years of the date of the incident.

Depending on the seriousness of the offence, one can be imprisoned for up to ten years for performing female circumcision or being involved in one. This also applies if a person residing in

Finland is taken abroad for the operation. The offence is punishable when it is directed at a Finnish citizen, someone who is a permanent resident in Finland or if the person performing the operation is a Finnish citizen. A person who has proved to be an inciter is convicted the same way as the actual offender, even if s/he has not taken part in the actual performing of the operation. Furthermore, if a doctor were to perform a circumcision on a girl, s/he might lose the right to practise the medical profession.

By the Child Welfare Act, a child is entitled to a secure and stimulating growing environment and a harmonious and well-balanced development. By Section 40 of the Act, if in the course of her/his activities, an employee or an elected official in health care, social welfare, education, the police or Church of Finland, finds out that a child is in evident need of family-oriented or individual child welfare, s/he must notify the social welfare board without delay. Open welfare actions, as stated in the Child Welfare Act, must be taken, if the child's growing environment endangers, or does not secure her health and development. If a girl is threatened by circumcision, she can also be taken into custody in order to protect her.

Taking a child into custody may be necessary for the child's physical and mental health, also if the circumcision has already been performed and the child's parents do not deem treatment as necessary. If a girl has been circumcised while she has been living in Finland, a social worker from child welfare estimates whether it is neces-

sary to request an investigation from the police, as in other assault cases. If possible, it is useful to consult a lawyer. In order to determine whether or not a crime has been committed, the police will request all necessary examinations as well as statements from social welfare and health care authorities.

A person who knows that an imminent aggravated endangerment of health or aggravated assault is being planned, has under penalty the duty to notify the authorities or the person who is threatened, and thus to prevent the act from happening (Penal Code, Chapter 15, Section 10). However, the duty to notify does not apply to relatives (spouse, sibling, direct ascendant or descendant, person living in same household or person close owing to another comparable personal relationship). Similarly to the duty to notify, as enacted in the Child Welfare Act (Section 40, Sub-item 1), the Penal Code's duty to notify supersedes the authorities' obligation to maintain secrecy.

Thus, for example, if a young girl tells a public health nurse that she is afraid that her family is planning to get her circumcised, the nurse's obligation to maintain secrecy is superseded and s/he has to notify the child welfare. In a situation like this, it is recommended that the nurse first contacts the girl's parents, discusses the matter with them and notifies them in advance of making the notification to child welfare. This makes the further settling process with the family much easier.

5. PREVENTING FEMALE CIRCUMCISION



5.1 Detecting and registering the circumcision status

The circumcision status of a woman or a girl is detected by discussion or/and by examination. Depending on the situation, this is conducted by a doctor and/or a public health nurse. The status is appropriately registered at the entry check, a child welfare clinic, school health care, maternity clinic, hospital or health centre. Furthermore, a circumcision performed on a girl or a woman must be registered at a health centre doctor's appointment, if there is no previous reference of it in the client's record. The circumcision may come up when the client seeks medical examination and treatment for example for menstrual pain, urinary tract infection or *vaginitis*.

It is recommendable that also the extent of the operation is described when registering a circumcision. For example, after a gynaecological examination performed by a doctor, such descriptive expressions can be used as "entirely closed, internal examination difficult", "opening of the urethra visible", "internal examination impossible to perform" or, it can also be registered if it is possible to insert a catheter. In addition, if a *de-infibulation* has been performed, it should be

mentioned. If the circumcision status is detected by discussion, it can be registered in her patient information card that, for example, "according to the girl, she has/has not been circumcised". Furthermore, it is in order to register at what age the client has been circumcised and in what kind of circumstances, whether the family's other daughters and mother and/or other female relatives have been circumcised and how the family (mother, father, other close relatives) views circumcision nowadays. Asking and registering this information is important in order to treat circumcised girls and women appropriately and to protect uncircumcised girls from circumcision.

If a girl is uncircumcised, the attitudes of both parents/guardians towards circumcision should be defined. The discussions can be registered, for example, as follows: "Father and mother at maternity clinic, I asked about intentions on circumcision. The father said the following and the mother said...". Furthermore, it must be taken care of that the families know that female circumcision is prohibited and what kind of injurious effects circumcision may cause.

The families must also be informed that the Child Welfare Act enacts on filing a report to the

child welfare authorities and that such a report may also come into question in situations related to female circumcision. In addition, discussions on cultural and religious points of view are often profitable. When registering information, the already existing fields in files or forms should be used, such as "observations", "details", or the field "operations" in a child's health information card. Because the forms are not alike everywhere in Finland, it is recommendable to agree on more detailed registering practices within regions or municipalities.

Registering the information is essential, not only for supporting one's own memory, but also for passing on information to other employees. The same issues related to circumcision should not, however, be trotted out every time the client comes to, for example, her maternity clinic appointment. Careful registration of the information builds a foundation for the follow-up and prevention of female circumcision. In addition, it must be noted that in the future, the police will have the right to request customer documents for the investigation and legal proceedings related to the suspected crime. Thus it is extremely important to register what has been discussed, with whom, which family members were present and whether an interpreter was used. By registering the discussions on circumcision, the employee also records that s/he has attended to his/her duties flawlessly.

If, during the discussion, it comes up that the girl/woman has been circumcised prior to her

move to Finland, this is registered in her papers and her situation and needs (e.g. for de-infibulation) will be monitored at different stages of her life. If the girl has been circumcised in Finland or abroad after the move to Finland, a report must be filed to child welfare authorities (see chapters 8 and 9).

5.2 Pregnancy and labour

In order to prevent female circumcision, it is extremely important to broach the subject, even though it might seem very difficult. At the same time, one should try to find a balance on how often the issue can be discussed. If the circumcision is taken up on each visit at the maternity clinic, in the end the girl/woman and her family may become reluctant and this may be negatively reflected on the *customership*. Thus, it is useful to check the patient information card in advance in order to see whether circumcision has already been discussed, and what kind of things have been dealt with. During the appointments, the employee may inquire of the client herself what has been covered in terms of circumcision and where the discussions have taken place. At the same time, the employee can check how the woman and/or her next of kin have understood the discussed matters.

The prevention of female circumcision starts already during the mother's pregnancy. If at least one of the parents comes from a country where circumcisions are performed on girls, the issue

should be dealt with. Both the public health nurse and the doctor should broach the subject when the mother visits the maternity clinic.

When asking for the case history at the first maternity clinic appointment, it should also be inquired, whether the mother-to-be has been circumcised. With questions, it is determined what kind of circumcision has been performed, at what age and in what kind of circumstances it has been performed (e.g. at the hospital or by a traditional midwife). It is also useful to determine whether the mother's sisters and other daughters in the family have been circumcised. In the course of later visits, the attitudes of the mother, father and the rest of the family towards circumcision are discussed further. For example, it can be asked what the mother thinks of circumcision on her future daughter or whether the family has discussed female circumcision. In addition, the mother is informed of the Finnish law, the points of view of human rights and child welfare as well as the injurious effects of female circumcision (see chapters 3, 4.2 and 4.3).

It is not obligatory to determine everything about circumcision at the first maternity clinic appointment. The important thing is that the subject is broached during the appointments at the maternity clinic. Questions on female circumcision can be taken up little by little as confidence and acquaintanceship develop. The information is registered in a file (see also 5.1).

In the context of prenatal classes and health education, which are affiliated with antenatal

education, female circumcision can be dealt with when discussing for example labour pain. After the daughter is born, the hospital stay offers natural contexts for finding out the father's and mother's opinions. The parents are told that the daughter is perfect uncircumcised, and that she is saved from various sufferings (e.g. related to labour), when she is not circumcised. After the mother has been released from hospital, house calls provide a good opportunity to broach the subject and to try to determine where the parents stand on the circumcision of their daughter. The brochure *Female Genital Mutilation* can be of help. It can be printed from the web pages of the Finnish Ministry of Social Affairs and Health (www.stm.fi) and it is available in Finnish, Swedish, English and Somali.

5.3 Babyhood and pre-school age

Child welfare clinic

During the girl's growth, the public health nurse and/or paediatrician take care of the follow-up in connection with periodic check-ups at the child welfare clinic. The genital area of a 2-3 year-old baby can be checked easily as the nappy is removed. In the same context it is easy to broach the subject of female circumcision. It has to be ensured that the parents know that circumcisions on girls are prohibited and that they are familiar with the points of view of child welfare as well as the health hazards associated with circumcision.

After the age of 2-3 years, it is easiest and most recommended to check the genital area in connection with medical examinations. However, public health nurses always have to be aware of the issue of circumcisions on girls in the context of the appointments and broach the subject every year. In connection with child welfare clinic appointments, one can outspokenly discuss the circumcision of girls with the parents and inquire the father's opinion as well. There may be differences even between the parents' opinions in relation to the circumcision of their daughter. Following things can be asked of the family:

"What are you planning to do this summer? Are you going to travel abroad?" The discussion can be continued with "I know that many girls are circumcised in your culture/home country. What are your plans regarding this? What if your relatives pressure you to have your daughter circumcised? What is your attitude towards that? I hope you are aware of that female circumcision is prohibited in Finland." If the family tells that they have visited their home country since their last appointment at the child welfare clinic, it can be inquired whether the subject of circumcision came up during the trip.



When inquiring the family's plans on circumcision, it is not enough to ask "are you going to have your daughter circumcised", but, if the parents answer negatively, it has to be asked again: "Are you going to touch your daughter at all? Are you going to have any kind of operation performed on her?" For example in Somalia, female circumcision means the most radical form of circumcision, i.e. the pharaonic circumcision. Thus the families do not necessarily consider the smaller-scale circumcisions, such as the *clitoridectomy* or cuts etc. as circumcisions at all. The health hazards and dangers of infection of these operations, such as being infected with HIV, hepatitis B and C, should also be discussed (see chapter 3). Creating a confidential *customership* builds a foundation for discussing also the difficult matters openly.

It is extremely important that the discussions with the parents and guardians are registered, for example in the following way: "Father and

mother at child welfare clinic, I asked about plans on circumcision. The father said this and the mother said...". One has to remember to register what has been discussed, with whom and whether an interpreter was present. The already existing fields in files or forms should be used, such as "observations" or "details". Registering the information is essential, not only for supporting one's own memory, but also for passing on information to other employees (see also 5.1).

It is recommended that groups are organised for mothers and fathers who come from countries where female circumcision is practised. In these groups they discuss the circumcision of girls and try to influence on the discontinuance of circumcisions. However, it is often beneficial to combine circumcision with another health theme (children's diseases, vaccinations, reproductive health, a healthy diet) or with questions related to the upbringing of children. It has been noted in practice that female circumcision is not enough to interest a group, but already when advertising a group, another, generally interesting subject should be broached. For example the film *KokoNainen (Whole Woman)*, produced by the KokoNainen project and suitable for Somali-, Finnish- and English-speaking viewers, can act as a conversation starter (see www.ihmisoikeusliitto.fi > KokoNainen). It is also recommended to find a key person from the same ethnic group to assemble the group and to preside over the discussion.

If, during appointments to the child welfare

clinic, suspicions arouse about that the daughter of the family is going to be circumcised, the issue should first be discussed with the parents. If there are still doubts about the matter, the public health nurse or paediatrician at the child welfare clinic must file a child welfare report to the social worker of the region's child welfare or to the social emergency duty. The parents need to be informed in advance about the notification to the authorities. By Section 40 of the Child Welfare Act, persons employed by the public health service in these situations have the duty to notify, and one's discretion can not be used in this matter. One can also consult the child welfare and ponder on if there is any reason to be alarmed. The threshold of filing the child welfare report should not be set too high; it is enough if one is worried about a child. One should not think about the probability of the threat by oneself for too long. The child welfare also needs time to act in imminent danger where, for instance, the family is planning to take the girl abroad for circumcision. The more imminent the danger is, the faster one must act.

If, during appointments to the child welfare clinic, suspicions arise about that the family's daughter has been circumcised while she has been living in Finland, the issue should first be discussed with the girl's parents/guardians. It should be explained to the parents and the child that there is doubt about the matter and in order to exclude the possibility the situation must be clarified. If the child and her parents agree, a paediatrician checks the girl's genital area in

order to clarify the situation. A public health nurse can also perform the check first, if the situation is natural. If the child/parents refuse, they are negotiated and discussed with. Child welfare can also be consulted. The aim is to clarify the situation as naturally as possible. A house call can also be a good way to survey the situation: perhaps the client feels safer in her/his own home and it is easier to talk there than at the clinic. House calls are also a good way to get hold of the family. A public health nurse and an employee of child welfare can also make the house call together. However, the important thing is that at least one qualified person, whom the family already knows, takes part in the house calls. If the doubt still exists, and the child and/or parents do not agree on a physical examination to be performed or if the situation remains unclear in some other way, the public health nurse/paediatrician files a report to the child welfare.

An employee of child welfare estimates the need for child welfare actions and whether it is in the best interest of the child to request an investigation from the police. In order to solve the possible crime, the police will request the necessary examinations and statements from the authorities of social welfare and health care.

Day-care centre

The personnel at the day-care centre should be familiar with the tradition of female circumcision and the guidelines related to it. Efficient co-operation with the public health nurses and paediatricians at the local public health clinic is important. If the personnel *knows* that the family is planning to travel abroad, the subject of circumcisions on girls may be broached in discussions with the parents. The parents should be reminded of the health hazards (see chapter 3) and of the fact that female circumcision is prohibited in Finland. If the day-care centre personnel have doubts that the girl is going to be circumcised, they should first discuss the matter with the parents. They can also consult an employee from the child welfare clinic or child welfare. If the day-care centre personnel continue to worry about the child, they must file a report to child welfare. Before filing a report, the parents must be informed (see chapters 8 and 9).

Suspicious of a performed circumcision on the girl can arouse because her behaviour has changed. The day-care centre personnel may find the girl in pain, quiet, withdrawn, anxious, depressed, aggressive, timid or tearful. She may also suffer from difficulties in concentrating or learning. In a situation like this, the day-care centre personnel should first discuss the situation with the parents. If the doubt about a circumcision remains, a report must be filed to child welfare. Before filing the report, the parents must be informed (see chapters 8 and 9).

5.4 School age

School health care

The school nurse and/or doctor should discuss with the girl in order to find out whether she has been circumcised or not, if there is no previous note of a circumcision in her patient information card. One can register, for example, that "according to the girl, she has/has not been circumcised" in the girl's papers. In addition, it is useful to ask whether the girl's sisters, mother or other female relatives have been circumcised and at what age. In addition, the attitudes of the mother, father and the rest of the family towards circumcisions on girls are inquired (see also 5.1).

Both the school nurse and/or doctor may broach the subject of female circumcision. The most important thing is that they know how to broach the subject and that the matter is dealt with. In terms of younger students, the circumcisions on girls should be discussed with the parents/guardians. When a girl reaches the age of 11–12, or is in the fifth grade, the subject can be discussed directly with her. However, it is difficult to give specific instructions in terms of what is the appropriate age. The school nurse and doctor should carefully consider the stage of development each girl is at and which other circumstances may affect the matter. Based on this, it is individually estimated how and at what stage the matter is discussed with each girl.

Circumcisions are discussed in context with regular appointments with the school nurse and doctor. One should be aware of the issue and approach it every year. It is natural to discuss the topic in context with the development stages of puberty, such as getting the first period. When the doctor checks the starting of puberty, circumcision should also be discussed. If the girl has, for example, problems with urinating or period pain, the doctor can naturally check the genital area in consensus with the girl and, when needed, with her parents/guardians. When needed, for example, if the school's facilities for examination are insufficient, it can be agreed that the examination is performed at a health centre.

The girl must be informed of the health hazards of circumcision as well as of the fact that even the smaller circumcisions are prohibited in Finland. In addition, the points of view of human rights and child welfare are clarified. Furthermore, it is important to discuss that no religion actually demands that female circumcision should be performed and that traditions are changing. For example, many young immigrant men do not deem female circumcision as important as before, with regard to getting married. If the girl comes from a community where circumcision is usually performed when a woman gets married or after that, she should get support with her decision to give up circumcision.

If possible, the issue should be taken up in particular before the summer holidays, when many families travel abroad. In the context of meetings,

it is worthwhile to ask the girl and/or her parents about their holiday plans, and remind her or them about the possibility that relatives or friends in the home country may try to persuade the girl and/or her parents to have her circumcised.

The girl's own opinion on female circumcision should also be asked, because in a class, there may be young people both for and against circumcision. It is possible that the girl wants to have some type of circumcision performed on her because of cultural or religious reasons. In the circumstances of immigration and the emotional turmoil of puberty, it is likely that in some cases circumcision may become a means to build one's own identity. Thus, school health care and teachers should try to support the growing up of girls into strong and confident women, without the girls considering circumcision as necessary. The school nurses should inform teachers about the questions on female circumcision, and they should do their part in developing the school's inner co-operation in the matter.

If the school nurse/doctor starts to suspect that circumcision is going to be performed on the girl, the matter should first be discussed with the parents/guardians. When needed, an interpreter is called to the meeting. If the suspicion still prevails, the school nurse or doctor must file a child welfare report to the social worker of the region's child welfare or to the social emergency duty. The person filing the report has to notify the parents prior to filing the report. By Section 40 of the Child Welfare Act, persons employed by

the public health service in these situations have the duty to notify, and one's discretion can not be used in this matter. One can also consult the child welfare and ponder on if there is any reason to be alarmed. The threshold of filing the child welfare report should not be set too high; it is enough if one is worried about a child. One should not think about the probability of the threat by one-



self for too long. The child welfare also needs time to act in imminent danger where, for instance, the family is planning to take the girl abroad for circumcision. The more imminent the danger is, the faster one must act (see chapters 8 and 9).

If the school nurse/doctor suspects that a girl has been circumcised, for example, during the holidays, the matter should first be discussed with the parents. When needed, a physical examination can also be performed at the school health care. If the school's examination facilities are not sufficient, it can also be agreed that the examination is performed at a health centre. It has to be noted that there is some normal variation in girls' anatomy, and for someone who is not used to examining children, it may be difficult to recognise the smaller types of circumcisions. It is recommended to consult a paediatrician when needed. The examination must be performed in consensus with the child, if she is old and mature enough to be able to decide on the operation. In principle at least a 12-year-old can be considered mature enough. In other cases, the examination must be performed in consensus with the child and her guardian (Act on the Status and Rights of Patients, Section 7). If the doubt about a performed circumcision still remains, the school nurse/doctor must file a report to the child welfare. Before filing the report, the school nurse/doctor must contact the parents and inform them about filing the report. An employee with the child welfare estimates which proceedings are made after the report (see chapters 8 and 9).

Class

It is often difficult to talk about female circumcision in class. If the subject is taken up spontaneously, it should be discussed. Thus it is worthwhile for the teacher to familiarise her/himself with the subject in advance and approach the subject culture-sensitively. The school nurse and doctor provide extra information on the subject when needed. The teacher should remember that there may be both circumcised and uncircumcised girls in the class. In addition, some of the uncircumcised girls may be in favour of continuing the tradition, whereas others may oppose it very strongly. It is worthwhile to organise separate health education classes for girls coming from communities that practise circumcision, and discuss circumcision as one of the topics in the classes. It is recommended to arrange the classes in co-operation with the school nurse.

Suspicious of a performed circumcision on a girl can arise because her behaviour has changed. The teacher may find the girl in pain, anxious, depressed, aggressive, quiet, withdrawn, timid or tearful. She may also suffer from difficulties in concentrating or learning. In a situation like this the teacher should first contact the school nurse and/or doctor. Thereafter, the teacher should discuss the situation with the parents (using an interpreter when needed). A doctor may perform a physical examination, if the child and her parents agree. If the doubt about a circumcision remains, the doctor either consults child welfare or files a report, based on the suspicions (see previous chapter on school health care).

6. YMPÄRILEIKATUT TYTÖT JA NAISET

6.1 How to regard a circumcised girl and woman?

It should be kept in mind that although female circumcision is often an incomprehensible matter to a European social and health care professional, it has generally been a normal and valued procedure in the home country of the woman. Culturally, circumcision has been a positive matter, which the parents and the family have wanted for the girl in order to protect her future. A circumcised woman or a girl is in a completely new situation when she moves to Finland or elsewhere in Europe, where the circumcision of girls is questioned in many ways. In addition to her minority status, she will become deviant also due to her circumcision. Therefore, meeting a Finnish health care worker may also include additional stress factors.

Circumcised women may for example avoid gynaecological examinations, because they are nervous about the surprised reactions of the doctor, when he/she detects the mutilated genitals. In some researches, it has also been brought out that according to the circumcised women and girls, Western health care workers may not always have enough information and

understanding on the cultural backgrounds related to female circumcision, or on the treatment of the childbirth of circumcised women.¹³

In the treatment and examination situation, it is extremely important to have a culture-sensitive approach as well as to maintain the dignity and privacy of the circumcised women. The workers should rather take their feelings of pity and shock caused by the circumcision on their work colleagues and not the client. Although circumcision is a part of the woman's identity, it is important to remember that the everyday life of a circumcised woman, with all its joys and sorrows, is fundamentally alike with the life of an uncircumcised woman.

6.2 Babyhood and pre-school age

In child welfare clinics, the parents of a circumcised girl need to be told that they can contact the public health nurse or the doctor in the area, if the daughter experiences problems due to her circumcision. The public health nurse of a child welfare clinic should also inform the local day-

care centre workers about the health risks, questions and guidelines related to female circumcision. The day-care centres should also be informed that they can contact the public health nurse in questions related to circumcision.

6.3 Puberty

School health care

If a girl complains about stomach ache, menstrual pain or difficulties to urinate, she should be asked about a possible circumcision. A *pharaonically* operated girl should be informed about the possibility of *de-infibulation*, and it should be clarified what it means. It is also ideal to dis-



cuss the *de-infibulation* with the parents/guardians and explain them the benefits of the operation (see chapters 3 and 7). The parents and the girl themselves may fear that the respectability of the girl suffers and she will not get married. If the girl and the parents do not desire *de-infibulation* yet at this point, they should be informed that they can ask for it at any point, for example when the girl is about to get married.

Public health nurses can also arrange their own discussion forums for the circumcised girls, where general questions regarding puberty, such as the changes taking place in the body, mood swings, menstruation and sexuality, can be discussed in a group. In addition, public health nurses can inform about the changes caused by circumcision as well as the consequences to the girl's body. S/he can also inform about the possibility of *de-infibulation*. These kinds of group meetings can be very productive, if they can be held with a worker who has the same ethnic background as the pupils. The girls should be told that they can come and talk to the public health nurse about the issues that may occupy their minds. Some of the young people may be too shy to ask questions in a group about matters that have been considered as personal. For some of the girls, the information on one's own circumcision may become as new and even shocking. They may not have understood before what has been done to them, and that they differ from the young Finnish girls. These sorts of discussions may start deep processes or even crises in the young girls. It is important that the young girls are able to discuss these questions if they

want to, either in personal meetings with a health care professional or, for example, in peer groups assembled by a public health nurse.

Some of the girls' parents may for cultural reasons object discussing sexuality and contraception issues in schools. The parents may fear that the young may therefore end up in premarital relationships more easily. It should be explained to the young and their parents that although the questions may not yet be topical to the young people, they might need the information later on in their lives.

Class

One classroom may include both uncircumcised and circumcised girls. Due to the sensitivity of the matter, the circumcised girls may experience themselves to be stigmatised, and they may have to answer to the questions of curious classmates about a very personal subject. For young people, it is often most important to be able to relate with others and not stand out in the group. If circumcision is spontaneously brought up in the classroom, it should be discussed with a culture-sensitive approach. In such cases, the teachers ought to sufficiently familiarise themselves with the topic, and possibly discuss beforehand with the circumcised girls of the class on how they wish the topic to be discussed. If the teacher changes, the new teacher should also be informed on the discussions on circumcision in the classroom.

It is good for the teacher to know that a toilet visit of a *pharaonically* operated girl

may last longer than usual, and the girl may be absent from school more often due to painful menstruation. Shower visits after gymnastic lessons can be facilitated by taking care of sufficient protection of intimacy by shower curtains.

6.4 Dating and marriage

It is recommended that *de-infibulation* (chapter 7) is preferably performed before pregnancy, and it should be offered to all *pharaonically* operated girls and women. The need for *de-infibulation* should be explained to the girl or the woman in an understandable manner. If a young girl suffers from lower abdominal pain, menstrual pain, infections and difficulties to urinate, both the girl and her parents should be informed about the advantages of *de-infibulation*. However, families may object to *de-infibulation* before marriage due to cultural reasons and fears of the girl losing her reputation. They should be told that they can receive a written clarification from the hospital, which attests that the operation has been performed in hospital settings.

It is important to inform the woman getting married and the spouse that by *de-infibulation*, the suffering of both the man and the woman during the first intercourse may be prevented. *De-infibulation* before pregnancy is also safer as regards the possible future pregnancy and child.



6.5 Pregnancy and labour

Maternity clinic

In a maternity clinic, the circumcision status of the mother is detected by discussion/examination by a public health nurse and/or a doctor, if there is no previous reference to it in the client records. By discussion and examination, it is found out whether the woman has been circumcised, how extensive the performed operation has been and whether *de-infibulation* has been performed. The information can be registered, for example, under "operations" in the patient information card (see also 5.1).

If monitoring the progress of pregnancy and delivery by internal examination is not possible due to the circumcision, *de-infibulation* is recommended to the client during the pregnancy. The mother has to be explained that the unopened vulva can cause problems during childbirth. It is recommendable to inform about the *de-infibulation* already in the maternity clinic. The mother and the spouse should also be informed that the vulva may look and feel different after labour and *de-infibulation*. It should also be explained to them that *re-infibulation* (re-stitching the opened labia after labour) is not performed in Finland, and the edges of the operation wound are only neatened. During the first visit to the doctor, the client is sent from the maternity clinic to the maternity hospital for *de-infibulation*. For a pregnant woman, *de-infibulation* is recommended to be performed during mid-pregnancy (see chapter 7).

The circumcised woman should be informed about the birthing process and the different possibilities of pain relief, just as all other expectant mothers. Especially the *pharaonically* operated women may suffer from fears of childbirth, which should be discussed in the maternity clinic. The women in their first pregnancy may have heard about the difficult childbirth experiences of their friends. The women who have given birth before, on the other hand, may remember the possible pains related to their previous childbirths. The fears of childbirth may appear as attempts to constrain the growth of the baby by trying to eat less: a smaller-sized baby is thought to be born more easily. The mothers may

also fear that a Caesarean section is performed to them. In the maternity clinic, circumcised women are advised to make an introductory visit to the hospital, just as all other women in their first pregnancy, as well as women who have moved to the region.

If there are several circumcised women living in the neighbouring region or in the same town, they should be assembled into their own group for maternity and family guidance as well as for peer support. In the group, the women can also receive support from each other to the *de-infibulation* and to being opened. Also women who are not pregnant at the time should be informed about the group. Even if the matter is not current now, the situation may change. The group can also discuss other matters related to health, such as healthy nutrition and the treatment of child illnesses. With the help of the group, the information on the matter will effectively spread also to the other women in the same community. If the group cannot be successfully assembled, family guidance is carried out in connection with the visits to the maternity clinic. If needed, an interpreter is arranged for the maternity clinic visits and family guidance.

Hospital

In the hospital, circumcised women may be encountered, for example, in the antenatal ward or in the maternity ward. After labour, the childbirth should be discussed calmly in the ward with the mother and preferably her husband.

A Caesarean section can be a traumatic experience to the mother, and profound discussion is therefore necessary. The mother should be informed about the home treatment of the wound and the possible rupture (showering, loose cloths, air baths). The mother and the father should also be informed that re-infibulations are not performed in Finland. They should also be informed about the changes that are caused by *de-infibulation* to the mother, and the advantages related to it. The mother and her husband need to gradually be familiarised with the thought that the perineum and vagina look and feel different after labour.

House calls

During house calls, the mother should be reminded about the importance of the treatment of the wound, and the signs of infection should be explained. The mother can be informed that the wound will heal slower than normally due to the scarred tissue. During the house calls, the childbirth process can be discussed again. Leaving the vagina open should also be discussed with the mother and the father.

It is recommendable to mention to the father that the mother needs to rest. If a Caesarean section and possibly also a *de-infibulation* have been performed to the mother, she needs special care. If possible, another house call should also be made, if the mother seems unwell and moving is difficult.

6.6 Protecting the newly born daughter from circumcision

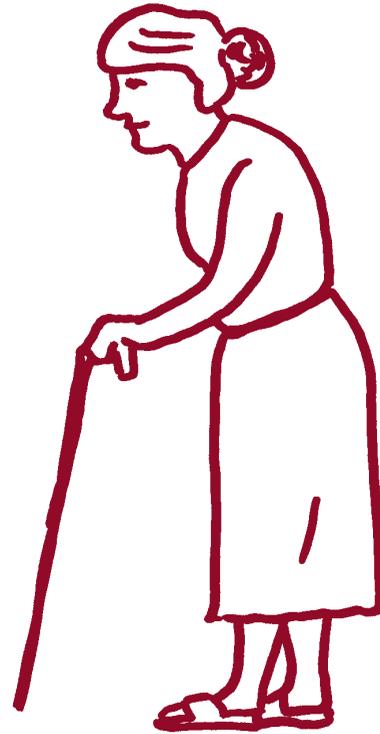
The prevention of the circumcision of girls starts already at the point when the mother is pregnant. The matter is discussed in the maternity clinic, in the maternity hospital and during house calls (see chapter 5.2).

6.7 Menopausal age

Circumcised women often come from countries where they have not been used to the treatment of reproductive and sexual health after fertile age. They should be informed about the importance of regular gynaecological examinations.

Grandmothers have traditionally had an important role in the circumcision decisions of their grandchildren. However, in the new cultural and social environment, their authority over the matter apparently decreases. When possible, the health care worker should also inquire the opinions of the grandmothers on the circumcision of girls. They ought to be told that female circumcision is prohibited in Finland, and they should be requested to protect for their part their children and grandchildren from circumcision.

As regards the preventive work, it would be of great value if, for example, the groups organised for circumcised women would include elderly women of the same ethnic group who object to female circumcision, since their opinions are usually listened and respected.



7. DE-INFIBULATION

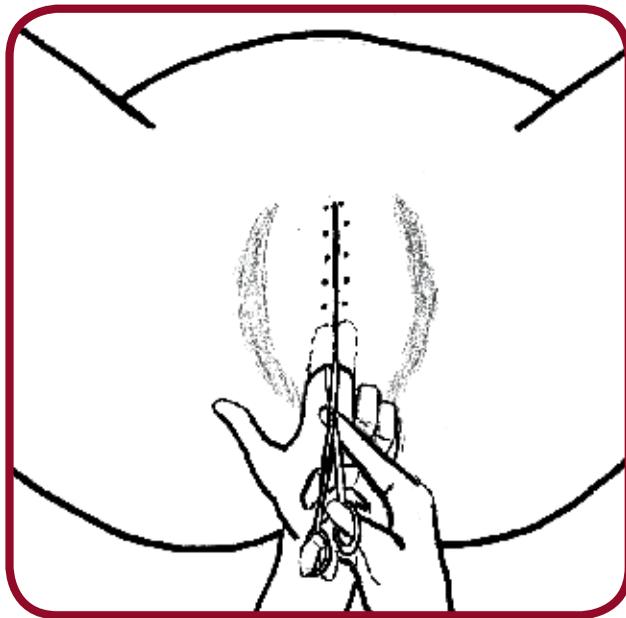
De-infibulation is recommended to be performed before pregnancy, and it should be offered to all pharaonically operated girls and women. The need for de-infibulation should be explained to the girl or the woman in an understandable manner. If a young girl suffers from pain in the lower stomach (lower abdominal pain), menstrual pain, infections and difficulties to urinate, both the girl and her parents should be informed about the advantages of de-infibulation. The women who are about to get married as well as their parents/guardians should especially be informed about the possibility to receive a written clarification on the performed de-infibulation. This may reduce the fears that a de-infibulated young woman will not get married.

In the Act on the Status and Rights of Patients (9§), it is enacted that if a minor patient because of his/her age or level of maturity can decide on the treatment given to him/her, he/she has a right to forbid providing his/her guardian with information on the treatment. In principle, at least a 12-year-old can be considered mature enough. In such case, the girl's parents should not be informed about the planned or performed de-infibulation, if she forbids it herself.

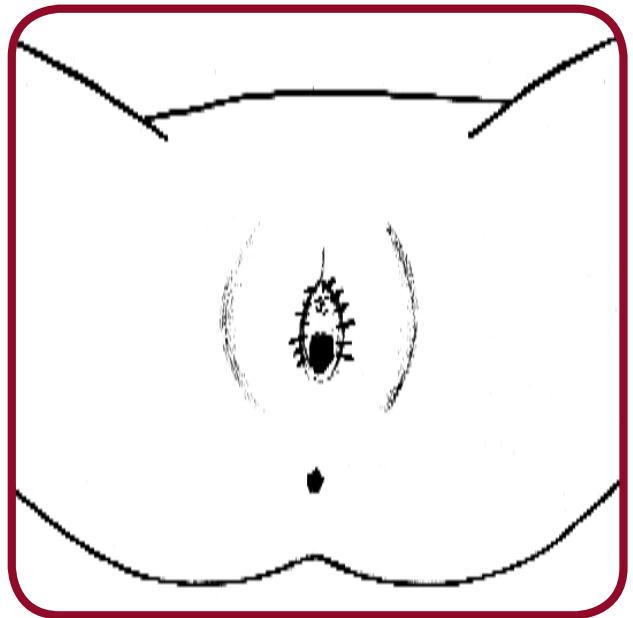
When a woman is about to get married, it is important to inform her and her spouse that the suffering of both the man and the woman during the first intercourse may be prevented by de-infibulation. An already married and possibly pregnant woman should be informed that it may be difficult to monitor the pregnancy and perform examinations during childbirth, if the woman has not been de-infibulated. It is important for the mother to understand that infibulation hinders monitoring the welfare of the foetus. De-infibulation performed in time also protects the mother from recollections of the circumcision experiences, which may come up in childbirth.

If de-infibulation is not performed before pregnancy, it is recommended to be performed during mid-pregnancy. This is due to the fact that, if de-infibulation is performed in the early pregnancy and the pregnancy ends in miscarriage, these two factors may be mistakenly associated with each other.

De-infibulation is performed at the clinic of a hospital. The operation is fairly simple; it normally lasts for 10–15 minutes and the recovery takes up to 1–2 days. No special follow-up examination is required. In order to avoid the flashbacks,



De-infibulation (during pregnancy)



After de-infibulation

de-infibulation is recommended to be performed under short anaesthesia. Alternatively, it can also be performed under local or spinal anaesthesia. A doctor places two fingers or a probe under the scar tissue, in order to protect the tissues under the scar. The scar is opened upwards along the median line so that the urethral opening is visible. If necessary, the wounds are sutured with self-dissolving stitches on both sides (3-0 or 4-0 *dexon/vicryl*).

If de-infibulation has not been performed during pregnancy, it is usually carried out in connection with childbirth. In that case, de-infibulation is usually performed by a midwife. De-infibulation is performed in the beginning of the second stage of

labour, before episiotomy (which is not often necessary). The scar is opened under local anaesthesia (see previous chapter). However, de-infibulation is not necessary for all women giving birth, if the scar tissue is sufficiently flexible.

In de-infibulation, the woman should be informed about the changes that are caused by the operation. The fact that urinating will take place faster and in bigger amounts than before may feel strange at first. The woman may feel herself to be too open. The woman should be told that if she desires, she can take her husband along with her to the discussion, since de-infibulation will most likely affect their sexual life in some way.

8. FEMALE CIRCUMCISION WITH REGARD TO SOCIAL AND CHILD WELFARE

8.1 Prevention

In Finland, performing and being involved in female circumcision is a punishable act. Everyone working with families with children have the responsibility of broaching the subject of circumcisions and preventing them. The matter may become topical at a child welfare clinic, day-care centre, in child welfare as well as in social welfare for adults, in schools or elsewhere where immigrant children, youths and their families are encountered. It is important to act impersonally and avoid making the family feel guilty when taking up the subject. Furthermore, it is important to handle the matter early and not when circumcision is already suspected to have taken place. For example young women or couples about to start a family, families to whom new babies are born or the younger generation in general represent groups that may have a key role to play in putting an end to the tradition of female circumcision and choosing a new direction. New generations pass the culture on to their own children.

In social work with families, it is in order to broach the subject of circumcision already at the stage of arriving into the country, i.e., at informative meetings, for example. The issue can also be discussed later on, when a *customer-*

ship has been formed with the family and the employee knows more of the family's life. The family must be informed of the injurious effects of circumcision as well as the fact that female circumcision is prohibited in Finland (see chapter 3). The families should also be informed of the fact that the Child Welfare Act enacts on filing a child welfare report, which may be applied also to situations concerning circumcisions on girls.

The subject of female circumcision has to be taken up at least once during appointments with the client. The subject can, for example, be taken up by inquiring whether the client has already spoken about circumcisions on girls with, for example, the school nurse and what has been told. The discussions are registered in client documents. Female circumcision may also be discussed in other natural situations, such as client groups. However, it has to be decided individually with each case and group when it is possible to discuss the subject.

The employees should educate themselves in matters related to circumcision as well as in discussing the subject. The so-called "cultural interpreters", who have the same cultural background as the clients, make the familiarising as well as handling the matter easier. Especially

social workers in smaller municipalities work mostly alone, and thus it is recommended to look for employees who come from cultures that practice circumcision or other key persons with whom it is easy to co-operate.

Brochures and other material make it easier to talk about female circumcision. For example, the brochure *Female Genital Mutilation* can be of help. It can be printed from the web pages of the Finnish Ministry of Social Affairs and Health (www.stm.fi) and is available in Finnish, Swedish, English and Somali. In addition, the film by Finnish League for Human Rights, *KokoNainen*, is very well suited for opening group discussions related to the matter. The film is in Somali, English and Finnish (see www.ihmisoikeusliitto.fi > KokoNainen).

8.2 Co-operation

Only a part of the families are clients at the social services' social work and the worries concerning a child and a family come to the notice of child welfare quite late. Thus it is extremely important that the other partners in co-operation discuss the matters related to circumcision with the families. In questions on female circumcision, it is necessary to develop regional co-operation and participate in co-operation networks, where suitable solutions for prevention as well as encountering possible acute situations can be discussed.

The suspicion about a female circumcision or worry about plans concerning it may arouse at day care, child welfare clinic, school, or in general when working with children and young people. Most of the time, the matter comes to the notice of child welfare this way. However, only very few cases come out overall and it is only exceptionally that an individual employee encounters such a case. Thus it is important to remember the possibility of circumcision, if a child starts to show symptoms.

Employees should not be left alone to contemplate the matter with their doubts, but partners in co-operation should be looked for. Co-operation is important, both at the stage of prevention, and in a situation when circumcision has already been performed, in order to support the child and family. Child welfare can be consulted, for example, on whether the worry is justified, or a nurse and a social worker from child welfare can make a house call together in order to clarify suspicions on female circumcision.

If an employee of social welfare and health care, the school system, the police or a parish has through his/her work found out that a child is in need of imminent family-oriented or individual child welfare, s/he must immediately inform the social welfare board (Child Welfare Act, Section 40). Some other person can also file the report. Authorities must inform the parents that female circumcision is such a serious matter that it is reported to child welfare authorities. In Finland, exposing a child to violence signifies the need for

child welfare. The employee must inform the family in advance of filing the child welfare report.

The report to child welfare may be based on a suspicion that a circumcision is being planned or has already been performed, or on a detected circumcision. Sincere concern of the child's health or development being likely in danger is enough grounds to file a report to child welfare. When filing a report, all one needs to do is to call the social worker at the child welfare of one's own region or the social emergency duty. The report can also be filed in writing.

A report received by the child welfare has always to be registered in client documents. A social worker at the child welfare estimates what can and should be done in the situation.

8.3 Threat and suspicion

If suspicions arise that a circumcision is being planned, the employee him/herself must first consider the seriousness of the threat. Each case has to be solved separately. However, the threshold of filing a report to child welfare should not be set too high.

For example, if a girl is to be taken to the home country to get circumcised, and the threat becomes apparent when the child herself or her parent/guardian tells about it at the

child welfare clinic, one should intervene. The child welfare can contact the police and request that the child's journey is stopped when she is about to be taken abroad for circumcision. In this kind of situation, it must be considered whether the child needs to be taken into custody without delay and, based on this, whether the police should be asked for executive assistance.

Another example could be that at school, a teenage girl announces that she supports circumcision and the suspicion of a circumcision being planned is aroused. It is then in order to first discuss with the parents and when needed, file a report to child welfare.

If the threat is obvious, filing a child welfare report and taking child welfare actions should not be postponed. After having received a report, an employee at the child welfare clarifies the situation with the family and estimates what can and should be done in the situation. Also at this stage, it is important to co-operate, for example, with a nurse who knows the family well.

Non-institutional social care actions enacted by the Child Welfare Act have to be taken if the child's growing environment endangers, or does not secure her health and development. The girl can also be taken into custody in order to protect her from circumcision.

A report must be filed to the child welfare also if it is suspected that a circumcision has been performed while the girl has been living in Finland. After having received a report, a social worker at the child welfare estimates the need for child welfare

action and whether it is in the best interest of the child to request for an investigation from the police. The necessity of requesting an investigation is estimated the same way as in other assault cases. If possible, it is also beneficial to consult a lawyer. In order to determine whether or not a crime has been committed, the police request the necessary examinations and statements from the authorities of social welfare and health care.

For example, if a girl starts to act differently at the day-care centre and thus suspicion arouses that she has been circumcised, the personnel should discuss the matter with the parents. The day-care centre can also consult an employee of the child welfare and, together with him/her, ponder on whether child welfare actions are necessary. After a possible report to child welfare, an employee continues clarifying the situation and contacts the parents in order to estimate the situation.

Likewise, if a teacher pays attention to the changed behaviour of a 10-year-old after the summer holidays, it is in order to start clarifying the matter. The school nurse and/or doctor can start to discuss the matter with the girl, but the parents/guardian is also called to the school for a discussion, or a house call can be arranged with the family. At this point, the school nurse/doctor can consult the child welfare and the possible house call can be made together with a social worker in order to clarify the situation. If the parents decline the meeting or the situation remains unclear, the parents are told that a

report will be filed to child welfare. After having received the report, a social worker contacts the parents in order to estimate what can and should be done.

8.4 Performed circumcision

If it comes out that the circumcision has been performed in the girl's home country before she has moved to Finland, no proper child welfare actions can be taken in any other sense than to prevent possible future circumcisions in the family (in case there are more children). In terms of child welfare actions, it is not enough justification that the cause for concern is a circumcision which has been performed on older daughters prior to moving to Finland. Based on this, however, the family should be supported with non-institutional social care, and if needed, this also justifies active intervention in order to prevent the younger daughters from being circumcised.

When the circumcision has been performed before moving to Finland, there is usually no danger of recurrence with the same child. However, intervening in the situation can have a preventive effect from the point of view of the family and community in question. Furthermore, it is important to estimate how the incident and intervening in it can affect the child's mental and physical health.

If, for example, the day-care centre, child welfare clinic or school personnel finds out that,

either in Finland or elsewhere, circumcision has been performed on a girl who lives in Finland, a child welfare report must be filed. The family is informed about the report in advance. Thus child welfare handles the child welfare report just like any other assault report, rendering the social work process similar to other types of assault.

After having received the report, the social worker at the child welfare starts settling the need for child welfare actions with the family, and estimates the seriousness of the case, taking into consideration whether the family has more children. If it is in order to clarify the situation in more detail, the social worker at the child welfare requests the parents to take the child for a medical examination, if she has not been examined before. If the parents do not consider that their child is in need of treatment and refuse a doctor's examination, taking the child into custody may apply in order to secure the child's physical or mental health. Based on the doctor's examinations it is considered how to *proceed* in the matter. It is very important to try to co-operate and agree on necessary actions with the parents.

Just like in other assault cases, the social worker estimates whether it is in the best interest of the child to request an investigation from the police. The matter is discussed with one's own partner, supervisor and/or team. If possible, it is beneficial to consult a lawyer. It is not the child welfare's job to ponder on what kind of criminal offence is in question but to estimate whether the offence should be reported to the police.

After the circumcision is reported to the police, the process of investigation and detection follows mostly the lines presented by the guide *Lapsen pahoinpitelyn ja seksuaalisen hyväksikäytön selvittäminen: Asiantuntijaryhmän suositukset sosiaali- ja terveydenhuollon henkilöstölle*, edited by Sirpa Taskinen in 2003 (Detecting an assault and sexual abuse of a child: Experts' guidelines to personnel in social welfare and health care).

REFERENCES

1. World Health Organization 1 August 2004.
2. On terminology, see also Chalmers & Hashi 2000, 229; Johnsdotter et al. 2001, 9.
3. Mölsä 2004; Gruenbaum 2001, 207.
4. The work by Roald (2001, pp. 237-253) provides excellent information on Islam's inner discussion on circumcision. On the significance of the sunna circumcision among Somali and Sudanese immigrants living in Finland, see Mölsä 2004.
5. World Health Organization 6 February 2007.
6. Iso Karttakirja 1996; Amnesty International 3 May 2004; World Health Organization 2001.
7. U.S. Department of State 24 April 2003; Gruenbaum 2001, 8-9.
8. E.g. U.S. Department of State 24 April 2003; Leye et al. 1998.
9. On implications of female circumcision, see e.g. World Health Organization 2000; Nour 2004.
10. See e.g. Mustanoja 1993; Nisula et al. 1995; Hakola 1996; Jokinen 2002; Tiilikainen 2003.
11. On more detailed contents of agreements on human rights see Haapea 2002.
12. Alkio & Tuominen 2002.
13. Chalmers & Hashi 2000; Mölsä 2004.

9. INSTRUCTIONS IN A NUTSHELL

Female circumcision is a crime.

By the Finnish Penal Code, female circumcision is prohibited in all its forms. This also applies to re-infibulation, i.e., re-stitching the labia.

One can be imprisoned for up to ten years for performing a circumcision or for being involved in one. This also applies to cases where a person residing in Finland is taken abroad to be circumcised. The offence is punishable when it concerns a Finnish citizen or a person permanently resident in Finland, or when the offender is a Finnish citizen.

What does the Child Welfare Act say?

Lastensuojelulain 40 §:n mukaan sosiaali- ja By Section 40 of the Child Welfare act if, in the course of her/his activities, an employee or elected official in health care, social welfare, education, the police or the Church of Finland gets to know about a child in evident need of family-oriented or individual child welfare, s/he must notify the social welfare board without delay. Because this is a question of the duty to notify, one can not use his /her own discretion in this matter.

Non-institutional social care operations, as enacted by the Child Welfare Act, must be taken, if the child's growing environment endangers, or does not secure her health and development. If a girl is threatened by circumcision, she can be taken into custody in order to be protected. Taking a child into custody is also possible in a case where the circumcision has already been performed and the physical and mental health of the child calls for taking a girl into custody.

How to file a report to child welfare?

A report to child welfare may be based on a suspicion that a circumcision is being planned or has already been performed, or on a detected circumcision. In order to file a report, it is enough to call a social worker at the child welfare of one's own region or the social emergency duty. The employee must inform parents/guardian in advance of filing the child welfare report. The child welfare can also be consulted and with them one can ponder on whether there is reason to worry. However, the threshold of filing a report to child welfare should not be set too high; it is enough if one is worried about a child.

A report filed to the child welfare is registered in client documents. After having received the report, a social worker at the child welfare starts to investigate the matter. S/he estimates which child welfare actions are needed to secure the best interest of the child, and whether it is necessary to request an investigation from the police. The necessity of a request for investigation is estimated the same way as in other assault cases. If possible, it is beneficial to consult a lawyer. In order to determine whether or not a crime has been committed, the police request the necessary examinations and statements from authorities of the social welfare and health care. It is very important to try to co-operate with the parents throughout the process.

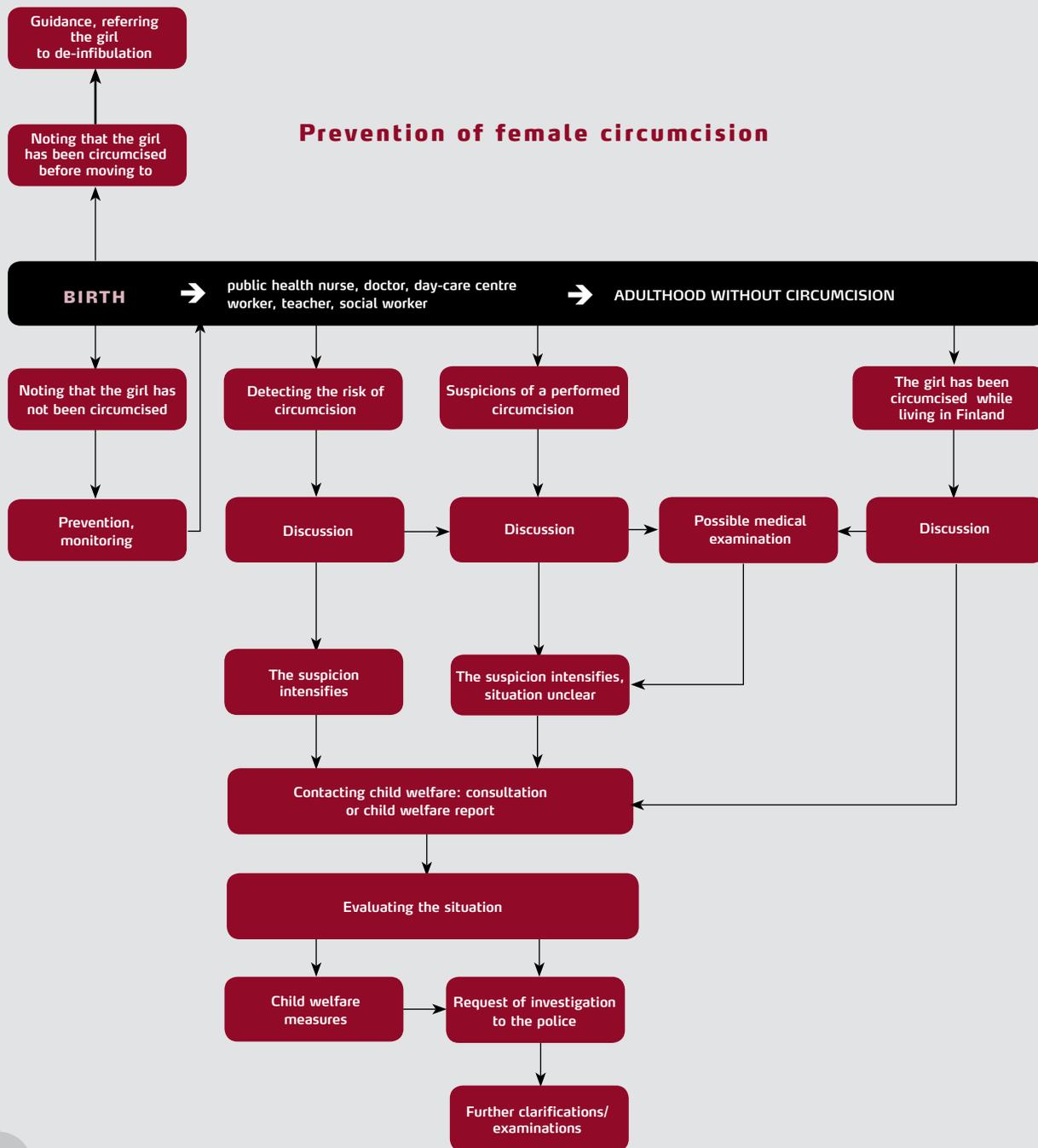
Who has the responsibility of preventing girls from being circumcised?

The possibility of female circumcision has to be kept in mind. The subject should be broached with all clients coming from areas where girls are traditionally circumcised.

The subject must be taken up in time and not postpone it until it becomes topical. All employees that work with families in social welfare and health care have the responsibility of taking the subject up. In order to solve questions related to female circumcision, local and regional co-operation networks must be developed.

The circumcision status of a girl/woman is detected by discussion and/or examination by a nurse and/or a doctor. The status is registered in the client file. If the girl has not been circumcised, the matter is regularly discussed with the parents and the girl's situation is monitored.

Prevention of female circumcision



What to do if one suspects that female circumcision is being planned or that it has already been performed?

If there is suspicion that a daughter of a client family is going to be circumcised, the matter should be discussed with the parents/guardians. If necessary, an interpreter is called to the meeting and enough time is reserved. If the doubt still remains, the child welfare workers are consulted or a child welfare report is filed. The child welfare report can be filed from a day-care centre, school, child welfare clinic or other unit of health care.

The suspicion about a performed circumcision may be aroused by the girl's changed behaviour. For example, at the day-care centre or school, one may pay attention to the child/young person being in pain, quiet, withdrawn, anxious, depressed, aggressive, timid or tearful. She can also suffer from difficulties in concentrating or learning.

A nurse/employee at the day-care centre/doctor investigates the situation by discussing with the family and the child/young person. At the child welfare clinic/day-care centre/school health care it can be explained to the parents that the child welfare clinic/day-care centre/school personnel are worried about the changes that have occurred in the child's/young person's behaviour and that they want to find out what causes these changes.

When needed, a doctor may perform a physical examination on the child. The examination must be conducted in consensus with the child/young person, if she is old and mature enough to decide on the operation. Usually, at least a 12-year-old is sufficiently mature. In other cases the examination must be conducted in consensus with the child and her guardian (Act on the Status and Rights of Patients, Section 7). If the situation is not clarified and/or the doubt of a performed circumcision still remains, the teacher/nurse/day care centre employee/doctor files a report to child welfare.

What to do if a girl or woman has been circumcised?

If the girl/woman has been circumcised before she has moved to Finland, the information is registered in her client documents.

The girl and her next of kin are informed of the possibility of de-infibulation, when the question is topical.

If a girl has been circumcised either in Finland or abroad after she has moved to Finland, a report is filed to child welfare.

SOURCES AND LITERATURE

Alkio, Paula & Jenni Timonen (eds.) (2002).
Seksuaalioikeudet osana ihmisoikeuksia.
[Sexual Rights as a Part of Human Rights.]
Helsinki: Väestöliitto.

Amnesty International (3.5.2004).
(www.amnesty.org/ailib/intcam/ferngen/fgm9.htm)

Chalmers, Beverley & Kowser Omer Hashi (2000).
Somali Women's Birth Experiences in Canada after Earlier
Female Genital Mutilation. *Birth* 27(4): 227–234.

Gruenbaum, Ellen (2001).
The Female Circumcision Controversy: An Anthropo-
logical Perspective.
Philadelphia: University of Pennsylvania Press.

Haapea, Arto (ed.) (2002).
Ihmisoikeudet 2000-luvulla: Sopimuksia ja asiakirjoja.
[Human Rights in the 2000s. Conventions and
Documents.] Helsinki: Ihmisoikeusliitto / Edita.

Hakola, Päivi (1996).
Kun sukupuoli on terveysriski: tutkimus terveyden ja
hyvinvoinnin ehdoista Suomessa asuvien somalialaisten
pakolaisnaisten keskuudessa.
[When Gender is a Health Risk: Terms of Health
and Welfare of Somali Women living in Finland.]
Kansanterveystieteen pro gradu – tutkielma.
Tampereen yliopisto, terveystieteen laitos. Helsinki:
Sosiaali- ja terveysministeriön monisteita 1996:19.

Iso Karttakirja (1996).
[The Great Atlas] Porvoo: WSOY.

**Johnsdotter, Sara & Aje Carlbom & Asha Omar
Geesdiir & Ali Elmi** (2001).

Som Gud skapade oss: Förhållningssätt till kvinnlig om-
skärelse bland somalier i Malmö. [Created by God: Atti-
tudes to Female Circumcision among Somalis in Malmö.]
Socialstyrelsen. (www.sos.se/FULLTEXT/123/2001-123-13/2001-123-13.pdf)

Jokinen, Riitta (2002).
Ympärioleikatun naisen kohtaaminen terveydenhuollossa.
Suomalaisten terveydenhoitajien ja kätilöiden asenteiden
osatekijöiden tarkastelua. [Facing a Circumcised Woman
in Health Care. Examining the Factors Related to
Attitudes of Finnish Public Health Nurses and Midwives.]
Uskontotieteen pro gradu –tutkielma. Helsingin yliopisto,
humanistinen tiedekunta.

Leye, Els & Maria de Bruyn & Stan Meuwese (1998).
Proceedings of the Expert Meeting on Female Genital
Mutilation, Ghent, Belgium, November, 5–7, 1998.

Mustanoja, Ulla-Marjatta (1993).
Naisten ympärileikkaus osana kulttuuria ja sosiaalista
identiteettiä. [Female Circumcision as a Part of Cultural
and Social Identity.] Sairaalaliitto tiedottaa 3/93: 20–24.

Mölsä, Mulki (1994).
Tyttöjen ympärileikkauksen hoito ja ehkäisy Suomessa.
[Treatment and prevention of female circumcision in
Finland.] Helsinki: Stakes.



Mölsä, Mulki (2004).

Ajat ovat muuttuneet. Selvitys tyttöjen ja naisten ympärileikkaukseen liittyvistä asenteista ja aikeista pääkaupunkiseudulla asuvien maahanmuuttajien keskuudessa. [Times have changed: an Account of the Attitudes and Intentions on the Circumcision of Women and Girls amongst Immigrants living at the Helsinki Metropolitan Area.] KokoNainen-projekti, Ihmisoikeusliitto. (www.ihmisoikeusliitto.fi > KokoNainen).

Nisula, Tapio & Anna Rastas & Kristiina Kangaspunta (1995).

Perinteen puhtaus ja somali-identiteetti: Pakolaistyöt kulttuurinsa vaalijoina. [The Purity of Tradition and the Somali Identity: Immigrant Girls as Cultivators of Tradition.] Nuorisotutkimus 13(2): 18–29.

Nour, Nawal M. (2004).

Female Genital Cutting: Clinical and Cultural Guidelines. Obstetrical and Gynaecological Survey 59(4): 272–279.

Roald, Anne Sofie (2001).

Women in Islam: The Western Experience. London: Routledge.

Taskinen, Sirpa (ed.) (2003).

Lapsen seksuaalisen hyväksikäytön ja pahoinpitelyn selvittäminen. Asiantuntijaryhmän suositukset sosiaali- ja terveydenhuollon henkilöstölle. [Detecting an assault and sexual abuse of a child: Experts' guidelines to personnel in social welfare and health care]. Helsinki: Stakes.

Tiilikainen, Marja (2003).

Arjen islam: somalinaisten elämää Suomessa. [Everyday Islam: The Life of Somali Women in Finland.] Tampere: Vastapaino.

Tiilikainen, Marja (2004).

Tyttöjen ympärileikkaus terveydenhoitajien työssä. Kyselytutkimus pääkaupunkiseudulla toimivien terveydenhoitajien kokemuksista ja koulutustarpeista. [The Circumcision of Girls in the Work of Public Health Nurses. A Survey on Experiences and Educational Needs of Public Health Nurses in the Helsinki Region.] KokoNainen-projekti, Ihmisoikeusliitto. Julkaisematon tutkimus.

U.S. Department of State (24.4.2003). (www.state.gov/g/wi/rls/rep/g305.htm)

World Health Organisation (2000).

A Systematic Review of the Health Complications of Female Genital Mutilation including Sequelae in Childbirth. (www.who.int/gender/other_health/systreviewFGM.pdf)

World Health Organisation (2001).

Female Genital Mutilation. Integrating the Prevention and the Management of the Health Complications into the curricula of nursing and midwifery. A Teacher's Guide. (http://www.who.int/gender/other_health/en/teachersguide.pdf)

World Health Organisation (1.8.2004).

(www.who.int/mediacentre/factsheets/fs241/en/)

World Health Organisation (6.2.2007).

(<http://www.who.int/reproductive-health/fgm/>)

FURTHER INFORMATION AND MATERIAL

Material for preventive work

The film *KokoNainen*, Finnish League of Human Rights and Dream Catcher. The feature is mainly in Somali, subtitles in Finnish and in English.
Inquiries: info@ihmisoikeusliitto.fi.

The video *Let Us Talk*, The Danish National Board of Health and Heller Film. In Somali, subtitles in English.
Inquiries: si@si.dk.

The video *Nå snakker vi samman*, PMV – Senter for helse, dialog og utvikling and Heller Film. In Somali, subtitles in Norwegian.
Inquiries: postmaster@pmv-senter.org.

The brochure *Female Genital Mutilation*, available in Finnish, Swedish, English and Somali at the web pages of the Finnish Ministry of Social Affairs and Health, www.stm.fi

Further reading

Dorkenoo, Efu (1995).
Cutting the Rose. Female Genital Mutilation: The Practice and Its Prevention. London: Minority Rights Publications.

Essén, Birgitta (2001).
Perinatal Mortality among Immigrants from Africa's Horn: The Importance of Experience, Rationality, and Tradition for Risk Assessment in Pregnancy and Childbirth. Malmö: Department of Obstetrics and Gynaecology, Malmö University Hospital, Lund University.

Essén, Birgitta and Charlotte Wilken-Jensen (2003).
How to Deal with Female Circumcision as a Health Issue in the Nordic Countries. *Acta Obstetrica et Gynecologica Scandinavica* 2003; 82: 683–686.

Johansen, R. Elise B. (2002).
Pain as a Counterpart to Culture: Toward an Analysis of Pain Associated with Infibulation among Somali Immigrants in Norway. *Medical Anthropology Quarterly* 16(3): 312–340.

Johansen, R. Elise B. (2006).
Experiences and Perceptions of Pain, Sexuality and Childbirth - A Study of Female Genital Cutting among Somalis in Norwegian Exile, and their Health Care Providers. Oslo: Faculty of Medicine, University of Oslo.

Johnsdotter, Sara (2002).
Created by God: How Somalis in Swedish Exile Reassess the Practice of Female Circumcision. Lund: Department of Sociology, Lund University.

Lightfoot-Klein, Hanny (1989).
Prisoners of Ritual: An Odyssey into Female Genital Circumcision in Africa. New York: The Haworth Press.

Prevention of Female Circumcision (2000).
Danish National Board of Health.
Inquiries: sundhed@schultz.dk

al-Sabbagh, Muhammad Lutfi (1996).
Islamic Ruling on Male and Female Circumcision. The Right Path to Health, Health Education through Religion. Alexandria: World Health Organization.



Organisations and networks against female circumcision

Amnesty International

(www.amnesty.org/ailib/intcam/femgen/fgmi.htm)

Finnish League for Human Rights

(www.ihmisoiikeusliitto.fi > KokoNainen)

FORWARD – Foundation for Women's Health, Research and Development

(www.forwarduk.org.uk/)

IAC – The Inter-African Committee on Traditional Practices Affecting the Health of Women and Children

(www.iac-ciaf.com/)

RAINBO – Research, Action and Information Network for the Bodily Integrity of Women

(www.rainbo.org/)

Stop FGM – International Campaign for the Eradication of Female Genital Mutilation

(www.stopfgmc.org/)

World Health Organization

(www.who.int/gender/en/ > Gender and other health topics)

World Vision Finland

(www.worldvision.fi/fgm/)

The booklet 'Female circumcision in Finland' is drafted by experts, aimed at professionals. It describes the background of the phenomenon as well as the judicial and health-related matters related to the practice. These guidelines help workers in social and health care to intervene in threats of circumcision as well as to act with circumcised women and girls at the different stages of their lives.

The booklet is available in electronic format at the web pages of Finnish League for Human Rights (www.ihmisoikeusliitto.fi > KokoNainen).