Action Plan

Action plan for the prevention of female genital mutilation (FGM)

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Abstract

Female genital mutilation/cutting (FGM) is a practice, which causes injury to girls' and women's genital organs for non-medical reasons. It is estimated that approximately 10,000 girls and women have undergone FGM and 650 to 3,080 girls are at risk becoming victims of the procedure in Finland. FGM violates several international human rights treaties and, based on the Penal Code of Finland, it can be considered to correspond to aggravated assault. The practice deteriorates women's equality and right of self-determination and causes health complications and social problems.

The Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence obligates Finland to prepare guidelines for a system for preventing FGM and to ensure their effective implementation. This action plan aims to continue the good practices that Finland has implemented to prevent FGM and to develop new means to help victims of FGM, for example.

The main objective of the action plan is to increase healthcare and social welfare professionals' knowledge and competence by ensuring that they are provided with training on how to talk about FGM and on their duty to notify. Another objective is to ensure effective dissemination of information to groups at risk of being subjected to FGM. The action plan includes useful information for decision-makers, education and research organisations, and other organisations, which should, for their own part, participate in the prevention of FGM and the promotion of the health and welfare of those who have been subjected to the practice. This action plan is a follow-on to the action plan for the prevention of FGM for 2012–2016, adopted by Finland.

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Tiivistelmä

Tyttöjen ja naisten sukuelinten silpominen (FGM) on perinne, jossa tytön tai naisen sukuelimiä vahingoitetaan ilman lääketieteellistä syytä. Suomessa on arviolta 10 000 silpomisen läpikäynyttä tyttöä ja naista ja silpomisen riskissä noin 650–3 080 tyttöä. Silpominen loukkaa ihmisoikeuksia ja se voidaan katsoa Suomen rikoslain perusteella törkeäksi pahoinpitelyksi. Perinne heikentää naisten tasa-arvoa ja itsemääräämisoikeuksia sekä aiheuttaa terveydellisiä ja sosiaalisia haittoja.

Euroopan neuvoston yleissopimus naisiin kohdistuvan väkivallan ja perheväkivallan ehkäisemisestä ja torjumisesta velvoittaa Suomea laatimaan ohjeet ja takaamaan toimivan järjestelmän silpomisen estämiseksi. Tällä toimintaohjelmalla pyritään jatkamaan käytäntöjä, joita Suomessa on jo toteutettu silpomisen estämiseksi ja kehittämään uusia keinoja muun muassa silpomisen läpikäyneiden auttamiseksi.

Toimintaohjelman pääasiallisin tarkoitus on ammattilaisten tiedon lisääminen ja osaamisen ylläpitäminen sekä tiedonvälitys riskissä oleville ryhmille. Lisäksi toimintaohjelma sisältää hyödyllistä tietoa päättäjille, koulutus- ja tutkimusorganisaatioille sekä järjestöille, joiden tulee osallistua omalta osaltaan silpomisen estämiseen ja silpomisen läpikäyneiden hyvinvoinnin ja terveyden edistämiseen. Toimintaohjelma on jatkoa vuosien 2012–2016 tyttöjen ja naisten ympärileikkauksen estämisen toimintaohjelmalle.

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Referat

Könsstympning av flickor och kvinnor (FGM) är en tradition där en flickas eller kvinnas könsorgan åsamkas skada utan något medicinskt skäl. I Finland finns uppskattningsvis 10 000 flickor och kvinnor som har genomgått könsstympning och cirka 650–3 080 flickor som löper risk att utsättas för könsstympning. FGM är en kränkning av de mänskliga rättigheterna och kan med stöd av den finska strafflagen betraktas som grov misshandel. Traditionen undergräver jämställdheten och försvagar kvinnors självbestämmanderätt samt orsakar hälsomässiga och sociala olägenheter.

Europarådets konvention om förebyggande och bekämpning av våld mot kvinnor och av våld i hemmet förpliktar Finland att utarbeta anvisningar och garantera ett fungerande system för att förhindra FGM. Genom detta handlingsprogram strävar man efter att fortsätta den praxis som redan har genomförts i Finland för att förhindra FGM och att utveckla nya metoder bland annat för att hjälpa de som har genomgått FGM.

Det huvudsakliga syftet med handlingsprogrammet är att öka yrkespersoners kunskap och upprätthålla deras kompetens samt att sprida information till riskgrupper. Handlingsprogrammet innehåller dessutom nyttig information för beslutsfattare, utbildnings- och forskningsorganisationer samt ideella organisationer, som alla för sin del bör delta i att förhindra FGM och främja hälsan och välbefinnandet hos de som genomgått FGM. Handlingsprogrammet är en fortsättning på verksamhetsplanen för förebyggande av FGM för 2012–2016.

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TO THE READER

Work aiming to prevent female genital mutilation has been carried out in Finland since the 1990s. Nevertheless, this subject is still experienced as difficult, and it evokes conflicting thoughts. In the communities that practise FGM, female genital mutilation has been seen as a positive act that protects the child, whereas according to Western ideas, it is child abuse, an offence and a human rights violation. Bringing about a change will require sustained efforts.

An Action Plan for the prevention of circumcision of girls and women was valid in Finland in 2012–2016. As an estimated 10,000 girls or women who have undergone FGM and approx. 650–3,080 girls at risk of FGM are living in Finland, preventing female genital mutilation remains a highly topical issue.

This new Action Plan for the prevention of female genital mutilation was prepared by the National Institute for Health and Welfare together with the Ministry of Social Affairs and Health and a broad-based steering group. The Action Plan contains recommendations addressed to municipalities, decision-makers, professionals, non-governmental organisations, members of communities practising FGM and others who encounter this issue on measures for preventing the practice and supporting women and girls who have undergone it.

The short-term objective is that girls who live and reside in Finland will not be mutilated in this country or sent abroad to be mutilated. To achieve this objective, professionals should be trained to bring the issue up when talking to clients, and cooperation with all actors who encounter the issue and members of communities practising FGM should be stepped up.

This publication will hopefully provide the readers with the information and guidelines they need in the work to prevent female genital mutilation.

Helsinki, 6 February 2019
Minister Annika Saarikko

Abbreviations

FGM	Female Genital Mutilation
FGC	Female Genital Cutting
FC	Female Circumcision
FGM/C	Female Genital Mutilation/Cutting
EC	European Commission
EIGE	European Institute for Gender Equality
EU	European Union
IAC	Inter-African Committee on Traditional Practices
MIGRI	Finnish Immigration Service
UNFPA	The United Nations Population Fund
UNICEF	The United Nations International Children's Emergency Fund
WHO	World Health Organization

1 Introduction

It is estimated that there are approximately half a million girls and women who have undergone genital mutilation living in Europe. The practice of female genital mutilation is the most widespread in Africa and certain Asian and Middle East countries. Due to increased migration flows, the number of girls who have undergone FGM is also growing in other areas. It is estimated that some 38,000 girls and women originating from countries where FGM is practised are living in Finland. According to estimates, about 10,000 girls and women have undergone genital mutilation, and about 650–3,080 are at risk of mutilation, depending on whether or not second-generation girls with a foreign background are included in these figures.

Female genital mutilation (FGM) refers to the cutting of a girl's or a woman's external genitals, or injuring them in some other way, for non-medical reasons. The reasons for female genital mutilation vary from one culture and region to another; frequently, it is justified by social, cultural or aesthetic reasons. The genital mutilation of girls is not part of the teachings of any religion, and the practice predates Christianity and Islam. Female genital mutilation is violence against women and children, a serious human rights violation, and an offence under the Finnish Criminal Code.

The exact number of girls and women in Finland who have undergone FGM is not known. While the subject has from time to time received extensive attention on the media and the previous action plan was published six years ago, the practice of FGM remains relatively poorly known, for example among social and healthcare professionals. Due to a lack of knowledge and a target group which may have been considered small, the subject has often received little attention in social welfare and healthcare as well as in the education sector, and prevention of FGM has not been prioritised over issues experienced as more urgent. Bringing up the topic has usually been considered awkward as it is sensitive and culture-bound, and professionals encountering girls and women who have undergone FGM have not necessarily

known enough about the practice to have the courage to intervene (WHO 2018a). As mutilating girls is a violation of the Finnish law and human rights, every professional should intervene in it and strive to prevent the potential genital mutilation of girls at risk.

Efforts to prevent FGM have been made in Finland since the early 1990s, among other things by informing members of communities originating from countries where FGM is practised and professionals encountering them about the issue. Produced on the initiative of the Ministry of Social Affairs and Health, the first Action Plan for the prevention of circumcision of girls and women 2012–2016 was based on the implementation of the Internal Security Programme 2008–2011. The Action Plan was intended as a guideline and recommendation on preventing female genital mutilation, and its objective was to establish effective and permanent national and regional structures in Finland to prevent this practice. The Action Plan was also a response to Finland's international obligations to promote women and girls' human rights and to prevent violence against women. After the expiry of the first Action Plan, preventing FGM was included in the national Action Plan on sexual and reproductive health 2014–2020 under the theme of violence. In this action plan, however, the topic was not addressed extensively enough to cover FGM prevention as set out in the Action Plan for the prevention of circumcision of girls and women.

In 2015, the Council of Europe Convention on preventing and combating violence against women and domestic violence, or the so-called Istanbul Convention, entered into force in Finland (Finnish Treaty Series 53/2015). Under Article 38 of the Istanbul Convention, female genital mutilation is to be made a punishable act. The Action plan for the Istanbul Convention for 2018–2021 (Ministry of Social Affairs and Health 2017,16) contains the preparation of a new FGM action plan as well as providing professionals with training on bringing up the phenomenon and on their reporting duties as actions related to FGM prevention.

As part of implementing the Council of Europe Convention, the Ministry of Social Affairs and Health also granted separate funding for updating the Action plan for the prevention of female genital mutilation. The work on the Action Plan was coordinated by the National Institute for Health and Welfare, and it was carried out in broad-based cooperation with different ministries, the education sector, social and healthcare professionals and various NGOs. Representatives from the

Ministry of Social Affairs and Health, the Ministry of Justice, the Ministry of the Interior, the Ministry of Education and Culture, the Finnish National Agency for Education, the Ministry of Economic Affairs and Employment's Integration unit, the Finnish Immigration Service, the Finnish Society of Obstetrics and Gynaecology, the Federation of Finnish Midwives, the Finnish Association of Public Health Nurses, the Finnish League for Human Rights, the Family Federation of Finland, City of Helsinki Social Services Division and the National Institute for Health and Welfare participated in updating the Action Plan. Participants representing the National Institute for Health and Welfare included experts of sexual and reproductive health, legal science, and multiculturalism. Representatives of NGOs working with immigrants, immigrant groups, the police and education and research organisations were also consulted during the Action Plan preparation process.

The principal purpose of the Action Plan for the prevention of female genital mutilation is to prevent the mutilation of girls' and women's genitals in Finland, to make sure girls living in Finland are not brought abroad to be mutilated, and to improve the wellbeing and quality of life of girls and women who have undergone genital mutilation. To achieve this objective, more information will be provided for at-risk groups about, among other things, anti-FGM legislation in Finland, the health harms of genital mutilation, the nature of female genital mutilation as a human rights violation, and other facts that may help stop this practice. The knowledge and competence of professionals and students of the relevant fields will be strengthened, especially concerning the statutory notification duty when a person is at risk of or has undergone FGM and bringing up the subject when talking to clients. Those serving as elected officials and in leadership roles as well as education and research organisations will be offered information, means of preventing FGM, and ways of improving the health and welfare of girls and women who have undergone FGM.

The updated Action Plan strives to continue the good practices already implemented in Finland in order to prevent FGM as well as to develop new methods, among other things for supporting girls and women who have undergone FGM. By updating the Action Plan, Finland also fulfils its international obligations. Work against female genital mutilation will be organised on a permanent basis in Finland, and the cooperation, division of duties and coordination in work to prevent FGM should be clarified at the national level. In addition, research associated with FGM will be carried out, supported and collated, and research evidence will be disseminated both at home and internationally. An effort will be made to create

specialised services to help girls and women who have undergone FGM. A risk assessment model will also be developed to recognise cases where a girl or a woman is at risk of female genital mutilation.

The Action Plan contains a plan for maintaining experts' competence by ensuring participation in international cooperation. In addition to FGM prevention, the Action Plan also recommends stronger measures for promoting the wellbeing of girls and women who have already been cut and improving the quality and availability of services offered to them. The Action Plan recommends that more attention be paid to encountering and supporting girls and women who have undergone FGM, thus also improving their access to help and treatment.

The measures of the Action Plan are addressed to different target groups. Cooperation between various actors and administrative branches will play a key role in Action Plan implementation.

The target groups of the action plan are:

1. Leading office holders, elected officials and political decision-makers in Finnish municipalities.
2. Professionals who encounter in their work persons with an immigrant background in whose home countries FGM is practised. Particularly important fields are social welfare and healthcare, early childhood education and care, education, youth work, immigration and reception services and integration, police work, and the media. As individual occupational groups should be mentioned physicians, nurses, public health nurses, midwives, social workers, Bachelors of Social Services, early childhood education and care professionals, teachers, the staff of Finnish Immigration Service's Immigration and Asylum units, police officers and journalists.
3. Education and research organisations, including universities of applied sciences, universities, other vocational education and training providers and central government research institutes.
4. NGOs operating at the grass-roots level, either among communities originating from countries where FGM is a widespread practice or in these countries.
5. Key persons in communities whose cultural traditions include FGM, such as leaders of religious communities and other opinion leaders.

The Action Plan and the material produced during the process to update it, including online training and a brochure, will be disseminated through the National Institute for Health and Welfare's website and the social media as well as at numerous training seminars and events for professionals. The National Institute for Health and Welfare and the Ministry of Social Affairs and Health will spread information about the new Action Plan once it has been completed. Information on the Action Plan's objectives and recommendations and the obligations it imposes on municipalities will be disseminated at the annual seminar organised by the National Institute for Health and Welfare and the Ministry of Social Affairs for their partners. The parties that were involved in updating the Action Plan will also disseminate information on it through their channels.

Rather than being in force for a limited period of some years, the Action Plan will be valid until further notice. The Action Plan will be updated as necessary, and it can be integrated in the Action plan on sexual and reproductive health in the future.

Practical implementation plays a key role in achieving the Action Plan's objectives and will be launched as soon as the Action Plan has been completed in early 2019. As part of its practical implementation, a national clinical pathway for preventing FGM and for improving the health and wellbeing of girls and women who have undergone FGM will be created. The National Institute for Health and Welfare's FGM website will be updated to support professionals, and a brochure in different languages will be produced for girls and women who are at risk of, or have undergone genital mutilation. The most important step in the practical implementation of the Action Plan will be disseminating information about it. The mid-term evaluation of the previous Action Plan carried out as an online survey was an effective intervention which reminded municipal decision-makers and professionals in different fields of the plan's existence. A mid-term evaluation of the current Action Plan will also be carried out four years after its completion to ensure that it has been translated into practice.

2 Background

2.1 Female genital mutilation

Female genital mutilation is a tradition that violates several international human rights conventions and the Finnish Criminal Code. It is a form of gender-based violence. FGM is often associated with honour violence, which refers to putting psychological pressure on or using violence against persons in a situation where they are suspected of having violated the community's moral code. Honour violence is linked to patriarchal exercise of power, and it derives from a mentality in which honour is seen as something that concerns the entire family or extended family. In this situation, the acts of an individual community member are regarded as having a bearing on the honour of the entire community, and chaste behaviour compliant with a certain sexual moral is thus expected of all community members. The genital mutilation of girls is associated with the honour mentality. In many cultures, it is considered a sign of a girl or a woman being modest and respectable, and thus a precondition for being marriageable. In many communities, forced marriages are more common among girls who have been cut than those who have not been mutilated. (Hansen, Sams, Jäppinen & Latvala 2016; National Institute for Health and Welfare 2018d; MIGS 2015; Andro, Cambois & Lesclingand 2014.)

Definitions

Female genital mutilation comprises all procedures that involve partial or total removal of the female external genitalia, or other injury to the female genital organs for non-medical reasons. (WHO 2018b.)

Internationally, the terms female genital mutilation (FGM), female genital cutting (FGC), a combination of these two (FGM/C), or female circumcision (FC) are used. In the early days of the prevention efforts, the term female circumcision was used; however, using this term is no longer recommended, as the term circumcision may be associated with the circumcision of boys, which is a very different procedure than the mutilation of girls' and women's genitals. In 1991, WHO recommended the term female genital mutilation, or FGM, which has since been used widely by the UN, the European Commission, the EU, the Council of Europe and other international and scientific organisations (UEFGM 2016). This term is thought to be a better description of the practice as a procedure that violates girls' and women's rights, and thus to promote more effectively global political activism against the practice, even if it may be experienced as disrespectful by some girls and women who have undergone FGM (UNFPA 2018a; WHO 2018a).

The term female genital cutting (FGC) is considered more neutral than mutilation and thought to be more suitable for preventive work among communities following this practice. Genital cutting does not carry a strong emotional or political charge, using this term does not stress the trauma caused by the procedure, and it can be regarded as covering better also minor forms of mutilation, including pricking and incising. (UNFPA 2018a; WHO 2018a.) The established terms in Finland are female circumcision in work with clients and female genital mutilation in advocacy work. When approaching the subject with a client originating from a country where FGM is practised, adopting the term used by the client is recommended.

In communities that practise FGM, different names in different languages exist for the procedure, including Sunnah, Qodiin, L'excision and Tahor. In local languages, FGM usually has a positive name as it is considered a useful procedure (UNFPA-UNICEF 2016). In spoken language, girls and women who have a connection with the practice often use descriptive words like 'opened' or 'closed'.

Classification

According to a classification published by the World Health Organisation (WHO 2008), there are four main types of female circumcision:

- Type I: Partial or complete removal of the clitoris and/or the clitoral hood.
- Type II: Partial or complete removal of the clitoris and the inner labia, with or without cutting the outer labia. (This procedure is also known as an excision.)
- Type III: Removal of the inner and/or outer labia and re-joining the sides of the vulva so that only a small opening is left for the passage of urine and menstrual blood. The clitoris may either be removed or left under the fold of skin covering or restricting the vaginal opening. (This procedure is also known as an infibulation or pharaonic circumcision.)
- Type IV: All other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterising the genital area.

(WHO 2008.)

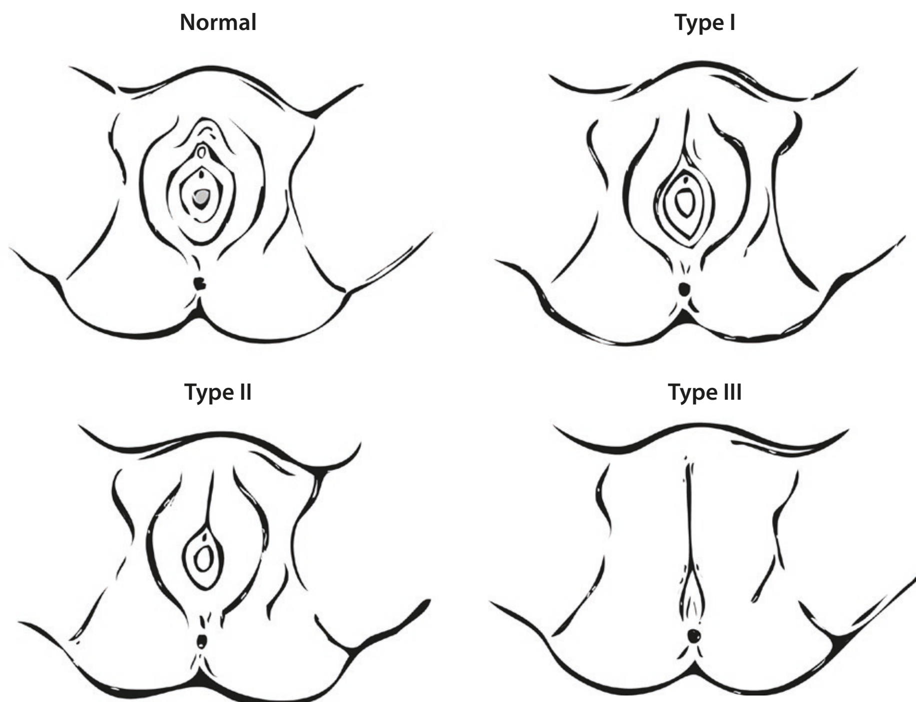

Figure 1. Types of female mutilation according to WHO classification. (Figure: Antikainen, Pitkänen & Shrestha 2016)

The WHO classification is indicative only. The clitoris is such an extensive organ that it is impossible to remove completely in a FGM procedure.

The most common FGM procedures are types I and II, which account for approx. 90% of all FGM cases. The remaining 10% represent type III. (WHO 2018c; Yoder, Wang & Johansen 2013.) In the Nordic countries, however, type III accounts for more than one half of the cases because the majority of immigrants arriving in these countries come from regions where type III is common (Ziyada, Norberg-Schulz & Johansen 2016). Mixed forms are also common, resulting from such factors as the skills of the circumciser and the conditions in which the procedure is carried out (WHO 2018a).

UNICEF has produced a simplified version of the FGM classification which can, for instance, be used in studies were women themselves report genital mutilation (UNICEF 2013).

Category 1. Cut, no flesh removed. (WHO type IV)

Category 2. Cut, flesh removed. (WHO types I and II)

Category 3. Sewn closed. (WHO type III)

Category 4. Type not determined/not known.

Due to the wide anatomical variation in external genitals, determining the type of mutilation is difficult in practice, even for experienced professionals. Additionally, childbirth and cutting open tissue that has been sewn together often change the anatomy to the extent that the original type of FGM cannot be established with certainty. (Creighton & Hodes 2016; Abdulcadir, Catania, Hindin, Say, Petignat & Abdulcadir 2016). Girls and women who have undergone FGM do not necessarily know what type of a procedure they have undergone or what actually happened during it, and the information provided by a client does not always correspond to the actual type of her FGM (Reisel & Creighton 2014; O'Neill, Dubourg, Florquin, Bos, Zewolde & Richard 2017).

Deinfibulation refers to a procedure in which labia sewn together are separated.

Reinfibulation means a re-narrowing or re-covering of the vaginal opening, i.e. re-joining the sides of the vulva (often by sewing them together) after childbirth or when a divorced woman remarries. Reinfibulation is prohibited in Finland.

Time of female genital mutilation

There are major variations in the age at which girls' genitals are mutilated and the type of procedure used depending on the country, region, ethnic group or clan, socioeconomic background and the family's living area. A girls' genitals may be mutilated as they are babies or toddlers, at school age, in their teens, before marriage, during their first pregnancy or only after childbirth. Most girls are mutilated between the ages of 4 and 10. Female genital mutilation is usually celebrated with traditional ceremonies. (WHO 2018b; UNICEF 2013.)

Procedure of female genital mutilation

Female genital mutilation is usually carried out by an older community member or a village midwife, and in some countries, increasingly a healthcare professional. The procedure frequently takes place in extremely primitive and unhygienic conditions. A sharp instrument, such as a knife, a razor blade, scissors or a piece of glass is used. The same implement may be used for several procedures without sterilisation. Painkillers or local anaesthetic are usually not available. (UNFPA 2018a; WHO 2018b.)

In some countries, including Egypt and Kenya, wealthier parents can take their daughters to a hospital or a doctor's surgery for an FGM procedure, in which case anaesthesia may also be available (UNFPA 2018b; UNICEF 2013). In other countries, such as Sudan and Kenya, midwives carry out circumcisions of girls. This is referred to as the medicalisation of female genital mutilation. The problem is that in these circumstances, the procedure may mistakenly be perceived as safer and more acceptable, even if the location of the procedure and the type of person carrying it out do not lessen its nature as a human rights violation and its harmful impacts. In many communities, healthcare professionals are respected, and this may often lead community members to think that as healthcare providers carry out female genital mutilation, the procedure is acceptable. This makes eradicating the practice even more difficult. WHO is putting strong pressure on healthcare professionals to give

up the genital mutilation of girls and women. (UNFPA 2018b; WHO 2018d; WHO 2010; UNICEF 2013.)

In some communities practising FGM, girls who have emigrated are sent back from their new home countries to their countries of origin to undergo FGM. Under Finnish law, the genital mutilation of a girl or a woman living permanently in Finland is an offence, also when it takes place abroad (Act 39/1889). So far, no sentences have been passed in Finland in criminal cases of this nature. Based on the final evaluation of the previous Action Plan for the prevention of circumcision of girls and women, we know that professionals of different fields have encountered situations in their work where it has been suspected that the genitals of a girl or a woman with an immigrant background had only been mutilated after her arrival in Finland (Koukkula, October, Kolimaa & Klemetti 2016). Fenix Helsinki has also reported on four girls living in Finland who had been take abroad for an FGM procedure (Ahmed & Ylispangar 2017). In European countries with large populations of immigrants originating from countries where FGM is practised, it is typical that children are taken back to their parents' home countries during school holidays to meet their relatives and to learn about their own culture and language. Concerns over uncut girls being taken back for the purpose of FGM are associated with the holiday seasons. In some countries, campaigns have focused on these times of the year. (WHO 2018a; Elgaali, Strevens & Mårdh 2005; Chalmers & Hashi 2002.)

Genital cosmetic surgery

Parallels between female genital mutilation and cosmetic surgery on women's genitals have sparked public discussion. Cosmetic surgery on the genital area refers to shaping the external genitals for aesthetic reasons, for example reducing the size of the labia or narrowing the vagina. Aesthetic surgery is underpinned by social, cultural and communal norms that define a certain type of aesthetic idea of female beauty and the appropriate female body. Surgical alteration of genitals meets the criteria for type 4 in WHO's classification of female genital mutilation types, and surgical alteration can thus also be interpreted as mutilation.

However, there is a clear ethical and moral difference between FGM and aesthetic surgery. Mutilation is perpetrated on individuals without their conscious consent as a consequence of strong direct or indirect coercion with no potential medical benefits. Female genital mutilation reflects deep-rooted gender inequality and is

a violation of many human rights. Cosmetic surgery on the genitals, on the other hand, is associated with conscious consent and the individual's willingness to undergo the procedure. As criteria for cosmetic surgery can be considered that the procedure is carried out on an autonomous person who is capable of giving her fully conscious consent to the procedure and who has been given extensive counselling before the surgery. The counselling should include a discussion on normal variations in genitals, physiological changes taking place as a result of ageing, pregnancy, childbirth, and menopause, and the undesirable consequences of the surgery. Those wishing to have surgery should also be informed of the lack of research evidence concerning cosmetic surgery on the genital area. (WHO 2018d; Berg, Taraldsen, Said, Sørbye & Vangen 2017.)

2.2 Prevalence of female genital mutilation

International prevalence figures

It is estimated that there are over 200 million girls and women who have undergone FGM in the world, with the greatest numbers found in 30 African, Middle East and Asian countries. Countries with a high prevalence of FGM in Africa are found in the areas of ancient kingdoms, including Nubia, Kush and Meroe (UNICEF 2013). In Somalia 98%, in Guinea 97% and in Djibouti 93% of girls are mutilated. The tradition of FGM is also practised in Iraq, Yemen, Oman, Saudi Arabia and the United Arab Emirates in the Middle East, among certain ethnic groups in Asian countries, such as Indonesia and India, and in Columbia in South America. Communities practising FGM can also be found in Europe, Australia and Northern America. Migration has turned female genital mutilation into a global phenomenon. **(**UNICEF 2018; WHO 2018b.) While the prevalence of FGM has dropped in the last 30 years, this reduction has not taken place equally in all countries (Kandala, Ezejimofor, Uthman & Komba 2018). In total, the prevalence of genital mutilation among girls aged between 15 and 19 in the 30 countries where the phenomenon is the most common has decreased from 50% to 35%. (UNICEF 2017; Koski & Heymann 2017.) Today, the likelihood of a young girl being subjected to FGM is one third less than 30 years ago (UNFPA 2014).

Studies indicate that certain sociodemographic factors influence the prevalence of female genital mutilation. The higher the parents' level of education, the less likely their daughters are to undergo genital mutilation (Yasin, Al-Tawil, Shabila & Al-Hadithi 2013; Saleem, Othman, Fattah, Hazim & Adnan 2013; Refaat, Farag & Ramadan 2009). If the mother works, this also protects her daughter from FGM (Yasin et al. 2013). The daughters of families living in cities are subjected to genital mutilation less often than the daughters of families in rural areas (Refaat et al. 2009).

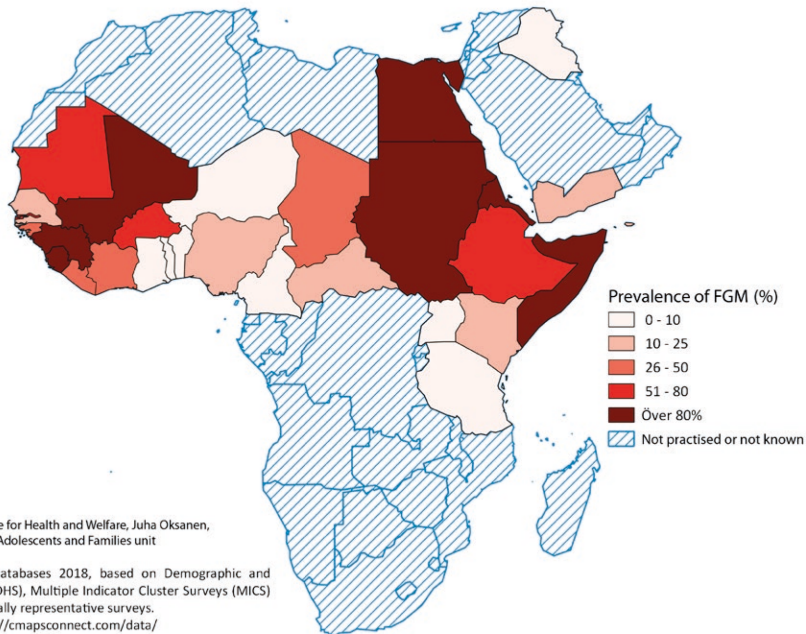

Figure 2. Percentage of girls and women aged 15 to 49 who have undergone FGM in African and Middle East countries. (UNICEF 2018.)

It is estimated that in Europe, approx. 500,000 girls and women have undergone FGM, and approx. 180,000 girls are at risk of the procedure. In Finland, as in many other countries, no comprehensive register data have been collected systematically on the prevalence of FGM, and consequently, no accurate estimates can be given of the numbers of girls and women who have undergone or are at risk of FGM. Obtaining an accurate estimate is important when developing evidence-based, effective prevention strategies and delivering health services. The European Institute for Gender Equality (EIGE) has made efforts to estimate the prevalence

of female genital mutilation in the EU. On the European Commission's request, EIGE has developed universal methodology and indicators for calculating the prevalence of FGM and the numbers of girls at risk and women who have already undergone cutting. Figures on the prevalence of FGM should be produced regularly to facilitate the evaluation of changes. If no register data are available, population statistics have to be used as the basis of estimates. The uncertainties and challenges associated with working out the numbers of girls and women at risk of FGM should be taken into account when interpreting the results and disseminating information about them to avoid their incorrect use and potential stigmatisation of migrant communities. (EIGE 2015a&b.)

Prevalence in Finland

In Finland, two studies of the National Institute of Health and Welfare have produced data on the prevalence of FGM so far: the Migrant health and wellbeing study (Maamu) in 2010–2012, and the Survey on work and well-being among people of foreign origin (UTH 2014–2015) (Koponen & Mölsä 2012; Koponen et al. 2015). As the Action Plan was being updated in 2018, the National Institute for Health and Welfare was working on a Survey on wellbeing among foreign born population (FinMONIK), which studies the wellbeing and health, employment and experiences of social and healthcare services of the foreign population living in Finland. A random sample of 13,650 people aged between 18 and 64 with a foreign background who were born abroad was selected for the survey. All subjects were asked if they had been circumcised and at what age the circumcision had taken place.

In 2018, the National Institute for Health and Welfare was also working on a survey on the health and wellbeing of newly-arrived asylum seekers (TERTTU) as part of a national project developing the initial health examination protocol for asylum seekers (2017–2019). The project is carried out in cooperation between the National Institute for Health and Welfare, the Finnish Immigration Service and Finnish reception centres. The TERTTU survey aims to produce representative population-based survey data on the health and wellbeing, health risk factors and service needs of newly-arrived asylum seekers. The systematic data collection in this survey consisted of health examinations and interviews carried out at reception centres. The goal was to examine at minimum 1,000 asylum seekers, both children and adults (interview questions were answered by guardians on behalf of children aged 0–12). All subjects were asked if they had been circumcised and at what age the

circumcision had taken place. The guardians of subjects aged under 12 were also asked if the child's mother had been circumcised.

The School Health Promotion Survey conducted by the National Institute for Health and Welfare every second year produces regional and local follow-up data on the wellbeing, health, school attendance, studies, participation, access to help, and services of children and young people of different ages. The School Health Promotion Survey provides data on approx. 120,000–240,000 schoolchildren and young adults. In the survey of 2019, a question on genital mutilation was included for all young people studying at general upper secondary schools and vocational institutions, asking if they had been circumcise and at what age.

The maternity card, which contains information on a mother's health, pregnancy, childbirth and postnatal period, is used for passing on information between the maternity clinic and the maternity hospital. Since 2017, a pregnant woman's FGM status has been recorded on the maternity card.

The Medical Birth Register maintained by the National Institute for Health and Welfare contains data on mothers, deliveries and newborn infants up till the age of 7 days. In this register, statistical data are collected for the purposes of conducting research, developing maternity care, deliveries and care of newborn infants, and offering services. Since 2017, the form used to collect data for the Medical Birth Register has contained information on genital mutilation and deinfibulation during delivery. As this Action Plan was being written, the maternity hospitals in the Hospital District of Helsinki and Uusimaa did not yet provide their information using the new data collection form. Once it becomes possible to register data from Helsinki and Uusimaa, an overall picture of the situation in Finland will be obtained, and the prevalence of FGM and deinfibulation in women who have given birth can be monitored reliably.

The purpose of the Care Register for Health Care is to collect information on the operation of health centres, hospitals and other institutions with hospital beds as well as the clients admitted to them and home nursing clients for statistics, research and planning. Reporting FGM, deinfibulation and problems and complications associated with them to the Care Register has been possible and encouraged since 2017.

Estimated number of girls and women who have undergone or are at risk of FGM in Finland

As this Action Plan was being prepared, an estimate was produced on the number of girls at risk of FGM in Finland, using EIGE guidelines (Step-by-step guide: Estimation of girls at risk of female genital mutilation in the European Union) (EIGE 2015b). The estimate is based on the most recent available data on the prevalence of FGM in countries practising this tradition, the typical age at which genital mutilation takes place in each country, and information on the countries of origin of first and second-generation members of communities originating from countries where FGM is practised and on asylum seekers' countries of origin. This way, a theoretical maximum number of girls at risk was obtained. This high-risk scenario means that the risk of a girl living in a new country is calculated as though she was still living in her country of origin, ignoring the impacts of migration and acculturation.

Studies conducted in Europe indicate that second-generation girls from countries where FGM is practised who have been born in Europe are mutilated significantly less often than girls living in the countries of origin. Reasons for this include the fact that social pressure to follow the tradition experienced by families is absent or weaker and the families' attitudes towards FGM change in a new country (UNFPA-UNICEF 2016; Gele, Johansen & Sundby 2012; O'Neill et al. 2017). In other words, the effects of migration and acculturation on attitudes and behaviour regarding FGM should be taken into account in the risk assessment calculation. This fact is accounted for in the low-risk scenario. In this scenario, the risk was calculated by factoring in the impacts of migration and acculturation on changing attitudes and customs related to FGM. For second-generation girls originating from countries where FGM is practised, the risk is lower or even non-existent. Second-generation girls from countries practising the tradition are excluded from the estimate. (EIGE 2015b.)

In addition to the 30 countries where the prevalence of FGM is the highest, it was considered necessary to include in the calculation girls and women with a Kurdish background, as FGM is known to remain common in some Kurdish communities (Koukkula, Keskimäki, Koponen, Mölsä & Klemetti 2016). Kurdish speakers were defined as individuals with a Kurdish background, and their proportion was thus calculated. Consequently, the 30 countries with the highest prevalence of FGM identified by the WHO as well as the Kurdish areas in Iran, Turkey and Syria

were taken into account in the calculation. Of Kurdish areas, Iraq is included in the countries with the highest prevalence of FGM identified by the WHO. Some countries were FGM occurs but is rare were excluded from the calculation. On the other hand, there is little migration from these countries (e.g. Indonesia and India) to Finland, making the impacts on the number of at-risk girls minor.

The calculation indicated that in the high-risk scenario, the maximum number of girls at a high risk of FGM was 3,075, whereas in the low-risk scenario, this number was 645 (Appendix 1.).

The number of girls and women in Finland who have undergone FGM was estimated at approx. 10,000.

Table 1. **Estimated numbers of girls at risk of FGM and their proportion of girls originating from FGM countries in Finland, Sweden (EIGE 2015b) and Belgium (EIGE 2015b).**

Country	Number of girls (aged 0 to 18) originating from FGM countries	Low-risk scenario (only those born abroad are cut), number and proportion	High-risk scenario (those born abroad and in Finland are cut), number and proportion
Finland	11,620	645 (6%)	3,075 (27%)
Sweden	59,409	2,016 (3%)	11,145 (19%)
Belgium	14,815	1,100 (7%)	3,400 (23%)

2.3 Background factors of female genital mutilation

The best way of promoting the abandonment of female genital mutilation is understanding the reasons that perpetuate this harmful practice. FGM is an ancient tradition founded on parents' need to protect their child and to anchor the girl strongly to their culture. It may also be justified by religious, aesthetic, sexual, moral, social and economic reasons, and those related to cleanliness. The reasons for FGM vary from one country, region and culture to another.

While it is often justified by religious reasons, no religious scripts prescribe the practice (WHO 2018b; Abathun, Gele & Sundby 2017). Female genital mutilation

predates Christianity and Islam, and it is practised across the boundaries of religious groups among Christians, Jews, Muslims and animists alike in the regions where the tradition is widespread. The views expressed by learned Islam leaders, according to which extensive mutilation of girls is against the teachings of their religion, have had the effect of reducing at least the most radical forms of FGM among Muslims. Smaller procedures, for example the ones referred to as sunna cutting among the Somalis, may be valued and respected on religious grounds, and stopping them has proven difficult. (Talle 2010; Newell-Jones 2016.)

Many communities practising FGM see genital mutilation as an essential part of a girl's upbringing and the cornerstone of moral. It prepares the girl for adulthood and marriage. Mutilation is considered a sign of sexual maturity, a gateway on the journey from a girl to a woman. Genital mutilation and the ceremony organised around it are an important rite of passage. In many communities in which FGM is considered a precondition for marriage, the roles of a wife and mother are also regarded as the woman's key roles, and the community members thus persist in following this tradition (Berg & Denison 2013). It may be difficult for a girl who has not been mutilated to be married. If a so-called bride price is paid to a girl's parents, a girl who has undergone FGM may be much more valuable financially for her family than a girl who has not. The payments received by the circumciser, who often is a self-taught villager, may motivate them to perpetuate the practice. (UNICEF 2010; WHO 2018b.)

The strongest influence on the decision to mutilate a girl's genitals is often exerted by mothers, grandmothers and older female relatives (UNICEF 2010), even if their decisions are usually underpinned by complex structures of patriarchal power (O'Neill et al. 2017). Local opinion leaders, including village elders, chiefs, religious leaders and healthcare providers may uphold the tradition. The practice of FGM may also spread between neighbouring communities, for example along with a religious movement, even if the tradition is not associated with religion per se.

FGM may be a symbol of womanhood, as it removes body parts that are in some communities experienced as masculine. Some communities also consider the clitoris and labia as unclean body parts, and their removal makes a woman clean and beautiful. It is feared that the clitoris may grow and, for example, harm the baby during childbirth or get in the midwife's way if it is not removed already in

childhood. Genitals that have been sewn together are believed to be hygienic, the girl is considered to have better protection from infectious diseases, and the foetus is believed to be safer during pregnancy. In some cultures, FGM is also believed to increase fertility. In communities were all girls undergo FGM, mutilated genitals are considered normal, and girls and women do not necessarily even know what the normal anatomy of female genitals should be like. (UNICEF 2013, WHO 2018a&b.)

FGM is also associated with ideas of what is considered acceptable sexual behaviour. Many communities believe that by mutilating girls' genitals, women's libido can be controlled, thus helping the woman to avoid extramarital sexual relationships (Berg & Denison 2013). Mutilation can also be seen as a sign of the man's power over the woman's body (O'Neill et al. 2017). FGM represents an effort to ensure that the girl remains a virgin until she marries and will remain faithful to her husband during marriage. The fact that girls and women who have undergone pharaonic genital mutilation are afraid of the pain caused by the opening of the infibulation and the fear that this will be found out are expected to discourage extramarital sexual intercourse. Female genital mutilation is believed to control women's excessive sexuality and increase the man's sexual pleasure. (UNICEF 2013; WHO 2018a&b.)

Female genital mutilation enhances the feeling of social togetherness. In a community where FGM is the social norm, the pressure to continue the tradition is strong. Muslim mothers, for example, gain more influence in their families and communities through their children (Isman, Ekéus & Berggren 2013; Akar & Tiilikainen 2009). The fear that an unmutilated daughter will encounter cultural or social problems or bring shame on herself often is so great that it overcomes the fear of the physical and psychological harms caused by FGM. A family whose daughter has not been mutilated may encounter discrimination. Female genital mutilation may also show that the daughter has been brought up to respect the authority of older women in the family who have undergone FGM. (Pashaei, Ponnet, Moeeni, Khazaeepool & Majlessi 2016.) Female genital mutilation is practised in an attempt to maintain cultural identity. As a result of migration and when living far away from one's country of origin, cultural continuity is experienced as important. (Isman, Ekéus & Berggren 2013.)

2.4 Conventions, obligations and recommendations relevant to female genital mutilation

International conventions and recommendations

The Council of Europe Convention on preventing and combating violence against women and domestic violence (the Istanbul Convention) is the most important regional human rights treaty binding to Finland that concerns the prevention of female genital mutilation (Finnish Treaty Series 53/2015). This convention has been valid in Finland with the status of an Act since 2015. Under Article 38 of the Istanbul Convention, the state parties shall criminalise excising, infibulating or performing any other mutilation to the whole or any part of a woman's labia majora, labia minora or clitoris. The obligation to criminalise FGM in this Article also states that inciting, coercing or procuring a girl to undergo FGM must be criminalised in the State Party. According to the Explanatory Report to the Convention, the express intention is to state that in addition to the actual mutilation of female genitals, assisting the perpetrator to perform these acts is a criminal offence. (Finnish Treaty Series 53/2015.)

Under Article 19 of the **UN Convention on the rights of the child,** the child must be protected from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation (UN 1989). Such protective measures should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child. Procedures for the prevention and identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement should also be developed. (UN 1989.)

The **Committee on the Rights of the Child** has issued a **general comment** (No. 13) on how the right of the child to freedom from all forms of violence should be realised (UN 2011). According to this general comment, strategies and systems to prevent and respond to violence must adopt a child rights rather than a welfare approach. The General Comment also identifies female genital mutilation as a so-called harmful practice. It stresses the fact that State parties' definitions must in no way erode the child's absolute right to human dignity and physical and psychological integrity by describing some forms of violence as legally and/or socially acceptable. (UN 2011.)

National legislation

Female genital mutilation is a criminal offence in Finland. Under Chapter 21 of the **Criminal code**, it is punishable as an assault (section 5) or aggravated assault (section 6) (Act 39/1889). The offence is aggravated if, for example, it places the victim in mortal danger, the offence is committed in a particularly brutal or cruel manner or an edged weapon is used, and the offence is aggravated also when assessed as a whole. The penalty for aggravated assault is imprisonment for at most ten years. Such persons as family members who do not themselves perpetrate the assault but whose actions play a key role in the perpetration of the offence as a whole may also be found guilty of assault. A family member who urges or incites another person to mutilate the genitals of their child could also be sentenced for aiding or abetting the assault. In that case, the offender could be sentenced under the provisions on participation or liability for negligence. Female genital mutilation is an offence for which sentence will be passed under the Finnish law also when it is committed outside of Finland and has been directed at a Finnish citizen or a foreigner permanently resident in Finland. (39/1889.) No charges have been brought for FGM in Finland so far (Finnish League for Human Rights & End FGM EU 2018).

The **Finnish Child welfare act** (section 25) contains provisions on the duty of the authorities and many other professionals working with children to submit a child welfare notification and a report to the police if it is suspected that a child has been the victim of a sexual abuse or an assault that is more serious than minor (417/2007). Investigating and preventing possible offences in acute situations is a task for the police, whereas the child welfare services have the duty to ensure the child's safety and offer support for the child and her family. Other parties than those listed in the Act also have the duty to submit a child welfare notification, for example if the safety of the circumstances in which the child is being brought up gives rise to concern. Additionally, everyone who knows that a serious offence, including an aggravated assault, is about to be committed has the duty to report it to the police or the endangered person (Chapter 15, section 10 of the Criminal code) (39/1889). Under the Act on the status and rights of patients (785/1992, section 13, subsection 4) and the Act on the status and rights of social welfare clients (812/2000, section 18, subsection 3) professionals shall, notwithstanding the secrecy obligation, report to the police information necessary for assessing a threat against a person's life or health and preventing a threatening act if they have, while performing their tasks referred to in this Act, received knowledge of

circumstances on the basis of which they have reason to suspect that someone is at risk of violence.

2.5 Work carried out to prevent female genital mutilation

International preventive work

The work to prevent FGM goes back to the early 1900s, at which time grass-roots level prevention programmes were already operating in African countries (UNICEF 2013). In the 1070s, NGOs and organisations advocating improvements in women's status started bringing the issue up more visibly in public. Actual milestones of international prevention efforts included WHO seminars organised in Khartoum in 1979 and in Dakar in 1984. At the conclusion of the 1979 seminar, UNICEF issued its first statement against female genital mutilation. The Dakar seminar resulted in the establishment of the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) between 28 African countries and other actors as well as 15 non-African actors. Based on the work carried out during the previous decades, WHO published its joint statement against FGM with UNICEF and UNFPA in 1997 (WHO 1997).

The African Union has prioritised the eradication of FGM in its long-term objectives, and it is striving to mobilise Ministers of Health and Equality to obtain more support for rejecting the tradition of FGM (African Union 2017). In 2008, UNFPA and UNICEF published a joint programme on accelerating abandonment of FGM/C and providing care for its consequences. This is currently the largest global programme aiming to prevent and treat FGM. (UNFPA-UNICEF 2017.)

Preventive work in the European Union

The European Commission is committed to eradicating the FGM phenomenon (EIGE 2015b). The European Parliament Resolution on Ending Female Genital Mutilation adopted in 2012 was an important step forward in eradicating FGM in European Union territory (UEFGM 2016). End FGM European Network, an umbrella organisation for 21 organisations operating in Europe, has raised awareness of the

FGM theme in addition to conducting field research and academic studies and is working to ensure sustainable efforts to prevent FGM in Europe. In addition, the European Institute for Gender Equality (EIGE) produces information and studies on the prevalence of FGM in the Member States and supports the Member States in their prevention efforts. EIGE has produced three extensive studies concerning the EU area; a report on the prevalence of FGM in the EU in 2012, an estimation of those at risk of FGM in Ireland, Portugal and Sweden in 2015, and an estimation of those at risk of FGM in Belgium, Cyprus, France, Greece, Italy and Malta in 2018 (EIGE 2012, 2015a, 2018). Work against FGM in Europe has been hampered by a lack of reliable information on the prevalence of the practice here and the absence of extensive structures intended for assisting the victims. End FGM EU and EIGE have sought to make a difference regarding this situation. (UEFGM 2016.)

International Day of Zero Tolerance for Female Genital Mutilation

Since 2003, the 6th of February has been celebrated as the International Day of Zero Tolerance for Female Genital Mutilation with the intention of attracting attention to the issue. The roots of this day go back to the Zero Tolerance conference organised by the IAC in Addis Ababa, and it has since spread around the world through numerous anti-FGM NGOs and actors. (UEFGM 2016.)

Legislation

In many countries, the principal prevention strategy has consisted of legislation prohibiting female genital mutilation (Berg & Denison 2013). The first anti-FGM law was drafted in 1965, and today 27 out of the 30 countries with the highest FGM prevalence have criminalised female genital mutilation (AWEPA 2016; WHO 2018d). Additionally, 19 countries outside Africa with high numbers of migrants originating from countries where the prevalence of FGM is high have criminalised female genital mutilation (UNFPA 2018a).

EU Member States, excluding Finland, Poland, Slovenia, Romania and the Netherlands, have passed separate acts prohibiting female genital mutilation. Sweden was the first European country to pass a separate anti-FGM act in 1982. (Leye & Sabbe 2009; Socialstyrelsen 2015.) In Norway, an act that prohibits female genital mutilation has been in force since 1995. In an effort to reduce the prevalence of FGM, the British government introduced a mandatory reporting

system in 2015, under which health and social welfare professionals and school staff must report all FGM cases known to them to the police. Opinions of the effectiveness of this practice are strongly divided. It is feared that mandatory reporting will push FGM further underground. (Amasanti, Imcha, & Momoh 2016.) In addition, 15 FGM/C clinics, which girls and women can contact for deinfibulation or counselling, operate in the United Kingdom (Amasanti et al. 2016).

The new challenges created by the criminalisation of FGM have sparked discussion. An act prohibiting the practice carries the message of the government's expectations and may complement prevention strategies by creating a positive atmosphere for change. Studies have found that anti-FGM legislation has worked not only as a deterrent but also an encouragement to abandon the practice (Berg & Denison 2013). According to UNICEF, however, criminalisation alone is not an effective method for eradicating the practice, and an effort should also be made to influence the factors that perpetuate this cultural tradition. Drafting laws without consulting and ensuring the commitment of the communities they target may undermine the effectiveness of legislation (UNICEF 2013; AWEPA 2016).

An anti-FGM act may in some cases also have serious adverse effects, including pushing the phenomenon underground and causing communities to adhere to the tradition more tightly (Berer 2015). Efforts to avoid bringing charges against the parents and the practitioner are also made by mutilating girls at an increasingly young age, thus making sure that they cannot tell anyone about it. Especially as a result of migration, it has also been observed that the practice has changed and a less severe form of genital mutilation is carried out, including pricking or incising, with the idea of this making it less likely for the perpetrators to be caught. (UEFGM 2016.) Mass mutilation events have increasingly been replaced by private procedures, making it easier to keep them secret (UNFPA-UNICEF 2016). The criminalisation of FGM may additionally lead to double victimisation of girls: they may be subjected to both genital mutilation and separation from their parents. Consequently, bringing charges against the parents and sentencing them to imprisonment is not usually the best option from the child's perspective, and criminal proceedings are thus very rare. (Amasanti et al. 2016.)

In addition to legislation, such EU Member States as Finland, Sweden, Italy and Portugal have produced a national action plan for the prevention of female genital mutilation, and others have included this theme in some other national strategy.

When preparing an action plan, it would be essential to also pay attention to its practical implementation and monitoring and to have the required budget. All key groups should be involved in preparing the action plan, including NGOs, religious leaders, healthcare professionals and decision-makers. (AWEPA 2016; Socialstyrelsen 2018.)

Prevention strategies

In efforts to prevent female genital mutilation, it is of primary importance to understand the factors underpinning it, thus making it possible to select the appropriate information and communication channels for each target group. Prevention strategies may aim to modify or eliminate determinants that perpetuate the tradition, or focus on factors known to make the practice less likely to continue. (Berg & Denison 2013.)

WHO has declared strengthening the health sector response as the most important strategy for preventing FGM. Guidelines, tools, training and policy should be used to ensure that health professionals can play an effective role in preventing female genital mutilation. (WHO 2018b, Amasanti et al. 2016, Finnish League for Human Rights & End FGM EU 2018.) To give professionals better capabilities for carrying out interventions, providing counselling, collecting reliable information on FGM, and reporting suspected or actual FGM cases or requests for FGM or reinfibulation, workplaces should have clear practices that enable professionals to develop their knowledge, skills and cultural competence. (Dawson, Fray, Homer, Nanayakkara, Turkamani & Varol 2015; Amasanti et al. 2016.) Providing professionals with training on the FGM theme is considered an effective prevention strategy, and different materials, guidelines and training programmes for professionals have thus been produced in various countries. (Dawson et al. 2015; WHO 2018b.)

Generating knowledge about the causes and consequences of female genital mutilation among communities practising FGM has also been proven an effective way of reducing FGM prevalence (WHO 2018b). Interventions aiming to raise awareness should be multidimensional, and they should be targeted at all social groups influencing the continuation of the practice, including the parents of girls, healthcare professionals, religious leaders and other key persons in communities as well as local authorities (WHO 2018d; Pashaei et al. 2016; Amasanti et al. 2016; Berg & Denison 2013). As it is known that the daughters of women who have undergone

FGM have the highest risk of being subjected to genital mutilation and that the mother's attitude towards having her daughter's genitals mutilated is the key determinant for FGM intentions (Pashaei et al. 2016), a risk assessment carried out in form of a survey before childbirth is considered an effective prevention strategy (Amasanti et al. 2016, EIGE 2015b; FGM UK 2016; FGM UK 2017).

Studies indicate that educational interventions targeted at communities practising FGM, in which the negative consequences of FGM are stressed and which correct mistaken beliefs and offer factual information to community members, have been found effective. Research shows that if practising communities themselves decide to abandon FGM, the practice can be eliminated very rapidly (WHO 2018b.) Sometimes the FGM ceremony has been replaced by an alternative celebration, a shared declaration where the community members pledge together to no longer mutilate girls' genitals.

In countries where the tradition is practised, a rite of passage where the girls are not mutilated as they were before has proven an effective strategy for reducing FGM. In Iraqi Kurdistan, an alternative symbolic ritual has been used, where the mother uses a knife to cut the daughter's clothes rather than to mutilate her. An alternative ritual of this type may release mothers and other older women in the family from guilt over not mutilating the daughters and thus alleviate fears of an unmutilated daughter bringing social and cultural shame on them. (Pashaei et al. 2016.) The possibility of being respectable without undergoing genital mutilation should be stressed among the communities practising FGM, bringing up the fact that the girl's honour can be protected and preserved without genital mutilation (Sopu work 2018).

Community attitudes towards female genital mutilation

In some communities practising FGM, a woman's body is regarded as being of high communal importance. It is associated with the family's honour, and it may be subjected to a man's power. The woman's body is also important for passing on traditions and giving birth to the next generation. (Akar & Tiilikainen 2009; O'Neill et al. 2017.) In efforts to prevent FGM in communities of this type, the harmful effects of mutilation on fertility, pregnancy and childbirth and thus women's important role in giving birth to the new generation should be stressed in information activities.

Girls' and women's attitudes towards FGM vary in countries where it is practised. In most cases, they have a negative attitude to FGM and they would like to see the practice eradicated. The largest proportion of women and girls in favour of the tradition is found in countries with a high FGM prevalence, including Mali, Sierra Leone, Guinea, Gambia, Somalia and Egypt, where more than one half of the female population believe that the tradition should be continued. (UNICEF 2018.) The principal methods for influencing women's attitudes include reinforcing their status as equal members of their communities, for example through education, legislation and economic opportunities. (UEFGM 2016.) In addition, open discussions between couples and, for example, talking aloud about the harmful effects of FGM and the mutilation of the daughter's genitals within the family would promote the abandonment of the practice (O'Neill et al. 2017).

Studies have shown that significant reasons for the lowered FGM prevalence include its health harms, personal negative experiences, the unlawfulness of the act, and the fact that genital mutilation is unnatural and unnecessary. Essential reasons for rejecting the tradition include acknowledging that religion does not require FGM, and fathers having a positive attitude towards not mutilating their daughters' genitals. In research and work aiming to include men in Belgium, the Netherlands and the United Kingdom, it has become clear that men play an important role in stopping the practice. So far, men have not assumed this role for some reason. (O'Neill et al. 2017.) Following emigration, a significant factor in giving up FGM is that after leaving their country, the family is no longer put under pressure by other women in their community, and at the same time, the negative attitude of the community in the new home country encourages families to abandon the practice. (Berg & Denison 2013.)

As the most important reasons in studies have emerged the negative consequences of FGM, especially the loss of sexual pleasure. Men's opposition to FGM has been supported by the idea that men do not wish their wives to suffer because of genital mutilation. Men should be involved in the work against FGM both as a target group and as opinion leaders to change mistaken beliefs caused by lack of communication. (Niskala 2015; O'Neill et al. 2017.) The prevalence of female genital mutilation has also been lowered by more widespread understanding of the fact that genital mutilation and infibulation are not a guarantee of virginity, as deinfibulation and reinfibulation procedures can be carried out. (Berg & Denison 2013.)

Preventive work in Finland

In Finland, the need to prevent female genital mutilation became topical in the late 1990s, as the number of refugees from countries practising FGM started increasing, and the preparation of guidelines for the health and social welfare sector began. The Ministry of Social Affairs and Health published a brochure on female genital mutilation, a printed version of which was available in Finnish, Swedish, English and Somali (STM 1997). The Ministry of Social Affairs and Health also published a guide on immigrant women and violence to support assistance work in the social welfare and healthcare sector, which includes a dedicated section on female genital mutilation (Kyllönen-Saarnio & Nurmi 2005). The Finnish League for Human Rights published a guide on female genital mutilation for social and healthcare sector personnel (Finnish League for Human Rights 2011), and the Family Federation of Finland created an action plan on improving immigrants' sexual and reproductive health in Finland (Apter et al. 2009). These guides aimed to provide information about FGM for professionals encountering in their work women and girls who have undergone female genital mutilation.

The subject was also addressed in the Action plan on sexual and reproductive health for 2007–2011 (Ministry of Social Affairs and Health 2007). This action plan referred to professionals' duty of notification when a girl is at risk of FGM and provided instructions for preventive counselling at maternity clinics. The Action plan on sexual and reproductive health for 2014–2020 deals with FGM, addressing it diversely in its objectives and measures under various themes (Klemetti & Raussi-Lehto 2013). The electronic Handbook for child health clinics contains basic information about female genital mutilation (National Institute for Health and Welfare 2018c). The Handbook of child welfare of the National Institute for Health and Welfare provides more detailed instructions for work on this issue in child welfare services (National Institute for Health and Welfare 2018b). The National Institute for Health and Welfare also maintains a website related to FGM and its prevention (National Institute for Health and Welfare 2018a). The Finnish Immigration Service published a brochure on Female genital mutilation in a number of different languages in 2015. This brochure contains basic information about female genital mutilation and notes that the threat of mutilation or serious problems caused by mutilation already carried out may be grounds for receiving a residence permit. (Finnish Immigration Service 2015.)

Action plan 2012–2016

The first FGM/C action plan in Finland was the Action plan for the prevention of circumcision of girls and women 2012–2016. It was drafted by an interadministrative expert group consisting of representatives of different ministries, central agencies and NGOs. The National Institute for Health and Welfare coordinated its implementation by producing brochures, guidelines and information for websites, by training professionals, and through information activities. An FGM expert worked at the National Institute for Health and Welfare in 2013–2015, during which period active prevention work was carried out. As the Institute's Sexual and reproductive health unit was closed down, resources for maintaining the website and carrying out other preventive work were no longer available. The Ministry of Social Affairs and Health and the National Institute for Health and Welfare have organised an annual FGM working meeting, which has been attended by around one hundred participants from different fields, including decision-makers, professionals, NGO representatives, students and immigrant community members. The working meetings have disseminated the most recent information on female genital mutilation and discussed the best practices for FGM prevention. In 2016, the National Institute for Health and Welfare organised training which covered female genital mutilation for asylum seekers who had received healthcare education. The Institute created a website on female genital mutilation for asylum seekers and professionals working with them.

The National Institute for Health and Welfare produced an interim evaluation of the Action Plan's implementation in 2014 (Koukkula, Parekh & Klemetti 2014) and a final evaluation at the end of its period of validity in 2016 (Koukkula, October, Kolimaa & Klemetti 2016). The purpose of the interim and final evaluations was to establish to what extent the Action Plan had reached the different target groups and what actions had been taken to implement it. While the response rate in the evaluation surveys was low, it was possible to conclude from the responses that encountering immigrants was already routine in social welfare and health care, early childhood education and care, and education. The majority of the professionals who responded to the evaluation surveys said they had encountered FGM issues in their work. While the topic had come up especially in healthcare, situations where girls were at risk of genital mutilation had also been encountered in the education sector. According to immigrant group representatives who responded to the surveys, FGM has become less common as communities have reacted to the problems caused by the practice. Slightly more than one third of the leading office holders and elected officials who

responded to the survey reported that actions recommended in the Action Plan had been taken in their area of responsibility.

The conclusion of the final evaluation was that more information and training related to FGM are needed. As a challenge was regarded integrating the theme more extensively in the basic instruction provided by vocational institutions, universities of applied sciences and universities and the offer of in-service training. Continued maintenance and updates of the National Institute for Health and Welfare's FGM website were considered important, as professionals encountering clients who have undergone genital mutilation found the website a significant source of support and information in their daily work. Another issue that came up was promoting the health and welfare of girls and women who have undergone FGM by offering them information about deinfibulation, securing them access to deinfibulation, and investigating the need and possibilities for providing reconstructive surgery.

Efforts of NGOs and networks

NGOs have also played an important role in the work to prevent female genital mutilation in Finland. The Finnish League for Human Rights (KokoNainen) has worked since 2002 to prevent FGM, promote the wellbeing of girls and women who have undergone FGM, and change attitudes in Finland. The main focus has been on grass-roots level preventive work among communities that practise FGM as well as the training of professionals. The Finnish League for Human Rights has also produced written material for FGM prevention and a training video to support it (Finnish League for Human Rights 2011, 2017). In 2017, the Finnish League for Human Rights established a network on FGM prevention. Its members include the Ministry of Social Affairs and Health, the National Institute for Health and Welfare, the Finnish Immigration Service, the Office of the Ombudsman for Children, the Finnish Red Cross, the Federation of Finnish Midwives and the Association of Iraqi women in Finland. The network meets twice a year to discuss topical themes related to female genital mutilation. The Finnish League for Human Rights also is the only member from the Nordic countries in the European End FGM EU network of anti-FGM organisations.

NGOs have an important role in raising awareness of FGM as a harmful practice. The four cases of genital mutilation of girls who were born in Finland described by

Fenix Helsinki association attracted wide attention in autumn 2017. Fenix Helsinki is striving to make community members' voices heard and involve actors, for example religious leaders, in communities practising FGM. The organisation also carries out preventive work in Finland among children and young girls with second-generation immigrant background who are at risk of FGM. Fenix Helsinki additionally provides training for professionals.

African Care is an NGO established and led by women with an immigrant background that works to improve the wellbeing and possibilities of being active of women and girls both in Finland and Somalia. The organisation has worked to prevent FGM in Finland and produced a brochure on FGM in four languages in 2012. (African Care 2018)

Since 2000, a multidisciplinary research network focusing on FGM called FOKO has operated in the Nordic countries (Forskning om Kvindelig Omskæring). Finland has participated in the meetings of this network. The Finnish League for Human Rights also organised FOKO seminars in Finland in cooperation with the Ministry of Social Affairs and Health in September 2007 and October 2016.

Theses and studies

A number of FGM-themed theses have been produced in Finland. The greatest numbers of these theses have been written in the healthcare sector at universities of applied sciences. They have included information packages for healthcare professionals and clients with an immigrant background (Rämö & Sofizade 2018; Tähtinen, Valonen, Vuori & Ylinen 2018; Nieminen & Raulamo 2017; Antikainen et al. 2016; Ryhänen, Savinainen & Suokas 2016); studies of women's experiences of genital mutilation (Khalifa & Paulose 2017); investigations of deinfibulation (Kytöaho & Rinne 2018) and instructions on deinfibulation for healthcare professionals (Laukkanen & Sorsa 2013). Other theses have focused on the experiences of FGM women and the care personnel related to care during pregnancy, delivery and the post-natal period (Lindroos & Määttänen 2018; Palojärvi & Seppälä 2016; Lehto & Qvist 2017); discussed bringing up the subject in school healthcare services (Haarala & Hilska 2013); investigated gynaecological problems related to FGM (Kurikka 2013); or developed a risk assessment model for FGM (Hongisto & Kahelin

2016). Topics of Master's theses produced at universities have included the attitudes of Somali community representatives towards FGM (Matsuuke 2011), bringing up FGM (Kortesniemi 2016), men's attitudes towards FGM (Niskala 2015), and the prevalence of FGM and the health harms caused by it (Koukkula 2015).

Projects and statements

In recent years, several local projects related to immigrants' health and welfare have been launched in Finland, in which female genital mutilation has also been addressed. MAUSTE, or Promotion of immigrants' sexual health and safety skills, is a two-year project (2015–2016) carried out in Jyväskylä and Kuopio with the objective of reducing health gaps between population groups and improving immigrants' knowledge and skills related to sexual health and safety skills. The project has developed sexual health training for professionals and a model of sexual health services for child health clinics and school and student health care services, set up groups related to sexual health and safety skills for immigrants, produced sexual health material to support instruction, established a regional and national online forum on the subject, and produced Finnish and international publications on the outcomes of the project. A brochure titled 'The pregnancy and delivery of a circumcised woman – care and sexuality counselling' was produced during the project as a thesis (Ryhänen et al. 2016.).

The Finnish Society of Obstetrics and Gynaecology and the Federation of Finnish Midwives issued a statement on female genital mutilation and the care of circumcised women on 26 September 2017. The statement notes that the current legislation on female genital mutilation is not complied with, and the authorities do not sufficiently stress the fact that this phenomenon is within the scope of the Criminal code. Providing more training and information for both healthcare personnel and the population is seen as extremely important. The statement recommends that FGM should be brought up during maternity and child health clinic visits, and information on FGM status should also be included in the data collection form for the Medical Birth Register. The statement recommends that pregnant women should be referred to specialised medical care for the planning of possible deinfibulation and the delivery with a low threshold, and paediatricians who carry out examinations on female infants at discharge from hospital should be encouraged to talk to the family about normal anatomy and stress the importance of preventing female genital mutilation. According to the statement, education

and information activities should also be started at schools, among both the mainstream population and immigrants. (Grénman & Rytkönen 2017.)

Schools and educational institutions

In health education instruction at general upper secondary schools, female genital mutilation is discussed in connection with sexual rights and sexual health. In online-based Peda learning materials, for example, FGM is discussed as part of the right to sexual self-determination and sexual harassment (Peda.net 2018).

The FGM theme is also included in some textbooks for healthcare students. A textbook for midwives from 2015 discusses the pregnancy, delivery and postnatal period of an FGM woman (Pietiläinen, Tiilikainen & Johansson 2015), and a later edition (2017) has been complemented with information about deinfibulation. A textbook focusing on the nursing of women from 2016 deals with caring for a woman who has undergone FGM in connection with violence against women (Botha & Ryttyläinen-Korhonen 2016).

While the FGM theme had not yet been included in the education of physicians at the time of writing of the Action Plan, it is known that the subject has been discussed in clinical teaching, at least when encountering a patient who has undergone FGM. A gynaecology textbook that was in print at the time the Action Plan was written contained a chapter on female genital mutilation (Brusila & Jakobsson 2019). A teaching package on FGM and the care of a client who has undergone FGM has been prepared for the instruction of medical students but, at the time of the Action Plan update, it had not been included in the curriculum of any faculty of medicine.

In social welfare sector instruction, the subject may come up in connection with human rights and child welfare, but the depth at which it is discussed usually depends on individual teachers.

3 Prevention of female genital mutilation and suspected FGM

Several signs have been identified in research and practical work aiming to prevent FGM indicating that a girl may be at risk of FGM. The clearest indication is if the girl's parents and family originate from an area where FGM is common and the girl's mother or a sister/sisters have undergone the procedure. If the family has difficulty adapting to the Finnish culture or becomes isolated from its own cultural community, the girl may have a heightened risk of FGM. The monitoring of a girl at risk at the child health clinic and in school health care services may have been irregular, and she may have missed examinations carried out at specific ages. The professional should watch out particularly if the family is planning an extended trip to their home country or the girl is talking about a trip whose timing or exact purpose she does not know. If a girl talks about an approaching ceremony or festivities, this may also refer to an FGM ceremony. (FGM UK 2016; FGM UK 2017.) (Appendix 3.)

If a professional suspects that a girl is at risk of genital mutilation, they should first bring it up with the girl and her parents. If a minor patient is, considering their age and level of development, capable of making decisions on their care (as a rule at the age of 12), under Finnish law they have the right to prohibit the disclosure of information on their care to their guardians (Act 785/1992). If it appears that informing the parents could put the child's safety at risk, for example the parents could resort to violence to punish the child for talking about the matter, the police should be contacted first. In other words, the threshold for the right to make a report is low, and contacting the police does not automatically mean that a report of an offence should be submitted; it means that the police will assess the likelihood of the potential threat and consider preventive measures. The professional may ask the girl herself if, for example, she knows about the

female genital mutilation practice, if FGM practised in her family, and if she has been circumcised. The professional should explain to the girl and her parents that FGM is a dangerous and harmful procedure and a criminal offence in Finland. It is important to say that female genital mutilation taking place outside Finland will also be considered a criminal offence here if it is perpetrated on a girl who is living in Finland. In addition to this discussion, the professional should submit a child welfare notification to the social welfare authorities and a report to the police. It is a good idea to ask the girl to visit the surgery again later for follow-up.

Signs of FGM already carried out may include the girl's extended absence from early childhood education and care or school. When she returns, the girl's behaviour may have changed, and she may say that something has happened she is not allowed to talk about. The girl may experience problems when passing urine, moving or sitting still, and vague abdominal pains and mood swings.

If a professional suspects that a girl has undergone genital mutilation while living or residing permanently in Finland, he or she should first talk about it to the girl and her parents and find out if the suspicions are correct. If the female genital mutilation took place before the family arrived in Finland, the circumstances in which the girl and any siblings she may have are growing up and their welfare after their arrival in Finland should be assessed as whole. The professional should inform the family about FGM being a punishable offence in Finland and the health harms of this practice. If the family members refuse to admit that the girl has been subjected to FGM but the professional suspects that she has, child welfare services and the police should be contacted, and they will investigate the matter further with the family. Based on the report, the police will assess if the case meets the criteria for launching a pre-trial investigation. If the family admits to the genital mutilation, the professional should contact the child welfare authorities and the police. The family should be offered support and a possibility of talking about what happened.

A professional encountering a girl or a woman who has undergone female genital mutilation

Encountering a girl or a woman originating from a country where FGM is practised may be a new and challenging situation for Finnish professionals of the social welfare and healthcare sector, education sector, reception activities, the police or

media. Professionals should be aware of their personal attitude towards female genital mutilation in advance, before encountering the client. They should reflect on the personal feelings and thoughts FGM evokes in them. Underlying strong emotions or belittling the practice will affect the professional's ability to encounter the client with empathy and sensitivity. Once the professional has adequate basic knowledge about FGM, it is easier for them to act constructively during the encounter. European research indicates that professionals encountering clients who have undergone or are at risk of FGM have insufficient knowledge about female genital mutilation, its treatment and the legislation relevant to it, and their access to information should be improved (Kaplan-Marcusan, Fábrecas, Muñoz-Ortiz, Moreno-Navarro & Torán-Monserrat 2009; Dawson et al. 2015; WHO 2018a). Clear guidelines are also needed on referring girls and women who have undergone FGM to treatment and on their care to enable the professionals to act correctly (Dawson et al. 2015).

The professional should encounter the client with cultural sensitivity. Cultural sensitivity refers to the professional's culturally respectful interaction skills and appreciative encounters and communication, both verbal and non-verbal, where both parties to the interaction have the right to express their culture and to be accepted and heard as representatives of their cultures. Female genital mutilation is often a taboo in the communities practising it, and talking about it is not always easy even for women. Privacy must be ensured at all times for these discussions, and the subject should not be brought up with the client in the hallway, for example, or when the rest of the family is present. Establishing a trustful relationship with the client also helps to talk about the subject. If necessary, a female interpreter should be provided for the discussion. Special cultural interpreters can be used where possible (Heino & Kärmeniemi 2013). If required, plain language and illustrative pictures should be used to support the discussion. (Castaneda et al. 2018; WHO 2018a.)

The most important thing required of the professionals encountering women and girls is courage to talk about the subject. By starting the discussion, the professional may offer the girl or the woman an opportunity to process the psychological stress caused by genital mutilation and a way of asking for help when they are at risk of FGM or need deinfibulation. The professional should approach the subject openly and with empathy. Rather than helping the client, expressing horror, being

judgemental or belittling what has happened will exacerbate the feelings of guilt and shame experienced by a woman who has undergone FGM. (WHO 2018a.)

The client should be made to understand that they are allowed to talk about female genital mutilation. For example, this can be managed by asking a direct question about the subject and avoiding whispered conversations when talking about it, which makes FGM appear shameful. Professionals encountering in their work girls and women who have undergone FGM should also talk about the subject in their work organisations and enable consultations with colleagues when the subject comes up (Dawson et al. 2015; WHO 2018a). The employer should offer sufficient support for professionals who work with a difficult theme. Multiprofessional co-operation, consultation with colleagues and team work as well as work instruction prevent vicarious traumatisation and compassion fatigue in those who work with a difficult issue. (Nipuli & Bildjuschkin 2016.)

4 Health and wellbeing of girls and women who have undergone female genital mutilation

Rather than having any health benefits, female genital mutilation causes many types of health problems. In female genital mutilation, normal, healthy tissue is removed, which usually has the effect of hampering the normal physiological functions of the genitals. The manner and extent to which the procedure is carried out, the girl's age at the time of the procedure, the practitioner's skills, the instrument used and the conditions in which the genital mutilation is carried out and in which the girl recovers from it are all relevant to the complications caused by mutilation. The conditions in which the woman later gives birth also affect the long-term complications of genital mutilation. The highest number of and the most difficult complications during pregnancy and delivery in infibulated women occur in poor and developing countries, in which high-quality healthcare is not available and where women's status and health are not highly appreciated. Reinfibulation carried out after childbirth also increases the risk of complications. The adverse effects caused by FGM can usually be minimised by healthcare of a high standard, for example deinfibulation. Complications during childbirth, on the other hand, can usually be reduced by means of high-quality obstetric care. (WHO 2018a; UNICEF 2013.)

4.1 Sexual and reproductive health of girls and women who have undergone female genital mutilation

Sexuality

All cultures have shared ideas, norms and rules related to human sexuality. Everyone also has a personal idea of how they experience their own sexuality; their identity, their self-image, their sexual worth and their gender. Migrating to a different culture may increase the family's need to uphold traditional customs. A woman's status and rights to her own body and the way a woman's sexuality affects her value may either be within her own control or subjected to her family's interests. However, sexuality is a person's most intimate, private and sensitive area. (Bildjuschkin & Ruuhilahti 2010; WHO 2018a.)

Depending on the culture, matters related to sexuality may be within the individual's control or decided by the family and the community. Sexual rights, which are part of human rights, mean that an individual should have control over their own body, sexuality, sexual health and sex as well as reproduction. A person's idea of their sexuality is formed by the environment in which they grow up and influenced by their parents and society. Things experienced as permitted and prohibited may be different depending on the society and the environment in which a person grows up, and the ideas related to cleanliness or hygiene, for instance, may vary. In some cultures, talking about sexuality and sex may be strictly regulated and, in any case, difficult for some people. Names that could be used for sexual body parts may not even exist. (WHO 2018d; Ala-Luhtala & Valkama-Hietamäki 2016; O'Neill et al. 2017; Sopu work 2018.)

Sexuality is a dimension of humanity, and sex is about how a person expresses their sexuality. Sexual identity and self-image are dimensions of human lives on which decisions cannot be made on behalf of another person. It is the sexual right of each person to search for and find an identity and a self-image with which they are comfortable. Violent interference with the sexual body always affects an individual's understanding of themselves. (Bildjuschkin & Ruuhilahti 2010; Ala-Luhtala & Valkama-Hietamäki 2016.)

Some women who have undergone female genital mutilation develop a negative body image, and they may be ashamed especially of their cut genitals. Problems related to sexuality caused by genital mutilation may prevent couples from

achieving healthy and satisfying sexual intercourse. This may result in frustration, sadness and, in the worst case, failure of the relationship. Due to sociocultural beliefs, a woman's sexual pleasure is not appreciated in certain communities, which makes it more difficult for women to enjoy sex openly. Sociocultural beliefs and traditions, including female genital mutilation, may be harmful for women's health and cause discomfort and pain during sex. (WHO 2018a.)

The possibility for erotic pleasure is part of sexuality. Sexual pleasure can also be experienced by caressing other body parts than the genitals, but the genitals are one of the most sensitive areas of the body. Interfering with the genitals harms the person's ability to enjoy having them touched. The cutting of a woman's genitals has been thought to control her libido. Mutilation may damage her tissues but also her personal ideas of a woman's right to sexual desire. (Bildjuschkin & Ruuhilahti 2010.) The post-traumatic stress reaction, pain and fear that a girl experienced as she was mutilated may be activated when she has sexual intercourse or already when she is planning it. (WHO 2018a.) Studies have found that genitally mutilated women are more likely to experience pain during intercourse and reduced sexual pleasure and desire than uncut women (WHO 2018a).

The objective of sexuality education is to make it clear for girls, boys and their parents what a woman's bodily sensations and her willingness and ability to experience pleasure are about. When bringing up sexuality, it should be remembered that, even though they are linked, sexuality and sex are two different things. A woman's sexual desire and pleasure are not defined by her genitals alone, as her sexual well-being consists of complex biological, psychological, sociocultural and interpersonal interactions. It would be a mistake to presume that all problems related to sexuality in communities practising FGM would be caused by female genital mutilation, as not all women who have undergone FGM have problems experiencing sexual pleasure. All people are sexual but not everyone has sex, and if they do, it should be something they have control over. (WHO 2018a; Klemetti & Raussi-Lehto 2013; Bildjuschkin & Ruuhilahti 2010.)

Women who have undergone FGM and who have problems with their sexuality and having sex have good possibilities of achieving a satisfying and pleasurable sex life once they have the necessary knowledge and skills. Usually, only the external genitals and the tip of the clitoris are removed in the female genital mutilation procedure, and plenty of tissue needed for sexual stimulation remains. Emotions

and psychological, sociocultural and interpersonal factors play an essential role in sexual wellbeing, and they can be influenced by means of support and counselling. The role of boys and men and their attitudes to FGM should also be addressed in sexuality education, and they should be offered information about the effects of FGM on the woman's ability to enjoy sex. (WHO 2018a; Sopu work 2018.)

Immediate health harms

The immediate health harms of female genital mutilation include severe pain and a neurogenic shock as well as bleeding which, if excessive, may lead to haemorrhagic shock and death. Genital mutilation may cause different types of infections, including infected wounds, a urinary infection, pelvic infections and septicaemia. Unsterilized instruments may cause viral infections, including HIV, hepatitis B and hepatitis C. The consequences may include genital tissue swelling, urinary problems including urine retention, problems in the healing of the wound and injury to surrounding genital tissue or other organs. As the girl is restrained, genital mutilation may also result in bone fractures and dislocations of limbs. (Banks 2006; Berg & Underland 2013; WHO 2018a&b.)

Long-term health harms

Long-term health harms caused by female genital mutilation include painful menstruation and urinary problems, such as urinary tract infections, urinary incontinence and painful urination. Mutilation may also cause faecal incontinence, chronic infections and consequences of scarring, including cysts and abscesses in external genitals, neuromas, keloids, inflexibility of tissues, retention of menstrual blood in the vagina and fistulae into the bladder and the bowel (WHO 2018a&b; Andro et al. 2014; Banks 2006). Such vaginal problems as discharge, itching and infections are typical in women who have undergone FGM. (Berg & Underland 2013.)

Research evidence indicates that genital mutilation may result in infertility and, especially in women who have undergone type 3 FGM according to the WHO classification, sexual intercourse may be impossible as the vaginal opening is too narrow. Other problems related to sexuality, such as fear of intercourse, painful intercourse and orgasm-related problems may occur. (WHO 2018a&b; Andro et al. 2014.)

Pregnancy and delivery

Monitoring women who have undergone FGM during pregnancy and labour may be difficult as performing a gynaecological examination is impossible. A prolonged second stage of labour, challenges associated with monitoring the foetus and the progress of labour, C-sections and tearing are more common in women who have undergone FGM than in other women. The incidence of transmission of chronic infections, including HIV or hepatitis B and C, from the mother to the child during delivery is also higher in FGM women than in others (Varol et al. 2016; Banks 2006; Wuest et al. 2009). Female genital mutilation has been estimated to be the cause of 1 to 2 additional neonatal deaths per 100 deliveries. Haemorrhage after delivery, need to resuscitate the newborn and the mother's extended hospital stay have been found to be more common in FGM women than in others. (Banks 2006). Other potential long-term health harms of female genital mutilation are a strong fear of childbirth and flashbacks to the mutilation as well as unwillingness to give birth again. (Banks 2006; WHO 2018a&b; Berg & Underland 2013).

4.2 Mental health of girls and women who have undergone female genital mutilation

Female genital mutilation is associated with psychological adverse effects and mental health problems. Usual causes for the traumatising experience are the pain and shock experienced during mutilation and the use of physical force by the practitioners. Psychological problems may also be caused by the physical and sexual health harms caused by FGM and surgical operations related to it, including deinfibulation. While the psychological adverse effects of female genital mutilation have not been studied extensively, they are known to vary considerably. The causation of psychological problems in girls and women who have undergone FGM may be influenced by such factors as the girl's socioeconomic status, cultural background, education, migrant status, the acceptability of the practice in the surrounding community, attitudes of healthcare representatives and legislation related to the practice. (WHO2018a&c.)

Immediate psychological harms of FGM are fear and stress. The most common long-term psychological problems in girls and women who have undergone FGM include a post-traumatic stress reaction, nightmares and sleeplessness. Female

genital mutilation may also lead to eating disorders, cognitive disorders and a low self-esteem. Other possible consequences are anxiety and depression. (Banks 2006; Berg & Underland 2013; WHO 2018a&c; Andro et al. 2014.)

The parents who have arranged the procedure may find it difficult to understand the effects of FGM on mental health. Parents often think that a young child will forget about it. They are not necessarily aware of the fact that a young child does not have the verbal skills for expressing what they have experienced and an ability to process the incident. Interfering with sensitive intimate body parts may leave a bodily trauma that affects the woman for the rest of her life. (O'Neill et al. 2017; Sopu work 2018).

4.3 Deinfibulation

Deinfibulation refers to an operation where the labia, which have been sewn together in connection with the genital mutilation, are separated so that the opening of the urinary tract and possibly remaining clitoral hood are revealed. So far, little reliable international research is available on deinfibulation, but based on the existing information, it has been found to improve the health and wellbeing of a girl or woman who has undergone FGM. After deinfibulation, passing urine becomes easier, urinary problems are usually alleviated, and menstrual blood can flow out of the vagina freely. The woman's sexual wellbeing has been found to improve as intercourse is easier and clitoral simulation becomes possible (Berg, Taraldsen, Said, Sørbye & Vangen 2018). Deinfibulation also makes it easier to monitor pregnancy and labour. The risks related to delivery caused by FGM, including prolonged labour, heavy haemorrhage, Caesarean sections and tearing are reduced by the deinfibulation equally regardless of whether deinfibulation is carried out during pregnancy or only in connection with the delivery (Berg & Underland 2013; Berg et al. 2018).

Deinfibulation is always recommended if the girl or woman has problems caused by genital mutilation (WHO 2018d). While deinfibulation may be carried out at any time, research evidence of the optimal time remains insufficient. In Finland, deinfibulation is recommended for young girls before they become sexually active or get pregnant. The most common time for deinfibulation is in connection with

delivery. Deinfibulation may also be arranged in connection with a Caesarean section. This is why it is important that a woman pregnant with her first child is referred to the outpatient maternity clinic during her pregnancy to discuss her options. If conducting internal examinations is difficult, deinfibulation should already be carried out during the second trimester to facilitate the monitoring of labour. (Kuismanen, Hautala, Pietiläinen, Raussi-Lehto & Jakobsson 2018.)

As a procedure, deinfibulation is simple and fast. It is usually carried out as an outpatient procedure using laser surgery or a diathermic technique and a local anaesthetic. Recovery usually takes a few days. Deinfibulation is not socially accepted in all communities by women, their husbands or the community in general. This is why deinfibulation has been experienced more acceptable in connection with delivery, as it can be justified by making childbirth easier and delivery safer for the newborn. (Berg et al. 2017.)

A woman going in for deinfibulation and her husband should be informed sufficiently about how the procedure will be carried out, and they should be shown pictures of what the end result will look like. In case of an underage girl, deinfibulation should also be discussed with her parents, and they should be informed sufficiently about the physiological changes it brings. If the girl is capable of making decisions on her treatment, considering her age and level of development (as a rule, aged 12 or over), and she does not want her parents to know, she has the right to prohibit access to information about her treatment to her guardians. (Act 785/1992.) If deinfibulation is carried out in connection with delivery, it should be explained to the mother that she will have a deinfibulation procedure during the delivery, and that once deinfibulated, her labia will not be sewn together again.

In the case of unmarried girls, the parents have sometimes asked for a medical certificate stating that deinfibulation has been carried out for physiological reasons to allow them to prove to the girl's future husband and his family that she is a virgin. Issuing so-called virginity certificates has not been considered ethical in Finland, or considered to promote women's rights. Today the client can herself print out a summary of any procedures, including deinfibulation, from the Kanta service. The physician can record physical problems as the cause of the procedure, which shows that it was not carried out due to problems with intercourse.

In the case of adult asylum seekers applying for international protection and victims of trafficking in human beings, deinfibulation may be one of the health services assessed as essential by a healthcare professional referred to in the Act on the integration of immigrants and reception of asylum seekers. Whether or not the treatment is essential is based on an individual assessment, which is affected by many factors, including the patient's illnesses, symptoms and personal preference. Factors related to the processing of the asylum application, such as the expected length of stay in the country in relation to recovery from the procedure and any rehabilitation required, may also affect the assessment of whether or not the treatment is essential. Deinfibulation may be carried out during the asylum process before a decision on a residence permit has been made. Minor asylum seekers and victims of human trafficking are entitled to treatment on the same grounds as the residents of the municipality. If she is returned to her home country after being denied asylum, the situation of an unmarried girl should also be taken into account when making a decision. Under the Health care act, undocumented migrants have the right to treatment assessed as urgent by a health care professional. Based on an individual assessment, deinfibulation may be considered an urgent treatment. Some municipalities and cities offer health services going beyond urgent treatment to undocumented migrants, and deinfibulation may be included in these services. (Act 1062/1989; Act 559/1994; Act 1326/1326; Act 746/2011.)

4.4 Reconstructive surgery

Post-FGM reconstructive surgery refers to a procedure where an attempt is made to reconstruct the mutilated genitals to resemble normal female anatomy. Removal of scar tissue and reconstruction of the labia and clitoris are a key part of the surgery. Tissue is pulled out from inside the pelvis minor, making it possible to shape new labia and a clitoris from the remaining tissue. The main objective of reconstructive surgery is improving the woman's sexual wellbeing and finding her ability to experience pleasure, but supporting her sexual identity and womanhood and building up her self-confidence also play an essential role.

So far, little reliable research evidence is available of the outcomes of reconstructive surgery. The international research that does exist indicates that reconstructive surgery could improve sexual functional capacity and reduce vulvodynia (complex

and problematic pain in the genitals and/or pelvic area) and pain during intercourse (Abdulcadir, Rodriquez & Say 2015b). On the other hand, there is also research evidence pointing to complications of these procedures, including repeat surgery, reduced clitoral sensitivity and absence of orgasms (Abdulcadir et al. 2015b). In France, the procedure has been covered by health insurance since 2004, and in other Western countries and parts of Africa, it has been advertised increasingly in recent times (Abdulcadir, Rodriquez & Say 2015a; Foldes 2012; Berg et al. 2017). Due to the lack of research evidence, WHO does not recommend reconstructive surgery. Recommending reconstructive surgery may lead to excessive and unrealistic expectations of its benefits. Additionally, the procedure is still only available in a small part of the world. (WHO 2016.) At the time this Action Plan was written, reconstructive surgery was known to be performed in Finland at Töölö Hospital in Helsinki.

Before reconstructive surgery, the client should always be given extensive counselling concerning female genital mutilation, female anatomy and physiology as well as sexuality. At the time of and after the surgery, psychosocial assessment, support and monitoring are also important. (Abdulcadir et al. 2015a).

5 Objectives and measures of the Action Plan

5.1 Preventive work

WHO calls for wider international involvement, monitoring, revised legal frameworks and political support for ending female genital mutilation (WHO 2018b). Additionally, sufficient resources (human and financial) need to be foreseen when designing policies and funding programmes so that prevention actions can be continued, specialised services can be set up and/or maintained, professionals can be trained, and research on female genital mutilation can be undertaken (EIGE 2015a.)

As FGM is a phenomenon with strong cultural links, trained cultural interpreters should be used in Finland in work carried out among communities practising FGM. It is easier for a person sharing the same cultural background to talk about FGM in a culturally sensitive manner to the clients, and accepting information from a person with a similar cultural background has been found to be more natural. A cultural interpreter refers to a trained professional who is well familiar with the cultures of both parties and who not only translates between the languages but also interprets the culture of the country they live in for persons with an immigrant background, and the culture of persons with an immigrant background to professionals in the country they live in, thus serving as a bridge between two persons with different cultural backgrounds. Assisted by a cultural interpreter, the parties find it easier to understand each other, for example at social work meetings. Cultural interpreters support immigrants with their integration in Finland and help Finnish people understand immigrants' culture and experiences. Cultural interpreters often also have personal experience of migration. When discussing sensitive subjects, such as

female genital mutilation, a cultural interpreter may assist the parties in achieving a mutual understanding, but the responsibility for the effectiveness of the discussion is always carried by the professional. (Castaneda et al. 2018; Heino & Kärmeniemi 2013; Heino, Kärmeniemi & Veistilä 2014.)

Healthcare

In universal services designed for the entire population, for example maternity and child health clinic services and school healthcare services, it is particularly important to strive to ensure a continuous client relationship with a client at risk of FGM, which also has a significant impact on establishing a trustful relationship. Asylum seekers are also entitled to maternity and child health clinic services, and in their case the contact person of the health services is the nurse at the reception centre. When a client is pregnant, she should be offered the possibility of meeting a maternity clinic physician already in an early phase of her pregnancy.

Especially to clients originating from countries where FGM is practised, home visits from the maternity clinic following childbirth and, potentially, home visits intended to promote early interaction already during the pregnancy should be offered. Home visits are part of maternity clinic work under the Government Decree on maternity and child health clinic services, school and student health services and preventive oral health services for children and youth (338/2011), and they offer a good opportunity for meeting the entire family and having discussions with them.

Under the Decree, all pupils are entitled to regular annual health examinations as part of school health care. During a pupil's time in basic education, three of the examinations (in grades 1, 5 and 8) should be so-called extensive health examinations, to which not only the pupil but also both her parents are invited and during which the family meets the school physician. Additionally, the pupil has the possibility of meeting the public health nurse and the physician privately. In school health care, it should be ensured that the annual regular health examinations are carried out on girls at risk of FGM. Under the Decree, an attempt shall be made to establish the support needs of pupils who fail to attend the examinations and, in the case of an underage pupil, his or her family shall be contacted. (Decree 338/2011). If the school finds it necessary to convene an individual pupil welfare group referred to in the Student welfare act when suspecting that a pupil is at

risk of FGM, it is a statutory requirement to also always invite the parents of an underage pupil and the pupil herself to individual pupil welfare meetings (Act 1287/2013).

Social work

Bringing the subject up with clients originating from countries where FGM is practised in child welfare services and other social work is an important part of FGM prevention. A professional who meets families with young children in their work should bring female genital mutilation up when encountering families coming from regions where FGM is practised. In immigrant reception work, families should already be informed of the Finnish legislation and the prohibition of FGM as they enter the country. It is vital that FGM is brought up in an early stage, rather than when it is already suspected that a girl may be at risk of genital mutilation. Anticipatory intervention is required of social welfare authorities under the Child welfare act. In FGM prevention, this intervention should comprise identifying children and young women who are potentially at risk. Child welfare services carry out an assessment of service needs, based on which the family may be granted social services as community care support measures. If genital mutilation threatening a girl cannot be prevented by means of support measures provided in community care, the girl may ultimately be taken into care. (Act 417/2007; Ministry of Social Affairs and Health 2012; Act 1301/2014.)

After receiving a child welfare notification, a social worker should immediately assess the need for urgent child welfare measures pursuant to section 26 of the Child welfare act. The need to proceed to child welfare measures must be decided within seven days. A social worker from child welfare services should assess the required child welfare measures. Child welfare services will also assess if, in view of the child's best interest, an investigation request should be made to the police. If the assessment points to a need for an investigation request, the child welfare services will make it. The necessity for an investigation request is assessed on the same grounds as in other cases of suspected assault. A lawyer should also be consulted where possible.

Not informing the parents of the child welfare notification is possible if the matter is urgent or if this is necessary for some other reason. Such reasons may include putting the girl's safety at risk. The child must be taken into care if their health and

development are at serious risk and community care measures are not possible or sufficient. A girl may also be taken into care if her genitals have already been mutilated and this is required in the interest of her psychological or physical health. (Act 417/2007; Ministry of Social Affairs and Health 2012, 20; National Institute for Health and Welfare 2016b.)

Non-governmental organisations

Such NGOS as the Finnish League for Human Rights and African Care work actively to prevent female genital mutilation in Finland. The impacts of preventive work carried out in Finland extend outside the national boundaries. Information on the health harms of the practice and its nature as a human rights violation spreads to the countries of origin of immigrants coming from regions where FGM is practised, and this may also help to eradicate the tradition. Such NGOs as the International Solidarity Foundation and World Vision focus on reducing the prevalence of FGM globally while carrying out awareness campaigns and fundraising in Finland.

Projects

Projects carried out in different parts of Finland strive to intervene in FGM through different activities. For example, while the Action Plan was being drafted, a project titled MARJAT was ongoing in Turku (2017–2019). It supported the integration of immigrants arriving in Finland by promoting their health and wellbeing. As part of this project, a plain language guide on female genital mutilation was produced (Tähtinen et al. 2018). In Tampere, a three-year project titled Niitty was launched in 2018 together with Tampere University of Applied Sciences and the City of Tampere on support from the EU's Asylum, Migration and Integration Fund. The objective of the project is to develop a peer-led family coaching model for third-country citizens. This project also addresses female genital mutilation.

In Helsinki region, Loisto Setlementti has an established work form, Sopu, aiming to prevent conflicts and violence related to ideas of honour in families and communities, to carry out crisis and client work and to provide training. The Bahar project carried out in parallel with Sopu work has the objective of supporting young people and young adults who are forced to leave their families and communities because of honour violence. (Sopu work 2018.)

Metropolia University of Applied Sciences is a participant in the Childbearing Migrant Women in Europe project (WoMBH), which focuses on promoting the health of immigrant women before, during and after childbirth and also touches on female genital mutilation.

Early childhood education and care, schools and educational institutions

Preventive work in early childhood education and care should begin early and before concerns over a girl's circumcision are raised. Early childhood education and care professionals bring up FGM in a culturally sensitive manner in discussions about the child's ECEC plan with parents in whose countries FGM is practised. The role of early childhood education and care in FGM prevention is to work in multidisciplinary cooperation with the child health clinic and, if necessary, child welfare services or other social welfare actors. Supervisors should ensure that the staff have sufficient competence and any support that may be necessary for having discussions about female genital mutilation. Participants in this discussion may include educational staff of the child group, a special kindergarten teacher, a family worker or the operating unit supervisor. Where possible, the discussion could also be attended by a public health nurse and/or a social worker. The safety manual of early childhood education and care should include operating instructions related to preventing female genital mutilation.

The FGM theme should be incorporated in health education at schools. Additionally, it would be important to consider how the subject could be brought up with children below school age – even before they reach the age at which girls' genitals commonly are mutilated in their countries of origin. Parents originating from countries where FGM is practised usually cannot talk about the issue, and some may wish to conceal the true nature of the tradition to stop the girl from talking about it, for example at school. Sometimes the parents may also talk about it as an honoured rite of passage which the girl expects respectfully. On the other hand, a child's worries about future should not be unnecessarily exacerbated by scaring them with talk about violence. Suitable opportunities for bringing up the subject could include different events, including health lectures at mosques, churches and temples, groups or clubs for children from countries where FGM is practised at school, and integration training for asylum seekers. (UEFGM 2016.)

The reception system

The social welfare and healthcare team at the Finnish Immigration Service's Reception unit steers, plans and supervises the activities and sees to the training of social welfare and healthcare professionals working at the reception centre. Nurses at the reception centres assess the need for urgent and essential care and consult the social welfare and healthcare team at the Finnish Immigration Service's Reception unit. At the reception centres, nurses carry out initial health examinations and provide initial health information. The reception centres should check that the FGM theme is included in the initial information given to the clients and that the professionals follow the recommendations in their work. A question about female genital mutilation should be included in the initial health examination of both adults and children. If necessary, a client who has undergone FGM should be referred from the reception centre to specialised medical care for deinfibulation.

The asylum process

If it is considered during the asylum process that the applicant has justified reasons to fear female genital mutilation, asylum is granted to her, unless it is possible to avoid this risk by resorting to protection by the authorities or internal flight. When processing applications, up-to-date country information regarding the prevalence of FGM in the applicant's region of origin, legislation on FGM in the country of origin, the applicant's possibilities of receiving protection from the authorities, and her possibilities of moving to another region within her home country will always be taken into consideration. The authorities take initiative in asking minor applicants about the risk of FGM if, based on information on her country of origin, it is known that FGM is practised in the applicant's region of origin or population group. (Act 301/2004; Act 746/2011; Finnish Immigration Service 2015; Finnish Immigration Service 2018; UNHCR 2009.)

The Finnish Immigration Service's Asylum unit together with the nurses at the reception centres have prepared a brochure handed out to applicants. It explains that female genital mutilation is prohibited in Finland and that the risk of FGM may be grounds for being granted asylum. The brochure encourages the applicant to ask for a medical report and to take the initiative in the asylum interview to tell the authorities if she is afraid of being mutilated or continues to experience serious physical or psychological symptoms because she has already undergone FGM. (Finnish Immigration Service 2015; Finnish Immigration Service 2018.)

A statutory initial health examination is carried out on all asylum seekers who have entered the country, in connection of which they are asked about their sexual and reproductive health and any FGM procedure they may have undergone or be at risk of (Act 746/2011; Finnish Immigration Service 2018). If, before the asylum interview takes place, it is known that the applicant is applying for asylum on grounds related to FGM or some other gender sensitive issue, the interpreter's gender and the sensitive nature of the subject should be taken into account when booking the interpreter as far as possible (Finnish Immigration Service 2018; Finnish Treaty Series 53/2015). If it is found during the asylum process that the applicant is in a vulnerable position and thus needs special procedural guarantees and an assistant, the Asylum unit will contact the reception centre to organise an assistant for the applicant (Act 746/2011). The assistant should also have up-to-date competence regarding the nature of FGM as a human rights violation, the legislative perspective and the professional's notification duty.

The police, prosecutor and courts

The police, the prosecutor and the courts work to implement criminal liability for female genital mutilation in cooperation with various parties. The criminal justice system serves to prevent FGM at the national level by implementing legislation that prohibits female genital mutilation.

Media

The role of the media in preventing FGM should not be overlooked. In 2016, international actors produced guides for media representatives on discussing female genital mutilation (UNFPA-UNICEF 2016; End FGM EU 2016). The media often focus on stressing the suffering of FGM victims; regardless of the good intentions, this increases the distance between the community practising FGM and the mainstream population. Alienation of the community practising FGM undermines the measures and support intended for supporting and assisting its members. What makes female genital mutilation a particularly difficult topic is that those who practise FGM do not usually wish to harm their child by this act. In most cases they believe that the genital mutilation of girls will lead to a better life for the child in terms of health, starting a family and becoming a full member of the community. The media plays a key role in raising awareness of the consequences

of FGM both among communities practising it and the general public. (UEFGM 2016; UNFPA-UNICEF 2016; End FGM EU 2016.)

Discrimination is less likely where there is empathy towards the victim. In this process, the media may play a significant part. While it is easy to feel empathy for young girls who have undergone cutting, having compassion for the parents or relatives who wish to subject a girl to genital mutilation is much more difficult. The challenge to the journalist is to elucidate the conflicting motives of parents, families and communities when making decisions on female genital mutilation. The victim–perpetrator framework complicates attempts to understand the tradition and thus hampers collaboration aiming to end the practice. Journalists should also avoid creating an 'us against them' or 'here vs. there' setting, which may alienate and stigmatise families, especially recently arrived immigrants. (UEFGM 2016; UNFPA-UNICEF 2016.)

Care should be taken when using pictures in news or other media reports on FGM. The images should not create or reinforce negative stereotypes concerning communities that practise FGM. For example, photographs of instruments used in the procedure may trigger traumas in those who have undergone FGM or lost a loved one because of it. The images may also have a paralysing and isolating effect on communities practising FGM and their members, and they may discourage the reporting of actual cases to the authorities and reduce the community's willingness to discuss the subject openly. (UEFGM 2016; UNFPA-UNICEF 2016.)

The social media offers a unique way of communicating between continents on real time and without limitations. It provides an open space where those who have undergone FGM can receive and share information and support and empower themselves to talk about the consequences of female genital mutilation. Many NGOs focusing on FGM prevention are already using the social media effectively in their campaigns and, for example, good online training packages are available on the websites of different actors (Socialstyrelsen 2015, UEFGM 2016, Health Education England 2018).

OBJECTIVE

Health services, social work, early childhood education and care, education, the police, the reception system, NGOs and the media will continue efforts to prevent FGM.

Actions:

- The counties/hospital districts will ensure sufficient resources for preventive healthcare, facilitating continuous client relationships, home visits and regular health examinations at maternity and child health clinics and in school health care. The municipality's health services will ensure that primary health care services complete the actions listed above.
- Decision-makers in municipalities will allocate sufficient resources to municipal social services, making it possible to bring FGM up at least once with clients originating from countries where FGM is practised and to proceed to the child welfare actions indicated in the guidelines if necessary.
- Municipalities with large numbers of residents originating from countries where FGM is practised will ensure that each unit has at least one professional responsible for preventing FGM with sufficient training for managing this role. These units include health centres, maternity and child health clinics, school healthcare, social services, early childhood education and care, reception centres and asylum units.
- Decision-makers will ensure that NGOs and projects are given sufficient support allowing them to continue their preventive work.
- Early childhood education and care, schools and parties organising club activities will take talking about FGM into consideration in their activities.
- Means of preventing female genital mutilation will be developed and implemented in grass-roots level projects.
- In client work, trained cultural interpreters will be used to improve interaction and mutual understanding.
- International guidelines on sensitive and respectful discussion of female genital mutilation will also be followed in Finland.

5.2 Ensuring sufficient training

All those who encounter persons originating from countries where FGM is practiced in their work should receive sufficient training on female genital mutilation, its health harms, talking about the subject, the nature of the practice as a human rights violation, the legislative aspects and the professional's notification duty. FGM prevention is part of competence in intimate partner and domestic violence prevention, child protection and sexual and reproductive health. Professionals have the duty to maintain and develop their competence and good practices related to them on their workplaces, for example by seeing to the induction training of new employees and keeping instructions up to date.

The theme of FGM should be brought up at national training events targeted at professionals of healthcare, education, social, immigration and youth work as well as the police. Events related to child protection, early childhood education and care, teacher education, maternity and child health clinic work, and social work research as well as those intended for public health nurses, midwives, nurses and physicians are forums where the subject should be discussed.

Education and research organisations should see to sufficient training of students in the relevant fields and those attending in-service training, the production of the required materials, and the provision of up-to-date research evidence to support development actions and training. Female genital mutilation should be included as a separate topic in basic studies in healthcare and social welfare fields. Including the topic in vocational textbooks and the learning contents of the relevant fields should be ensured. Additional and in-service training on FGM should also be offered for those who need it.

The topic should also be included in health education teaching content and textbooks for higher comprehensive schools and general upper secondary schools. In national core curricula and qualification requirements, the topic is seen more extensively as learning outcomes on the basis of which teachers prepare and use their teaching methods. Incorporating FGM in curricula should be investigated further.

In autumn 2018, the National Institute for Health and Welfare produced an online training package on encountering girls and women who have undergone FGM and

the risk of FGM for social welfare and healthcare professionals (https://verkkokoulut.thl.fi/web/monikulttuurisuus).

OBJECTIVE

The FGM theme will be included in vocational education and training, and schools will also be encouraged to discuss it in basic education.

Actions:

- Universities of applied sciences, universities and other vocational education and training providers will ensure that the FGM theme is incorporated in the curricula in the fields of social welfare and healthcare, education and police work. The online training produced by the National Institute for Health and Welfare will be used in the instruction, and a dedicated teaching package developed for this purpose will be used for training physicians.
- Universities of applied sciences, universities and other vocational education and training providers will develop additional and in-service training on the FGM theme and undertake to offer it to the students.
- Universities of applied sciences, universities and other vocational education and training providers will draw on NGO competence and use NGOs as training providers.
- Parties responsible for teaching will be encouraged to integrate the theme in the health education curricula for basic education and general upper secondary schools, and larger packages on the theme will be offered for health education textbooks.
- Supervisors and leading office holders will enable professionals' participation in continued, additional and/or in-service training related to FGM.
- Teachers in the social welfare and healthcare field will systematically obtain in-service training on FGM and ensure that their knowledge is up to date.
- Parties responsible for national training events will include FGM in the training contents.

- The National Institute for Health and Welfare will participate actively in FGM information activities at national training events and in professional journals.
- The online training on FGM produced by the National Institute for Health and Welfare will be used as a foundation for vocational education and training and in-service training.
- The Ministry of Social Affairs and Health will secure sufficient resources for the National Institute for Health and Welfare, making it possible to carry out the actions listed above.

5.3 Maintaining and developing professionals' competence

As indicated by their tasks, professionals who encounter clients originating from countries where FGM is practised must have the competence they need to prevent female genital mutilation, understand their notification duty when a girl is at risk of FGM or mutilation has already taken place, and refer the client to treatment and deinfibulation if necessary. At the local and regional level, the municipalities are responsible for sufficient training provision and the up-to-date competence of their employees related to the prevention and treatment of female genital mutilation. The Finnish Immigration Service trains personnel at all reception centres and supervises the reception activities. The FGM theme should be part of the vocational competence of each person working in reception activities. Supervisors should enable sufficient access to training for professionals and reserve time for familiarisation with the theme, for example online. Professionals should have the possibility of consulting other professionals across sectoral boundaries and opportunities for regional networking.

Social welfare and healthcare professionals, in particular, should have a clear and easy-to-use risk assessment model at their disposal, and instructions for submitting reports of an offence and child welfare notifications (Baillot, Murray, Connelly & Howard 2018)(Appendix 2,3,4). The police, on the other hand, are responsible for investigating criminal offences. Media representatives should pay more attention to the sensitive nature of the theme and utilise their potential for promoting FGM prevention.

All those who work with families with children have the duty to bring up and prevent female genital mutilation, whether they work in such healthcare service systems as maternity and child health clinics, in school and student healthcare or social work, or corresponding private services. Female genital mutilation must be brought up with and the Finnish legislation must be explained at least once to those clients who originate from countries where FGM is traditionally practised. A girl's or a woman's FGM status will be established by means of discussion and/or examination by a public health nurse, nurse, midwife and/or physician at the initial examination after entry in Finland, in school health care, or at a child health clinic, maternity clinic, hospital or health centre. The subject can be naturally discussed with parents and they can be informed of it in connection with maternity and child health clinic visits, for example.

Professionals must be able to adopt a culturally sensitive approach and protect the dignity and privacy of clients who have undergone FGM in care and examination situations. Especially paediatricians and gynaecologists should be able recognise female genital mutilation carried out on a girl or a woman and the extent of the procedure. It is important to enter information on female genital mutilation in the patient records and maternity card and to report it to the Medical Birth Register. Healthcare personnel should know how to care for pregnant FGM women and offer deinfibulation to all girls and women who have undergone female genital mutilation. If necessary, follow-up treatment will also include psychological support.

If a girl or a woman has problems caused by genital mutilation and she would like a deinfibulation procedure, it can be carried out even if she did not yet have a permanent residence permit in Finland if the physician treating her considers it necessary. If plans to perform female genital mutilation are suspected, the threshold for submitting a report to the police and a child welfare notification should be low. The police and child welfare authorities should also be notified if it is suspected that genital mutilation was carried out while the girl was living in Finland, even if the procedure had taken place some time ago. Female genital mutilation would probably be classified as aggravated assault in Finland, in which case the statute of limitations would be twenty ears. The police may request executive assistance from the Border Guard, for example to prevent exit from the country if a girl is being taken out of Finland for genital mutilation. The Handbook of child welfare contains instructions on what the child welfare services should do

and how the cooperation should be arranged in these situations (https://thl.fi/fi/web/lastensuojelun-kasikirja).

Awareness of female genital mutilation as a phenomenon and its special characteristics as a criminal offence, including international human rights obligations and legal practice related to FGM, should be built up among the police, the prosecutor and the courts. A suspected offence against a child is investigated in interauthority cooperation, where the pre-trial investigation of the offence is led by the police. The police will request for the examinations and statements required to investigate the potential offence from the social welfare and healthcare authorities. When a case of female genital mutilation comes to light the relevant authorities, or the police, the prosecutor and the courts, will each for their part ensure that the suspect will be prosecuted and that the persons who perpetrated female genital mutilation will be brought to justice.

OBJECTIVES

Professionals' competence related to female genital mutilation will be kept up to date and built up continuously. Professionals will have access to up-to-date guidelines on helping a person at risk of or having undergone FGM.

Actions:

- The different ministries working together and leading office holders, elected officials and political decision-makers will secure sufficient resources for organising training and enabling professionals to participate in it.
- Leading office holders, elected officials and political decision-makers will ensure that Finnish municipalities and cities have up-to-date guidelines on preventing female genital mutilation, which have also been included in regional crisis response and operating models.
- Professionals encountering in their work girls and women who are at risk of or have undergone FGM will know how to, as indicated by their roles, talk about and prevent female genital mutilation, act when coming across a girl at risk of FGM, and refer a client who has undergone FGM to treatment and deinfibulation, if necessary.

- The stress caused to professionals by situations related to FGM will be taken into account, and the employer will offer them opportunities for debriefing and work instruction to deal with psychologically stressful situations.
- Supervisors in social welfare and healthcare, early childhood education and care, schools, the reception system and the police will ensure that all professionals on these workplaces have access to up-to-date guidelines on what to do when coming across a girl at risk of FGM and where to find help and support for this situation.
- Supervisors will enable professionals to attend training related to the theme and reserve time for familiarisation with it. All professionals encountering the FGM theme in their work should complete the online training produced by the National Institute for Health and Welfare as a minimum level of training on female genital mutilation. Supervisors will ensure that professionals have the possibility of consulting other professionals across sectoral boundaries and opportunities for regional networking.
- NGOs' competence as instruction providers will also be utilised to maintain professionals' competence.
- Professionals will keep their competence related to female genital mutilation up to date, obtain additional information about it, participate in training and also share information with their colleagues in their work organisations.

5.4 Production and collation of material

Up-to-date material based on research evidence is needed to carry out preventive work. The National Institute for Health and Welfare has previously produced written instructions on female genital mutilation (an FGM brochure, a Know and Act card, a website, content for the Handbook of child welfare), and the Finnish Immigration Service has produced a brochure for asylum seekers. NGOs have also contributed to producing material (the Finnish League for Human Rights, African Care). In recent years, projects focusing on immigrant wellbeing have also produced different guides and brochures related to female genital mutilation in form of theses (Ryhänen et al. 2016; Tähtinen et al. 2018).

Plenty of international material is available, and it should be followed up and used in Finland as far as possible.

OBJECTIVES

Material to support FGM prevention will be produced in Finland and updated at sufficiently frequent intervals. Material will be available in a sufficient number of languages, including plain language, and it will be easily accessible to users.

Actions:

- The National Institute for Health and Welfare will update the brochures on FGM prevention and produce different language versions of them in cooperation with NGOs.
- The National Institute for Health and Welfare will maintain a website related to FGM prevention at: thl.fi/silpominen
- The National Institute for Health and Welfare will maintain its online training for professionals
- The Ministry of Social Affairs and Health, the Finnish National Agency for Education, the Ministry of Justice, the Ministry of the Interior, the Ministry of Economic Affairs and Employment, the Finnish Immigration Service, vocational education and training organisations, trade unions and NGOs carrying out grass-roots level preventive work will share on their websites the link to the National Institute for Health and Welfare's website as a source of additional information
- NGOs working with FGM prevention will also actively produce new material consistent with the Action Plan for FGM.

5.5 Influencing attitudes among communities practising female genital mutilation

Grass-roots level work will be needed to change attitudes among communities originating from countries where FGM is practised. This work should be carried out among both men and women and also target different generations. Work carried

out by experts originating from countries where FGM is practised is particularly valuable, as they can discuss difficult issues related to female genital mutilation in their native language. They can also reach people who would not otherwise necessarily be within the scope of the services. Communities can be influenced through immigrant organisations and other NGOs that carry out projects related to immigrants' sexual and reproductive rights and health and the promotion of rights to self-determination. This includes information activities in the immigrants' languages and discussion events. An important role is also played by key persons originating from countries practising FGM and in religious communities, including religious leaders, through whom a change in attitudes can be promoted. Long-term investments in cooperation are needed in order to influence communities' attitudes. (Baillot et al. 2018.)

OBJECTIVES

The attitudes of communities originating in countries where FGM is practised will be influenced, especially through their key persons, including religious leaders and other role models.

Cooperation in work to prevent FGM between different NGOs, between NGOs and the authorities, and between the authorities and communities practising FGM will be stepped up.

Actions:

- When granting support for NGOs, the ministries and political decision-makers will take into account work focusing on FGM prevention.
- NGOs will invest in FGM prevention, guide grass-roots level activities and use experts originating from countries where FGM is practised. Such information sources as the material produced by the National Institute for Health and Welfare can be used to support the work to influence attitudes.
- The NGOs will reach out to key persons in communities originating from countries where FGM is practised and focus on involving them in the work to change attitudes.
- The Ministry of Social Affairs and Health and the National Institute for Health and Welfare will invite representatives of groups originating from

countries where FGM is practised and NGO representatives to an annual FGM/C working meeting, thus enabling discussions between community members, professionals and others working on the theme. Community representatives will also increasingly be invited to work together with the authorities.

5.6 Promotion of research

Producing and following the most recent national and international research evidence on female genital mutilation will be important in order to target preventive actions correctly. Two doctoral dissertations on this theme are being written in Finland. One of them deals with immigrants' attitudes towards FGM and awareness of its health harms (Mohamed 2018), while the other discusses young men's agency in work to prevent FGM in Somaliland (Väkiparta 2018).

Research evidence is also needed as the foundation for training and other materials. In recent years, a number of theses relevant to female genital mutilation have also been produced in Finland. Universities of applied sciences and universities are encouraged to guide students of different disciplines (including social sciences, anthropology, medicine, nursing science) to produce theses and studies on topics associated with and touching on female genital mutilation. Research on the following topics, among other things, is called for: effectiveness of the service system, the scale of FGM as a phenomenon in Finland, the need for reconstructive surgery, as well as men's attitudes and their impact on FGM. Several survey projects that also contain questions about female genital mutilation are currently underway in Finland. In a near future, register data will also be available in Finland on the prevalence of FGM, as the first data collections of the Medical Birth Register and the Care Register for Health Care are completed. Finnish researchers and experts of the field should also follow international research and participate in international networks, including the FOKO network. The European Institute for Gender Equality (EIGE) and End FGM EU, for example, disseminate the latest research evidence and organise training and meetings on the subject. Applications for research funding can be addressed to such providers as the Academy of Finland, Appropriations for health promotion, the SOLID funds, EU funding, Nordic funding sources and foundations.

OBJECTIVE

Research on female genital mutilation will be carried out, international research will be followed, and cooperation with international researchers and networks will be maintained in Finland.

Actions:

- Scientific communities will be encouraged to conduct further research on FGM and phenomena associated with it in Finland.
- Universities of applied sciences, universities and other vocational education and training providers will encourage students of different disciplines to produce theses and studies on topics related to and touching on female genital mutilation.
- The ministries will ensure sufficient funding for research and expert work on female genital mutilation.
- Researchers will follow international research and scientific discussion in this field.
- Researchers and experts will participate in international cooperation aiming to prevent FGM.
- Educational and research institutions will enable researchers' and experts' participation in international cooperation to prevent FGM.

5.7 Development of cooperation and coordination

The division of duties and cooperation between different actors should be developed to improve the efficiency of measures aiming to prevent female genital mutilation, to eliminate overlaps and to share good practices at the national level. In the previous Action Plan for the prevention of circumcision of girls and women, municipalities were guided to produce guidelines on FGM prevention, which were to be incorporated in regional crisis response and operating models (including the health promotion model, wellbeing plan for children and young people, action plan on preventing intimate partner and domestic violence). These guidelines should be updated or, if they do not exist yet, they should be created. In particular,

it should be ensured that all those dealing with this issue have access to up-to-date instructions on what to do if they encounter a girl at risk of FGM. Municipalities with large numbers of immigrants have been tasked to create local and regional structures related to immigrants' health and wellbeing, and these models and plans were to also cover the theme of female genital mutilation. The final evaluation of the previous Action Plan revealed that many municipalities had created FGM cooperation networks. Such structures should be created in municipalities that do not have them as yet.

At the local and regional level, the municipalities are responsible for guidance by information and self-monitoring related to the Action Plan, as well as ensuring that their employees have sufficient training on preventing female genital mutilation. Finland should participate in international cooperation aiming to prevent FGM at the level of public servants, researchers and NGOs, and the ministries should provide the resources that make this possible.

OBJECTIVE

Cooperation, division of duties, responsibilities and information exchanges associated with FGM prevention between different actors will be improved.

Actions:

- Leading office holders, elected officials and political decision-makers will ensure that municipalities and regions with large numbers of residents originating from countries where FGM is practised have operating models and cooperation networks for preventing FGM at the municipal and regional level.
- Once a year, the Ministry of Social Affairs and Health together with the National Institute for Health and Welfare will convene an FGM working meeting, to which key contact persons of different actors will be invited to exchange information and engage in cooperation (of the Ministries, the Ministry of Social Affairs and Health, the Ministry of the Interior, the Ministry of Economic Affairs and Employment, the Ministry of Education and Culture, the Ministry of Justice and the Ministry for Foreign Affairs, as

well as the Finnish Immigration Service, the National Institute for Health and Welfare, the Finnish National Agency for Education, social welfare and healthcare services, education and youth services, reception centres, the police, universities of applied sciences and universities, NGOs, and immigrant and religious communities).

- The ministries will work together to support international cooperation aiming to prevent female genital mutilation.
- The guidelines on FGM prevention will be incorporated in the municipalities' crisis response and operating models, and the municipalities will have local and regional structures which also address female genital mutilation.

5.8 Information activities and launch of Action Plan implementation

The Ministry of Social Affairs and Health will assume responsibility for national information activities regarding the Action Plan together with the National Institute for Health and Welfare. At the local and regional level, the Action Plan assigns responsibility for guidance by information and self-monitoring related to its implementation to the municipalities. Rather than allocating the municipalities a separate appropriation for implementing the Action Plan, its implementation will be based on the imputed central government transfers to local authorities as so-called normal activities. Different providers can be applied to for separate funding for research.

OBJECTIVE

Information about the Action Plan will be disseminated as widely as possible at the national level, and guidance by information and self-monitoring related to it will be organised.

Actions:

- The Ministry of Social Affairs and Health will distribute the Action Plan to the other ministries, the Association of Finnish Local and Regional Authorities, the Regional State Administrative Agencies, the Finnish Immigration Service, the hospital districts, the municipalities' social welfare and healthcare services, educational institutions, key NGOs, immigrants' associations and religious communities.
- The Ministry of Social Affairs and Health, the Ministry of Justice, the Finnish National Agency for Education, the Ministry of Education and Culture, the Ministry of the Interior, the Ministry of Economic Affairs and Employment, the Finnish Immigration Service, the Finnish Union of Public Health Nurses, the Federation of Finnish Midwives and the Finnish Society of Obstetrics and Gynaecology as well as NGOs will distribute the Action Plan on their websites.
- The National Institute for Health and Welfare will produce articles and press releases on the Action Plan and the new materials for professional journals.
- The National Institute for Health and Welfare will disseminate information about the Action Plan online.
- The municipalities will see to guidance by information and self-monitoring related to the Action Plan.

5.9 Promoting the sexual and reproductive health of girls and women who have undergone genital mutilation

Gynaecological health

Female genital mutilation causes many gynaecological problems, which may emerge months or years after the procedure. In a client who has undergone FGM, healthcare professionals should consider the possibility of the following problems: chronic vaginal pain (vulvodynia), clitoral neuromas, vaginal infections, menstrual pain and discharge problems, urinary tract infections, pain when urinating and other urinary problems, and epidermoid cysts and keloids in the genital area. (WHO 2018a.)

Girls and women who have undergone FGM may find it difficult to use contraceptives fitted through the vagina, including women's condoms, contraceptive rings, IUCs and pessaries. The use of men's condom may also be challenging. Vaginal infections, which are more common in women who have undergone FGM, hamper the use of IUCs. (WHO 2018a.)

Because of the narrow vaginal opening, taking a gynaecological cell sample (smear test) for cervical cancer screening may be challenging in a girl or woman who has undergone FGM. (WHO 2018a.)

OBJECTIVE

Appropriate treatment of gynaecological problems caused by genital mutilation will be given to all women and girls who have undergone FGM, and support will be offered to them to promote their sexual wellbeing.

Actions:

- The care provider will offer girls and women who have undergone FGM an opportunity for deinfibulation and removal of any other scar tissue.
- The care provider will offer sexuality counselling as well as an assessment of and, if necessary, support for the psychosocial situation of girls or women who have undergone FGM and are experiencing gynaecological problems.
- The care provider will treat vaginal infections appropriately and guide the client in looking after her personal hygiene.
- The care provider will check for a urinary infection in a urine sample and treat the infection with antibiotics. If the client has recurring urinary tract infections, she will be referred to specialised medical care.
- The care provider will refer the client to specialised medical care, where epidermoid cysts and keloids can be removed if they are causing problems.

- Smear tests should be taken from girls and women who have undergone FGM in the same way as from other clients. Encouraging the client to relax and using lubricating gel and a small specula may help. If a sample cannot be taken, deinfibulation is recommended.
- The care provider will find a suitable method of contraception for a girl or a woman who has undergone FGM if she so wishes.

Sexuality

In order to secure the realisation of the sexual rights of girls and women who have undergone FGM, counselling, support and help should be offered in Finland. Professionals must be able to bring up sexuality and its dimensions, as in some cultures talking about sexuality is a taboo (Greenberg, Bruess & Oswalt 2016). When working with an interpreter, the possibility of the relevant vocabulary missing in the language should be taken into account. Girls and women who have undergone FGM and who have problems with their sexuality and having sex have good possibilities of enjoying a satisfying and pleasurable sex life once they have the necessary knowledge and skills. By means of good interaction and open communication, couples may achieve a satisfying sexual relationship regardless of female genital mutilation. Attention should be paid to the sexuality education of girls who have undergone FGM, and sexuality counselling, guidance and therapy should be offered as necessary to individuals and couples. Support and counselling related to changes in sexuality will also be needed in connection with deinfibulation or reconstructive surgery. (WHO 2018d; WHO 2016.)

OBJECTIVE

Help will be offered to girls and women who have undergone FGM for problems related to sexuality. Girls or women who are having deinfibulation or reconstructive surgery will be supported through the changes in their sexuality caused by the procedure. Sufficient resources will be secured for supporting the sexuality of girls and women who have undergone FGM.

Actions:

- Professionals encountering girls and women who have undergone FGM will talk about sexuality and its dimensions with these clients.
- Illnesses affecting the sexual health of a girl or a woman who has undergone FGM will be treated in primary healthcare or specialised medical care, and the client will be referred to deinfibulation if necessary.
- The care provider will give the client essential information about sexuality and sexual health and the ways in which female genital mutilation affects these areas, bring up the relationship of the client and her spouse, and offer a positive view of sexuality.
- The municipality will offer sexuality education, counselling and guidance for girls and women who have undergone FGM and, as preventive work, for couples expecting a child.

Managing the pregnancy and delivery of an FGM woman

Pregnancy is an opportune time for providing health advice, and it should thus be used to prevent female genital mutilation in the next generation. Pregnant women who have undergone FGM should be offered an opportunity to talk to a professional and have deinfibulation, sexuality counselling and psychological support. Female genital mutilation should be brought up with both parents as part of family guidance during pregnancy. If family guidance is only available in virtual form, FGM should also be incorporated in its topics.

While the pregnancy and delivery of a woman who has undergone FGM usually progress without problems, research evidence suggests that type III mutilation increases the risk of complications during and after delivery in both the mother and the child.

OBJECTIVE

Female genital mutilation will be recognised during pregnancy, the client will be referred to specialised medical care, and she will be provided with information about the harmful effects of FGM and offered the possibility for deinfibulation.

Actions:

- Professionals will ask clients originating from countries where FGM is practised about mutilation and perform a gynaecological examination to establish the extent of the mutilation in an early part of the pregnancy, guide a pregnant woman who has undergone FGM to a gynaecologist/obstetrician in specialised medical care, and offer her the possibility of deinfibulation. Any fear of childbirth will also be addressed in this discussion.
- Clients will be informed of the harmful effects of female genital mutilation, legislation relevant to it and the human rights perspective during pregnancy and after delivery. If necessary, the care provider will notify child welfare services and the police if it is suspected that the newborn is at risk of FGM. Female genital mutilation will also be discussed with both parents during family guidance before the birth, and FGM will also be addressed in virtual guidance.
- If the client is willing to have deinfibulation, it will be carried out during the second trimester or, at the latest, at the time of birth.
- After deinfibulation, the client will be given good home care instructions that also address the impacts on sexuality and the changed self-image.

Deinfibulation and reconstructive surgery

Social welfare and healthcare professionals should have sufficient knowledge about deinfibulation, or surgery to separate labia that have been sewn together at the time of the mutilation. All professionals encountering in their work girls and women from countries where FGM is practised should have basic knowledge about deinfibulation to enable them to offer it to clients if necessary. Healthcare professionals should also have the competence to assess the extent of the mutilation, and physicians working with women should have skills in performing deinfibulation. Healthcare professionals working in school health care or at maternity clinics and maternity hospitals should have the competence and resources for guiding a girl or a woman going for deinfibulation appropriately. If female genital mutilation causes problems for a girl or a woman, deinfibulation should be performed if she prefers, even if she did not yet have a residence permit decision. Counselling for clients going for deinfibulation should be developed and made use of by all professionals encountering women with an immigrant background.

Social welfare and healthcare professionals should have enough information about reconstructive surgery following female genital mutilation to enable them to advise clients in questions related to it if necessary. As research evidence of the benefits of reconstructive surgery remains conflicting and scant, more information is needed on this subject.

OBJECTIVE

All girls and women living in Finland who have undergone FGM will have access to deinfibulation, and they will receive adequate counselling and support before and after the procedure. Professionals will have sufficient competence related to referring clients to deinfibulation and performing it. An effective clinical pathway will be developed in Finland for access to deinfibulation. The needs for and possibilities of performing reconstructive surgery will be investigated.

Actions:

- The ministries will ensure sufficient resources for offering deinfibulation for all those who need it.
- The counties/hospital districts will ensure that specialists have sufficient competence to carry out deinfibulation.
- The counties/hospital districts, municipalities and training organisations will ensure that nursing staff have sufficient competence in directing clients to deinfibulation and supporting them.
- The National Institute for Health and Welfare together with healthcare professionals will develop an effective national clinical pathway for access to deinfibulation.
- Universities of applied sciences, universities and other vocational education and training providers will be encouraged to conduct research on the need for reconstructive surgery following female genital mutilation, the willingness of girls and women to have reconstructive surgery, and the possibilities of performing such surgery in Finland.
- The counties/hospital districts will investigate the possibilities of performing reconstructive surgery in specialised medical care.
- The Ministry of Social Affairs and Health and the National Institute for Health and Welfare will follow international discussions on reconstructive surgery and update the guidelines as necessary.

5.10 Promoting the mental health of girls and women who have undergone genital mutilation

While the main focus in Finland has so far been on treating the physical problems caused by FGM and FGM prevention, sufficient attention has not been paid to the psychological wellbeing of those who have been at risk of or undergone genital mutilation. Deinfibulation and reconstructive surgery may reshape the woman's entire identity, and a girl or a woman who has undergone FGM may need professional help to cope with the change. According to WHO, offering cognitive behavioural therapy to girls and women who have undergone FGM and who experience symptoms of an anxiety disorder, depression or post-traumatic stress disorder should be considered (WHO 2018d).

OBJECTIVE

Sufficient resources will be guaranteed in Finland to support the mental health of girls and women who have been at risk of or undergone FGM. Help will be offered for mental health problems.

Actions:

- The ministries will ensure that sufficient resources are available for supporting the mental health of girls and women who have been at risk of or undergone FGM.
- Leading office holders, elected officials and political decision-makers will contribute to ensuring that mental health services are offered in Finland for girls and women who have been at risk of or undergone FGM, and access to the services will be secured.
- Professionals will pay attention to the mental health of clients who have been at risk of or undergone FGM, and they will be able to direct clients to help if necessary.
- The counties/hospital districts will contribute to ensuring that girls or women going for deinfibulation receive sufficient support for the psychological change caused by the procedure.

5.11 Development of clinical pathways for girls and women who have been at risk of or undergone female genital mutilation

The clinical pathway is a guideline for organising the treatment and the division of duties related to it in a certain area for those with a certain illness or, in the case of female genital mutilation, experiencing certain problems. The objective of the clinical pathway is to safeguard the appropriateness of the patient's treatment and its smooth progress from the client's perspective across organisational boundaries and between different occupational groups. Clinical pathways help harmonise treatment practices and improve treatment quality. Uniform clinical pathways improve cooperation between professionals and the regional equality of patients. Clinical pathways also help reduce the use of services that do not benefit the patient. (Ketola et al. 2006.)

OBJECTIVE

A clinical pathway will be created to describe the assistance provided for girls and women who are at risk of or have undergone FGM.

Actions:

- In cooperation with healthcare services, social welfare services and the police, the National Institute for Health and Welfare will create a clinical pathway for assisting girls and women who are at risk of or have undergone FGM.

6 Action Plan implementation, monitoring and evaluation

The implementation of the Action Plan for the prevention of female genital mutilation will be cross-cutting and traverse the boundaries of different sectors and branches of administration. The Action Plan will be integrated in the municipalities' preventive services, the social welfare and healthcare system, the early childhood education and care and the education and training sector, police work and the reception system, and it will be adapted to changes in these systems in the future. Media as a separate field will take into account the recommendations prepared for it in the Action Plan in its activities. The Action Plan will be implemented in primary health care, specialised medical care, municipalities, schools, educational institutions, reception centres, police work and the media in connection with normal operation and without specific additional resources.

Information on the Action Plan was already disseminated actively while it was being prepared in autumn 2018, for example at numerous training events for professionals, in professional journals and other media, and through the social media. During the year 2019, the objective is to spread awareness of the Action Plan. The Action Plan will be published as an electronic version on the websites of the National Institute for Health and Welfare and the Ministry of Social Affairs and Health. The parties involved in preparing the Action Plan may also publish the electronic version on their websites.

At the **Ministry of Social Affairs and Health**, responsibility for Action Plan implementation will be assumed by the Department for Wellbeing and Services. The public servants responsible for Action Plan implementation at the **Ministry of Education and Culture, the Finnish National Agency for Education, the Ministry of Justice, the Ministry of the Interior, the Ministry of Economic**

Affairs and Employment and the Finnish Immigration Service will have a key role in ensuring that the proposals related to general and vocational education and training, police work, reception activities and integration will be carried through. These actors will attend regional and national training and cooperation meetings at which new information will be shared and the implementation of the proposals will be planned. They will organise education and training content relevant to the theme for their training events, for example at the National Institute for Health and Welfare's TERVE-SOS event, the Association of Finnish Local and Regional Authorities' Hospitals theme day, and the meeting for the management of health centres.

The **Regional State Administrative Agencies** will be responsible for implementing the Action Plan through their role in steering and overseeing social welfare and healthcare services. The counties, **hospital districts** or similar coordinators of regional healthcare will be responsible for the regional implementation of the Action Plan and the tasks assigned to specialised medical care services in preventing female genital mutilation. At the local level, the responsibility for Action Plan implementation will rest on the **management of social welfare and healthcare services** in municipalities, joint municipal authorities or local government co-management areas for social welfare and healthcare services. **Officers responsible for health promotion** in municipalities and at health centres and hospitals will ensure that the Action Plan will be translated into practice and that cooperation will be established between the administrative branches.

Regional actors, including **hospital districts and counties**, will ensure that the operating units have access to the practices and guidelines referred to in the Action Plan. The regional parties will also ensure collaboration between different actors. The various parties will additionally develop practices, guidelines and cooperation together with professionals to be increasingly in line with the Action Plan. Regional actors should designate contact persons for FGM prevention, see to their training, and establish regional and sub-regional networks to coordinate the prevention work and to create permanent service structures if necessary. The regional actors will also be responsible for building clinical pathways for girls and women who are at risk of or have undergone FGM.

The Action Plan for the prevention of female genital mutilation should be used in strategy and development work relevant to social welfare and healthcare as well

as education services. Pursuant to the Health Care Act, the **municipalities and primary health care services** have designated parties responsible for promoting health and welfare. It is the task of these parties to ensure that structures and cooperation networks aiming to prevent female genital mutilation are created and to assume responsibility for Action Plan implementation in other respects. They should integrate FGM prevention in other preventive work and treatment of illnesses. They are also tasked to develop the planning and monitoring of services and the spreading of information about the services in a manner that promotes FGM prevention. The municipalities should account for the Action Plan when preparing their welfare reports. Inclusion of FGM prevention in the municipalities' activities can be monitored in the comprehensive welfare review prepared once during the local council's term of office and in the health and welfare report produced once a year.

Key actors responsible for Action Plan implementation in early childhood education and care, schools, universities of applied sciences, universities and other vocational education and training providers are the **heads of early childhood education and care, teaching, fields of education or education programmes**. The Action Plan should be used in curricula preparation and teaching development in basic education and in health education at general upper secondary schools as well as at vocational institutions, universities of applied sciences and universities. **Teachers educating social welfare and healthcare field professionals** will be in a key role, and they should also use the Action Plan as teaching material. **Professional organisations** in the social welfare and healthcare sector, early childhood education and care, education, reception activities and the police also play an essential role in including the theme in their vocational in-service training. National coordination and the initiative of individual institutes or faculties will be needed to promote research on the theme and to step up research cooperation.

Social welfare services will adopt the objectives of the Action Plan in child welfare, youth work and work with immigrants. In the field of FGM prevention, social welfare services will cooperate with the health services and other necessary parties regarding prevention of violence and treatment.

Employees in social welfare and healthcare, early childhood education and care, general and vocational education and training, reception activities and the police have a statutory duty to follow the good practices presented in the Action Plan

and to develop their vocational competence. A particularly vital role is played by preventive healthcare personnel at maternity and child health clinics, in school and student health care and occupational health care as well as sexual and reproductive health professionals in primary health care and specialised medical care. The police will participate in the cooperation to ensure that effective local-level practices can be created to help girls and women who are at risk of or have undergone FGM. Reception activities also have a significant role in informing, guiding and supporting people who have recently arrived in Finland as set out in the Action Plan. NGOs will work in their own sector as significant operators carrying out preventive work and developing new practices.

Trade unions will support Action Plan implementation in regional and local cooperation with health service leaders and discuss the Action Plan at their training events, in their publications and on their homepages. Other **organisations in the sector** will support Action Plan implementation in their own fields and work together with the other actors.

Action Plan implementation already started at the National Institute for Health and Welfare during its drafting, as at that time, the Institute had an FGM expert funded by the Ministry of Social Affairs and Health. In the future, the National Institute for Health and Welfare will assume the main responsibility for planning and carrying out national level data collection. To raise awareness of the Action Plan, the National Institute for Health and Welfare will spread information about it at its events. Information activities will also be carried out online and on the media. The National Institute for Health and Welfare will produce new learning materials, for example for vocational basic and in-service training in the healthcare sector. Additionally, the National Institute for Health and Welfare will produce new material in cooperation with other actors to support FGM prevention, including brochures in different languages and plain language as well as online information.

The National Institute for Health and Welfare will maintain societal discussion on the theme by participating at events addressing it. The National Institute for Health and Welfare will continue working together with communities originating from countries where FGM is practised and with NGOs engaging in preventive work, thus supporting the parties' opportunities for participation. The National Institute for Health and Welfare will participate in international information exchanges and liaise with international FGM actors, for example by participating in international

seminars and research network meetings. It will also participate in international research as far as possible.

Monitoring and evaluation

The National Institute for Health and Welfare will organise the regular monitoring of Action Plan implementation. In 2023, the National Institute for Health and Welfare and the Ministry of Social Affairs and Health will produce an interim evaluation to examine the progress made with Action Plan implementation. The National Institute for Health and Welfare and the Ministry of Social Affairs and Health will organise an annual FGM working meeting to discuss Action Plan implementation in different areas and share the latest information and experiences.

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Appendix 1. Risk assessment calculations

*Prevalence of FGM not known

Girls and women in Finland originating from countries where FGM is practised		Number of those who have undergone FGM living in Finland
Afghanistan	3,771	*
Benin, Burkina Faso, Togo, Ivory Coast	76	13
Egypt	305	177
Eritrea, Djibouti, Yemen	261	149
Ethiopia	1,079	592
Ghana	758	11
Guinea, Guinea Bissau, Sierra Leone, Liberia	152	74
Indonesia	382	*
Iraq	7,777	369
Iran	3,561	320
Kenya	879	108
Mali, Mauritania, Senegal, Gambia	278	166
Somalia	9,532	7,084
Sudan, Central Africa, Cameroun	1,430	597
Syria	2,716	183
Tanzania, Uganda	372	16
Chad, Niger, Nigeria	1,203	152
Turkey	3,075	243
Total	**37,607**	**10,254**

First-generation girls at risk of FGM	
Somalia	391
Egypt	64
Syria	60
Iraq	53
Sudan, Central Africa, Cameroun	24
Iran, Turkey, Yemen	23
Other Western African countries (Gambia, Ghana, Guinea, Guinea Bissau, Sierra Leone, Liberia, Nigeria)	23
Other Eastern African countries (Ethiopia, Kenya)	7
Total	**645**

First and second-generation girls at risk of FGM	
Somalia	2,348
Sudan	127
Egypt	108
Iraq	107
Syria	80
Turkey	70
Ethiopia	65
Iran	42
Nigeria	35
Kenya	23
Gambia	19
Sierra Leone	11
Other	40
Total	**3,075**

Appendix 2. An example of instructions on investigating suspected FGM for school health care

HOW TO INVESTIGATE THE SUSPECTED GENITAL MUTILATION OF A GIRL - INSTRUCTIONS FOR SCHOOL HEALTH CARE

SUSPECTED THREAT OF FGM:

The family is planning to have a holiday or send the girl to their country of origin, no actual suspicions of FGM:

1. **Bringing the subject up: Use the term 'circumcision' when talking to the client.**
   - First find out if the family's country of origin is one where the prevalence of FGM is high.
   - Ask the parents how they feel about female genital mutilation. If their attitude is clearly negative, let them know that this is great, and increasingly the case among immigrants in Finland.
   - Explain what the FGM situation in the family's country of origin is.
   - Explain that sometimes a grandmother or other relative has had a girl cut without the parents' knowledge. Urge the parents to discuss the matter with the grandparents before the trip if the girl is going to them.
   - Explain that sending a girl abroad to be cut is a punishable offence in Finland.
   - During the discussion, it should be mentioned that the subject is brought up with all those originating from a country where FGM is practised.
   - Record the content of the discussion in the patient data system.

2. **If suspicions are aroused concerning a plan to have the girl undergo FGM, submit a child welfare notification and a report to the police. A preventive unit of the police can assess the likelihood of the threat and possible preventive actions.**
   - This is about planning an aggravated assault on a child, an offence to which the authorities' notification duty applies. You do not need to be certain that a plan exists. A 'reasonable suspicion' is enough to submit the notification and report.
   - As a rule, the parents are not informed of the notification and report. Also remember to set a delay for the text becoming visible to the patient in the patient records.

– If you hear about FGM or plans to subject a girl to FGM from several people (e.g. a friend of the child - an afternoon club leader - a school social worker - a public health nurse - a school physician) and there is no acute suspicion, urge the authority who has heard about the matter first to make a child welfare notification and a report to the police. Explain that if the child welfare services or the police so wish, you can discuss the matter with the child and/or the parents at the school. If no request is received, do not get involved.

CONSULTATION PHONE NUMBERS IN HELSINKI

Replace the numbers in the following list with the numbers of your own region

	Telephone (Helsinki)	Number in your area
Consultation number of a forensic psychology unit	050 4287888 (weekdays between 9.00 and 15.00)	
Police: Preventive work	029 547 4300 ennaltaestava.helsinki@poliisi.fi	
Violent offences investigation	Group e-mail: vakivaltarikokset.helsinki@poliisi.fi	
On-call criminal investigation patrol (only in acute situations)	029 5470 237	

SUSPECTED CASE OF A GIRL HAVING ALREADY UNDERGONE FGM:

1. **Follow the procedure for an assault case**:
   – Record carefully what is said and who is saying it; do not ask leading questions. Do not attempt to carry out a detailed interview yourself. The parents and the child should not be interviewed together.
   – Submit a **child welfare notification** and **a report of an offence to the police concerning an assault**. **As a rule, the parents are not informed of the notification and report. Also set a delay on the visibility of the patient records to the patient.** (The general guideline is that the issue should first be discussed with the parents. However, in recent times the actions of the Helsinki Police Department, child welfare services and forensic psychology services have increasingly been arranged to give the police and the child welfare services the possibility of interviewing the family members 'unexpectedly' in cases of suspected assault on a child.)

- If you know that the victim has sisters, mention it in the notification and the report. In the victim's case, the risk of a repeat offence is small. It is unlikely that placement outside the home need be considered, and the child welfare notification does not necessarily need to be made outside office hours, either.

2. If it is possible that the girl has been cut very recently, examine her genitals non-intrusively yourself. If she has a fresh wound or other injuries, draw up a referral to emergency paediatric surgery or gynaecology services (depending on the child's/young person's puberty degree).

3. If her situation is not medically acute, an examination is not necessarily needed. If suspicions are raised by something that the child says, for example, and an examination of her genitals cannot otherwise naturally be carried out in the situation, it need not be done. The police will request an examination as an executive assistance request at the Children's Hospital if they find this necessary when investigating the matter. If the girl has urinary problems or other symptoms in the genital area, an examination is carried out as usual, anything that needs treatment is treated, and the findings are recorded.
   - In young girls, variations in the size of the visible clitoris are great, it is possible that the external genitals stick together, and other anatomical variations may also occur. Well-healed scarring from less severe mutilation is not necessarily easy to spot. Interpreting the anatomy may be difficult. Only record what you see. A closer examination will be carried out at the hospital on request of the police.

If it is obvious that the girl has been cut before the family migrated to Finland, no report to the police need be made, as this cannot be regarded as an offence in Finland. A child welfare notification should be made to allow an assessment of the circumstances in which the girl and any siblings she may have are growing up. Consider if the girl needs treatment/information about possible treatments later (psychological and physical), and if actions are needed to prevent the victim's sisters from being mutilated.

In the preparation of these instructions, guidelines produced by the Physician's services for children and young persons of the City of Helsinki in 2017 were used, which were written by Paediatrician Ilona Visapää in cooperation with supervisors and several authorities.

Appendix 3. A model for assessing the threat of FGM

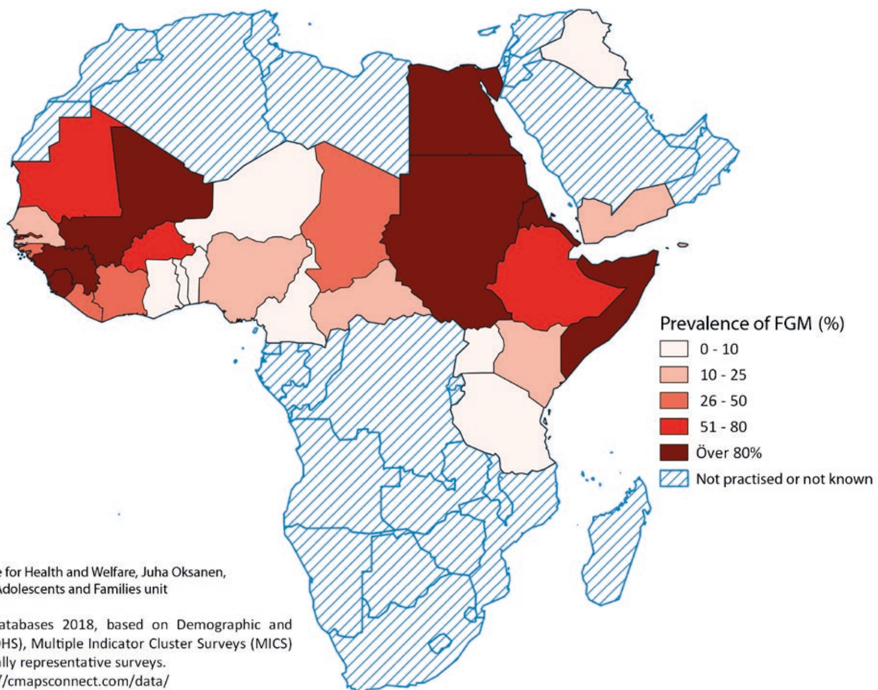
Assessing the threat of female genital mutilation

The assessment form can be used to assess the threat of female genital mutilation or to find out if mutilation has already taken place. The form is a tool for working with clients. By filling in the form and filing it with the client documents, it can be ascertained that the subject has been brought up with the client, and other employees and necessary parties will also be informed.

- **From which country have the client, her parents or her spouse come from?**

– Using a map and a list of countries, find out if the client comes from a country where FGM is practised.

Risk countries:



HIGH PREVALENCE:

Somalia, Guinea, Djibouti, Sierra Leone, Mali, Egypt, Sudan, Eritrea

RELATIVELY HIGH PREVALENCE:

Burkina Faso, Gambia, Ethiopia, Mauritania, Liberia, Guinea-Bissau, Chad, Ivory Coast, Nigeria, Senegal, Central African Republic, Kenya

LOW PREVALENCE:

Yemen, Tanzania, Benin, Iraq, Togo, Ghana, Niger, Uganda, Cameroun

IN ADDITION:

Kurdish regions: Iran, Syria, Turkey

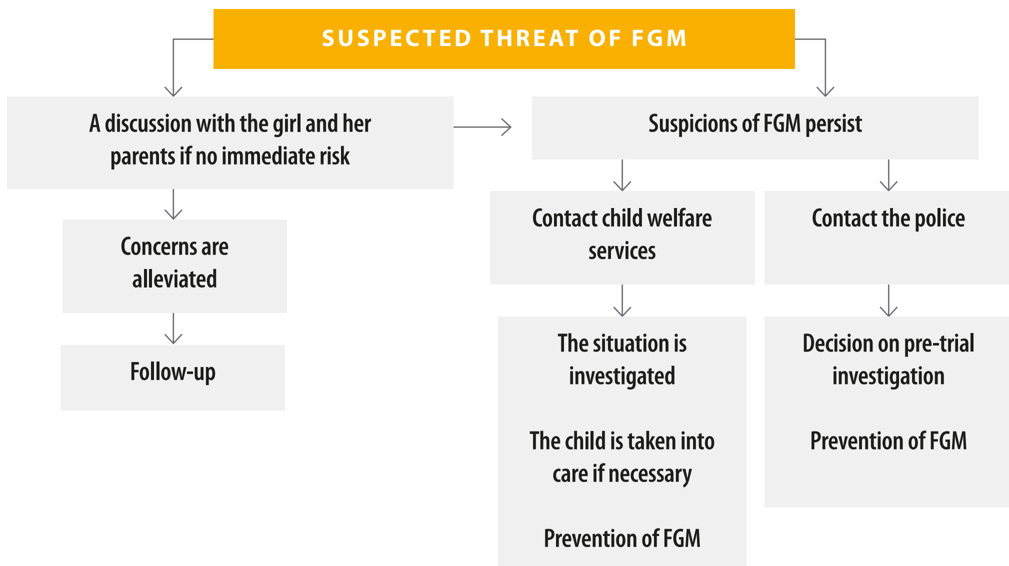
Indonesia, Afghanistan

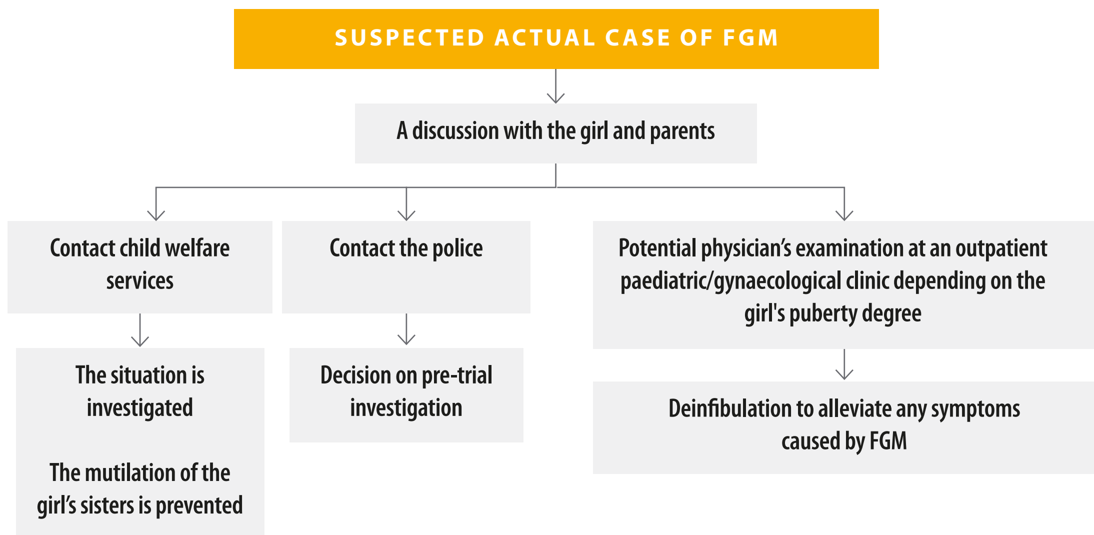
Ask about the following:

- Has the client's mother, sisters or other relatives been circumcised?
- Has the family found it difficult to adapt to the Finnish culture? Is the family also isolated from their own cultural community in Finland?
- Is the family planning an extended holiday in their home country, or are they sending the girl for a longer period to some other country where FGM is practised?
- Is the girl aware of an approaching family ceremony or a festival organised in her honour?

Also pay attention to the following:

- if there are gaps in the monitoring of the girl at the child health clinic or in school health care or she has missed regular examinations at a certain age
- if the girl, her parents or some other person close to the family says that FGM is important for the family for cultural or religious reasons
- if the girl, a friend of hers or a family member expresses their concern over the girl being subjected to FGM





If the genital mutilation took place before the girl migrated to Finland, contact child welfare services to prevent the mutilation of any siblings

Planning FGM is about planning an aggravated assault on a child, an offence to which the authorities' notification duty applies. The notification duty overrides the duty of confidentiality. National Institute of Health and Welfare 12/2018.

Term used for FGM

Country	Term used for FGM	language
Somalia	Gudiniin, Halalays, Qodiin	Somali
Sudan	Khifad, Tahoor	Arabic
Egypt	Thara, Khitan, Khifad	Arabic
Iran	Xatna	Farsi
Ethiopia	Megrez, Absum	Amharic, Harari
Turkey	Kadin sunneti	Turkish
Eritrea	Mekhnishab	Tigrinya

HM Government (2016) Multi-Agency Statutory Guidance on FGM

Appendix 4. Clinical pathway of a pregnant women who has undergone FGM

If it is suspected that the mother has undergone FGM while residing/living in Finland (even if it was carried out abroad), contact the police. Female genital mutilation is an aggravated assault which becomes statute-barred in 20 years. If it is suspected that the family intends to subject their daughter to FGM, contact the police and child welfare services.

Appendix 5.

Experts who participated in writing the Action Plan for the prevention of female genital mutilation

Steering group

Bildjuschkin, Katriina, National Institute for Health and Welfare
Bruun, Anna, Ministry of Economic Affairs and Employment
Hieta, Päivi, Finnish Immigration Service
Jakobsson, Maija, Finnish Society of Obstetrics and Gynaecology
Klemetti, Reija, National Institute for Health and Welfare, Chair
Koukkula, Mimmi, National Institute for Health and Welfare, Secretary
Kolimaa, Maire, Ministry of Social Affairs and Health
Kunelius, Maria, Finnish Immigration Service
Latvala, Johanna, Finnish League for Human Rights
Lempiö, Heidi, Ministry of the Interior
Lyyra, Marjo, Federation of Finnish Midwives
Nordström, Soila, Finnish National Agency for Education
October, Martta, National Institute for Health and Welfare
Parviainen, Immo, Ministry of Education and Culture
Piispa, Minna, Ministry of Justice
Possauner, Monika, City of Helsinki
Saarinen, Aija, Finnish Association of Public Health Nurses
Terho, Laura, Ministry of Social Affairs and Health
Zandkarimi, Mina, Finnish Family Federation

Other experts

Aapakallio, Johanna, SOPU work, Loisto setlementti
Abbasi, Fardin, Setlementti Tampere
Aden, Amina, Fenix Helsinki
Ahmed, Ujuni, Fenix Helsinki
Enqvist, Måns, National Police Board
Farik, Sirwa, Association of Iraqi Women
Hintikka, Satu, Setlementti Tampere
Holopainen, Elina, Finnish Society of Pediatric and Adolescent Gynaecology
Huhdanperä-Ketonen, Anna-Maija, Häme University of Applied Sciences
Markkanen, Outi, Association of Iraqi Women
Raussi-Lehto, Eija, Metropolia University of Applied Sciences
Saarikoski, Elina, Finnish Immigration Service
Tiilikainen, Marja, Migration Institute of Finland
Tiittala, Paula, National Institute for Health and Welfare

Appendix 6.

More information online:

WHO guide on care of girls and women who have undergone female genital mutilation:

WHO. 2018. Care of girls and women living with female genital mutilation: a clinical handbook. Geneva.
http://apps.who.int/iris/bitstream/handle/10665/272429/9789241513913-eng.pdf?ua=1
Includes an instruction video for healthcare personnel (QR code on page 227) about deinfibulation.

UEFGM online course for professionals of different fields working in the EU:

UEFGM. 2016. United to End Female Genital Mutilation. Online training.
https://uefgm.org/index.php/e-learning/

A UK online training course on FGM:

www.safeguardingchildrenea.co.uk/resources/female-genital-mutilation-recognising-preventing-fgm-free-online-training/
Requires login, select 'International' in the location menu at the beginning. Can be completed in sections. The instructions must be applied to Finnish circumstances by the learners themselves.

A Swedish online course on encountering women who have undergone FGM:

https://utbildning.socialstyrelsen.se/course/view.php?id=35
Requires login, can be completed in sections. The instructions must be applied to Finnish circumstances by the learners themselves.

Internet: stm.fi/en/publications

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