FEMALE GENITAL MUTILATION

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Abstract
Female Genital Mutilation (FGM) is not anymore a practice experienced by the African communities and the Middle East. FGM is becoming a concern in Europe, The U.S.A and other parts of the world that had not been affected before. This situation has been brought about by increasing rates of migration and the search for better living standards by citizens of developing countries.

Increasing concern and the unawareness of FGM in western countries has encouraged the authors to write an informative booklet for all the health care professionals working in the field of girls' and women's health in Finland. This is to raise awareness of the issues surrounding the practice of FGM and by doing so to work towards eliminating the practice. The health care professionals have a role to play in the protection and empowerment of women and girls. Education is an important aspect of reaching these goals.

The project was carried out in close co-operation with Jyväskylä University of Applied Sciences, School of Health and Social Studies. A booklet was given to maternity and labour wards of Central Hospital of Central Finland, as well as the library of Jyväskylä University of Applied Sciences, School of Health and Social Studies.

The booklet is aimed to provide information about the meaning of FGM, the types, psychological and physical implications and other related issues. The booklet also gives a list of other reading material and resources that can be accessed for additional information.

The need for the project originated from the authors' own interest that was justified by the lack of literature about the topic of FGM in Finland. The aim of the project was to produce an informative booklet and to do a lesson based on the booklet, which will support the knowledge of future health care professionals.

The project has shown a need for further research in FGM related issues in Finland.

Keywords
Female Genital Mutilation, FGM, booklet, human rights

Miscellaneous
The report includes the booklet: "Female Genital Mutilation"

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Tiivistelmä
Naisten ympärileikkausta ei harjoiteta enää vain Afrikan ja Keski-Aasian yhteisöissä. Naisten ympärileikkaus koskettaa Eurooppaa, Amerikkaa ja muita maanosia, joissa tätä ei ole enne harjoitettu. Tilanteeseen ovat vaikuttaneet kasvava siirtolaisuuden vauhti ja kehitysmaalaisten etsiessä parempaa elämänlaatua.

Kasvava huoli ja tiedon puute naisten ympärileikkauksesta länsimaissa rohkaisi tekijöitä kirjoittamaan informatiivisen kirjasen terveydenhuollon ammattilaisille jotka työskentelevät tyttöjen ja naisten terveyden parissa Suomessa. Tämä on tarkoitettu nostamaan esille tietoisuutta asioista jotka ympäröivät naisten ympärileikkauksen käytäntöä ja näin tekemällä, työskennellä kohti käytännön eliminointia. Terveydenhuollon ammattilaisilla on rooli vedettävänä tyttöjen ja naisten turvaamisessa ja täysivaltaistamisessa. Koulutus on tärkeä näkökulma päämäärän saavuttamisessa.

Projekti tehtiin läheisessä yhteistyössä Jyväskylän Ammattikorkeakoulun Sosiaali- ja terveysalan kanssa. Kirjanen annettiin Keski-Suomen Keskus Sairaalan synnytysosastolle ja Jyväskylän Ammattikorkeakoulun Sosiaali- ja terveysalan kirjastolle.

Kirjanen on tarkoitettu välittämään tietoa naisten ympärileikkauksen tarkoituksesta, tyypeistä, psykologisista ja fyysisistä seuraamuksista sekä muista aiheeseen liittyvistä asioista. Kirjanen antaa myös listan muista kirjallisuuksista ja lähetistä joista voi hakea lisää tietoa.

Projektin tarve lähti tekijöiden omasta kiinnostuksesta naisten ympärileikkausta kohtaan, mikä perusteltiin kirjallisuuden puutteella Suomessa. Projektin tavoite oli tuottaa informatiivinen kirjanen naisten ympärileikkauksesta ja pitää tunti tähän pohjautuen, joka tukee tulevien terveydenhuollon ammattilaisten tietoutta.

Projekti osoitti tarpeen naisten ympärileikkauksen tutkimustyöhön Suomessa.

Avainsanat (asiasanat)
Naisten ympärileikkaus, Ihmisoikeus, Kirjanen

Muut tiedot
Liitteenä kirjanen ”Female Genital Mutilation”

CONTENTS

1 INTRODUCTION

Female Genital Mutilation (FGM) is becoming a world wide issue. There is an increasing need for strategies to eradicate and prevent FGM, and to end this practice which inflicts pain and torture to vulnerable women and girls. A wide range of strategies is required in approaching this project. Education among others is a significant method and a starting point to start making changes. (Dorkenoo 1995, 47-49; Ihmisoikeusliitto ry 2004, 12, 36-37; WHO 2000, fact sheet no. 241.)

There is a pressing need to raise awareness about the health and legal issues, and about the services and sources of information that are available amongst communities that practice Female Genital Mutilation. All health care professionals should be trained in to culture sensitivity and how to meet the needs of women and girls who have undergone Female Genital Mutilation, as this practice greatly affects women and girls. Matters of Female Genital Mutilation should be handled with sensitivity taking into account differing cultural issues, but the welfare of women and girls should be the main goal. (Dorkenoo 1995, 59; WHO 2000, fact sheet no. 241.)

Despite laws forbidding the practice, FGM has proven to be an enduring tradition; difficult to overcome on the local level with deeply held cultural and sometimes political significance. The difficulty lies significantly in the fact that the practice, as an identifying feature of a native culture, is firmly associated with the potential of young women. Therefore, for only one or a few families within a given setting to "deprive" their daughters of the operation is to significantly disadvantage them in finding husbands. (Sosiaali- ja terveysministeriö 2004; Dorkenoo 1995, 135.)

Because the practice holds such cultural and marital significance, the individuals willing to end the practice must realize the necessity to work closely with the local communities affected by FGM and involving

them in the fight against the practice. Despite the suffering, in the communities where it is practiced, few women speak out about FGM. It has been a taboo topic, both between the sexes and among women themselves. So talking about it openly is a breakthrough in itself. (Ihmisoikeusliitto ry 2004, 16-17.)

The aim of the thesis project was to provide information about FGM for health care professionals, as it carries along so many inappropriate myths and believes (Dorkenoo 1995, 47-49). The goal is also to encourage health professionals to increase their knowledge about the practice and to gain the courage to talk about it openly among immigrants who are bringing the culture along with them as they migrate to Europe. The authors also aimed at providing information to midwifery and International students at Jyväskylä University of Applied Sciences, School of Health and Social Studies.

Jyväskylä University of Applied Sciences, School of Health and Social Studies was the best target group for the project because of the wide range of health care professionals that it has. The authors established a partnership and a working cooperation which was reinforced by FGM lessons in different professional settings. The booklet was also given to maternity and labour wards in Central Finland Central Hospital as they deal with women whom may have under gone FGM.

The interest for this particular topic rose in a multicultural course during the authors nursing studies in 2005. The authors wanted to gain more knowledge about the FGM phenomenon and to use the knowledge to create a booklet with collective information from different sources. Considering the probability of working abroad, the authors realized that in future careers as nurses, issues relating to FGM are likely to be encountered.

2 BACKGROUND OF THE PROJECT

2.1 Culture and Transcultural Nursing

FGM is a very harmful tradition which violates women's human rights. The reasons for practicing FGM are usually hidden within the pressures that the community has imposed on women and girls. The social pressure that has been imposed on girls' is big. It is challenging to be the only or among the few unmutilated in the society. In some countries mutilation is mandatory in order to be socially accepted and respected as a woman. (Vohlonen-Córdova 2001, 19.) For this reason FGM is a culturally influenced practice. Health care professionals should have a transcultural nursing approach when dealing with people from different cultural backgrounds.

Culture symbolizes a way of life in a specific group and it is found universally (Leininger 1994, 125). Every person is connected to a culture. The culture is also connected to and influenced by communication and environment. It forms a base for persons world view. (Rusanen 1993, 32-33.) This abstract concept of behaviour in a culture includes values, beliefs and practices. Culture is something that is passed from one generation to the next who might change it somehow, but yet it always has some constant stability. Culture is also a factor that influences how people stay healthy and how they care sick ones due to the learned and transmitted processes. (Andrews & Boyle 1999, 3; Leininger 1994, 85, 125-127.)

Cultural rules direct people how to live their lives, Nevertheless, individuals live and behave differently by making all societies to have different cultures. People have different approaches to every aspect of their lives, like body image, health or attitudes towards illness which are all influenced by cultural background. That is what influences individuals' health and health care. However, culture is only one of the

aspects that influences people, also individual-, educational-, and socio-economic factors affect people and this is why culture should not be generalized into individuals of same group. When discussing about people and their culture, also historical, economical, social, political and geographical elements should be considered. (Helman 1995, 3-5.)

The need for transcultural nursing is growing and becoming more important every day due to the growing diversity of population in different countries. Transcultural nursing is often thought to be about understanding different cultures and becoming more aware of them; however, it should also be the base of caring and health education. This supports the planning and implementing of care and education. (Andrews & Boyle 1999, 5; Alexander, Beagle, Butler, Dougherty, Andrews Robards, Solotkin & Velotta 1994, 414, 422.)

Anthropologist Leininger is one of the leading characters of theory in transcultural nursing (Alexander et al 1994, 410). Leininger is focused on researching and teaching transcultural nursing (Andrews & Boyle 1999, 4). Transcultural nursing compares and analyses different cultures by respecting their caring behaviour. Its aim is to identify, understand, and implement culture-specific nursing care to people. This way people are treated individually and their cultural difference is being respected. (Leininger 1994, 8-9.)

2.1.1 Leininger's Sunrise Model

Caring is characteristic to all people in different ways concerning their cultural background. Since the beginning of human beings, there have been different caring methods that have enabled the survival of humans. According to Leininger, caring has two aspects, one specific in a culture and the other that is transcultural. The first is about health practices in one culture acquired from its people. The second symbolizes methods that have more professional views and comes from outside of a specific culture. Health care professionals should consider

peoples' knowledge and blend that to their own knowledge to realize the conflict and compatibility areas between them. (Leininger 1991, 36-37)

In 1950s Leininger found out that anthropology was the missing link in nursing profession, including health education and that inspired Leininger to study those together and later to form a theory from it. (Leininger 1991, 14-16, 36) Leininger's Culture Care Theory enables the essence of nursing and health educations reach its goal. The goal of Culture Care Theory is to understand the diversity and universality of care, by providing culturally congruent care that will maintain and restore client's well-being and health (Leininger 1991, 36-37, 39).

Leininger's Sunrise Model is a characterization of the Culture Care Theory (See figure 1). It is used as a cognitive map to orient and describe influencing dimensions, components or major concepts. The model defines and predicts the knowledge, development and influence of cultural care. The model should be viewed in its entity where all the dimensions interrelate with each other. Health care is related to all of those parts. Health care workers are encouraged to start working through the model from a part that serves their goals best. (op.cit, 49-51.)

The Sunrise Model has an upper and lower part. The upper part represents worldview and social structures, which has influence on health and caring. The lower part represents relation and professional systems and nursing care. It also includes individuals, families, groups, communities and institutions. The upper and lower part put together creates a sun that symbolizes caring and all the elements that health care professionals need to reflect on to truly be able to understand caring. (Alexander et al. 1994, 420-421.)

Once the health care professionals become familiar with clients' social and cultural aspects, they are able to plan nursing care and educate

their clients. There are three options how to plan and implement care: Maintain or preserve, accommodate or negotiate, and repattern or restructure the cultural care. The first option supports and assists the good and healthy ways that the client may already have to maintain or gain good health. This option is seen the easiest at times out of these three options, although its implementation can be hard work. The second option is about negotiating with the clients to change partly the caring patterns and actions, by maintaining what is useful. There might be times when the health care professional should also change something in his/her attitude. The last option is to change the old patterns to new and healthier ones. (George 1995, 381-383.) Leininger (1991) points out that the health care professionals should realize that the client might have a different perspective towards their health problems. This brings out the need for health care professional to collaborate with the client, family members and cultural group. (Leininger 1991, 55.) Culture care is the key to caring due to a fact that it includes learned and transmitted values, beliefs and practices which have significant meaning to the client (op.sit, 36-37, 39; Lundberg 2000, 279).

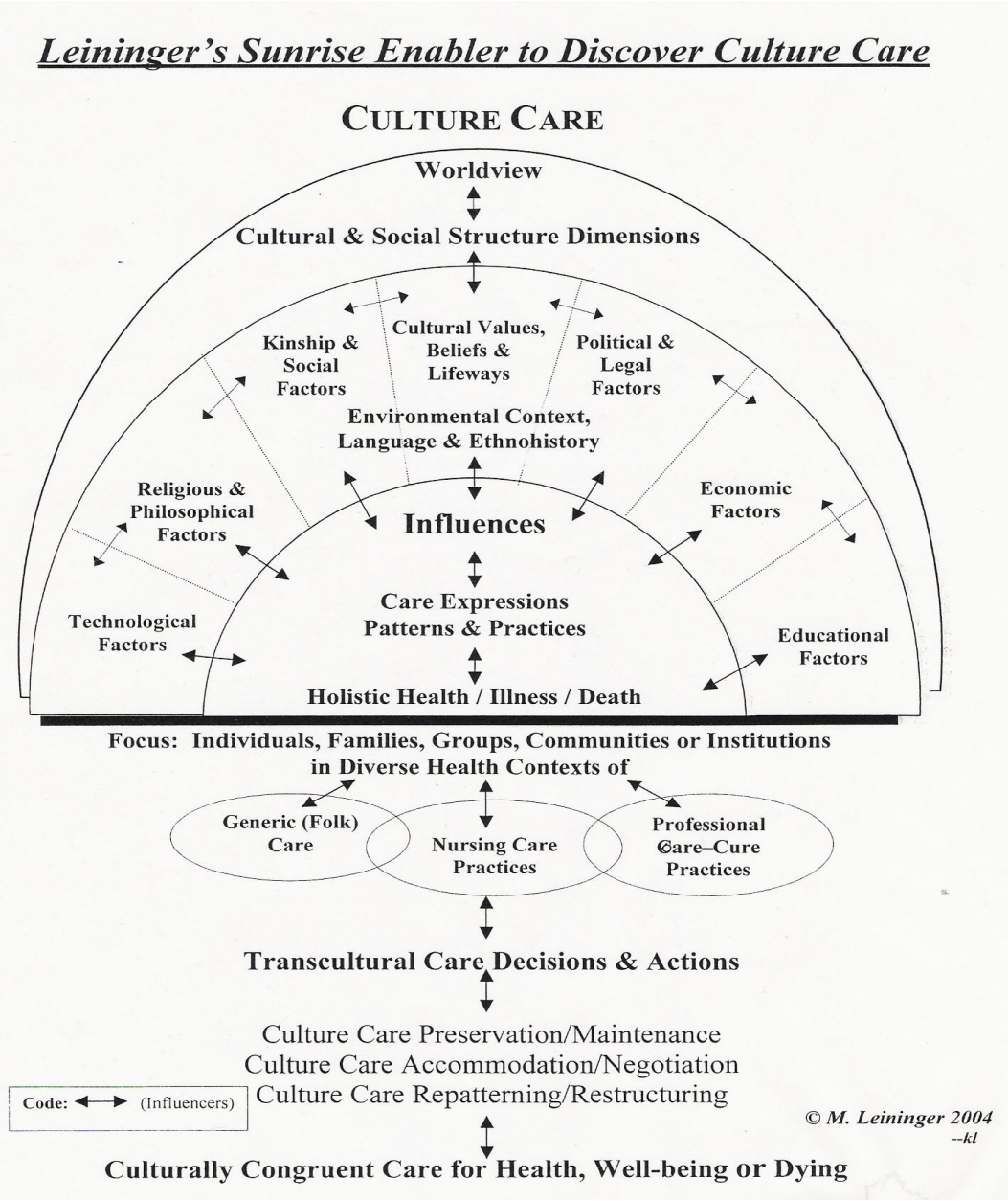

Figure 1. (Reynolds & Leininger 1993, 27)

2.2 Literature Review

People can find information about FGM through internet fairly well. Many organizations which are fighting against FGM have done researches before starting their projects. However, lack of time or skills to access internet might prevent this information to be spread.

In 2004 Human Rights had a project in Finland called KokoNainen (A whole woman), which was targeted to social and health care profes-

sionals. The nature of this project was to recommend ways to social and health care personnel of how to proceed when involved with such cases. The aim of the project was to intensify prevention of FGM and promote good care for women and girls who have gone through FGM already. Two researches were conducted as a base for this project KokoNainen. (Ihmisoikeusliitto ry 2004, 5.)

The first research was done by Mölsä (2004), who was also a Somalian born doctor, concentrating on immigrants that came from countries where FGM is still practiced. A definite change had happened compared to her first research in 1994. Ten years back these people supported FGM, however, opinions had changed and nowadays none of the interviewed persons supported Pharaonic, the most severe way of mutilation. Nevertheless, they were uncertain about other issues concerning FGM. Mölsä also came across difficulties when conducting the research. The main problem was to find enough people to interview due to the fact that the issue was so sensitive and sexual matters were not usually discussed especially between women and men. (Ihmisoikeusliitto ry 2004, 5, 16-17.)

The other research was done by Tiilikainen (2004), concentrating on public health nurses around Helsinki. The answers in the research survey brought up the difficulties to speak about FGM and lack of knowledge, clear instructions and material. No matter how awkward the health care professionals find it to talk about FGM, it needs to be confronted and professionally dealt with. (Ihmisoikeusliitto ry 2004, 5.) These researches clearly state that there are issues concerning Female Genital Mutilation in Finland and those are present in our everyday life.

Wright (1996) in her overview of Female Genital Mutilation states clearly that the dilemma of FGM is not concerning only Africa any more; Nevertheless, it has clearly taken a turn and is spreading greatly in Europe and other parts of the world. FGM is undoubtedly a cultural

issue and something that holds the society together. Anton (1995) in the work of Wright (1996) said that when criticizing the act of FGM you are affecting on peoples' sense of values, identity, wellbeing and their inner self's'. When suggesting an eradication of FGM it practically means the eradication of their whole culture in these peoples' eyes.

Poline Nyaga, a government councillor asked the British government in 1993 to legalize FGM as 'a right' for some African families living in the United Kingdom. Moreover, the Prohibition of Female Circumcision Act in 1985 made FGM an offence in the United Kingdom. The legislations against FGM in Africa have not been successful. The former President of Kenya Daniel Arab Moi banned the practice of FGM when already 14 girls had died for the complications of the procedures. Nevertheless, approximately 50% of the girls continue to be circumcised. On the other hand the legislation seems to work against the means, by pushing the practice underground and prevent getting necessary medical treatment in the fear of prosecution. (Wright 1996)

Hopkins (1999) studied the legal aspects of Female Genital Mutilation. In Britain there has been a law since 1861 protecting from bodily harm. However, Female Genital Mutilation was covered some time after by the existing law, when noticed that a child under the age of 16 could not agree on an act consisting of grievous bodily harm. The Children & Young Persons Act was added in 1933. (Hopkins 1999)

In 1985 a specific legislation of the Prohibition of Female Circumcision Act was authorized in Britain. See appendix 7 for the main parts of the prohibition of female circumcision act.

The Act about FGM is supported by the British Medical Association, the Royal College of Obstetricians and Gynaecologists and other medical and pressure groups.

The General Medical Council in The United Kingdom ruled the performance to be unethical in any other grounds than medical. (Hopkins 1999)

The subject of FGM is very sensitive and these moral dilemmas are so easily seen as racism and as Western values being imposed upon other cultures. Nevertheless, if the subject is approached with delicacy and indicated to be based upon humanitarian instead of cultural grounds, then eradication would be an issue of child protection. Hopkins (1999) says that the care of these girls, women and families can be enhanced by raising awareness of the subject and by developing clear policy guidelines. There will always be obstacles for open discussion of this highly sensitive issue by the fear of overriding the culture of ethnic minority groups and the difficulties of the obvious sexuality link. (Hopkins 1999)

2.2.1 What is Female Genital Mutilation?

Female Genital Mutilation (FGM) can also be referred to as Female Genital Circumcision. FGM forms from procedures where the external female sexual organs are surgically taken out partially or totally and other injury to the female genital organs for cultural or other non-therapeutic reasons. The women and girls' usually suffer from severe physical and psychological damage. The practice has a deeply unfavourable effect on women and girls' health which lasts a lifetime. The practice is more prevalent in the African communities and The Middle East. (Sosiaali- ja terveysministeriö 2004.) According to Rahman and Toubia's study, presented in the work of Comhlámh, says that FGM "...is at its essence a basic violation of girls and women's rights to physical integrity" (Comhlámh 2005).

FGM has been criticized as a disregard of the human rights and the exploitation of women. However, advocators of the practice consider it to be a significant aspect of transition to woman hood and should be maintained. (Haddi 2003, 9.)

2.2.2 Female Genital Mutilation and Sexuality

Female Sexuality and FGM

Female Genital Mutilation usually makes the first sexual experience torturous for women. It can be excessively painful and even put the woman's life at risk. Women who have been reinfibulated may experience painful intercourse throughout their life. In cases where pain is not experienced, sexual fulfilment may be impaired. The clitoris is a significant organ in experiencing sexual pleasure and orgasm. Mutilation comprising of partial or total removal of the clitoris would negatively influence sexual achievement and fulfilment. (Amnesty International 1997.)

The majority of researches and studies conducted on women's enjoyment of sex indicate that Female Genital Mutilation does negatively affect a woman's enjoyment. In a study conducted, 90% of the women who had been mutilated disclosed having experienced an orgasm. The components that influence sexual enjoyment and having an orgasm are still not well understood. Some factors such as psychological are thought to diminish the effects of clitoridectomy and other sensitive parts of the genitals, which explain why some mutilated women can still experience an orgasm. (Amnesty International 1997.)

2.2.3 Different Types of Female Genital Mutilation

Each community has their own ways of practicing FGM; however those can be divided into five main groups. They differ from each other by the ways of doing them and their severity.

Circumcision

This is done by taking out the hood of the clitoris. Circumcision is known to be the gentlest type of FGM, which is experienced by a minority of millions of women suffering from the practice. It is a type that can be classified as female circumcision which is rated the same as

male circumcision. Nevertheless, all female mutilations have been grouped under the deceptive terminology of female circumcision. From a physiological point of view, the identical process of male mutilation would be the total removal of the penis. (Dorkenoo 1995, 5.)

Excision

It is either the incomplete or the total removal of the clitoris and/or part of the labia minora. In some instances the labia minora are completely taken out without suturing. This is the most widely practiced form of Female Genital Mutilation. (Dorkenoo 1995, 5.)

Infibulation

This is the practice of surgical closure of the female labia majora by sewing them together to seal off the female genitals, leaving only a small hole for the passage of urine and menstrual blood. This is usually done on young girls around the onset of puberty, to ensure chastity. It is usually linked with the removal of the clitoris and the labia minora as well, in order to render women theoretically less sexual. (Dorkenoo 1995, 5.)

Intermediate Infibulation

It involves various methods of mutilation and stitching. The clitoris can either be taken out and the labia minora stitched together. It can also be done by leaving the clitoris untouched and removing the labia minora. The labia minora is stitched together and the clitoris is left inside. (Dorkenoo 1995, 5-8.)

Unclassified

This is the scarification of the hood of the clitoris, incisions done to the clitoris, labia minora and vagina and the removal of the hymen (Dorkenoo 1995). This also includes pricking, piercing or stretching of the clitoris and/or labia. (Comhlámh 2005.)

Deinfibulation (opening up)

After women and girls have gone through infibulation, they should remain closed until they get married. Usually the husband opens up the closed genitals during the wedding night. A dagger or a knife is usually used. This is a description of a wedding night when the husband uses a dagger to open up the woman. (Dorkenoo 1995, 13.)

"According to tradition, the husband should have prolonged and repeated intercourse with a woman during eight days. This "work" is in order to "make" an opening by preventing the scar from closing again. During these eight days, the woman remains lying and moves as little as possible in order to keep the wound open. The morning after the wedding night, the husband puts his bloody dagger on his shoulder and makes the rounds in order to obtain general admiration"(Dorkenoo 1995, 13).

2.2.4 Prevalence of Female Genital Mutilation

FGM is mostly practiced in 28 African countries and Asia (See Appendix 1 and 2); However, Europe, Australia, Canada and USA are coming next mainly among immigrants from Africa and South West Asia. World Health Organization states that 132 million women and girls' have undergone FGM globally, and another two million girls' are at risk every year (Comhlámh 2005). There are many organizations working to eradicate FGM, to mention few: Amnesty International, World Health Organization and Finish World Vision (See Appendix 3).

2.3 The Need for the Project

Female Genital Mutilation has been a problem especially in African countries for centuries. Different organizations have been working towards eliminating this tradition for sometime already. However, in Europe FGM is still fairly unknown even among health care professionals. Nevertheless the amount of girls undergoing FGM in Europe is growing due to the increasing rates of migration. (Afrol News 2006.)

A study carried in 1998 had shown that the number of migrants coming from countries practicing Female Genital Mutilation is the highest in Britain counting more than 300,000 individuals, France with almost 200,000 women immigrants from those countries, followed by Italy and Germany with 133,847 and 77,795 women immigrants respectively. (Afrol News 2006.)

Moreover, almost 50 per cent of health care providers in the UK have been confronted with FGM complications, and most of them over 90 per cent would never perform a FGM procedure. However, the British Medical Association estimates the number in the UK to reach 3000 procedures every year. (Afrol News 2006.)

There are no statistics on FGM in Finland. According to Mölsä (2004) talking about FGM is difficult, in communities where men and women are not used to communicating together about sexual issues and in Finland where the practice of FGM is a foreign tradition and an illegal act. (Ihmisoikeusliitto ry 2004, 17.) The stigma on FGM that makes it less discussed in the society showed a need for this project in Finland.

2.4 The Target Group

The target group for the project was mainly the health care professionals, in particular midwives and nurses, who are working with women and girls migrating from countries practicing FGM. The authors also intended to target Midwifery and other health care students in Jyväskylä, to prepare them on how to deal with FGM and related issues in their future careers.

2.5 The Objectives

The ultimate goal of any effort towards the issue of Female Genital Mutilation should be to stop the practice world wide and to support those who have already been victimized. However, it has to start from

somewhere. It is relevant that all health care professionals be informed about FGM, especially in areas where the practice is unknown and is beginning to spread. Educating influential people, in this case the health care professionals, is a key factor. By working with these respected members of the community, effective and lasting change can be promoted. Below are some of the objectives.

- To provide some information on Female Genital Mutilation to health care professionals in the Central Hospital of Central Finland.

- To provide information for midwifery and International nursing students in Jyväskylä University of Applied Sciences, School of Health and Social Studies on the effects of female genital mutilation and how to deal with women and girls who have gone through the practice.

- To encourage health care professionals to increase their knowledge about the practice and to gain the courage to talk about it among the immigrants who are bringing the culture with them as they migrate to Europe.

2.6 Co-operator of the Project

When starting to brainstorm about the project in the beginning of the year 2006, the authors faced difficulties while looking for working life connection. Most of the international as well as national organizations had done their research studies prior to the beginning of their projects affecting FGM. The authors retained their options open for other propositions the organizations might have had. However, the organizations either did not respond or responded with negative results.

Considering the effect that migration has had in the spread of Female Genital Mutilation in Finland, having Jyväskylä University of Applied Sciences, School of Health and Social Studies was a good opportunity for students especially Midwifery and Nursing to benefit from information about the practice. (Comhlámh 2005.) A booklet about FGM was also going to be supplied to health care professionals in Central Hospital of Central Finland, to enlighten them about the practice and its effects.

3 PLANNING OF THE PROJECT

3.1 Theoretical Base for a Project

Plans for a project should be well planned and strategized. However, a fixed project plan is not always achievable which is why it should be left open for later modification if need be. Open planning enables the analyzing of potential risk factors and therefore needs to be flexible. Open planning goes hand in hand with the implementation of a project and the project implementers may work together with the target group. By doing this, a sense of commitment is created towards the project and it allows a wide range of opinions to be shown. (Virtanen 2000, 22, 27, 89.) A properly planned project is easily implemented and can reach the expected objectives (Eriksson 1985, 52).

A good project plan should include the following qualifications: Objectives that are realistic and explicit, a manageable timetable and enough resources. Despite the fact that the criteria for the project are clear, it might be difficult to put them in practice. At times the aims and objectives can be unpractical and unable to be implemented. (Silfverberg 2001, 12-13.)

Nowadays there are theories aimed to assist educators in the planning of lessons which are highly recommended for use (Lorig 2001, 21).

However, in the work of Tight's (1998), it has been suggested that the focus of the attention should be toward learning and the learning process other than models when training adults (Tight 1998, 26). In Eriksson's (1985) theory planning the care pedagogical process was experienced to be valuable for both, the target group and educators. Virtanen's (2000) and Silfverberg's (2001) guidelines for project work was connected to Eriksson's (1985) pedagogical thoughts, which made it easier to understand the whole context. These three works are combined and utilized when implementing this whole project.

Project work can be divided into different phases such as; defining the objectives and analyzing the possibilities, planning and structuring the content, implementation and finalizing the project. This kind of breaking down of areas helps noticing potential risks for the project. The project starts by characterizing the objectives, which are based on analyzes of the needs for the project. Analyzing includes taking into consideration the type of the project, its target group and the kind of purpose it has. Goals for the implementation of the project are important as well. A project itself can not be the purpose; it is expected to gain more value by having useful benefits. A project needs a clear goal, mission and vision from the outcome. (Eriksson 1985, 52-56; Silfverberg 2001, 13, 45- 49; Virtanen 2000, 73-74, 93.)

When the needs and objectives for the project have been defined, planning can take place. Planning allows forming alternative methods to implement the project. Every project needs resources such as human, social and economical. Evaluation of resources is important; who is providing them, what kind, how much and when those are used. Limitations and prohibitions of the use of resources should be evaluated closely. (Eriksson 1985, 50-55; Silfverberg 2001, 38-39, 56; Virtanen 2000, 74, 95.)

The method of how to carry out the project should be chosen according to the comparison of the benefits and risks of different options.

The aim is to find the most beneficial way with the least risks involved. To ease implementation the project could be divided into smaller sections. During implementation a constant evaluation should be carried out in order to find out gained objectives, productivity and efficacy. Furthermore, the project plan should include clear objectives and methods to measure issues mentioned above to enable evaluation. (Silfverberg 2001, 24, 40-41.)

The last phase is the project closure. The end of the project depends on the type of the project and discovered results. During final evaluation the focus is on how the set objectives were reached and implementation. Motives of evaluation need to be considered as well in critical evaluation; such as how information received is used and whose interests are taken into account. The sustainability and accountability of the evaluation should be considered. Evaluation can include client feedback plan and routes to find result information as a newcomer. (Eriksson 1985, 54-55; Virtanen 2000, 77, 153-156.)

Essentiality of education and teaching is important to remember. According to Engeström (1991) people learn all the time, even without teaching. However, teaching is an important tool to have deeper, more purposeful and systematic learning. The educator has a leading role in the whole process of teaching. The educator contributes to the teaching by deciding the ways of presentation and outline of the topics. (Engeström 1991, 62, 64.)

3.2 Good Health Educational Material

Good writing expresses a clear point, is firmly structured, grammatically and syntactically correct, real and interesting. The ability to express oneself briefly and straight to the point is a general but very important skill. It is important to get the balance right so that the intended users have sufficient information for their purposes. (Swetnam 2000, 25, 70.)

There are some principles of general written communication that a writer should consider. The information firstly should be clear to the reader and easy to understand. Professional jargon can be used if the intended audience is in the same profession as the writer. Clearly written work will be easier to understand and will accomplish the intended purpose. (Castledine 1998, 11.)

Any writer should consider what the person reading the information may want to know. The information can be read by the intended audience or also by other people. It is important to stick to the required information which should be given to the reader. Information may be well written down and accurate, but if it is not well organized and presented, the information may not be well utilized and may be ignored by the reader. Planned presentation of the information is the key to effective written communication. The written work should be appropriately organized into a proper format. (Castledine 1998, 11-12.)

After a booklet has been written and successfully completed, it should be evaluated in order to determine how well it has been written and if the information given is correct and well presented. (Teacher & Educational Development 2002.)

The booklet evaluation used was adapted from Teacher & Educational Development (2002), which was followed while writing the booklet on Female Genital Mutilation. It made it easy to decide what information was going to be included in the booklet. It also provided guidance on how the headings were chosen and including pictures and graphics in the booklet. A good layout and plan was adapted which facilitated a complete and proper representation of the information that was in the booklet. (See Appendix 4)

3.3 Booklet as a Source of Health Information

A booklet is a good source of information for people who do not have access to internet, do not know how to use internet or have time to search information from the internet (Archard 2000). The language should be clear and understandable without any jargon. The sentences need to be kept short to allow the reader grasp information quickly and effortlessly. In addition, booklets are easy to carry around and they will not require much space to store. Booklets are a sufficient tool for busy professionals, with its compact and direct style of bringing specific information noticed. (Nunley 2003.)

The reason for writing a booklet was partly because of authors own interest towards the subject but also the lack of material about FGM. A booklet is easy to spread around among people as well as companies and carry it from place to place. It offers information in a very efficient way. People who will specifically read this booklet will benefit from its direct style to bring information in a compact form. The authors of the booklet did the research from the existing material and put it into this booklet to save time and to help fellow health care professionals.

3.4 Planning of the lessons of FGM

The aim of the lesson was to make FGM known among midwifery students and international nursing students, so that when they graduate they have some knowledge about FGM and they are able to work according to the regulations of Finnish legislation with the people affected by FGM. The lesson was planned to be part of midwifery and international nursing students' course which are chosen by the teachers of Jyväskylä University of Applied Sciences, School of Health and Social Studies.

The lesson was done to allow open interaction between educators and students. The lesson covered information shared in the booklet which

was one part of the project. The students were taught through PowerPoint presentation and they were given a handout from it, which they could take home and have it as a guide in their working life. The language of the lesson was carried out in English and the Finnish students were given a chance to ask questions in Finnish.

When planning the lesson the main aim of the educator was to have a clear picture of the achievements expected through a lesson. The needs of the lesson should be acknowledged and evaluated. It is extremely essential to prioritize the output due to the time limits and information adaptability of the clients. The information shared should be short, clear and understandable. The objectives are easier to write down, when the set of priorities are well done. (Lorig 2001, 53, 86, 89-90; Webb 1995, 23.) The teaching should deliver few well picked out and clear subject topics (Engeström 1991, 63). The key message in the works of Lorig (2001), Elliot (1995) and Webb (1995) goes along with Engeström's (1991) statement that only three to four key elements should be presented during one lesson. However, if more is used the over load of information is not receiving attention well enough anymore. Given information ought to be accurate, clear and understandable, with the usefulness to the client. (Lorig 2001, 53, 89-90; Elliot 1995, 204-205; Webb 1995, 23.)

The content of the lessons should be dependent on the needs of the client instead of what is found easier to teach (Babcock & Miller 1993, 164; Jaarsma, Abu-Saad, Dracup & Halfens 2000, 117). Clients are more motivated to learn when the expectations of learning have been identified and the learning becomes essential and personal. The educator should be aware of the clients' developmental, emotional and experimental maturity prior to the teaching. (Fuszard 1995, 5; Babcock & Miller 1993, 165.)

After selecting the content of the lesson, the educator considers the way of presenting the topics. (Lorig 2001, 53; Webb 1995, 23.) The

teaching methods during lessons should be variable and enjoyable to the clients. Three main methods of teaching are; teacher centered, where the teacher does all the work, client centered, where the study group does all the work and co-operative, where the teacher and the study group interact with each other. Never forget the importance of repeating and revising the main contents of the topics covered in previous lessons. (Engeström 1991, 67, 123, 133.)

Materials are intended to be a supportive addition to the teaching by making it more understandable, but should not be used as a substitute of a person. Different accessories and elements create more interest towards the topics and theories as well as making the affecting experience more extended. (Babcock & Miller 1993, 205-206; Elliot 1995, 203-205.) The material is only valuable if it accomplishes the expected. The material should include the information based on client needs, so that it is understandable and usable. Visual aids and culturally relevant analogies are highly recommended when the members of the study group have insufficient literacy, to make the topics more understandable. (Lorig 2001, 171, 173, 183, 190, 196.)

3.5 Ethical Consideration of the Project

Health care professionals must be prepared to care and educate clients' from diverse cultures. Suitable caring happens when learning from others cultures. Unless being aware of the values of the client, ethical dilemmas with harmful outcomes are ought to happen. (Donnelly 2000, 119-120.) Considering clients' culture and beliefs enables health care professionals for ethically correct care (Eliason 1993, 225). It is extremely important for health care professionals to notice the difference between their own and clients' values, beliefs and ethical issues. To be able to do that they should first understand their own culture and worldview, in order to deliver culturally relevant care. (Andrews & Boyle 1999, 446.) It might be easier to see and compare the differences between cultures, rather than understand their real char-

acteristics. (Leininger 1994, 87.) The values and beliefs should not be misunderstood or ignored. Health care professionals must not assume that clients coming from same the culture and speaking the same language have also the same values. The values and beliefs are mostly influenced by age, gender, class, education, caste, geographical location, political and religious beliefs, and traditions of the individual. (Andrews & Boyle 1999, 446-447.)

Ethics is the very essence of this project. When starting with this project ethical consideration needed to be part of it. This project combined so many cultures and individuals together with this highly sensitive issue of FGM that was covered. Like said in the literature review, it is better to present this issue from the humanitarian point of view rather than presenting it so that it would seem like you are trying to attack that specific culture and community, which would seem like racism. The lecture and the booklet were challenging to do, due to the fact that it might offend ones values and beliefs. To avoid conflict between scientific knowledge and ideological religious, cultural or economical beliefs (Bandman & Bandman 1995, 10), cultural and ethical aspects were kept in mind.

It is always difficult to know how to teach and write ethically correct information. Should it be only a presentation about facts and figures, and let the person decide how to go on, or try to get them to do what seems right for them, or tell them straight out what to do. Ethical problems can also rise when one does not feel like there is need for an improvement. (Norton 1998, 1269.) The lesson and the booklet was done so that it would represent the universal guidelines and give information about FGM.

3.6 Methods of the Project

3.6.1 Booklet: Information about Female Genital Mutilation was to be conveyed to health care professionals in the Central Hospital of Cen-

tral Finland and students in Jyväskylä University of Applied Sciences, School of Health and Social Studies through a booklet. The booklet was to contain information on; an introduction, what is female genital mutilation, types, prevalence of the practice, when it is performed, who performs it, why it is performed, physical and psychological consequences, ethical cultural and religious issues, human rights and the prevention. The aim of the booklet was to enlighten the readers on the entire phenomenon of Female Genital Mutilation.

3.6.2 Lesson: In English language was to be carried out. The lecture included a presentation on the subject of Female Genital Mutilation, which was intended to teach people about the subject. The Lecture was used to convey critical information, history, background and strategies to help stop FGM.

To make the lecture more effective, a video was shown about projects and activities which are being done in Finland to help stop FGM. A PowerPoint presentation was done and handouts containing the contents of the lecture were given out. These were some of the tools that comprised a good lecture and they increased the chance of putting a certain message forward to the audience. (Teacher & Educational Development 2002.)

3.7 Resources

Authors had all the means needed to achieve the objectives and to make the project a success. The supervision by the lecturers of Jyväskylä University of Applied Sciences, School of Health and Social Studies was much needed and a great importance as authors headed forward and had constant consulting with them.

Working in a team was also important, and actually being able to maintain the team work spirit during the entire project. Authors were

able to work and pool their efforts together which contributed greatly in achieving their goals.

The Jyväskylä University of Applied Sciences, School of Health and Social Studies library and the city library of Jyväskylä were used constantly as the sources of information. Articles, books and researches were of great importance and were well utilized. The internet was also used as a source of information. Computers to aid in the written output and putting authors' ideas and efforts on paper were available and functioning reliably.

4 IMPLEMENTATION OF THE PROJECT

The transcultural aspect of work was essential in the project to be able to understand the meaning of culture and how it affects human beings in interaction with others. It helped to realize the cultural differences and behavioural patterns in transcultural work.

In September 2006 the planning for the booklet started and in October 2006 implementation took place. The Lesson was planned during January 2007 and presented in early February 2007 in the venue of University of Applied Sciences.

4.1 The Lesson

The lesson was planned and aims to be achieved were set within the structured time frame. The following layout was used for the lesson.

Topic and Timing	Objectives	Implementation	Material
Female Genital Mutilation Thursday 1.2.2007 at 16:00-17:30	- Share FGM information - Information about Finnish law - Participants would recognise the cultural aspects of FGM	- Welcome letter was sent prior to the presentation - KokoNainen-video showed - Theory of FGM - Discussion forum - Handing over handouts - Filling of evaluation form	- Invitation letter (Appendix 6) - KokoNainen video - Power Point presentation - Handouts - Overhead projector - Evaluation form (Appendix 5)

Discussion of the Lesson

The objectives for the lesson were accomplished well. Despite the fact that the lesson was held late evening the attendance was high. The participants were encouraged to ask questions and comment about the topic. The topic was familiar to very few participants and the rest had no previous knowledge about FGM. The lesson was started by showing a video about a Somalian family living in Finland who wanted to circumcise their youngest daughter. A power point presentation followed the video and at the end of the lesson a forum was opened for discussion.

An evaluation form (See Appendix 5.) was handed out to each participant to evaluate the presentation done, the presenters' skills and the value of the information given. The general feedback given showed that the information was valuable and needed. The presenters' skills were adequate and the teaching methods were diverse. The schedule went

as planned and the lesson ended in time. Some participants expressed their shock towards FGM and its consequences.

4.2 Results of the Project

The concrete results of this project were the informative booklet of FGM and the lesson held for midwifery and International nursing students in the Jyväskylä University of Applied Sciences, School of Health and Social Studies. The results of the planned lesson created an interest to offer lessons to other health care students in the University. These lessons were planned and held according to the first lesson done.

5 DISCUSSION OF THE PROJECT

5.1 Evaluation of the Project

As a Bachelor's Thesis for authors' Nursing Degree in Jyväskylä University of Applied Sciences, School of Health and Social Studies an informative booklet was produced and a lesson was held, which was based on the booklet, about Female Genital Mutilation for health care professionals. The project started in the autumn 2006 when the topic was accepted. The objectives of the project were to provide information for midwifery and International nursing students in Jyväskylä University of Applied Sciences, School of Health and Social Studies and health care professionals in Central Finland Central Hospital on the effects of female genital mutilation and how to deal with women and girls who have gone through the practice. It was important to bring out the issues of FGM because of the growing numbers of migration.

The project started by writing the booklet, which did not take much time. The information was easily available on the internet however; local literature review was very limited. It showed the need for this

project. Prior to finalising the booklet authors held a lesson about FGM. The ready booklet was introduced during thesis presentation.

Information about FGM was plenty on the internet by different organisations. Moreover, it was challenging to find adequate and recent information. Also pictures for the booklet tended to be hard to find. The organisations fighting to eradicate FGM had very good information world wide.

The practice of FGM was horrifying to the authors and the scientific knowledge they had was very little. One of their goals was also to educate themselves about FGM and be more prepared for the future work as nurses. In the booklet they have covered the main principles of FGM, for it being a fairly unknown issue in Finland and other western cultures. Comments during and after the lesson was held, second the fact that knowing more about FGM would make a difference in working life situations.

Completing the written report for the project was very challenging, as this was the first big project the authors had done; the authors had no previous experience what to write and how. There were some books about how to write a project report however; a practical and detailed guide on how to write Bachelor's Thesis would have been very helpful. The written work was reviewed many times and corrections made. The time authors spent on writing was challenging in every way and it gave a new meaning for team work. However, the skills and experiences gained during the process were useful.

The goals that had been set for the project were reached. The booklet and the lesson were produced according to the plans and objectives that were set at the beginning. Personally and professionally the authors gained experience in writing theoretical and scientifically important information, searching for information and pedagogical skills.

5.2 Conclusions and future perspectives

The issue of FGM that was thought to concern only Africans and Middle East people is now facing Europe including Finland. Female Genital Mutilation is practiced in countries where cultural legacy is very strong. Now that people are freer to move from place to place, the traditional heritage is following and being spread to new places.

While collecting information for the project it was evident that there is a great lack of written material in Finland and especially in Jyväskylä about the practice of FGM. Studies also show that the knowledge of FGM among health care professionals is not adequate (Ihmisoikeusliitto ry 2004). This shows that there is need for further research and studies concerning FGM, to help educate people about the practice and how to deal with it.

Having laws that govern Female Genital Mutilation in countries where immigrants still follow this tradition is a significant factor. Although this is not the only solution to the big problem, it will reduce the numbers of FGM performed in a given period of time. Culture sensitive Education combined with clear laws governing this practice is a way forward toward eradication.

Initiating community dialogue about the practice of Female Genital Mutilation will be an approach towards eradication. In many communities, FGM is rarely talked about, let alone a subject for public debate. Bringing people together, men and female alike to talk about the issues openly and beginning discussions that examine the value of FGM and expose its harmful consequences will help in future eradication of the practice.
Supporting individual change is also a needed strategy. This is to the people who have been victimized by the practice and people who the practice is part of their culture. Encouraging these people to come out strongly and courageously will help in eradication of FGM. The sup-

port can be offered by NGO'S, health care professionals who are familiar about the practice and also on individual level by people willing to fight against Female Genital Mutilation.

Empowering individuals who already know the effects of Female Genital mutilation to educate others about the practice, and to gain the courage to fight for the rights of their friends and family members is a future development. The booklet produced could also be distributed and used all around Europe. This will help health care professionals around Europe gain some knowledge about FGM.

Enhancing and increasing professional growth and awareness at the end of this project will be a positive contribution towards the impact of the health care professionals and health institutions to the society. This will be an achievement in fighting for women and girls who are in the risk of facing FGM and those who are already victims. Equipping health care professionals with knowledge and how to deal with the issue of Female Genital Mutilation in their future career is a professional development.

Future challenges in the field of FGM are; a continuous eradication of the practice, education of the health care professionals and communities where FGM is still being practiced and bringing the subject open to different fora.

Due to the fact that FGM is such a sensitive issue there are still many areas uncovered which could act as future research topics. Topics such as, why this tradition is still continuing? Different methods of performing rites of passage and less harmful practises which could act as culture identity can be potential research areas.

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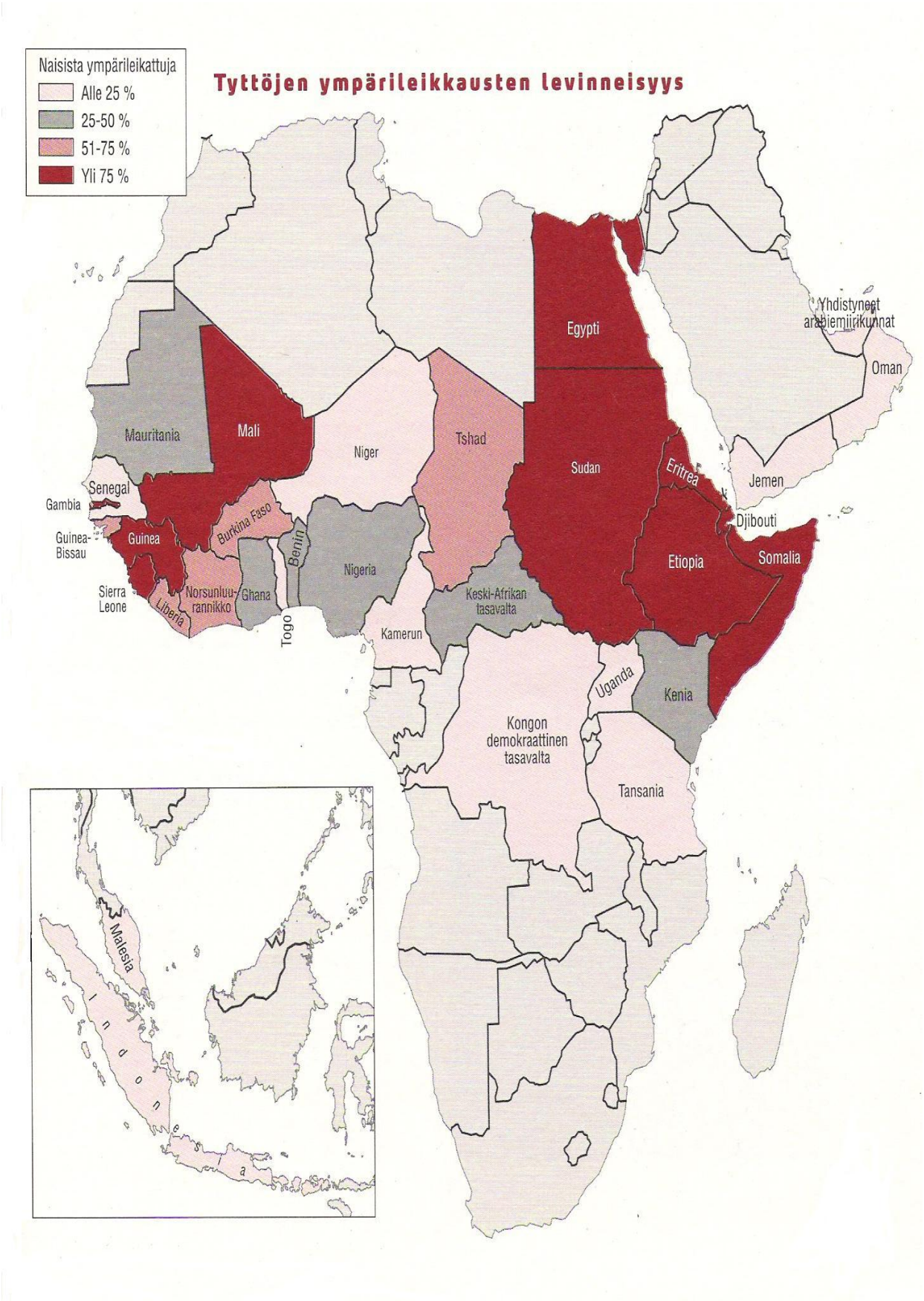
Appendix 1. The Prevalence of FGM



(Ihmisoikeusliitto ry 2004, 13)

Appendix 2. FGM Practices by Country

Country	Prevalence	Type
Benin	5-50%	Excision
Burkina Faso	up to 70%	Excision
Cameroon	local	Clitoridectomy and Excision
Central Africa Republic	45-50%	Clitoridectomy and Excision
Chad	60%	Excision and Infibulation
Côte d'Ivoire	up to 60%	Excision
DRC (Congo)	local	Excision
Djibouti	98%	Excision and Infibulation
Egypt	85-95%	Clitoridectomy, excision and infibulation
Eritrea	95%	Clitoridectomy, excision and infibulation
Ethiopia	70-90%	Clitoridectomy, excision and infibulation
Gambia	60-90%	Excision and Infibulation
Ghana	15-30%	Excision
Guinea	65-90%	Clitoridectomy, excision and infibulation
Guinea Bissau	local	Clitoridectomy and excision
Kenya	50%	Clitoridectomy, excision and some infibulation
Liberia	50%	Excision
Mali	94%	Clitoridectomy, excision and infibulation
Mauritania	25%	Clitoridectomy and excision
Niger	local	Excision
Nigeria	60-90%	Clitoridectomy, excision and infibulation
Senegal	20%	Excision
Sierra Leone	90%	Excision
Somalia	98%	Infibulation
Sudan	90%	Infibulation and excision
Tanzania	18%	Excision, infibulation
Togo	12%	Excision
Uganda	local	Clitoridectomy and excision
Based on statistics from Amnesty International and US govt. (Afrol News 2006)		

Appendix 3. List of Some Organizations Working with FGM Issue

LIST OF ORGANIZATIONS FIGHTING AGAINST FGM

- Amnesty International (www.amnesty.org)
- CARE (www.care.org)
- Equality Now (www.equalitynow.org)
- Finnish World Vision (www.worldvision.fi)
- FORWARD (www.forward.dircon.co.uk)
- IAC (www.iac-ciaf.ch)
- RAINBO (www.rainbo.org)
- Stop FGM (www.stopfgm.org)
- World Health Organization (www.who.int)

Appendix 4. The Criterion to Evaluate a Booklet

Required elements	Several required elements were missing from the booklet.	All but one of the required elements is included in the booklet.	All required elements are included in the booklet.	The booklet includes all required elements as well as additional information.
Headings	There are few headings which are far between. The various sections are not obvious.	Many sections of importance in the booklet are labeled.	Almost all sections of importance in the booklet are clearly labeled.	All sections of importance in the booklet are clearly labeled with appropriate headings.
Graphics-Relevance	Graphics do not relate to the topic or several sources are missing.	Relate to the topic and one-two borrowed graphics have a source mentioned.	Related to the topic. Some borrowed graphics have a source mentioned.	All graphics are related to the topic and it is easy to understand. All graphics have their sources.
Layout and planning	Distractingly messy or very poorly designed. It is not attractive.	Acceptably attractive though it may be a bit messy.	Attractive in terms of design, layout and neatness.	Exceptionally attractive in terms of design, layout and neatness.
Grammar/ Spelling	4 or more grammatical/ spelling mistakes.	3-4 grammatical/ spelling mistakes.	1-2 grammatical/ spelling mistakes.	No grammatical/spelling mistakes.

(Teacher Net UK 2007)

Appendix 5. The Evaluation Form

Female Genital Mutilation Presentation Evaluation

Female Male

Age 20-25 26-30 31-35 36-40 41-45

Presentation evaluation

1. The presentation was well organized
2. The presentation provided new and/or additional information
3. The handouts strengthened the presentation
4. The teaching methods were diverse

Presenters' skills

1. Presenters were effective in presenting the information
2. Communicated interest and enthusiasm for subject
3. Made eye contact with audience
4. Voice had good clarity and volume
5. Body language and gestures were appropriate

Value of information

1. Importance of the information
2. Previous knowledge
3. Usefulness of the information

Would you like to add something that was left out?

Evaluation should be done with the scale from 1 to 5, 1 being the poorest and 5 the greatest

Thank you for your participation!

Appendix 6. The Invitation Letter

Dear Students

We are happy to invite you to our presentation about Female Genital Mutilation on 1.2.2007 in class room 3023 at 16.00

You are all warmly Welcomed!

Monicah Kiarie

&

Johanna Wahlberg

Appendix 7. The Prohibition of Female Circumcision Act

1 (1) Subject to section 2 below, it shall be an offence for any person –

(a) To excise, infibulate or otherwise mutilate the whole or part of the labia majora or labia minora or clitoris of another person; or

(b) To aid, abet, counsel or procure the performance by another person of any of those acts on that other person's own body. (Hopkins 1999)

2 (1) Subsection 1(a) of section 1 shall not render unlawful the performance of a surgical operation if that operation –

(a) Is necessary for the physical or mental health of the person on whom it is performed and is performed by a registered medical practitioner; or

(b) Is performed on a person who is any stage of labour or has just given birth and is so performed for purposes connected with that labour or birth by –

(i) A registered medical practitioner or a registered midwife; or

(ii) A person undergoing a course of training with a view to becoming a registered medical practitioner or midwife. (Hopkins 1999)

3 In determining for the purposes of this section whether an operation is necessary for the mental health of a person, no account shall be taken of the effect on that person of any belief on the part of that or any other person that the operation is required as a matter of custom or ritual. (Hopkins 1999)

Female Genital Mutilation

Johanna Wahlberg
&
Monicah Kiarie

Definition of FGM?

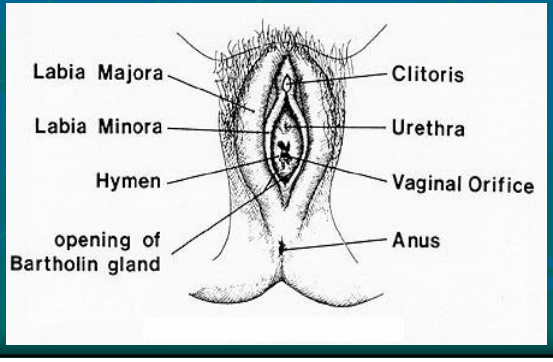
- Female genital mutilation is also referred to as female circumcision and female genital cutting
- It is the cutting away part or all of the external female genitalia

- Collective term for various traditional practices which are all related to the mutilation of the female genital organs. Five different forms and grades of FGM have been distinguished.
- FGM is a severe violation of human rights and burdened with severe health and mental dangers.

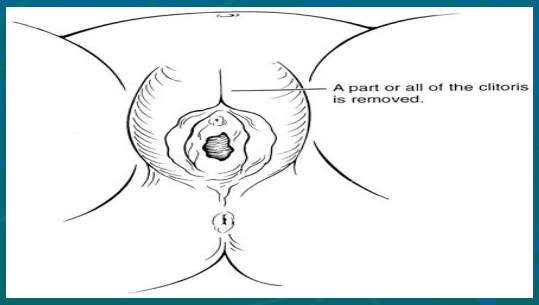
Types of FGM

- Circumcision
- Excision
- Infibulation
- Intermediate infibulation
- Unclassified

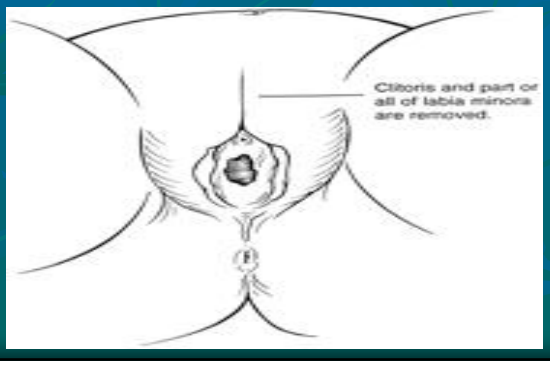
Normal Female Anatomy



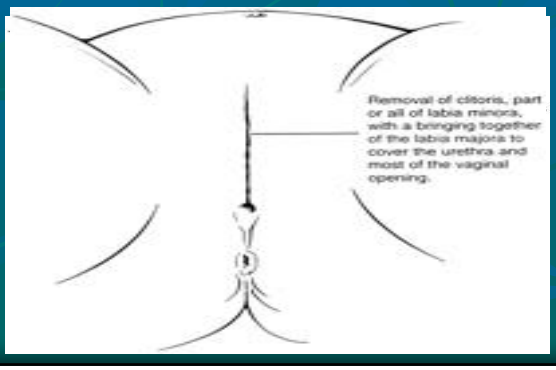
Circumcision

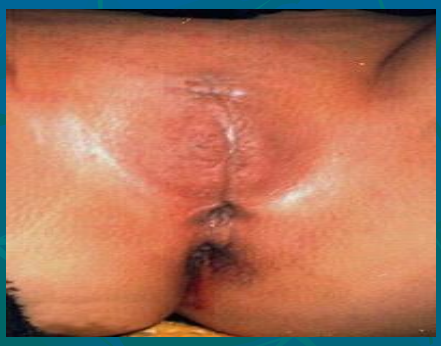


Excision

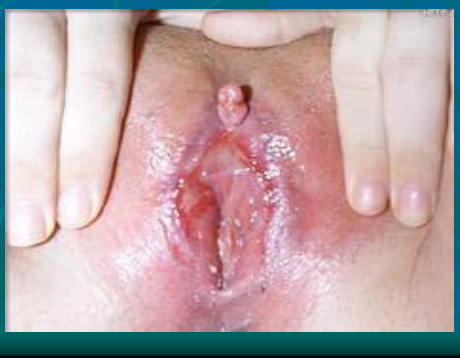


Infibulation





Intermediate infibulation



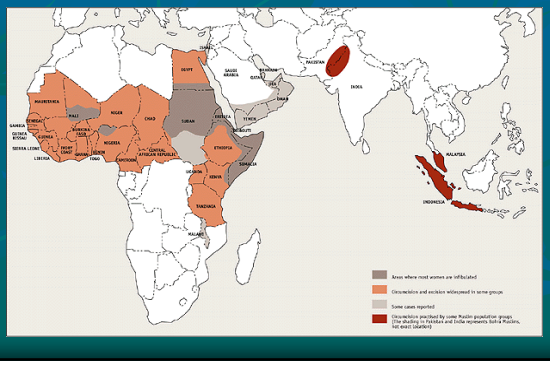
Why is FGM practiced?

- Aesthetic
- Psycho-sexual
- Religion
- Sociological

Religious issues

- Muslims
- Christians
- Jews
- Animists

Prevalence of FGM



Prevalence of FGM

- Practiced in 28 countries
- 132 million women and girls have undergone FGM globally
- 2 million women and girls are in risk every year

Practitioners

- Traditional birth assistants
- Untrained midwives
- The elder of the community

Tools used

- Knives
- Razors
- Scissors
- Broken glass

Tools used

Consequences of FGM

Vary by:

- Practitioners
- Types of FGM
- Place and conditions of operation

Immediate physical complications

- Excessive bleeding
- Wound infection
- Urine retention from pain, swelling or blockage of the urethra
- Shock of blood loss and intense pain
- Damage to adjoining organs
- Possible death

Long-term effects

- Anemia
- Overgrowth of scar tissue
- Abscesses
- Recurrent urinary tract infections
- Infertility

Reproductive and sexual health consequences

- Painful or blocked menses
- Risk of HIV/AIDS
- Recurrent reproductive tract infections
- Difficult or impossible gynecological exams and limited contraceptive choices
- Painful sexual intercourse
- Reduced sexual fulfillment

- Increased risk of illness or death to mother and child due to obstructed labour
- Fistula formation
- Strain on marriage

Psychological effects

- Lower self-esteem
- Post-traumatic stress disorder
- Severe depression and anxiety
- Psychosomatic illness
- Long-term physical illness

Medicalization of FGM

- Sanitation (+)
- Use of anesthesia (+)
- Use of pain killers and anti-tetanus drugs (+)
- Less tissue cutting and trauma (+)
- Does not address long-term FGM issues (-)
- Reason for health care providers to begin practicing FGM (-)
- Does not discourage the traditional circumcisers to stop the practice (-)

Rising positive trends

- Against religious convictions
- Formal education
- Harmful effects of FGM
- Loss of significance
- Less severe forms of FGM preferred
- Young and more educated females disapprove the practice
- Percentage of circumcised women are decreasing with age

- More organizations are getting involved in eradication
- FGM presented in national, regional and international fora

Finnish Law

- Criminal law nr. 21
- Extreme assault
- Imprisonment 1 to 10 years

List of organizations fighting against FGM

- Amnesty International (www.amnesty.org)
- CARE (www.care.org)
- Equality Now (www.equalitynow.org)
- Finish World Vision (www.worldvision.fi/fgm/)
- FORWARD (www.forward.dircon.co.uk)
- IAC (www.iac-ciaf.ch)
- RAINBO (www.rainbo.org)
- Stop FGM (www.stopfgm.org)
- World Health Organization (www.who.int)