

FEMALE GENITAL MUTILATION (FGM) AND ITS FUTURE
AMONG SOMALI WOMEN IN FINLAND

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Abstract

Female Genital Mutilation (FGM) is largely practiced in Somalia and it forms an essential part of a Somali girl's life. Ending FGM under Siad Barre's regime was encouraged even if there was no law specifically prohibiting FGM. However, still 98% of Somali women undergo FGM in Somalia.

With global mobility in terms of refugees, asylum seekers, workers, immigrants and tourism, different cultures are coming together and absorbing aspects from each other. New acculturation modes are emerging with changed perceptions of old traditions. According to some studies the change in traditions takes at least two generations. This was one of the interesting points to verify in this study. In Finland FGM is prohibited. Thus young Somali generation in Finland is growing up in Finnish cultural environment and with Finnish cultural values.

This study wanted to find out how important the female genital mutilation is in Somali women's identity in today's Finland, change in the attitude and how FGM's future in Finland is evolving. The study was based on thematic interviews that were conducted on a basis of prepared set of questions by the author. The interviewed group was identified through previous connections on a voluntary basis and consisted of five Somali women living in Finland. The study results showed that the continuation of FGM tradition in new generations was not seen necessary and the overall result of the study was very straight forward: FGM should be abolished from the tradition. FGM had left marks on those of the interviewees, who had had it done, but the significance of FGM in their female identity was insignificant. Best ways to eradicate the tradition, according to the interviewees were massive, community based education and awareness raising programs to be accessed by everybody.

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ABBREVIATIONS

EDUVAKE	The All party Parliamentary Group on Population and Development
ETNO	Advisory Board of Ethnic Relations
FC	Female Circumcision
FGC	Female Genital Cutting
FGM	Female Genital Mutilation
IAC	Inter-African Committee
NICEHEARTS	Women and girl's Productive Association
PLAN	International Children's Development Organization
PRB	Population Reference Bureau
STAKES	Finland's National Institute for Health and Welfare
UN	United Nations
UNFPA	United Nations Female Population Association
UNICEF	United Nations International Children Fund
USAID	United States Agency for International Development
WHO	World Health Organization
WUNRN	The Women's UN Report Program & Network

INTRODUCTION

WHO uses the term Female Genital Mutilation (FGM) to cover all forms of female genital cutting and female circumcision. The term FGM was agreed upon as an appeal to use the term in the 6th general assembly of Inter-African Committee (IAC) in 2005 in Bamako, Mali (WHO: An interagency statement 2008). FGM is used in this study to cover the whole procedure in all its' various forms. Hence, a procedure, where a girl's genitals are cut either partially or totally and the remaining area is closed, leaving but a tiny opening for the passing of urine and menstrual blood, can have various names according to how it is seen in the context of a particular society. Female circumcision, female genital cutting or female genital mutilations are all names used for the previously described procedure (Abdalla 1982; Brusa et al. 2009; Denison et al. 2009). WHO estimates that up to 140 million women worldwide have undergone this procedure and that every year about three million girls are at risk to undergo FGM (WHO: 2008).

The procedure of FGM is practiced indisputably in numerous countries all over in the world. Its highest prevalence is in African countries, but it is also common in the southern part of the Arab peninsula along the Persian Gulf, in the Middle East and among of the Muslim population of Indonesia and Malaysia (Lightfoot-Klein 1989; Lockhat 2004; Odeymi 2008). With the global population movements and immigration populations, we are now facing FGM practices amongst cultures where the practice is not exercised by the original population. FGM is thus prevalent also among certain immigrant communities in Europe, Canada and Northern America (Abdalla 1982; Population Reference Bureau, PRB 2008). The tradition of FGM is often seen as a Muslim tradition, set in religious rules of Islam even if FGM is a tradition linked with several cultures and religions. There are descriptions of FGM dating back to ancient Egypt and as far as The Book of Moses (El Sadaawi 1980; Hakola 1992; Gruenbaum 2001)

In Somalia FGM is still strongly practiced. Approximately 98% of Somali women have undergone the procedure, the forms of which vary by region. The tradition is respected and seen as an important, necessary event in a Somali girl's lifespan. It is normally performed between the ages of 3-11 years, but exceptions occur in both ends and the

procedure can be performed also earlier than 3 years or later than 11 years due to the time and the availability of the performer (Abdalla 1982; UNICEF 2005). The Somali population in Finland is over 11.000 people. Interaction of cultures is evident, the cultural values introduce new perspectives and dimensions to people's attitudes (Pajunen 2011).

The study's topic: "Female genital Mutilation (FGM) and its future among Somali women in Finland" is based on the importance, yet the lack of information, on the topic from a Somali woman's point of view. We have researches referring to the health personnel and how to deal with healthcare customers who have been circumcised. There are also two studies, conducted by Mölsä in 1994 and 2004, where the FGM is brought up but there is no updated knowledge about what kind of a role does FGM play amongst Somali immigrants in today's Finland? The aim of the study is not only to find out is FGM still an important factor in Somali women's identity in Finland, but also to collect information on the feelings and memories linked to this tradition and, furthermore to get opinion whether or not this tradition should be continued or could it be left out from Somali culture?

The data of the study consists of five interviews with young Somali women living in Finland. The interviews were carried out in Finnish and conducted by the author of the study. The style of the interviews was individual thematic conversations and supportive questions were guiding them. The aim of the study was also to get perceptions of Somali women in Finland on FGM's importance in the Somali female identity and in the modern Somali culture in the Finnish Diaspora.

1. LITERATURE REVIEW

Generalities

A little girl of about three, four years can hardly close her eyes for sleep as her mother had just whispered in her ear: "Tomorrow is a big day for you, we must wake up early and go." "What is happening tomorrow? Where is mother taking me? I have heard something about a big event and to be circumcised, to be proud, but I don't know if mother is talking about this in my case now? Am I really going to have something that I can be proud of and I will be as the big girls in the village? I wish the morning comes quickly and we would be going already with mother. I can hardly wait."

"How little did I know about what became my destiny on that day! I remember being taken to an old woman I had never seen before and, suddenly, she kneeled down on me, my mother took a stronger grip on me and the woman started hurting me in the area between my legs. I screamed and yelled and struggled to get out from my mother's holding hands. I screamed for help and screamed for letting me go, but the woman kept on hurting me, cutting me with a sharp object and forcing some piercing thorns into my skin in my genital area. After, what seems to have taken an eternity, the woman detached her grip from me and I was held still in my mother's arms. I was bleeding and I was in agony of pain, but now my mother comforted me and told me that I was a big girl and would be better soon and I would just need to lie still for many days to allow the wound to heal" (Lee Barnes 1995; Dirie 1998; Dirie 2009; Kassindja 1998; Walker1992; Walker 1993).

Stories similar to this author's own summarized from examples in the literature, are thousands and thousands around the world and similar examples in the following reasons for FGM are based from religion and health demands up to myths and beliefs. The combining factor being that FGM holds the stronghold form of a respected act of a tradition. Just in Africa. WHO estimates that about 3 million girls are yearly at risk of undergoing female genital mutilation. Globally, 14 million women are estimated 14 to have undergone FGM. (WHO 2008)

1.1.The definition of FGM

WHO defines FGM as “all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons “(UNICEF: Female Genital Mutilation/cutting, A statistical Exploration 2005).The practice was firstly referred to as Female Circumcision (FGC), but by the late 1970s, FGM became the popularly used term for the procedure. The term FGM is used by WHO, and since 1991, also United Nations system took the term in use.

1.2. Different types of FGM

It is clear from studying different sources of FGM literature that however common the practice of FGM may be in the respected countries and however old tradition we are tackling, the classification of the various forms of FGM is not yet very clear. Some group the various types into four categories, some into five and even the inside groupings have over-lapping. Different types of FGM are classified either in three, four or into five different categories, depending on the year, culture, and on the country. The classification varies in coverage of the action and grouping of the various forms of FGM overlap with different categorizations (Brusila 2008; Dorkenoo 1992; Mason 1995; Rahman et al.2008).

Circumcision is the mildest form and consists of removal of the prepuce of the clitoris only. It is also called the Sunna, which means tradition in Arabic.

Excision or Clitoridectomy is more severe and consists of either partial or total removal of the clitoris together with the adjacent tissues of labia minor. This can also be called an intermediate type of FGM

Infibulation, also called Pharaonic circumcision, is the most severe form of female genital mutilation involving both excision and infibulation. The labia minor and the inner walls of labia major are cut and then attached to each other, leaving just a miniscule opening for the urine and menstrual bleeding (Wangila 2007). The Pharaonic form of FGM involves, after excision of part or all the external female genitals, stitching or narrowing the genital opening. In Somalia stitching is normally done by thorns, and often a small piece of wood or a reed is left to facilitate the passage of urine

(WHO: Female Genital Mutilation A Handbook for frontline workers 2000; Lockhat 2004 pg.9, Abdalla 1982; Dorkenoo 1992; Rahman et al. 2008).

Unclassified group includes all the mixed forms of FGM. Various types of piercing, pricking or incision of clitoris or labias are included into this group as well as stretching the labias or clitoris, burning of clitoris, inserting substances into the vagina in order to cause bleeding. Tightening the vagina or any other procedure that involves partial or total removal and harming the female genital area. Introcision, which means enlargement of the vaginal orifice by tearing it downwards, is common in parts of Somalia (Lightfoot-Klein 1989). Moreover, the re-infibulations that are done either after a delivery or after an injury are included in this category. Sometimes girls who have had premarital sexual intercourse have themselves sutured, reclosed their genitals to prove their virginity as this is demanded from a girl. Some authors specify a separate group five for a symbolic female genital circumcision where, by nicking the clitoris bleeding is introduced but no changes are caused to the genitals. This habit is reported from Indonesia and Malaysia (Shell-Duncan et al. 2000).

Current estimates state that around 90% of female genital mutilation cases belong to the groups one and two. Cases of group four and infibulation cover 15% of FGM forms in Africa. In Somalia the types 1 and 3 are mostly used, but exceptions are many as variations and modifications of the types (Abdalla 1982). Types 2 and 4 are normally found in Egypt, in Western Africa, and in Arab peninsula respectively. Type 4 is found in everywhere where FGM is practiced (Abdalla 1982).

1.3. Geographic distribution and prevalence of FGM

Recent publications show that FGM/FGC (Female Genital Cutting) is practiced in more than 40 different countries. The following table includes over 50 countries, many of which lack any essential registered data, which gives some evidence of FGM's presence as they show the diversity of the countries where FGM is still practiced. The information was modified and included in into a table by the author of the study.

Table 1. FGM prevalence and types in different countries

COUNTRY	FGM PREVALENCE %	FGM TYPE IF KNOWN
Africa		
Algeria	FGM present	n/a
Benin	17 %	type 2
Burkina Faso	71.6 %	type2
Cameron	20 %	types 1,2
Central African Reb.	43.4 %	types 1,2
Chad	60 %	types 1,2
Comoros	FGM present	n/a
Ivory Coast	44.5 %	type 1
Dem.Reb.ofthe Congo	5 %	type 2
Djibouti	90–98%	types 1,2
Egypt	78–97%	types 1,2,3
Eritrea	90 %	types 1,2,3
Ethiopia	76.7–94.5 %	all 4 types
Gambia	80–90%	all 4 types
Ghana	40 %	types 1,2,3
Guinea	98.6 %	types 1,2,3
Liberia	60 %	type 2
Libya	FGM present	n/a
Malawi	FGM present	n/a
Mali	92 %	types 1,2
Mauritania	71 %	types 1,2
Mozambique	FGM present	n/a
Niger	20 %	type 2
Nigeria	25.1 %	types 1,2,3
Reb.of Congo	5 %	type 1
Senegal	20-30%	types 2,3
Sierra Leone	90 %	type 2
Somalia	95 %	types 1,2
South Africa	FGM present	n/a

COUNTRY	FGM PREVALENCE %	FGM TYPE IF KNOWN
Sudan	91 %	types 1,2,3
Tanzania	17.6 %	types 2,3
Togo	50 %	type2
Uganda	< 5 %	types 1,2
Zaire	5 %	n/a
Zimbabwe	FGM present	n/a
Central Asia		
Tajikistan	FGM present	n/a
Ingushetia	FGM present	n/a
South East Asia		
Indonesia	FGM present	types 1,4 among Muslim population
Java	43.5 %	n/a
Malaysia	FGM present	types1,4among Muslim popul.
Near and Middle East		
Afghanistan	FGM present	n/a
Iran	FGM present in Western and Southern Iran	
Iraq	72.7 %	types 1,2
Jordan	FGM present	n/a
Oman	FGM present	n/a
Palestinian territ.	FGM present	n/a
Pakistan	FGM present	n/a
Saudi-Arabia	FGM present	n/a
Syria	Some FGM present	n/a
Turkey	Some FGM present	n/a
UAE	Declining	n/a
Yemen	23 %	n/a

(WHO 2008; Clarence-Smith 2008)

FGM continues to be increasingly practiced also in other continents, like Europe (mainly in the UK, France, Belgium and Italy), Australia, Canada and the USA,

primarily among the immigrant population from Africa and southwestern Asia (UNICEF: Female Genital Mutilation/Cutting 2005). WHO estimates that between 100 and 140 million girls and women have undergone one form of a female genital mutilation, out of which 92, 5 million girls over 10 years and women are living in Africa. And 12, 5 million of these girls are between 10 and 14 years. This shows a huge increase in the practice, as the estimate in 1991, twenty years back, was about 80 million women and girls globally (New Scientist, February 2, 1991). Presently every year approximately three million girls are subjected to FGM in sub-Saharan Africa, Egypt and Sudan alone (WHO 2008; UNICEF 2005). African overall figures show also a huge increase as the figure for FGM in Africa in 1994 was 136,797,400. (WHO: 2000).

1.4. The age for a girl to undergo FGM

In Somalia, Circumcision or Clitoridectomy is done for a girl from three to four years of age and Infibulation is done between eight to ten years of age (Abdalla 1982). In Ethiopia there are communities where FGM is done to a girl only eight days after birth and in some Maasai tribes in Kenya FGM is done shortly after marriage or after the birth of the child (in certain tribes in Guinea). The tradition varies, but generally any form of FGM affects young girls and it is done systematically in these cultures to every woman of the society (Odeyemi 2008). Some sources say that the tradition is carried out to girls between 3 and 8 years of age. Other sources set the age range between 4-12 years. Normally FGM is carried out by a traditional practitioner and mostly the operations are carried in the villages and not in a health institution (Tukia1993).

1.5. Reasons behind FGM

The removal of external female genitals has its origins in various reasons and beliefs but the tradition is very prominent and strongly exercised in the prevailing FGM cultures. Reasons for the removal of the external female genitals vary from strong religious reasons to inborn social reasons that were never argued nor questioned before as the tradition has been seen a must and an heritage for the women to accept in their communities (Karanja 2003).

Fear is one very strong and dominant reason for women to be made undergo FGM. In the societies where FGM is practiced women normally do not have any economic rights, they have only a modest access to education and they are strongly dependent on their husband's support for survival. Therefore, women in each of the respective FGM cultures are easily subjected to this requirement of "a good wife- to be ". This is considered to be a legitimate expectation by the husband and, in order to get married with a good dowry for the bride's parents, the women succumbs to this procedure. In this environmental context, FGM plays a major role and is required as it proves that a woman is "clean", a virgin and sexually submitted only to her husband(Gruenbaum 2001; Barnes 1994 ; Kassindja 1998; Masho 2009; Msuya et al. 2002).

Social acceptance is important to African families and the opposite, ostracism is feared and shamed for. A girl who has not undergone FGM is mocked, rejected and isolated from her society. It is of ultimate shame also for a boy to be called the son of an uncircumcised mother, or for a man to be known to be a husband of an uncircumcised woman (Shell-Duncan et al.2000). Stigmatizing is very common against those who have not had a FGM done and stigmatizing affects the whole family, not only the woman who is the primary cause for this stigmatization (Momoh 2006).

FGM is often seen as a rite of passage and as a proof of respected adulthood. FGM raises a girl's status in her community and shows her positive character, ability to obey by submission and ability to endure pain. Once FGM is carried out, the girl is accepted amongst the other women in the society and she enjoys positive attention and acknowledgement. Her sexual lust is believed to be lessened as well as her possible interest for masturbation. Hence a circumcised girl is considered to be pure and preserved for marriage. It is believed that FGM eliminates any possibilities of rape, supposedly, circumcised women will not provoke men. For married men FGM confirms the fatherhood as the husband is considered the only possible candidate for fatherhood (Karanja 2003).

Some cultures believe that female genitals are remnants from a scorpion and have to be removed before marriage and childbirth for they might poison and kill the husband or the to -be -born babies (Piekkari 1992). If the genitals are not cut or removed, they might also grow down to the woman's ankles and be very ugly. The women who are not cut are sexually too active and aggressive and cannot certainly be virgins at marriage or

expected to be faithful to their husbands (Momoh 2006). Only good girls are cut and this is done based on deep tradition and cultural influence and is therefore beyond question. FGM simply has to go from mother to daughter in order to secure the daughter's marriage and hence her happiness and livelihood (Turkia 1978; Momoh 2006).

One particular example for a FGM is “deodorizing” female herders. The infibulations are to hinder the menstruation blood to flow in abundance. Therefore the odor of the blood cannot be so easily detected by the wild animals or by the sheep and goats. According to some studies these animals avoid the menstrual blood which makes it difficult to approach, milk or attend to them in general. The presence of infibulated women is less disquieting and thus enhances the survival as the sustenance of the livestock is crucial for survival. These women are often left alone with their children and livestock for prolonged periods when the husbands go tendering the camels far away (Shell-Duncan et al.2000).

Classifications

WHO (2000) summarizes the above reasons for FGM practices in different categories. In general FGM is seen as an issue of social integration and also important in maintaining social cohesion. It simply has to go from mother to daughter in order to secure the daughter's marriage and hence her happiness and livelihood. Where religion, myth, society and hygiene as well as aesthetic reasons fall as separate, individual, but interlinked concepts, and where each interlinked concept has its own defined reasons of being underneath. The necessity for spiritual cleanliness is the defined religious reason whereas rite of passage and requirement for acceptability fall under social reason.

- **Social reasons:** Only good girls are cut and this is done from deep tradition and culture influence and is therefore not questionable at all. FGM binds culturally and is automatically handed down in a culture. FGM is also the link carrying from girlhood to womanhood and playing an important role in initiation. It is also seen as an important factor for cohesion in a society.
- **Hygienic and Aesthetic reasons:** External female genitalia are considered dirty and therefore they need to be removed for improved hygiene of women. Fears about ugly looks or bad odor are the main underlined reasons. All of these are

influenced by family honor need to control the sexuality and to maintain the girl's virginity and chastity of girls.

- **Psychosexual reasons:** The women who are not cut are often considered sexually too active and aggressive and cannot be virgins and to stay faithful to their husband. FGM is also performed to increase male sexual pleasure. A woman who has undergone FGM is seen aesthetically more pleasing as the external female genitalia are removed. She is giving more sexual pleasure to her husband when her genitals are tight.
- **Religious reasons:** In some communities their faith demands women to undergo FGM. Several Muslim societies practice FGM, in particular in Africa, but very often it is an earlier cultural tradition that has been transformed in a religious tradition. Though FGM is generally seen as a tradition in Muslim religion, FGM is also practiced in other religions due to its cultural behavior and not due any religion demands.
- **Myths:** There are myths that female genitals are have to be cut off before marriage and childbirth as they may poison and kill the husband or the to -be - born babies. Other myths make believe that if the genitals are not cut or removed, they may grow down to the woman's ankles and are hence very ugly. There are also myths that fertility is enhanced and child survival is claimed to improve if the woman has had FGM.

1.6. History of FGM

FGM has a long history. The oldest source of a FGM description is found in the work of Herodotus (484-424 BCE) and he states that excision was carried out by Phoenicians, Hittites, Ethiopians and Egyptians. The mummies of Cleopatra and Nefertiti do not have clitoris (Hakola 1991; Lockhat 2004; H. Lightfoot-Klein 1989). At those times FGM was carried out mainly in order to prevent girls from being raped as herding the kettle and it was also used as a birth control (Lockhat 2004). Lightfoot-Klein indicates in her book of Prisoners of ritual how circumcision at some early point of human history was seen as a form of sacrifice to placate hostile forces and evil spirits (Lightfoot-Klein1989). She also states that circumcision was done to Greek girls at least in 163

B.C. once the dowry had been paid. The Greek geographer Strabo reports that in 25BC female circumcision was performed on high cast women in Egypt and was an essential part in premarital rites (Lightfoot-Klein 1989). In the Egyptian slave markets, the infibulations was a brand mark to obtain higher prices. Most probably the infibulated slaves were from the Sudan (Hakola 1991).

There are two main theories regarding the origins of the tradition of FGM according to R. Abdalla. The first one presumes that performing the FGM started in the Middle East and diffused from there to Africa. The second theory states that the tradition of FGM developed independently in different societies and at different times (Abdalla 1982).

Though FGM is mainly considered to be a phenomenon of the Islamic societies, history reveals that FGM has also been practiced in other societies and in the Western world, also in USA, England, France and other European countries. The reasons for FGM in Western countries have been mostly medical: treating sexually too active women or female masturbation or FGM was carried out for cleansing purposes touching women of the higher society (Shell-Duncan et al. 2000).

In Somalia FGM is deeply rooted in the tradition throughout the history. Even if many perceive the tradition as a negative side of the culture, the majority still supports this as a tradition. FGM is strongly underlined as a rite of passage to adulthood and an uncircumcised woman is immature and unable to have children and hence not socially accepted as such. According to the study carried out by WHO in 1932-1992 the main importance of FGM practice in Somalia has been the need to protect of virginity of a woman before marriage. Other reasons mentioned are controlling women's excessive sexuality and enhancing health, beauty and cleanliness (Serkkola 1992; WHO 2000).

1.7. FGM in practice

FGM is usually executed by special performers, dayas, the village midwives, or Traditional Birth Attendants. The performer can also be former smiths who are handy with their hands and have the proper tools. Any performer needs a piece of glass, a knife, a razor blade, thorns or sticks and cotton thread to perform the procedure. These practitioners are respected in their societies, they set the dates and time for operations. They often also have power over even the parents of a girl to dictate which form of

FGM is carried out. After the FGM is done, the fee is paid and the practitioner's livelihood is gained (El Saadawi 1991; Armstrong 1991). Modern times have brought the procedure of FGM to towns, clinics, hospitals and even to private practices. FGM is now performed by trained health personnel like nurses, midwives or doctors (Serkkola 1992). In spite of these possibilities and choices by the wealthier people, millions of FGM are still taking place in villages under very poor hygienic conditions, with poor instruments and without any anesthetics. Thus still too many of these procedures are causing unbearable damage to the girls' genitals and in addition, physiological disorders, pain and complications in every day physical functions, gynecological problems, psychological traumas and hindrances for sexual pleasure (Rahman 2008). This is the reason why FGM needs to be studied and its negative effects mitigated.

FGM is resulting to enormous annual costs in the practicing countries in different complications' treatment. WHO made a study on economic costs of FGM in six African countries and it showed the costs of FGM-related complications to amount up to US 3.7 million and a loss of 130 000 life years due to FGM's association with obstetric haemorrhage (WHO 2008).

1.8. Negative effects of FGM

Effects on the health and on the psychological condition of a girl who undergoes a FGM are various. As the study concentrates on the emotional side of either continuation or elimination of FGM, the effects of FGM are discussed only in a general manner.

The most common effects of FGM are presented in a form of a table to make it easier for the reader to fully grasp them. Both the physiological and the psychological effects are brought out to illustrate the multiple varieties of FGM's dominance and importance in a girl's life.

Table 2. The most common effects of FGM

<u>Immediate effects</u>	<u>Short and long term effects</u>	<u>Additional effects</u>
Severe pain and shock	Retention of urine	Repeated corrective operations
Excessive bleeding	Genital malformations	Urinary, and menstrual problems
Infections, HIV	Chronic pain	Painful sexual intercourse
Difficulty in passing urine	Infections, HIV, Septicemia	Infertility due to complications of FGM
Psychological consequences (trauma)	Quality of sexual life, Birth complications at childbirth	Destroyed organs due to FGM
Unintended labia fusion	Danger to newborn	
Death	Psychol.consequences (fear of sexual intercourse,depression, memory loss)	

(WHO 2000)

It needs to be underlined that the complications are not always known to the performers of the FGM. They usually come either to the homes or have several girls at the same time to undergo the FGM at a given location. Generally the girls are taken home immediately after the procedure and provided attention by the relatives whilst the one who carried out the actual FGM is not responsible for the recovery period anymore.

The psychological effects are also difficult to measure as FGM is a solemn act of tradition and hence strongly linked to the culture. It is not questioned nor even talked

about. However, its effects can be long term maturing risks which demand careful treatment and attention. Unfortunately these risks are not always properly dealt with. They fall in the women's domain which is not publicly discussed or complained about and the women suffer from the risks of FGM in silence. The possible shame or the complications are not dealt with, nor treated (WHO 2008).

Interestingly enough, FGM can also be taken as a very ordinary incidence in a girl's life. FGM is merely just considered as an ordinary thing that goes easily unmentioned when everyday habits and cultural proving aspects are asked about. This attitude of considering FGM as unimportant, not even important enough to be told proves how in some cultures female genital mutilation is merely a part of growing up. This is true in some parts of Tanzania where it is not mentioned nor talked about in a girl's lifespan. Much more attractive is to discuss about if a girl be attending or not school (Gruenbaum 2001).

1.9. International initiatives and actions against FGM

With political uncertainties, wars, natural disasters, famine and insecurity, human mobility is reaching far beyond the neighboring borders, causing ample variety of cultural integration amongst communities and hence creating new demand for the receiving cultures to be sensitized to different cultural values and practices. As cultures collide and interact in new boundaries, different aspects need to be taken into account and melted into behavior of each existing culture of the area.

FGM is certainly one cultural tradition which is bound to cause strong debates when introduced in any single country where it has not yet been practiced. It is vital for governments when their country is receiving immigrants to be aware of the current customary practice of FGM by the immigrant population. The hosting governments should focus on both upholding the rights of women and girls and applying means to ensure these rights to be followed and accessible to every immigrant female (Brusa et al. 2008; Alvarsson et al. 2007; Rahman et al. 2000). It needs to be noted that resistance to continue the tradition of FGM has grown also in the societies where the tradition is still prevailing. Organized groups, organizations and individuals are raising awareness of the risks and possible harmful complications of the FGM practice and gradually the curtain of the taboo circled around FGM is lifted up. FGM is gaining attention in

various international panel discussion forums and changes in the current FGM practices are gradually gaining supporters in all over the world.

International awareness considering FGM came up already in the early 80s'. The FGM was a major public health problem identified in the WHO Seminar in Khartoum, Sudan in 1979. The United Nations declared a Decade for Women 1975-1985 (Shell-Duncan et al. 2001). In 1984 African Women organized a Conference in Dakar, Senegal to prevent and eradicate FGM (Oske 2011). Next significant international seminar for FGM was in 1995. Beijing was hosting the United Nations fourth World Conference on Women, where the action emphasized the empowering of women and elimination of all forms of discrimination against women. In 1997, WHO, UNICEF and UNFPA came up with a joint statement to support policies and programs that aimed at eliminating FGM practices (Rahman et al. 2000).

Ever since 1997, vast international efforts have been made to act towards elimination of FGM through research, work within the communities, and push for changes in the public policies (WHO 2005; PRB 2010). UNFPA joined people around the world adopting the 6th of February to be an International Day Against Female Genital Mutilation. Many countries, nine in Africa and seven industrialized countries outside Africa have succumbed FGM under their criminal laws and some European countries, i.e. Belgium, France and U.K. have prosecuted cases of FGM/FC (Female Circumcision) on the basis of Penal Code. In 2007 FGM was banned in Eritrea, but in Somalia as there is no central government FGM is still legal. Somalia has ratified in 1990, the Covenants of Civil and Political Rights and the Covenant of Economic, Social and Cultural Rights and in 1988 the government endorsed a campaign to stop the FGM in all of its forms. Unfortunately the follow up for this campaign was interrupted and quieted down with the downfall of the government in 1991 (Rahman et al. 2000).

As awareness of FGM arose at the global level, different legal prospects have been included in the discussions. The Universal Declaration of Human Rights, the Convention on the Elimination of All Forms of Discrimination Against Women, the Convention on the Rights of the Child, and the Maputo Protocol are all instrumental in the global direction towards elimination of FGM. There have been many international conferences and seminars which all aim at eradicating harmful social and cultural practices, among which FGM is one. Appeals for support in elimination of FGM

continue and in 2008 the United Nations Economic and Social Council and the World Health Assembly issued devoted resolutions to promote actions for ending FGM/C. In 2008 a new statement emphasizing the FGM abandonment advocacy with wider United Nations support was launched (WHO 2008).

In August 2010 in the 65th session of the General Assembly the UN Secretary General brought out a report on intensification of efforts to eliminate all forms of violence against women (Advancement of women). Its emphasize is on political commitment and leadership at all levels that should also be complemented by large range of partnerships and involvement of all relevant stakeholders. It continues that communities and environments must be made safe for girls and women and efforts to end violence against women must also involve men and boys of the concerned communities (UN 2010). Improvement of laws, policies and programs should be complemented by accurate prevention, advocacy and awareness raising programs. Their implementation, monitoring and evaluation should be carefully carried out on regular basis to detect any setbacks that may cause hindering a smooth development and adaptation of programs. In the international forum of FGM the NGOs play a vital role in the implementing of strategies and programs, working together with various populations in an educative and comprehensive manner and in sensitizing community leaders and health personnel on FGM-related issues and interventions (Momoh,2005; Rahman and Toubia, 2000).

Millennium Development Goals (MDG) were adopted at the 2000 Millennium Summit. The deadline for achieving the MDGs is 2015 and the MDGs assess, among other issues, the progress in improving maternal health and attaining the set targets in other issues, reducing maternal mortality ratio (MMR) by three quarters. Here the practice of FGM plays an important role, though no direct data is available of FGM's direct impact on maternal mortality. The estimated MR in Somalia was 1200 and the proportion of maternal deaths among females of reproductive age (PMDF) was 34.5% (WHO Trends in maternal mortality 1990-2008). Solidarity organization, Solidaarisuus in Finland, has worked together with Organization Candlelight in fighting against FGM in Somaliland since November 2008. Women and girls' productive association (Nicehearts) and the Finnish Parliamentary group on population and development (Eduvake) organized a seminar in Helsinki, Finland in November 2008 with a title STOP FGM! Similar seminars were held in different European countries at the same day and were all part of the European Network for the Prevention of FGM campaign.

All these above mentioned actions towards the end of FGM show that the topic is out for discussions and debates. It needs time to be handled respectfully, though firmly and the acceptance to the change must derive from the respective communities and the principal actors of FGM.

The media has covered some individual cases, where trials have been conducted to give verdicts to those who have performed FGM illegally in European area and FGM has intrigued public debates in many countries around the world.

Twenty years ago, a Malian woman was sentenced to serve five years' sentence for having excised 17 young girls in France. In 1993, a Gambian man was sentenced to prison for one year after having ordered an excision for his daughters. Another Malian man was imprisoned for having ordered his wife to arrange excision for their daughters. In England health workers are alarmed of tens of thousands girls being at risk to be circumcised because of traditional values (Dilday 2007). There have also been different kinds of challenges within the FGM where girls have been taken to their home countries where the operation is carried out just to undergo the traditional procedure. There are cases where the women themselves have gone back to their own countries and demanded the traditional operation to be carried out even if the normal age for it is long past (Walker 1982). This just shows how very deep in the culture this tradition lies which makes it very difficult to eradicate. There are also cases in Switzerland where women wanted to keep the tradition ongoing. A study made by Wuest et al. in 2009 notes that from 122 patients with FGM four wanted to be closed again like before delivery and two wanted to be closed even tighter than before delivery (Wuest 2009).

In recent years, innovative forms raising awareness of the FGM have been gaining attention as FGM has been brought to **art and culture**. FGM has been up, not only in the literature, but also in films (Desert Flower), music, lyrics, poetry, drama and plays. There are many ways of tackling the strong tradition. On the basis of past experience, it is recommended that the delicate topic of FGM should be tackled in the form of music, drama and literature spectacles (Shell-Duncan et al.2000). In these ample and vastly permitting grounds for a sensitive topic to be brought to public, the opinions of FGM, either pros or cons in view of the tradition can openly be debated without insult or anger. In the end of these cultural and traditional sceneries of information the interpretation is left entirely for the public to elaborate. FGM has fast and increasingly

become an axis in discussion topics of human rights, feminism, Africa, HIV/AIDS and religious or political fundamentalism (Tobe et al. 2009).

Some studies confirm that, once the knowledge of the possible problems and harms are stated out, many of the former FGM practitioners put down their “knives” and withdrew from that particular practice of FGM. In Kenya and Tanzania there are studies to show how, once the information about complications due to FGM were told to the performers, many of them withdrew from their practice of FGM. The same applies to Ghana and Sudan. Globally this subject is out in the open in the point of view of the Human rights and Women’s right activist (Wangila 2007). In Egypt there are powerful organizations and women groups who are advocating against the FGM. And in West Africa the mode of FGM is more and more changing towards a milder type of the practice (Dedeurwaeder 2011). Though there are arguments against the FGM emerging all the time around the world, it is mostly the women of the societies practicing FGM that insist on continuing performing FGM. They want to ensure that their daughters are having a prosperous and happy life and the respected tradition is continued. A success story in eliminating the tradition comes from an American Molly Melching. She has succeeded in influencing to abandon FGM in over 2000 Senegalese villages through human rights education and raising awareness projects since 1990’s. Her methods are to concentrate on training and education, through poetry, songs and plays. Women are being offered information and opportunities to be able to support themselves and get better conditions (Global Finland).

Female genital mutilation and some strong condemning opinions against the procedure have been popping up also in the African literature already in the 1960’s. In those days the tradition was strongly defended in the name of tradition and culture and to oppose the “Western feminist neo-colonization” (Tobe et al. 2009). Though some changes in social practices and national laws have occurred during the last forty years, the resistance to change the tradition of female genital mutilation because of strong anti-colonial identity, pride and self justification is powerful and cannot be dismissed lightly. The fear or doubt that a girl’s honor is not perceived nor would she be a significant candidate for a marriage, urges the mothers, and at times also fathers, to persist on the tradition’s continuation and to insist for the FGM. In the end of the day, the majority of parents want the best for their children. As girls are to be married to another family, they must be among the top of the candidates’ list in order to secure a prosperous future

and happy, respected status in her society. In Eritrea 95% of women have undergone FGM and 90% of them reported that their daughters had undergone FGM, for it was the tradition and FGM was expected from women in the society (Shell-Duncan et al.2001).

1.10. FGM in a Somali context in Finland

The first Somalis came to Finland in 1990 as political refugees. They were granted asylum on grounds of humanitarian causes or because need for protection. Today, Somalis represent a major portion of Finland's immigrant population and have formed their own special Finnish Diaspora. The conventions of Somali culture are practiced and the Somali identity is respected. The term, Diaspora, comes from Greek and means dispersion, scattered, living in randomly. Diaspora signifies forced movement when certain group or ethnic group is forced to move to another country or to another area for living (Wikipedia).

Theory of acculturation examines the phenomenon of cultural changes when different cultures meet. Acculturation can be understood either as a process, when cultural changes in the beliefs, behaviors and feelings are gradually taking place or acculturation can take the form of individual changes in behavior, attitudes and feelings (ETENE 2005). In the approaches to FGM, acculturation can easily be detected. FGM is not practiced in Finland and the new Somali generation is growing up in a society where FGM is not included any longer in the tradition. In the present study, acculturation theory was applicable, as all the interviewees had been living under the influence of Finnish cultural values for more than ten years and their approaches to certain aspects in their own Somali values had certainly been influenced by the pressures from host country's cultural behavior. The study results back up the previous assumption that to change this type of a tradition it takes at least two generations to see the effects of the change.

Ari Serkkola states that FGM is considered as a premarital rite in Somali culture. FGM prepares the girl to adulthood and joins her to marriage (Serkkola 1992; Abdalla 1982) confirms Serkkola's views, but she has a somewhat bit deeper view on FGM. Abdalla explains how Gudniin (FGM in Somali language) is seen as a positive function in relation to other components of the patriarchal Somali family practices. Same as marriage, modesty code, family honor, women's social role and life patterns are linked

to Somali family practices and all of them are fundamental codes in a Somali culture (Koivulehto 1983). It is to be remembered, that these values are honored values in a Somali culture in general and especially in Somalia. We can also see this same attitude in the interviews as the interviewees stated that even the tradition of FGM was not continuing in Finland as such, it was still dominant part of a girl's life in today's Somalia.

A Somali doctor residing in Finland, M. Mölsä has conducted two studies on FGM in Finland. First one was conducted in 1994 and included interviews of 130 Somali women . At the time interviewed Somali mothers were pretty certain to continue the tradition on their daughters. Over half among the single mothers were, however, uncertain of the issue. Among the interviewed mothers, many supported the infibulations and type 2 circumcision and many were favoring minor types of female genital mutilation (Tiilikainen 2007). In her other study "Times have changed: an account of attitudes and intentions on the circumcision of women and girls amongst immigrants living at the Helsinki Metropolitan Area", Mölsä interviewed 18 Somali women and 12 Somali men in 2004. Now none of the interviewees wanted their daughters or possible future daughters to be infibulated. But even if they were not certain of the necessity of circumcision of girls, as they stated it is not only the parents' wishes, but also a question of desires and identity of teenage Somali girl (Mölsä 2004).

In Finland, general interest towards FGM has risen and FGM has been up in the media. FGM came to the surface in spring of 2010 and in July 2010 with its two different aspects. The first article was about FGM and its challenges to the health personnel for correct response to prevent and treat patients with FGM (Kivimäki 2010). The other article quoted a Member of Parliament comparing FGM to the treatment of beggars in terms of discrimination (Laitinen 2010). FGM seems still to be a subject that is carefully scratched from the surface, but easily left to itself as quickly as possible. Is this because of ignorance or fear to seize something challenging that might start living its own life on the Finnish debate society?

FGM was also a major topic during an international week held in Helsinki Metropolia (University of Applied Sciences) in March 2011. FGM was included in the program as it is an internationally recognized topic to be addressed in every suitable forum. In her presentation, M.Dedeurwaeder pointed out that many efforts of eliminating FGM are

being carried out in Western Africa and the message of quitting the tradition is gradually kicking in. But getting FGM abolished in the different cultures will certainly require at least another generation for the message to go through (Dedeurwaeder 2011). As information is made available globally through the different media, debates, seminars and individual approaches, FGM is gradually changing from a silent topic to a prominent one in headlines and open opportunities to organizations for include modules of FGM in developing programs and mass educational projects.

2. AIM OF THE STUDY, THEMATIC INTERVIEW AND CONTENT ANALYSIS

In Finland the FGM is a punishable act in all its forms under the Finnish Penal Code. The overall aim of the study was to get review of how the female representatives of Somali culture describe and feel about their traditional procedure of FGM as it is neither demanded nor possible to have FGM performed in Finland. To achieve the above aim, following specific aims/research questions were asked: what kind of a role does the FGM play among Somali women in Finland? Is FGM mainly seen as a form of a tradition that could possibly be abolished or replaced with something else?

In the study, the interviewer and the interviewees were from different cultures, and though the language used in the interviews was mutually understood, the meaning of words and the context of usage of words needed to be clarified prior to the interviews. Each of the interviewees was met personally prior to the actual interview, a relationship with trust and confidentiality was established and the interviews were carried out in an open and relaxed atmosphere.

2.1. Thematic interview and analysis

In the study, the interviewer and the interviewees were from different cultures, and though the language used in the interviews was mutually understood, the meaning of words and the context of usage of words needed to be clarified prior to the interviews. Each of the interviewees was met personally prior to the actual interview, a relationship with trust and confidentiality was established and the interviews were carried out in an open and relaxed atmosphere.

Thematic interview was chosen as a data collection method for the study. As the topic of FGM is a highly sensitive and delicate one, open, one – to – one, interview was a relevant data collecting method. Thematic interview is used for collecting different opinions, comparing them with each other together, and deriving a theoretical understanding of the traditions and beliefs surrounding the topic of FMG. There are, of course, no wrong or right answers, when paddling in complicated and emotionally sensitive ground of human tradition and dignity of cultural values (Pope et al. 2006; Silverman 2006). Thematic interviews are ways to conduct a conversation of this given

theme studied and the method is widely used to gather informative data in health related qualitative research topics. The challenge is that only what is heard from the recording of the interviewee's answers can be collected. What the interviewee is actually doing in reality cannot be verified (Green 2004). All interviews were recorded. Each interview took approximately two hours or more and the interviews were conducted between October and December 2010. The interviews were immediately verbatim. The total data set consists of 48 pages of transcribed text. Following the basic principles of thematic content analysis (Green 2004) the data was at first read through and organized under three themes. Second, the data was reread and reorganized in order to get a more comprehensive view of the differences and similarities in the answers. This was to allow conclusions on tendencies to be drawn from them. The questions were pre-prepared set of themes that were presented to each of the interviewee. These three sets of themes were devised by the author on the basis of the literature. This allowed highlighting the common tendencies in the answers, grouping them and referring them to the literature. The narrative analysis approach was chosen by the author as a natural approach to this delicate topic.

2.2. Interviewer's points

As a starting point, it is underlined that FGM is a complicated phenomenon that strongly directs a girl's future and status in her culture and society. Therefore, approach to the subject had to be professional, uncritical, and not judgmental. The aim has been to produce information from a certain number of selected topics that can be trustworthy retrieved from the accounts of the interviewees. In order to obtain as accurate and as truthful accounts as possible, mutual understanding, respect, consensus and language between the interviewer and the interviewees must be proven throughout the process of interviews (Blaxter et al. 2006; Eskola 2001; Green 2004; Pope et al. 2006; Ruusuvaori 2005; Silverman 2006).

In face-to-face conversations the positive outcome of each player is produced through a continuous flow of exchange of words. In-built values and words used by each party of the interview play a significant role for their input in the discussion and therefore for the output of the interviews. Interpretations of ourselves, of our world and how it is presented in us, in our values, rules, norms and through regulations, we underline our

choice of words. The way we are expressing our thoughts may differ even greatly, from the hearer's interpretation and understanding as he/she is referring these words to his/her understanding of the world. The interviewer is valuing statements against his/her own learnt and gained values (Pope et al. 2006; Silverman 2006).

2.3. Implementation of the interviews

Prior to the actual interview information on the purpose of the interviews and the used interview material, like pen, paper and recording machine, were explained to each of the interviewees by the conductor of the interviewer. As the recording of the interviews was explained and anonymity of them was prevailed all the time no disturbance of the recording of the interviews was detected. The purpose of the interviews and the interview methods were accepted by all participants.

2.4. Structure of the study questions

For the interviews 41 various questions had been prepared by the author.

The questions were further gathered into three different themes according to how they related to the topic. The three themes were:

1. Generalities and background information
2. Memories and feelings about FGM
3. Present situation and future trends in FGM.

The purpose of the separate groups of questions was to serve as the main support in case the interviews would have become stalled because of delicacy of the topic. Thanks to this organization of the interviews, they flew well. The questions were a good tool to keep the conversation on the right track and sticking to the topic. The questions can be seen in the appendices 4 (English) and 5 (Finnish)

To build up the answers to main study questions, several supportive and leading questions had to be used to direct the interview to the core of the questions. One could not just straight away ask about the role and significance of FGM in someone's life. To

better understand the top, one has to know the base from where the top is built. On a solid basis, it is safer and more diplomatic to tackle the more sensitive issues.

At times the delicateness and sensitivity of the topic could be sensed in the interviewees. This is due to the simple fact that the issue of FGM is almost never talked about, and certainly not talked about with someone non Somali. The interviewees found themselves in a new situation and it was not always easy for them to tackle their own inner feelings and express them to a stranger. In spite of the newness of the discussions and the feelings that did arise in the interviews, each one of them accepted to have a full interview and participated with sincerity and openness which were truly appreciated by the author.

2.5. Sample group, gender, language, interview site and time factors

The sample group was identified and composed on the basis of previous contacts to Somali communities in Helsinki. One of the contact persons acted as a coordinator of all the other contacts.

The five interviewees were between 23-43 years old and all have lived in Finland for more than ten years. Three of the interviewees had undergone FGM in their childhood, whereas two did not and hence have escaped the procedure.

Four of the interviewees were married and among them two had children. One was pregnant at the time of the interview with her first child.

Four out of the five interviewees were from South Somalia, one from the North Somalia/Kenya.

All the interviewees were women. In this study the aspect of the role of FGM in a woman's identity was approached solely from the perspective of a woman. This aspect would, however, be an interesting subject to research as in the Somali culture FGM is merely seen as women business and fathers do not interfere in the procedure of FGM. The decision of FGM is taken by grandmothers and other female family members.

Language used in the interviews was Finnish. This was agreed between the interviewees and interviewer.

The interviews were conducted in the library meeting room of The Helsinki Main Post Office. Confidentiality and privacy was ensured at all times of the interviews.

All the interviews went fine and an open and mutually respecting atmosphere prevailed in each of the interviews. It was impressive to conduct these interviews and to be in a position to be able to collect truthful information of a delicate, intimate topic.

2.6. Ethical aspect

From the ethical point of view, the topic and questions were drawn up in a way not to offend the interviewees' privacy, self confidence or cause harm to them. Each and every participant was fully aware of the reason of being of the study.

Each interviewee accepted to participate on a voluntary basis and agreed that the results could be included in the study. No names, no identity numbers nor anything that could reveal the identity of a participant was used.

2.7. Outcome generalities of the interviews

All interviews were carried out in a positive atmosphere and no pressure was put on the interviewees to disclose other than what they wanted to disclose on the topic. All the interviews were conducted in accordance with the interviewee's willingness to disclose information and serve as informative source in the topic. The outcome of an interview is always based on interaction and both the interviewee and the interviewer produce language data about behavior and beliefs, not the actual actions, and this has to be acknowledged.

The power of FGM in the context of values is put strongly in the literature. FGM is the pride of a girl and one rather supports the pain caused by the FGM than lives with the shame of not having had a FGM performed (Shell-Duncan et al. 2001; Wangila 2007; Odeyemi 2008). The statement of the FGM power was taken as a mental starting point when discussing the issue in order to avoid inappropriate methods or comments during the study process with the interviewees.

How the interviewees relate to the fact that FGM is being part of her culture (as an unquestionable act that belong to womanhood) as well as what kind of feelings and

possible complications they had after the procedure was done to them, play considerable part in the way the interviewees see the future of FGM and its part and appropriateness in the new society.

It was central to deal with the feelings and the perceived importance of this tradition, as now these women are living in another culture where FGM is not part of a girl's growth path and where FGM is actually banned from practice by law. Knowledge enhances the ways of comprehension and understanding of the existing culture and cultural values and acts as a vital tool to deal with new cultural values. This is true especially when there is a visual contradiction between old and new values

2.8. Quotations of the interviews

Essential answers are extracted directly from the transcriptions of the interviews. They serve as basis and they are in bold to make it easier to find in the text. The quotations of the interviews are in numeral order. Number one indicates the interview that was carried out first, on the 25th of October 2010, and number five the last one that was carried out on the 14th of December 2010. **I** stands for Interviewee and **E** for Eeva, the conductor of the interview/study.

3. RESULTS

3.1. General and background information

FGM is normally done for girls under ten years in Somalia. This goes also for those interviewees of this study who had undergone FGM in their childhood. They had all been between four and seven years of age at the time of their procedure. All had knowledge about FGM, but not how it would be done and what it meant. They merely had heard about it and that it was done to every girl. The interviewees brought up in this study, how they themselves had been anxious about having FGM due to the fact that they had heard about their cousins and friends having undergone a FGM.

In the group studied education of mothers was not seen as an essential factor in approaches to FGM. According to the group, FGM's place in the Somali culture comes from a long respected and persistent tradition which is carried on as it is considered a normal action in a girl's life in Somalia. The educational level of the mothers of the group studied varied from primary level of education to medium level of education. The mothers of the interviewees normally had stayed home taking care of the house, while the fathers worked outside.

Prior to having undergone FGM, information about FGM had been limited and weak amongst the interviewees. They did have a vague idea of FGM and FGM was an eagerly awaited procedure in connection with expectations to become part of the valued women of the society. To others it proves to have been simply something that was done as always and to every girl. The deeper reasons for FGM were not understood before the actual ritual. Those of the interviewees who had undergone FGM were not prepared in any way for the procedure. They were taken to the place of carrying out the procedure of FGM or a person just came home to perform it. Being obedient to their culture, they never questioned the tradition or its meaning, but left themselves to the hands of the practitioners. Like other girls in the surroundings, the interviewees were eagerly waiting for the big day when they would become big girls and respected in their respective communities.

E: What do you know about the FGM? How were you prepared for it?

I: When I was small they just told me that I will be having a FGM and nothing else. It wasn't discussed much at all. (1)

I: I remember, that it was just said that today we go, for we have found a good doctor. I remember that the taxi came home and we went to the hospital, because there was a good doctor and good nurses. And after the operation we came home with the taxi and that was it. (2)

I: No, no. I didn't know anything I just knew the name as a FGM, but how it is done or what or anything I didn't know anything, but once I was on the table and being butchered, (laughter) then I knew what it is about. And it was done without any anesthesia. (3)

3.2. Memories and feelings of FGM

This study shows out that the main initiators of FGM were the grandmothers of the interviewees. The pressure to undergo FGM in the society from the neighbors, friends and relatives was significant. However, this tradition is respecting responsibilities among members of the society, where performing FGM to the girls is of major importance. The most consistent demand was always from the grandmothers. Interesting aspect of the stronghold of women in the culture in FGM issues: it was recognized that FGM was considered to be of women's business where men did not much interfere. The role of grandmothers was significant as they were the persons demanding the FGM to be carried out. This was because it was a must for a girl to undergo for her to get married and be respected in the society. The group brought up how FGM is an old tradition in Somali culture. It has its roots far back in history and is seen as a normal practice and reins no reflections.

E: Do you know why FGM was done to you? Who initiated the idea that you should have a FGM?

I: My grandmother who keeps this tradition on takes it very important. She sees that a circumcised girl is protected or something...To her it was extremely important. (4)

Reasons for FGM were not elaborated further amongst the group studied. FGM was seen as part of the tradition which was taken as having to be continued and respected. Reasons for FGM that come out from the study are social reasons and cultural pressure.

All the interviewees told that their mothers, sisters and almost every female relative had had FGM. This shows how the action is something considered simply existing in the Somali culture, something that has always been part of a Somali girl's life. The only exception to this rule concerned younger cousins or sisters who came to Finland as young girls, or those, who were born in Finland.

E: Are all females in your family gone through FGM?

I: Yes, every woman in my family, all have undergone FGM. All my cousins, my aunts, all relatives of my age or of my mother's age. (2)

I: No, it hasn't been done to me personally. But in my family yes, FGM has been done to my mother, my sisters and my cousins. (5)

Memories linked to FGM within those in the group studied who had undergone FGM consisted of mixed feelings between anxiety, bewilderment, fear and pain on one hand, and feelings of pride and courage on other hand. Pain was the most prominent and first memory they all shared of FGM, but their memories were also filled with many details of the procedure, place and aftermath of the procedure. Those members of the group studied, who had undergone FGM, had all suffered, beyond fear, bleeding, and agonizing pain and complications of urinary track. The first passing of urine had been painful. In one case, the situation had grown serious as threat of urine retention was imminent. None of the interviewed women, however, ever developed severe chronic physical complications. Psychological effects of FGM were sited during the interviews, but this aspect could not be studied any further

E: What do you remember of FGM when it was done to you?

I: I just remember that I was taken to a room and put in a bed and I remember that I screamed and yelled a lot ,and they had to bring two other nurses to hold me, for I was terrified and now I don't know if there had been someone before me or not, or if I was the first , I don't remember at all that from where did I have

that terror or fear that I was going to have this procedure, but I was very scared and anxious and I just yelled and shouted HELP HELP! But anyway one just was there and then they started to do the FGM and it was freaking horrible. Very painful I still remember and as I didn't stay and one more nurse came to hold me I remember they were four nurses to hold me. It has left a horrible memory. (1)

I: I was very anxious about it and wanted it as all my cousins, with whom I used to play when we were little, were operated during the year and I wanted also to have FGM. I remember I had a lot of pain , but I didn't want to cry for I wanted to prove to be brave and for I wanted to show to mother that I was a big girl, good , I remember.(2)

I: Yes, I remember. It was so painful. So very painful! And I still have the pain coming out as a smoke from my head and the screams from my ears. It hurt me so much. (3)

Female Genital Mutilation made, or not made for a Somali girl is a delicate topic to talk about. FGM has a place in a Somali girl's life. Though it is thought essential in the growth path, FGM is not something that is discussed about; not before nor after the actual procedure. FGM is seen like a taboo, something not to be discussed with anybody. It can also be taken as a common factor, which is not worth of mentioning when asked about the habits or traditions. The group studied was open and talked about their experiences and reflected thoughts on FGM and the author greatly appreciated that the topic could be discussed. Generally they hadn't been discussing FGM at all with others. It is certainly not a topic to discuss with one's mother and even with sisters or peers it is seldom tackled at all. Some pointed out how FGM is still difficult to handle in oneself and therefore it is not discussed. FGM is difficult to take up with others, who haven't undergone it, as then it is difficult to share the feelings about FGM. Only one of the interviewees pointed out that she hadn't talked about FGM with Finns, because she felt that they wouldn't understand the concept at all.

E: Have you discussed the topic (FGM) with your peers/Somali/Finnish women?

I: I said: Mother this is a horrible thing and why have you done this??? And she said: "Shame on you, quiet! We are not discussing this!" (3)

3.3. Present and future trends of FGM

All the interviewees thought that FGM should no longer be part of the Somali tradition and there is no need to be altered or replaced with anything in order to harm girls, causing them pain or possible severe damages.

Every one's view was in favor of abolishing FGM without alterations or replacements. The indicator of having a party for the girl after her FGM procedure was recognized, but not considered to be of significance as a reason to maintain FGM. All were in favor of simply abolishing the old custom and forgetting it.

Due to the fact that the interviewees are now living in Finland, the need for FGM is no longer felt as compelling and its importance in the context of their life no longer exists. Also concern of potentially contracting HIV-virus through the dirty instruments used in FGM was brought up by some of the interviewees. In their view this is an additional supportive reason to stop the tradition.

The unchallenged way of conducting this tradition came to the spotlight in the interviews. FGM has become lately a topic of a general discussion. New views came about and were developed in the minds of the interviewees once in Europe and in Finland. It was recognized that often the tradition of FGM was carried and insisted upon by the grandmother who cherished the tradition as a requirement of a religious nature. Once this perception was proven wrong grandmothers often still gained respect to redeem their demand and firmness on carrying on FGM. Changes are taking place everywhere and the importance of FGM will gradually phase out.

E: What do you think, should FGM be continued or abolished?

I: Yes it is just a habit that should be given up. It is just invented and now it should be abolished. Even if we would go to Somalia or anywhere else I wouldn't accept it for my daughter for it is against my principles. (2)

I: Yes, this could be taken away and nothing is needed in the place. It can be forgotten and taken totally away. (3)

3.4. Suggestions for Abolishing FGM

The question of how FGM could be abolished was discussed at depth. The main conclusion was that mass education campaigns are needed, with the involvement and participation of community members. Only with participation of community member's right from the beginning, the message can be introduced and finally adopted throughout the whole country. It was also pointed out, that campaigns just in Finland or outside Somalia would not help but the mass campaigns should be conducted in Somalia, with Somalis in their villages and with their language terms each community comprehends and speaks. Education and educational programs are of great importance and a successful means to approaching the topic. Education creates opportunities and broadens spheres, thus allowing reaching out for new dimensions and perspectives. Education should be reaching not only the laymen and –women, but also the practitioners of FGM. Often the origins of the FGM were claimed to be from the religion, but once this perception was explained and corrected, many of the practitioners changed their views and asked for forgiveness. Sometimes the practitioners were gaining their livelihood by performing of FGM as their only income. In terms of abolishing FGM, the practitioners should at least at the outset be offered another form of income. Hence important education effort is needed to give the practitioners an access to something else with which earn their livelihood. Men and boys of these societies should be included in the educational programs as their acceptance of a woman who has not undergone FGM plays a vital role in the disappearance of FGM.

The key is to abolish the tradition of performing any form of FGM according to the interviewees. Thus there is a need of a massive, educative campaign all around Somalia it is important to get the villagers and leaders motivated and included into this campaign. Education, raising awareness, information sharing, different forms of bringing up ideas and thoughts, learning from each other and from outsiders (all forms to improve more understanding of the tradition), possible complications and damages caused are needed to influence the gore issue in the FGM tradition.

Once the harm, dangers and complications are explained and, even more importantly, once the false belief that FGM is a religious demand, it seems that many would be willing to dismiss this present part of the Somali culture to abandon it as necessary part of a Somali girl's life.

There are examples in the literature of the change in peoples' mind. In Kenya the FGM performers were educated and informed about the harm, dangers and complications most of the girls whom they had operated had suffered afterwards. Consequently most of the performers gave up their instruments of FGM and gave up performing FGMs anymore in the area (Shell-Duncan 2001 pgs 193-214; Wangila 2007).

This direction of new values overtaking old ones can also be seen in the study. New values have gradually taken over in Somali girls lives. Profession, self-supportive life and ability to possess are accepted and attainable in the lives of the interviewees. In Somalia a girl is expected to get married, take care of her husband, house and children. The husband provides everything material for his wife, who, in majority of cases, stays at home and takes care of the house and children. No professionalism education is demanded and as the husband takes care of all the necessities, the wife remains completely depended and supported by her husband. It was clear in the study that women, married or single, were reaching for a career and education was highly appreciated amongst all of them.

3.5. FGM's role in a Somali woman's identity

In Somalia, girls and boys are raised in a very different way. The education is primary for the boys, and the head of a household is seen primarily as a job for a man. Girls are thought to become wives and mothers, i.e. taking care of their husband, home and children. Present times have permitted to girls some access for education and studies, but still a girl's role as a wife and a mother plays a very important role in the road to happiness for a Somali girl. Nevertheless, in order to get married, a Somali girl should be cleaned, purified and guaranteed to be a virgin and not sexually too impulsive. She therefore has to be circumcised, cut, and mutilated as a girl child, definitely before marriage. Somalia's present instability and continuous warfare has, however, changed women's roles. Present time Somali women in Somalia are entering from a status of uneducated housewives to the workforce and are gaining growing empowerment in the instable Somalia. Values are changing and development in women's status is prominent (UNICEF: 2002). Education creates understanding and understanding leads to acceptance of new standards in life. Reflecting this in the group studied FGM was representing an old habit that could be abolished. FGM did not represent an important

enough role as such among the women studied. However, for those, to whom the FGM had been done, it had had already an important physical impact on their lives. For female dignity or respect, FGM did not represent a specific bonus in view of the interviewed. FGM was taken for a fact. It had taken place because of tradition and beliefs of their mothers, and in particular grandmothers. It did not feel at all important to continue neither was it seen as a must for a girl to gain respect or guarantees for a good marriage. As to bringing seal to something for a woman's dignity, FGM did not have a role to play in their view. This might have resulted from the interviewees' status in Finland. They were all either studying or working and were economically independent. Though three of them were married, marriage did not seem to be their ultimate goal; hence the importance of FGM in guaranteeing any marital status was not considered essential amongst them.

This was an interesting result indeed, as FGM has previously been presumed to be an important factor building the female dignity of a Somali girl. Dr. Mölsä's study from 2004 stated that parents were concerned about the young Somali women to lose their dignity in case they felt that FGM should not be continued (Mölsä 2004). In this study, the study group pointed out that FGM didn't play any role in their identity. Surprisingly, in this study, the group did not mention any significant basic difference to their identity with or without FGM.

E: What does FGM signify to you? Does FGM have a role in a Somali woman's identity?

I: As to me personally, it doesn't signify anything and I surely wouldn't have it unless my parents wouldn't have wanted to for me. Yes, I don't think it is important. (1)

I: No, it is not in their identity, because they have got their identity and they understand what a woman must have and what is needed. Then in Europe those who live in Europe they understand and the more they have gone through schools the more they have information they understand that this is not right and has nothing to do or influence in a person's life or for the studies or life or success or marriage or anything what happens in the future. It is the way you yourself are. (2)

I: I think it is old. It is wrong. It is just very old. It is just in the culture it isn't demanded in a book or anything. I think when you are born, you are born like you should be that as if something should be cut off, it isn't like any shame or anything. It is like a nose. Why does one have a nose? Nose has a meaning, the eyes have a meaning and the ears have a meaning so this (referring to female genitals) what is cut off has its own meaning and function and if it is taken away so the task cannot be done and then it leaves the function undone. I noticed that afterwards that it is just a silly thing. No one should be cut off, for it (female genitals) is meant to be. You have born with it and it should be left like that. If you are born blind it is different but you are born with it (female genitals) for a reason and they have a function which shouldn't be denied or worth to be touched and excluded. (3)

I: I am very much against it for there is nothing joyful nor pleasure in it. It is just a harmful thing that is done and it is not mention in the Koran or Bible. (4)

The opposite was though pointed out in Talle's article (2008) Precarious Identities: Somali Women in Exile. Talle brought up a concept of reconstructing identity in which dress code was proved to play an important role for Somalis and the veil was an essential identity code for Somali women in Norway. Talle reflected the use of veil to the FGM as an identity issue, and in exile the religion seemed to be playing even a more significant role. FGM was seen an act of religious nature, even in higher educated families (Talle, 2008).

The fact that FGM would not be carried out in Finland awoke surprise in the study group. They had all took for granted that FGM is done to every woman around the world and it came as a surprise that this was not the case. This shows how the tradition had never been questioned. It was merely assumed to be a general procedure for every woman in the world. Though surprised, none among the study group felt negative or accusative feelings towards their mothers or grandmothers. None felt anger as such in view of the fact that FGM had been done to them. Curiosity and realization of cultural behavioral differences paved the way for an opportunity to further explore the rules of the tradition and accepting the way tradition had been applied to in each individual case. Respect of tradition is a major issue of family bondage for the women interviewed, and none of them signaled any criticism towards their mothers and grandmothers for having

carried out the FGM. They accepted the depth of the tradition and the purpose of their mothers to have made them undergo it, as FGM was considered as a rule, the girls were to obey. Breaking the rule could have easily meant they become outcast from the society as well as neglect the girl and her family. Certainly this was to be avoided. FGM was seen to be a normal part in the life for a girl and it was taken as a necessity for a woman to undergo. Only after they had moved to Finland, information on women without FGM reached the study group members and they started seeing FGM in a different light and as a concept.

It stroke out, that when talking about the role of FGM, the world role didn't actually fit in the given context. FGM was merely a concept that exists, something to undergo, something that belonged to the interviewees' life in their childhood in Somalia, and as a performance of a particular act of tradition that was never questioned or criticized in their childhood. How this all reflects in the interviewees' comprehension of a woman's lifespan today, is purely through the physiological existence of scar tissue. The more challenging facts are also the physiological aspects, the persistent pains in menstruation and inconveniences in urinary systems that the interviewees may be facing.

3.6. Additional comments

In the end of the interview a possibility to add and discuss anything else which had not been covered on the topic during the interview was offered.

E: Would you like to add something else on the topic?

I: Yes, it awakes thoughts in me and I remember when I entered in the teenager yeas and I heard that Finnish girls don't go through a FGM and they will never be operated. So of course it surprised me for then I thought that why then our women have it and why in my country we have to have it and women have to suffer from it as in some other countries like in Finland the women don't have it. It made me wonder and think about it that could it be stopped one day in our country. For I kind of noticed that it really doesn't make any sense that FGM should be done. (2)

I: I thought before as I was living in Somalia and there everybody underwent a FGM I thought it is done to everybody in the world. That everybody is like me. Now I noticed that no, it is not done to everybody. Not at all. (3)

3.7. Summary of the result

The number of women interviewed was relatively small but, nevertheless, indicative. The answers were honest and corresponding to the trends in Mölsä's studies (1994, 2004) and the studies conducted in Sweden and in U.K. The result of this study confirms the suggestions of literature. It will take one to two generations to have any changes in the practice of FGM. Surely each one of the interviewees had her own, individual unique story about FGM but when it comes to the question of FGM's significance in a Somali girl's life in Finland or about the continuation/ abolishing of the tradition or the future trend of FGM amongst Somali women, the answers were blown from the same horn: FGM should be abolished from the culture and FGM should continue to play no role in a Somali girl's identity here in Finland.

The younger generation is more determined, more independent and their understanding of different values is broader. With global emersion, information is rapidly spread and new values are gaining ground amongst the young and demands are changing together with requirements. Awareness and acceptance of differences become more common and expectations are changing. This in turn does not necessarily include that a woman has to have undergone FGM in order to be pure, accepted or respected. Other values are replacing the value of FGM in a woman's life span, and "Times have changed" like Mölsä named her second study. Not only times are changing, but people's minds are changing with the time, places and concepts of life. Questions about the tradition's reason of being have arisen. With education, ability to compare and adapting to new norms, the ground also of a firm tradition can be shaken. New values are emerging and gaining room in acceptance and in practice. Like one interviewee stated very clearly: We have talked a bit about FGM with my Somali friends. Does it really make any sense to continue this tradition? (Interviewee1)

Communication is the key to many developmental change procedures and to make abandon detrimental FGM requires educational panels, discussions, sharing information and various forms of awareness raising in order to get the information disseminated amongst everybody involved in the performing of this tradition. Even if FGM is strongly "the women's business", men have to be involved and they have to accept the wave that abolishes the tradition of FGM.

“In addition, not only to inform the girls and mothers, but also fathers and boys. They should be involved as well. And to tell, that girls are precious and even more so without a FGM“(Interviewee 3). The conclusion of the study is that attitudes towards elimination of FGM are emerging and, though this study was just a start, in viewing the delicate subject, change is possible in an old form of FGM tradition. The floor is open for a widespread discussion awareness raising seminars and boarder researches with larger target population groups. They hopefully may result in a change in the number and demand of FGM in the Somali society.

4. CONCLUSION AND DISCUSSIONS

The International awareness towards FGM increased already in the early 80s' and numerous panel discussions worldwide have taken place ever since. FGM has raised many hot discussions amongst the medical, social, health professionals, but also in the anthropological and cultural communities. People are fiercely either defending or accusing the tradition. In some parts of the world FGM has been diminished, but in many countries FGM is still persisting to its stronghold as part of the tradition. This, no matter what contradictive evidence is brought to the table, the custom persists.

It is interesting also to note that in the Western world, women who are not satisfied with the looks of their genital organs can, against compensation, get the wanted part fixed and modified according to their wishes. This is totally acceptable in the society, even with a hint of admiration. However, the same procedure, executed in other circumstances, is totally doomed. These are of course two very different phenomena: the first is performed from the free will of the client, whereas the latter is performed against the client's will. Never mind, the reason for the procedure, the outcome is nevertheless alike in both cases. Cleaner and tidier outlook of female genital organs. It must indeed seem absurd to watch these exclusive operations done in a private clinics all shown on TV, when one herself has been a victim to similar operation and against one's own will mostly in very much poorer circumstances than those shown on TV (Olojubi 2009). In 2003, American surgeons carried out 1, 8 million cosmetic surgery operations. Among these operations a growing demand for cosmetic surgery of female external genital organs was significant (Hellman 2007).

In the respect of cultural tradition, FGM is seen as a requirement for a woman to have undergone regardless of her social status, wealth or position. The Universal Declaration of Human Rights (1948) states clearly the evidence what different complications, dangers and horrific pains and agony are included in the procedure of FGM and yet it is still prevailing. Sharing information, disseminating adequate knowledge on the subject, while at the same time taking into account the cultural importance of FGM, it should be feasible to convince the communities to withdraw this part of a tradition and abandon FGM without losing the dignity of women.

4.1. Finnish – Somali perspectives

How do we define ourselves as respected women in our society? What makes Finnish women respected and honored? What are the indicators for happiness for a Finnish woman?

Finnish women are known to the world to be the first ones to gain the right to vote in Europe and to be rather independent. Finnish women are almost as well paid as men and can obtain high positions. Both our president and our prime minister are women in 2011!

Finnish women can keep their maiden names when they marry, Finnish women do not lose their property or individuality in marriage and children are primarily judged to be under custody of the mother in case of a divorce. These are all common knowledge and privileges in Finland and no hesitation exist on their legality. Finnish girls and Finnish boys are growing under more or less the same rules of conduct and expectations for their individual choices, not gender based choices, for their future. Finnish women are respected as they form an integral part of their society as career women or housewives and they enjoy having achieved their own goals in life. How do our Finnish values as women, at a society, differ from those of women of a Somali culture and how do the Somali women see themselves here in Finland where other and very different values play a significant role in the womanhood and female identity?

Somali population in Finland is growing every year. The first Somalis came to Finland in 1990's and today there are over 11.000 Somalis in Finland. Somalis form, together with Russians and Estonians, 44 % of the immigration population in Finland. The Somalis thus are a major group of immigrants in Finland. The share of immigrants in the total census has grown up to 70-90% and it is estimated that by 2030 the proportion of immigrant population is 25% of the whole Finnish population (Pajunen 2011).

In Finland the practice of FGM is not part of the path of a girl to womanhood. FGM is a punishable act in Finland up to ten years of detention (Amberla 1993; Vahtera 1992). Information of the negative implications and dangers in FGM are widely known and the whole procedure is not accepted in any means. It is normal in Finland for a child to ask and challenge a thing that is presented, but not understood. In many African, Asian, Middle East cultures, parents, elders or customs are never questioned or challenged. The children simply have to obey and surrender to the existing rules. They cannot contradict

or disobey. Ancient tribe customs are to be followed and cherished without hesitance of any kind. Rules are to be obeyed and traditions are to be followed. And in particular if you are a girl!

With new emerging Somali-Finnish generations, cultural behavior is influenced by governing behaviors of the host country and hence traditions are gradually being molded according to the general behavioral acceptance. Modifications are taking place in the practices of FGM, and FGM might be required no longer as a part of a Somali girl's transformation from childhood to womanhood.

4.2. FGM's stronghold

What keeps the tradition of FGM so persistent and dominant in spite of all and numerous anti-FGM demonstrations, declarations, law settlements and arguments? Traditional practices are ways of showing care. They are submerged in the behavior according to age, gender, lifestyle and social class, and they are inherited from previous generations. In these countries where FGM has always been an integral part of a girl's lifespan, the procedure is keeping its stronghold.

The practice for FGM comes to money and wealth. Girls who have undergone a FGM are valued at a better price when wedded. The more severe form is the FGM, the bigger the dowry and the bigger the fee for the operation. Thus the family of the bride to be needs to be addressed with an alternative income method in order to change the habit or abolish it. The one, who performs the FGM, has also to find livelihood from something else (Booth 1985; Abdalla 1982; Momoh 2006). The sad point here is the fact that, even in the discussion of altering the rite of FGM, the "victim", the girl herself, is not considered at all. "Because I am a girl" was the slogan for PLAN Finland this year. In the related seminar various examples on what girls have to undergo or what they always are deprived of. Lack of education rights or having a say in general on their life because they are girls were brought up. In all matters, the girls themselves have no voice at all to speak out their opinion, and no change at all. They are not entitled to give their views, opinion and they have no change at all to stand for their rights.

Ancient traditions cannot be swept away in a wink of an eye, nor can they be altered in one life time, but the more we are able to share views and information, the more we can

have a directive influence on the action. Hence, bit by bit we proceed forward to changes, still dignified and respected in cultural behavior. FGM can be considered as a taboo, something which is not talked about, but also the specific circumstance in a country (in this study Somalia's situation) must be recognized. In Somalia there is no central government and the country is very unstable.

In working for a change, many challenges may arise as dissemination of awareness is not always accepted in the various communities. We often come face to face with the fact that, no matter how outsiders may put their efforts on showing the cons of FGM, the locals have their pros for the practice and it is simply out of the question for outsiders to get mixed in this matter. We have a few examples of this from Gambia, where outside programs that seemingly opposed FGM or tried to make out medical hazards an evidence of the practice and where the government supported ongoing awareness programs, the local practitioners clearly stated that culture and tradition cannot be legalized. Opposition continued and general attitude culminated into mixed feelings towards the earmarked aid money for FGM eradication. Outside help was seen as "Imperialist meddling in what should be an internal matter" (Shell-Duncan et al. 2001).

4.3. Suggestions on FGM elimination methods

Raising awareness of the harm and dangers in FGM, education programs and proving wrong some of the beliefs - like poisoning the husband or the baby with the clitoris, unstoppable genital growth, and other myths in the FGM, getting the communities to participate in these programs should always be used in the work of influencing diminishing FGM. Understanding and acceptance of the change as necessary must be the key to persuading the respective FGM communities. For the FGM operation practitioners themselves, alternative income should be out in place (Denison et al. 2009; Odeyemi 2008; Shell-Duncan et al. 2000; Dorkenoo 1992)

Two of the interviewees of this study pointed out how their grandmother, after having learnt the harms and complications of FGM, not only stopped performing FGMs, but also apologized to many of the girls they had operated for not having been aware of the possible dangers. Their apology concerned the fact that now they knew FGM was not demanded in their religion, contrary that they had been presuming.

Education creates more opportunities and broadens spheres, enabling one to reach out for new dimensions and perspectives. Empowering women with education, raising awareness in health, human rights and economical issues and allowing women to be involved in their own matters, harmful practices may be left behind and new values grow together with increasing development of societies (Hellsten 2004).

Components of FGM related activities are being included into health education programs of UNICEF, WHO, USAID and other organizations working in FGM influenced communities in Somalia and elsewhere in Africa. Different strategies are implemented and governments are urged to stand up to their commitments. Empowering women and girls through information dissemination campaigns and facilitating their access to education and control of economical resources, will enhance women to comprehend their rights and give them a choice to end FGM practices (UNICEF: Eradication of Female Genital Mutilation in Somalia). Only time will tell how dissemination programs are bearing fruits in changing perceptions of cultural customs concerning FGM.

4.4. FGM's future

However, future trends for FGM seem still to be continuing the same path: sporadic eradication spots are established in some countries, zero tolerance for the FGM is declared in the Diaspora, and, as usual, there are always those, who choose to remain undecided and take no active part in the debate or have no stand on how to proceed.

According to the Population Reference Bureau's updated report (2008) on data and trends in FGM in some African countries there is a slight diminution of FGM practices, but in other countries there is no significant change yet. The variety of prevalence of FGM practices seems to be linked more to the ethnicity and social interaction than country borders. The age factor shows a major decline of FGM practices in younger women in countries as Ethiopia, Ivory Coast and Kenya and this indicates possible permanent change in the FGM practice in those countries (PRB: FGM/FC: Data and Trends). In countries like Egypt, Mali, Sudan and Guinea, where the prevalence rate is still high, this difference between ages is only trivial (UNICEF 2005). In another study, made in Nigeria, decline in FGM was shown because of modernization in practices of

cultural rites and childbearing, but also on the basis the of government policies and media interventions in the awareness raising campaigns (Adeokur 2006).

Yet, in a country like Somalia, struggling with serious problems like the impact of war, lacking infrastructure, having no central government, and enormous unemployment all in addition to every day practical problems like lack of electricity, clean water or food, the aspects of FGM do not strike as a cord number one priority. In 1992, many Somalis in Finland wanted to preserve the tradition of FGM and continue it for their daughters. It was confusing for them to find out that in Finland this custom is prohibited by law and therefore they were obliged to withdraw from fulfilling the tradition (Aunila 1992).

Interesting trends are explained in the studies by Dr. Mölsä in Finland in 1994 and in 2004. In the first study of 1994 the majority of the interviewed married mothers were first of the opinion that they wanted to continue the tradition in their daughters, whereas in the second interview, none of the interviewees (18 women and 12 men) wanted to continue the tradition anymore in their daughters. However, in the second study Ms. Mölsä conducted, there was a strong concern about potential loss of identity by the younger generation in case.

This study's results show clearly that the FGM do not have any influence on the identity or to the picture of a respected woman in the society. Those interviewees who had had FGM done did not seem to value FGM as such for woman's identity. Those interviewees, who had not had FGM done, did not feel inferior to those who had a FGM. It can be concluded then that the absence of FGM did not have any crucial meaning to women's identity. From the interviews it can easily be summarized that other priorities than mere perspective of an honorable marriage have taken over. These priorities in a Somali girl's life here in Finland are getting a profession, self-supportive life and ability to assets. As this new approach has gained importance in what is considered the normal live in Finland for a Somali woman, the importance of FGM has totally lost prominence and therefore the old, never questioned tradition can be ignored also without causing an expressed damage to the old, respected and fine Somali culture. Kind of sadness was expressed in some of the interviews as they compared female genitals to be part of a female body, and hence should be left alone and not cut off. This shows a deeper level of relating to the effect of FGM and acculturation may have a part in this analytical consideration.

International commitment towards ending FGM is commemorated every year on the 6th of February on International Day against Female Genital Mutilation. With modernization, urbanization, mass communication and education people are getting more exposed to new ideas (UNFPA news 2007). Women are getting more independent, participating more in labor and economic market with new priorities and values in their reach, gaining a respected status in the society. The role of FGM has no place any longer in this new, modern world of educated and self supportive women. The change of woman's values was evident also in study interviewees' views. They did not feel that the old tradition of FGM played any significant role anymore and, for them, there was no reason for the FGM to be continued any longer. FGM could easily be just dropped out and allow girls to keep their full female genital organs. Just like one interviewee (3) of the study group acknowledged: "We are born with it (Female genitals) and they have a function and meaning and no one should be cut off anything."

In the article: "The challenge of Female Genital Mutilation in Somaliland" Gulaid, (2008) highlights that younger and more educated generations are disapproving the practice and the firm norms of the cultural tradition around FGM are softening permitting the changes in the tradition (Gulaid 2008). Similar attitude could be seen in a study made in Sweden, where Ethiopian and Eritrean immigrant families were interviewed concerning their children's possible future FGM. The result was that their children were unlikely to be subjected to FGM (Johnsdotter 2009). The trends in these studies show that accepted abandoning of the FGM tradition is feasible in a timeline of one to two generations. It is rewarding to notice that the trend to abolish and to fully abandon FGM in the tradition seems to gain support in the Somali Diaspora, but not in Somalia itself. Is this due to outside influence or to awareness and education effort or could it just be a coincidence?

Similarly, in London with awareness raising and legislation, FGM is declining in the immigrant population like the author, F. Hussein, in her article: Changing attitudes towards FGM in the Somali Community in London states and is feasible that changes could reach Somalia as well through education and sharing information (Hussein 2008). Then again, in another study, conducted in U.K. the girls and boys interviewed (56 participants) clung to the tradition. The participants of the study believed that FGM was done due to religion and culture, to prevent women from being dirty and protect the girl from being promiscuous. Some of the boys maintained that FGM is to be done in

order to preserve the honor and to ensure that the girl could marry (Momoh 2005). Thus pros and cons of FGM are still existing and evident and more time is needed to spread information and allow change to be absorbed in practice.

The amount of FGM related source material is enormous and it has been challenging to limit the reference materials to the frame of this study. It was essential to obtain diverse background information for a comprehensive picture of the multiple impact levels of FGM in a woman's life. The gathered information, both from the resource materials and from the interviews, was studied and analyzed against the study's purposes.

The aim of this study was to review the importance of FGM and changes taking place in attitudes of young Somali women in Finland. Even if the study group was small and the result of the study cannot be directly generalized to all Somali women in Finland, the study clearly demonstrated the primary importance of FGM and its key place in the concept of a proper Somali woman. Each of the interviewed women was on the opinion that FGM did not play any role in the female dignity and it could thus be abolished and left out from the Somali tradition. It is also very clear, that every cultural change needs its appropriate time and process of development before a new direction can be adopted. The change must be, if not initiated, understood, accepted and carried out by the members of those respected in "FGM cultures", if the change is really to be permanent. Community based educational programs together with awareness raising programs implemented in health interventions would contribute positively in disseminating the right information, dangers and risks in FGM practices and henceforth enhance the fight against FGM tradition.

Communication is central and vital through information, education, awareness raising or just in sharing ideas and thoughts. At this point in time the stage has been reopened for discussions and workshops and seminars are organized on traditional FGM. Changes in attitudes and perceptions on this tradition are gradually gaining foothold in the minds of young generations and breaking at the same time strong old beliefs of older generations. As the globe is spinning around, our perceptions, values and traditions are spinning within the globe, removing some behavior, while letting new ideas to become instrumental in updating, reforming and modernizing the ways of setting values and dignity codes. Today's world is open to words. Hopefully we are ready to tell and to listen!

5. ACKNOWLEDGEMENTS

Different cultures, traditions and behaviors have always fascinated and captivated the human history.

With global shrinking in terms of refugees, asylum seekers, workers and tourism, different cultures are crossing together and absorbing aspects from each other. New acculturation modes are emerging with changed perceptions of old traditions.

In this aspect, the FGM is also getting influenced by other cultures concerning female context in the tradition and hence evolving into new stages of female respect and cultural values. This study gives useful information on the aspects of FGM's role in the Somali woman's identity in Finland.

Discussions on FGM are gaining more space in international platform and the global interest has been turned towards eliminating the old tradition which is affecting millions of women in the world.

To me, the FGM has always been a passionate issue. The first time to be face o face with FGM was in 1980's in Somalia, and now with our Finnish Somali population I wanted to find out how strong a role does it still play amongst Somali women here in Finland.

I am very grateful to the Somali women who consented to the interviews and shared valuable information with me in order to carry out the study and to my supervisor, Assistant Professor of Public Health, Pirjo Lindfors from the University of Tampere to have guided me through the jungle of writing Master's Thesis. Not forgetting the input of Professor Reijo Salmela from the University of Tampere, whose contract came in Tampere University, came to an end in the middle of the thesis process.

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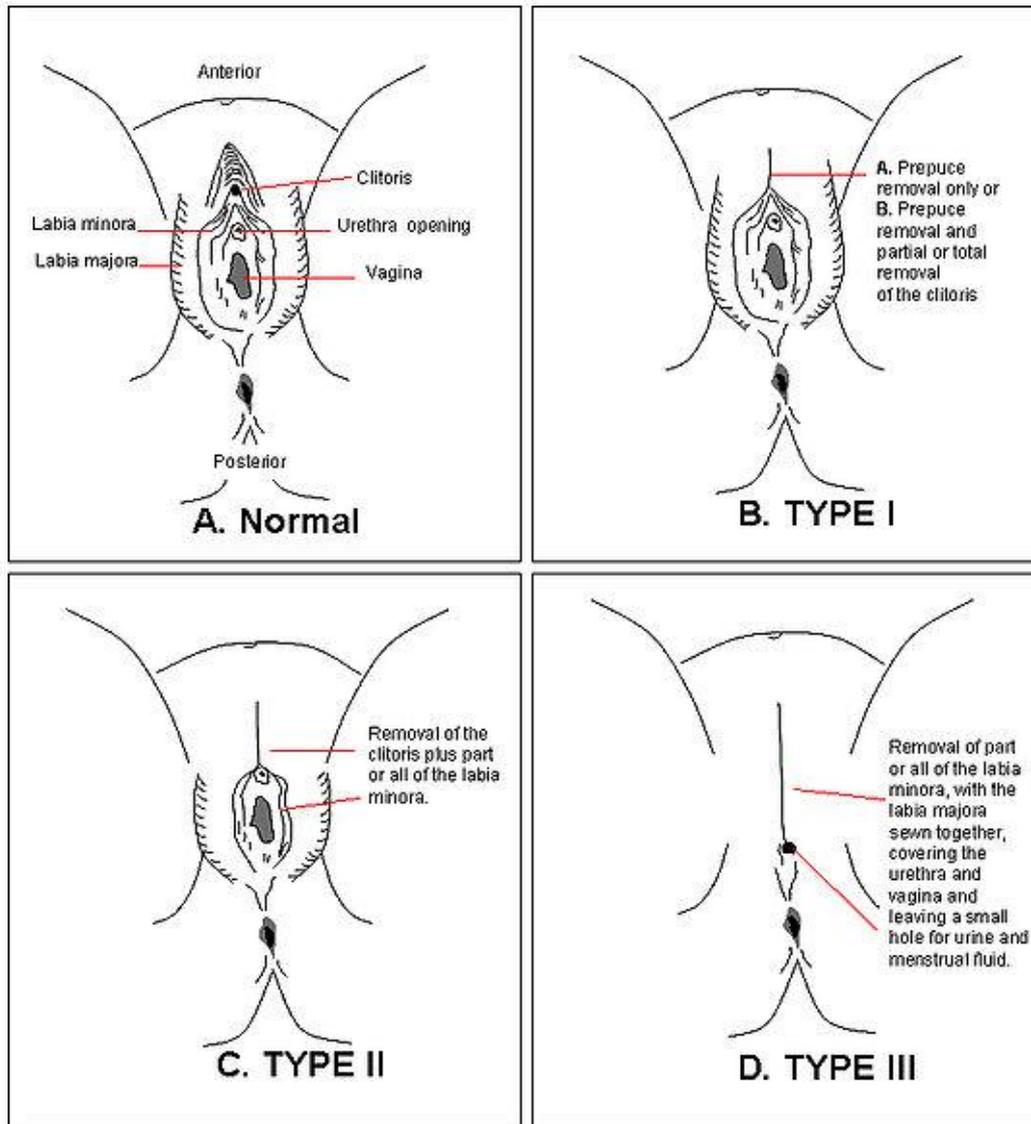
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APPENDIX 2.**Graphical pictures of FGM types**

<http://www.google.fi/images?hl=fi&source=hp&biw=1024&bih=509&q=FGM&gbv=2&aq=f&aqi=g1&aql=&oq=>, accessed on the 2nd of April 2011

APPENDIX 3.**Typical instruments used in FGM**

<http://www.google.fi/images?hl=fi&source=hp&biw=1024&bih=509&q=FGM&gbv=2&aq=f&aqi=g1&aql=&oq=> ,accessed on the 2nd of April 2011

APPENDIX 4.**The study questions (English)****Generalities and background:**

1. How old are you? a:(18-25yrs) b: (26-30yrs) c: (>30yrs)
2. Which part of Somalia are you from?
3. Where did you live when you were young (< 10 years)?
4. What is your mother's educational background?
5. What do you know about female genital mutilation (FGM)?
6. Have you had a FMG?
7. Did you have any complications because of the FGM?
8. If yes, how do they present themselves?
9. Are you married?
10. Do you have children?
11. Do you have a daughter /daughters?
12. Would you like your daughter/s to undergo FGM?
13. If yes, what type of a FGM?

Memories and feelings**What do you remember of your FGM?**

14. What does FGM signify to you? Does it have a role in a Somali woman's identity?
15. Who initiated the idea that you should have the FGM?
16. How were you prepared for it?
17. Do you know why it was done to you?
18. How old were you when it was done?
19. Where was it done? In a city or in urban surroundings? In hospital or at home?
20. Who did it to you?
21. How was it done to you?
22. What type of FGM was it?
23. How did you feel about the FGM
24. Were you alone or with other girls when it was done to you?

25. What was your reaction to the procedure?
26. What do you remember of it?
27. How long were you in bed after the procedure?
28. Who took care of you during your recovery period?
29. How long was your recovery period?
30. Was the procedure successful?
31. Did you have any celebrations afterwards?
32. Are all females in your family gone through the FGM?

Present and future trends in FGM?

33. How do you feel about it now?
34. Have you discussed the topic with your peers/Somali/Finnish women?
35. Do you think women should undergo FGM?
36. If yes, what type of a FGM?
37. What do you think of women who haven't had FGM?
38. Should FGM be continued or abolished?
39. What could be replacing the FGM if it is abolished?
40. How do you see future development in the practice of the FGM tradition?
41. Would you like to add or discuss something else on the topic?

APPENDIX 5.**The study questions (Finnish)****1. Yleis-ja tausta tiedot:**

1. Kuinka vanha olet? a:(18-25v) b: (26-30v) c: (>30v)
2. Mistä päin Somaliaa olet kotoisin?
3. Missä asuit lapsena? Alle kymmenen vuotiaana?
4. Mikä oli äitisi koulutus?
5. Mitä tiedät naisten ympärileikkauksesta?
6. Onko sinulle tehty ympärileikkaus?
7. Oliko sinulla jotain ongelmia ympärileikkauksesta?
8. Jos oli, niin mitä?
9. Oletko naimisissa?
10. Onko sinulla lapsia?
11. Onko sinulla tytär/tyttäriä?
12. Tahtoisitko ympärileikkauttaa tyttäresi?
13. Jos kyllä, niin minkä tyyppin leikkaus?

2. Muistoja ja tunteita

14. Mitä naisten ympärileikkaus merkitsee sinulle? Mikä rooli sillä on Somalinaisen identiteetissä?
15. Kenen aloituksesta sinulle tehtiin ympärileikkaus?
16. Valmisteltiinko sinua ympärileikkaukseen? Miten?
17. Tiedätkö miksi sinulle tehtiin ympärileikkaus?
18. Kuinka vanha olit kun sinulle suoritettiin ympärileikkaus?
19. Missä ympärileikkaus tehtiin sinulle? Kotona/sairaalassa?
Maaseudulla/kaupungissa?
20. Kuka teki sen?
21. Miten ympärileikkaus tehtiin?

22. Minkä tyyppin ympärileikkaus sinulle tehtiin?
23. Miltä sinusta tuntui/tuntuu?
24. Olitko yksin, vai oliko kanssasi muitakin tyttöjä, joille tehtiin ympärileikkaus?
25. Mikä oli reaktiosi ympärileikkaukseen?
26. Mitä muistat tapahtumasta?
27. Kuinka kauan olit vuodepotilaana ympärileikkauksen jälkeen?
28. Kuka hoiti sinua ympärileikkauksen jälkeen?
29. Kuinka pitkään olit toipilaana?
30. Onnistuiko ympärileikkaus?
31. Oliko sinulla juhlia ympärileikkauksen jälkeen?
32. Onko kaikki naiset suvussasi/perheessäsi ympärileikattu?

3. Naisten ympärileikkauksen nykyaika ja tulevaisuus

33. Mitkä ovat tunteesi nyt ympärileikkauksesta?
34. Oletko puhunut ympärileikkauksesta Somali/suomalaisten ystäviesi kanssa?
35. Tarvitseeko naisten olla ympärileikattuja mielestäsi?
36. Jos kyllä, niin minkä tyyppin ympärileikkausta ajattelet?
37. Mitä mieltä olet naisista, joita ei ole ympärileikattu?
38. Pitäisikö naisten ympärileikkausta jatkaa vai voisiko sen poistaa?
39. Jos ympärileikkaus poistetaan, pitäisikö jotain saada tilalle?
40. Miten näet naisten ympärileikkauksen tulevaisuuden?
41. Olisiko sinulla jotain lisättävää aiheesta?

APPENDIX 6.**International Treaties of FGM**

- African Charter on Human and Peoples' Rights 1981, entry into force 1986
- African Charter on the Rights and Welfare of the Child 1990, entry into force 1999.
- American Convention on Human Rights 1978.
- Committee of Economic, Social and Cultural Rights 2000 the right to the highest attainable standard of health.
- Committee of the Rights of the Child 2003, Adolescent health and development in the context of the Convention on the Rights of the Child.
- Committee on the Elimination of All Forms of Discrimination against Women. General Recommendation 1990, Female Circumcision, General Recommendation 1992, Violence against women, general recommendation 1999, Women and Health.
- Convention against Torture and Other Cruel, Inhuman or Degrading treatment or Punishment (1984), entry into force 1987.
- Convention on the Elimination of all Forms of Discrimination against Women (1979), entry into force 1981.
- Convention on the Rights of the Child (1989), entry into force 1990.
- Convention relating to the Status of Refugees (1951)
- Dakar Conference of The Inter-African Committee on Traditional Practices Affecting the Health of Women and Children. 1984
- European Convention for the Protection of Human Rights and Fundamental Freedoms. 1950, entry into force 1953.
- Human Rights Committee 1992. Prohibition of torture and cruel treatment or punishment.
- Human Rights Committee 2000, Equality of rights between men and women.
- International Covenant of Economic, Social and Cultural Rights (1966), entry into force 1976.
- International Covenant on Civil and Political Rights (1966), entry into force 1976
- Protocol relating to the Status of refugees(1967)

- Protocol to the African Charter of Human and Peoples' Rights of Women in Africa 2003, entry into force 2005.
- United Nations General Assembly, Declaration on the Elimination of Violence against Women.1993
- Universal Declaration of Human Rights(1948)
- WHO Seminar in Khartoum on Traditional Practices Affecting the Health of Women and Children 1979