



# Challenges in Addressing Female Genital Mutilation in Primary Health Care

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The goal of this study was to examine the perspectives and experiences of health care professionals in primary health care concerning discussions on female genital mutilation (FGM) with female patients. The primary objective was to identify the preventing and facilitating factors in raising and discussing the culturally sensitive topic in their work. The secondary objective was to provide recommendations for health care providers based on the identified development needs.

FGM is an increasingly important global public health concern. Currently 200 million girls and women alive have been subjected to some form of FGM and 4 million girls are at risk of FGM every year. Regardless of the decline in FGM practice, the number of girls undergoing the procedure will increase due to population growth, medicalized FGM as well as the consequences of the COVID-19 pandemic. Global efforts are needed to prevent FGM, due to the growing migration from countries with high prevalence of FGM to areas where the tradition is not commonly known or practiced. There are estimations of around 10,000 women who have undergone FGM living in Finland and up to 3,000 girls being in the risk of undergoing FGM. Previous research shows low awareness of FGM among health care professionals as well as various barriers in raising the topic in health care settings.

A qualitative approach was used in this study. The data was collected through an anonymous online questionnaire with open-ended questions and analysed using inductive content analysis method. The data consisted of 14 responses by registered nurses and public health nurses in primary health care setting. Participants were recruited through a contact person at the research setting. Primary health care as the research setting was chosen due to higher levels of usage of services among the population with foreign background as well as being the service with a lower threshold for diverse health issues.

The results of the study showed a lack of knowledge and experience on FGM among nurses in primary health care. The lack of knowledge was linked to the confidence in addressing FGM and related health issues with women. Based on the results, there is a need for further training for nurses working in primary health care. The results demonstrated similar outcomes as previous research. Significant knowledge gaps, lack of common guidelines, cultural barriers to raise the topic and a need for further education were reported.

This thesis was a small-scale study, which may however inspire larger studies on health care professionals' competencies on FGM and abilities to bring up culturally sensitive topics. Examining the perspectives of women who have undergone FGM and their experiences on interactions and discussions with health care professionals in Finland concerning FGM and related health issues would also be valuable.

Keywords: Female genital mutilation (FGM), health care professionals, primary health care, women's health, cultural sensitivity

## Contents

1	Introduction .....	7
2	Female genital mutilation (FGM).....	8
2.1	Prevalence and reasons behind the tradition .....	10
2.2	Medicalization of FGM .....	12
2.3	Health consequences of FGM .....	13
2.3.1	Physical health consequences .....	13
2.3.2	Mental health consequences .....	15
2.3.3	Sexual health consequences .....	15
2.4	Deinfibulation and reconstructive surgeries.....	17
2.5	FGM in Finland.....	17
2.6	Research on FGM in Finland .....	18
2.7	Human rights and legislation on FGM.....	20
2.8	Prevention of FGM in Finland.....	21
3	The role of health care professionals in addressing FGM .....	22
3.1	Importance of addressing FGM in health care settings .....	24
3.2	Language barriers, interpreters, and cultural mediators.....	26
3.3	Cultural sensitivity as a facilitator for sensitive discussions .....	26
4	Goal, objectives, and research questions.....	27
5	Methods.....	28
5.1	Qualitative research .....	28
5.2	Research setting.....	29
5.3	Data collection .....	31
5.4	Inductive content analysis .....	33
6	Results .....	35
6.1	Experiences and perspectives on FGM in primary health care.....	36
6.2	The role of nurses in addressing FGM .....	37
6.3	Barriers for bringing up FGM.....	38
6.4	Facilitators for bringing up FGM .....	43
6.5	Cultural sensitivity as a facilitator for addressing FGM.....	47
7	Discussion.....	48
7.1	Discussion of the results.....	48
7.2	Limitations of the study.....	54
7.3	Trustworthiness .....	54
7.4	Ethical considerations .....	56
8	Conclusions.....	58
9	Recommendations.....	59

References.....	60
Figures .....	66
Tables .....	66
Appendices .....	67

## 1 Introduction

Female genital mutilation (FGM) is an increasingly important global health concern. Currently 200 million girls and women alive have been subjected to some form of FGM and 4 million girls are at risk of FGM every year. Regardless of the decline in FGM practice, the number of girls undergoing the procedure will increase due to population growth. Also medicalized FGM is a growing concern as well as the COVID-19 pandemic and its consequences, which are estimated to result in an increase of FGM practice in the coming years (United Nations Children's Fund UNICEF 2021). Female genital mutilation is also a financial burden, with estimates of annual 1.4 billion USD for treating FGM related health complications in 27 high FGM prevalence countries (World Health Organization WHO 2020). Additionally, due to the growing migration from countries with high prevalence of FGM to areas where the tradition is not commonly known or practiced, global efforts are needed.

FGM is a harmful and non-medical practice with short- and long-term physical, mental and sexual health complications as well as social consequences. It is a form of gender-based violence and an extreme violation against human rights on many levels. FGM is defined by WHO as any procedure that involves partial or total removal of external female genitalia or other injury to female genital organs for non-medical reasons (WHO 2021). The tradition is prevalent in communities with deeply rooted gender inequality. It is an age-old, cultural practice, which continues to be performed for different reasons and socio-cultural factors depending on the country, region and community. (United Nations Population Fund UNFPA 2022; UNICEF 2021; WHO 2021.)

Global response for the elimination of FGM are continuous and have resulted in several international agreements, national legislations and campaigns against all types of female genital mutilation. United Nations (UN n.d.) Sustainable Development Goal SDG 5.3 on Gender equality and women's empowerment, also strives to eliminate FGM. However, ending FGM requires international, regional as well as local efforts, by increasing advocacy and providing evidence on health consequences of the tradition.

FGM has been an increasingly relevant issue in Finland since the early 1990s, when the number of refugees and migrants from FGM prevalent countries started to rise. The estimated number of girls and women in Finland who have undergone FGM is around 10,000 and an estimated 650 - 3,080 girls are under the risk of being subjected to FGM. (Koukkula & Klemetti 2021, 20-22.) Prevention and advisory work has been taking place for over two decades in Finland; legislation, policies and action plans on FGM for different sectors has been issued. Several non-governmental organizations are working to raise awareness of the

tradition and its harmful consequences as well as trying to open a public discourse on the topic. Nonetheless, attitudes towards the tradition are rapidly changing in the practising communities after migration (Berg & Denison 2013). Research on the topic is, however, still highly needed and encouraged.

The growing level of immigration also requires assessment of culturally diverse needs especially in the health care sector. Health care professionals in primary health care play an important role in the prevention of FGM as well as in the provision information, quality care and guidance for women who have undergone FGM. However, addressing a culturally sensitive topic such as FGM has proven to be challenging. Lack of confidence, knowledge, training and guidelines create barriers for provision of quality care for women who have undergone the procedure. FGM and related health issues are also commonly considered as a taboo in the practicing communities, which hinders women further to seek help. (Johnsdotter & Essén 2016; Dixon et al. 2021.) Health care professionals are in a key role to bring up and discuss the topic, providing accurate information to enable women to make well-informed decisions and receive quality care and guidance.

The goal of this study is to examine the perspectives and experiences of health care professionals in primary health care concerning FGM in the context of Finland. The primary objective is to identify the preventing and facilitating factors in bringing up and discussing a culturally sensitive topic, such as FGM, in their work. The secondary objective is to provide recommendations for health care providers based on the identified development needs in the research. These recommendations could further improve the competencies in identifying women who have undergone FGM and being able to provide them quality care, support and guidance in a culturally sensitive way.

## 2 Female genital mutilation (FGM)

Female genital mutilation (FGM) is a harmful and non-medical practice with short- and long-term physical, mental and sexual health complications as well as various social consequences. FGM is defined by World Health Organization (WHO) as any procedure that involves partial or total removal of external female genitalia or other injury to female genital organs for non-medical reasons. (Koukkula & Klemetti 2021, 13-14; WHO 2021.)

The terminology used when addressing FGM varies depending on the context. WHO (2018, 19) recommends using female genital mutilation (FGM) when the issue is addressed in general, to emphasize the fact that it is a grave human rights violation as well as to differentiate FGM from male circumcision. However, when addressing the issue in a health care setting with girls and women from practicing communities, a more neutral, culturally sensitive, and non-



judgmental terminology is recommended, such as female genital cutting (FGC), excision or genital cutting. In addition to these terms, there are other common names describing the tradition depending on the community and local context, for example *khatna/khafz*, *sunna/sunna circumcision* (Type 2, 3 or 4) and *pharaonic* (Type 3), which are recommended to be used if the patient wishes to (End FGM European Network, Equality Now & US End FGM/C Network 2020, 8). However, it is important to acknowledge that the term used by a person from practicing communities can refer to various types of FGM procedures depending on context and for instance the term *sunna* may not even be perceived as FGM within some communities (Finnish League for Human Rights 2020, 36). Furthermore, studies have shown that the self-reported form of FGM is low on accuracy (Elmusharaf, Elhadi & Almroth 2006).

WHO classifies female genital mutilation into four main types, and several sub-divisions (Figure 1). The classification of WHO provides only a general typology on FGM, therefore it is noteworthy that in practice the types of FGM often varies. (WHO 2018, 27-33.)

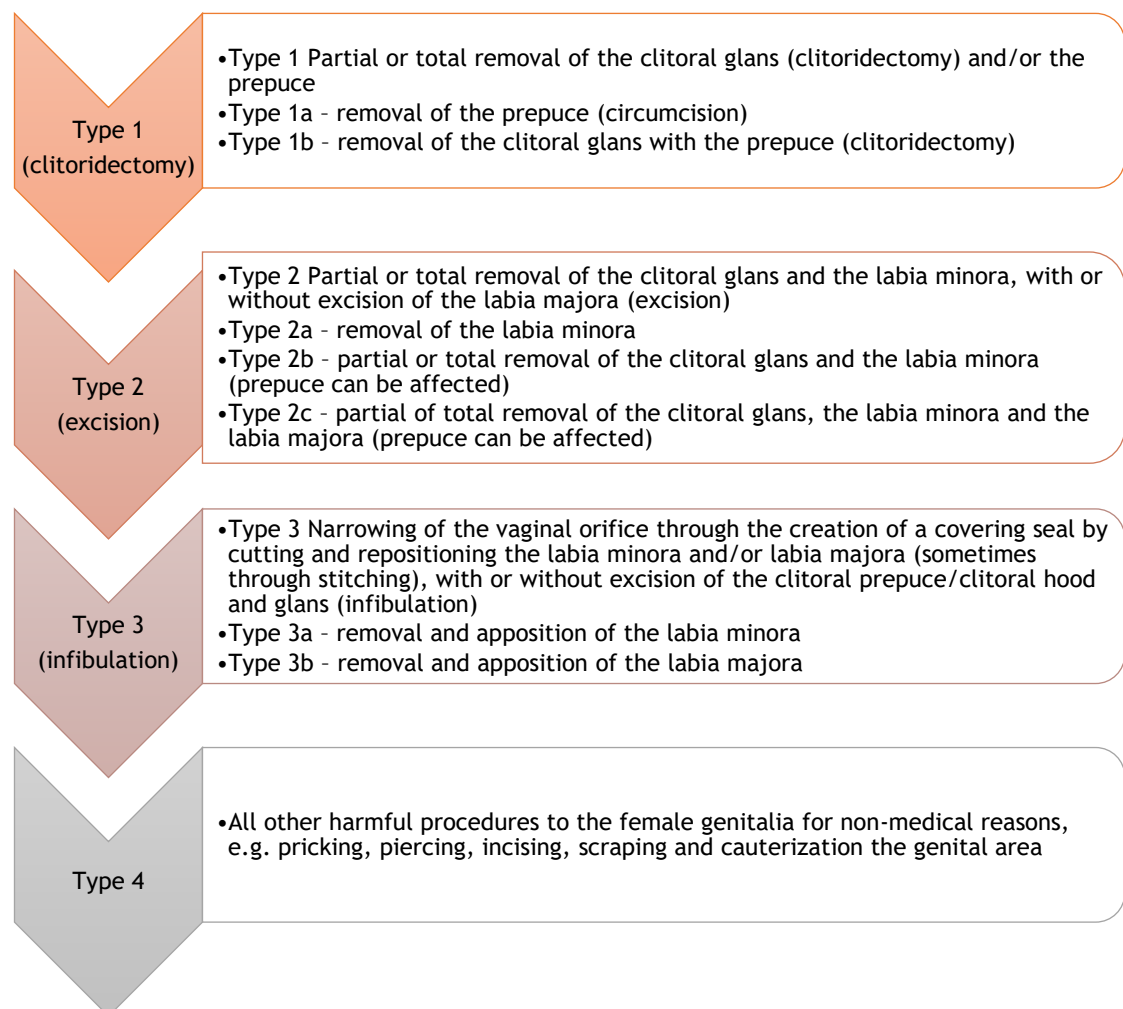


Figure 1: FGM classification (adapted from WHO 2018, 27-33)

## 2.1 Prevalence and reasons behind the tradition

Currently 200 million girls and women alive have been subjected to some form of female genital mutilation and an estimated 4.2 million girls are at risk of FGM every year. Regardless of a decline in FGM practice, the number of girls undergoing FGM is increasing due to population growth. (UNFPA 2022; WHO 2021.) There are estimations of 2 million preventable cases of FGM occurring due to the COVID-19 pandemic and related disruptions in FGM prevention programmes (UNFPA 2022).

Girls between infancy and adolescence are in the greatest risk of FGM. Women might undergo FGM also during their first pregnancy or after giving birth (WHO 2021). According to research certain sociodemographic determinants have an influence on the prevalence of the tradition, for instance parents' higher education level as well as mother's employment decrease the likelihood of the girl being subjected to the procedure. Also, families living in cities are less likely to have their daughters undergo FGM in comparison with families living in rural areas. (Koukkula & Klemetti 2021, 23.)

### FGM PREVALENCE AMONG GIRLS AND WOMEN AGED 15 TO 49

Countries with high prevalence of FGM (83-98 %)	Somalia, Guinea, Djibouti, Sierra Leone, Mali, Egypt, Sudan and Eritrea.
Countries with fairly high prevalence (19-76 %)	Burkina Faso, Gambia, Ethiopia, Mauritania, Liberia, Guinea-Bissau, Chad, Cote D'Ivoire, Nigeria, Senegal, Central African Republic and Kenya.
Countries with low prevalence (lower than 18.5%)	Yemen, Tanzania, Benin, Iraq, Togo, Ghana, Niger, Uganda and Cameroon.
Countries with significant prevalence	Indonesia (49% girls aged 0-11) and Afghanistan as well as the Kurdish areas in Iran, Syria and Turkey.

Table 1: FGM prevalence in the 30 countries with highest FGM levels (End FGM European Network, Equality Now & US End FGM/C Network 2020, 21; WHO 2021; Finnish institute for health and welfare THL 2021a)

FGM practices are mainly concentrated in 30 countries in Western, Eastern and North-Eastern regions in Africa as well as in Middle East, and Asia (Table 1). In addition, FGM prevalence is growing in areas where the practice is not customary, such as Europe, North America and Australia, due to migration from FGM prevalent countries. The countries with the highest prevalence of FGM are Somalia, Guinea, Djibouti, Sierra Leone, Mali, Egypt, Sudan and

Eritrea. In addition to these eight countries, there are thirteen countries with fairly high prevalence: Burkina Faso, Gambia, Ethiopia, Mauritania, Liberia, Guinea-Bissau, Chad, Cote D'Ivoire, Nigeria, Senegal, Central African Republic and Kenya. Additionally, there are nine countries with lower prevalence of FGM: Yemen, Tanzania, Benin, Iraq, Togo, Ghana, Niger, Uganda and Cameroon. Also, Indonesia and Afghanistan as well as the Kurdish Areas in Iran, Syria and Turkey have significant prevalence of FGM practices. (WHO 2021; Finnish institute for health and welfare THL 2021a.) Additionally, there are smaller communities and specific regions around the world where FGM (mainly FGM Type 1 or 4) is occurring (Appendix 1) (End FGM European Network, Equality Now & US End FGM/C Network 2020, 48-52).

FGM is prevalent in communities with deeply rooted gender inequality. It is an age-old, cultural practice, which continues to be performed for different reasons and socio-cultural factors depending on the country, region, and community (UNICEF 2021; WHO 2021). Its origin is still unknown, but the generally accepted hypothesis is that FGM originates as far as from Ancient Egypt. There are Egyptian mummies found with signs of excision as well as records on papyrus from 200-25 BCE from the area, where excision is described as a common practice. FGM, both clitoridectomy and infibulation, have been also practiced in the Western world, for example on female slaves in Ancient Rome to avoid pregnancies as well as in the Middle Ages, where the so-called chastity belts (a type of mechanical infibulation) were used. Also, clitoridectomy, was believed to cure and repress deviant behaviour in women's sexuality as well as hysteria. Clitoridectomy was performed for these reasons for instance in the United States until the 1960s. (Andro & Lesclingand 2016.)

Traditionally FGM is performed by the elderly in the community and traditional birth attendants. It is more often women who are designated to carry out the procedure. Depending on the community and context, FGM may be performed by traditional health practitioners, barbers, herbalists, or female relatives. Instruments used for the procedure include knives, scissors, scalpels, pieces of glass and razor blades. Usually, there is no use of anaesthesia nor antiseptics in the procedure when performed outside health care settings. (UNFPA 2020.)

In communities where FGM is practiced nowadays, it is often primarily motivated by the need and will to protect the child as well as a preparation for adulthood and marriage. However, reasons include also social, moral, aesthetical, sexual, and economic reasons as well as reasons related to cleanliness. In addition, falsely interpreted religious motivators are also common. (UNICEF 2021; WHO 2021.)

Most of the communities practice FGM as an age-old cultural tradition, which helps to maintain the cultural identity and the respect for cultural continuity. The tradition is often unquestioned. FGM is also seen as a social convention, where the ones who adhere to the

tradition are better accepted in the community, whereas others might be excluded or condemned. The fear of being rejected by the family or even the entire community is a strong motivator for the continuation of the tradition. (THL 2021a; WHO 2020; WHO 2018, 16-17.)

FGM is often practiced in the name of the religion, however it has not been mentioned in any major religious texts nor do any religion require the practice of FGM, unlike male circumcision. It is also practiced by numerous different religious groups such as Muslims, Christians (Copts, Catholics, and Protestants), Jews as well as among animist religions (Andro & Lesclingand 2016). FGM is often assumed to have religious support. However, religious leaders take varying positions on the topic, some promote it, some work against it when the third consider it irrelevant (WHO 2020).

Moral reasons for FGM include ensuring the virginity as well as the honour and marriageability of the girl. There are beliefs that men will only marry women who have undergone FGM, therefore the pressure to be married, increases the risk of being subjected to the procedure. Marriageability is also related to financial reasons as many communities practice payment or bride price as a compensation for their daughter in marriage. Some cultures emphasize FGM as a cleansing procedure, where organs which are considered masculine or unclean are removed. It is also believed that FGM increases hygiene as dirt cannot enter the vagina and therefore protects the girl from diseases. Cleanliness and beauty in regards of FGM may also refer to spiritual purity. Reasons related to sexuality and aesthetics are highlighted in many communities. A girl or woman who have undergone FGM is considered beautiful in their own community, and it is seen as a rite of passage into adulthood and increase femininity and modesty. FGM is also considered to decrease the sexuality and libido of the woman as well as prevent marital infidelity. It is also believed to increase fertility. (THL 2021a; WHO 2020; WHO 2018, 16-17.)

The various reasons behind the tradition highlight the need to engage the entire community to change attitudes and work against FGM practices. Therefore, the increasing levels of medicalization of FGM in many countries is highly worrying since it signals a false perception of approval of the tradition as well as prevents open discussion and ending FGM globally.

## 2.2 Medicalization of FGM

Medicalization of FGM is a growing concern. It refers to situations where a health care professional provides FGM practices, including re-infibulation, regardless of the place or the time in a woman's life. Re-infibulation stands for the procedure where the vaginal opening is narrowed again after deinfibulation, for instance after childbirth (also referred as re-suturing) (WHO 2018, 219). World Health Organization and other UN agencies as well as international professional federations have given a clear opposition to medicalization of FGM and

instructed health care professionals to never perform FGM nor re-infibulation (WHO 2018, 391-395). FGM is always a violation against the right to health as well as physical integrity, and when performed in a clinical setting it violated also medical ethics. Medicalized FGM communicates a false image of legitimacy as well as suggests a procedure free from complications. However, in some countries even 3 in 4 girls have undergone medicalized FGM (UNFPA 2022). Reasons behind medicalized FGM are many. More often the health care professionals are part of the community themselves, others may see it as a duty to respond culturally and socially motivated requests from the families and some see it a way of reducing harm. Financial motivation also exists. (UNFPA 2018.)

According to UNFPA (2018), comparing mother-daughter statistics on FGM, medicalization is clearly increasing FGM practices. For example, in Egypt the FGM rates have more than doubled between the mothers and daughters, being 38 per cent and 82 per cent, respectively. The highest levels of medicalized FGM are in Egypt, Sudan and Guinea. In Egypt, the procedure is mainly performed by doctors, whereas in Sudan and Guinea, it is performed mostly by midwives or nurses. In Indonesia, where 49 per cent of girls have undergone FGM, medicalized FGM is considered and practiced for new-borns in health facilities as part of the service. According to UNFPA (2018) data from eight countries a total 4.5 million girls have undergone medicalized FGM, 93 per cent of whom live in three specific countries: Egypt, Nigeria and Sudan.

### 2.3 Health consequences of FGM

The practice of FGM has no health benefits and harms girls and women in multiple ways. Immediate complications may include for example excessive bleeding, infections, severe pain, shock, and death. The long-term complications can include urinary, vaginal, menstrual, and sexual problems as well as an increased risk of childbirth complications. Furthermore, psychological issues and social problems are common among girls and women subjected to FGM. All types of FGM increase the risk of health problems in general, however the severity of damaged tissue increases the health complications even further. (Koukkula & Klemetti 2021 48-56; WHO 2021.)

#### 2.3.1 Physical health consequences

The immediate physical consequences of FGM occurring during and following the procedure are severe. The girl or women subjected to the practice is at grave risk of traumatic bleeding as well as infection. Infections include wound infections, gangrene, sepsis, and tetanus. Other immediate complications include severe pain, injury to other surrounding organs, urinary problems as well as shock and death (Reisel & Creighton 2015; WHO 2021). In addition, there is also a great risk of bone fractures and dislocations of limbs, due to the restraining of the girl or woman during the procedure (Koukkula & Klemetti 2021, 51). Binding the legs together

after infibulation for several weeks to allow healing and scar tissue formation, increases the risk of aggravated infections (Rushwan 2013; UNFPA 2020).

According to a systematic review by Berg and Underland (2014) immediate complications were usually more than one for girls and women undergoing FGM, however some differences were found depending on the type of FGM performed. An increased risk for immediate complications were found for girls and women with FGM with infibulation (Type 3) than with FGM Type 1 and 2. Under-reporting of complications was found to be common, but unquestionably regardless of the type of FGM, there are more often several and serious immediate complications (Berg & Underland 2014).

Long term physical consequences of FGM are commonly divided into two main areas: gynaecological and obstetric. The FGM related gynaecological long-term issues include infections, menstrual, vaginal, and urinary problems. Obstetric complications occur often during pregnancy, labour, and post-partum period. (Reisel & Creighton 2015; WHO 2021). There are also suggestions and research on FGM causing infertility (Koukkula & Klemetti 2021 51-52), but according to Reisel and Creighton (2015) there is no sufficient supporting data yet on the issue.

Long term infections include chronic genital abscesses, vaginal infections as well as blood borne infections such as HIV and Hepatitis B (Reisel & Creighton 2015; WHO 2021). According to lavazzo, Sardi and Gkegkes (2013) most infections are identified with women who have undergone Type 3 FGM. Nevertheless, infections are common for girls and women with all types of FGM. Infections such as urinary and genitourinary tract infections, abscess formation, sepsis as well as HIV were identified in a study where a total of 22,052 patients with the age range from 10 days to 20 years (lavazzo et al. 2013).

Menstrual problems such as painful periods and hematocolpos, meaning accumulation of blood in the vagina due to a narrow vaginal opening, have been frequently reported. Genital scar tissue, keloid, and inclusion cysts, although varying a lot depending on the extent of removed tissue, is a common problem, which causes pain and might require surgical excision. (Reisel & Creighton 2015; WHO 2021.) Vaginal problems include discharge and itching, in addition to bacterial vaginosis and other infections already mentioned above (WHO 2021).

FGM related urinary symptoms due to damage on the urethra, can lead to urethral strictures and fistula. Scar tissue and obstruction of the urethral opening causes difficulties in urinating and recurrent urinary tract infections, which are reported to occur up to 22 per cent of women who have undergone FGM according to Reisel and Creighton (2015).

An increased risk of obstetric complications is also common for women with FGM. Difficulties during pregnancy, labour and in the post-partum period are commonly reported but depend

also on the context. Access to antenatal care as well as resources and knowledge on possible complications play a significant role in decreasing obstetric difficulties. Risks include difficult and prolonged delivery, excessive bleeding, caesarean section as well as the need of neonatal resuscitation, stillbirth, and early neonatal death. Furthermore, there is an estimation of FGM leading to 1-2 perinatal deaths per 100 deliveries. (Reisel & Creighton 2015; WHO 2021.)

### 2.3.2 Mental health consequences

According to Mulongo, McAndrew and Hollins Martin (2014) psychological effects and mental health issues are common among girls and women who have been subjected to FGM. These are results of the traumatizing experience of shock and pain as well as the physical force used by the practitioners, but also due to physical and sexual complications caused by the procedure. Also, surgeries such as deinfibulation might have psychological effects on girls and women. The girls and women's socioeconomic status, cultural background, migrant status, education level as well as the attitudes and legislations of the surrounding community towards the practice, including the behaviour and acceptance of the health care professionals, may have a major impact on the psychological issues as well (Koukkula & Klemetti 2021, 52-53). According to Kawous et al. (2020) it is shown that the change in perception when migrating to a country where FGM is not prevalent may increase mental health issues. However, more research on the relationship between FGM and mental health issues are urged. A systematic review by Abdalla and Galea (2019) show weak quality in studies regarding FGM and its relation to mental health issues. Also, Mulongo et al. (2014) stresses the need for research and interventions on women with FGM and mental health.

The immediate and short-term psychological consequences of FGM are primarily stress and fear. Long term complications include depression, anxiety, nightmares, insomnia, and post-traumatic stress disorder (PTSD). There is also research showing that the experience of FGM may result in eating disorders, cognitive disorders as well as a low self-esteem. (Koukkula & Klemetti 2021, 43-44; Reisel & Creighton 2015; WHO 2021.)

Koukkula and Klemetti (2021, 43-44) state that the parents, family, and community are not necessarily aware of the mental health effects of FGM on the child. Rather it is commonly considered that the procedure will be forgotten due to the young age of the girls who are subjected to it. However, interference on intimate body parts can induce a bodily trauma for girls of any age, which may have life-long consequences.

### 2.3.3 Sexual health consequences

Sexual health is defined by WHO (2022) as "a state of physical, emotional, mental and social well-being in relation to sexuality". The absence of disease or disability is not sufficient to have an enjoyable and healthy sexual life but requires also "a positive and respectful

approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence” (WHO 2022). Gender norms, roles, as well as expectations have an influence on sexual health depending on the culture. Also, the particular social, political, and economic contexts have to be considered. Respect and protection of a person’s sexual rights are an essential part of sexual health (WHO 2022).

Sexual health is widely affected by FGM both physically and psychologically, nevertheless female genitalia is not the only factor of female sexual response. Emotions as well as psychological, sociocultural, and interpersonal determinants influence women’s sexual health and well-being. Support and sexual counselling may have a positive impact on these issues (Koukkula & Klemetti 2021, 40-42; WHO 2018, 341.)

Sexual health issues caused by FGM are for example pain during sexual intercourse (dyspareunia), reduced sexual satisfaction and desire. Furthermore, there are many determinants that have negative influence on women’s sexual health and well-being in addition to causes related directly to FGM. These are for instance repeated negative sexual experiences (no pleasure during sexual intercourse), personal beliefs related to sexuality (personal and sociocultural factors), previous traumatic experiences (pain and fear during events such as forced sexual intercourse or FGM itself), negative emotions in connection to FGM (negative body image related to genitalia) and marital or relationship problems connected to FGM, for example chronic sexual pain, refusal, fear of intimacy might lead to frustration and sadness in both partners. (WHO 2018, 340-343.)

All cultures have shared ideas and norms concerning sexuality as do all the individuals have their own experience and understanding of their own sexuality. Issues related to sexuality are not always decided by the individual, however it might be a common concern of the family or community. The idea about sexuality and sexual health is based on the impact of the surrounding community and family norms, and for example the understanding of sexuality might differ significantly from the norms of the dominant culture. This might lead to an increasing need of strengthening the family’s and community’s traditional values. The discrepancy on ideas might also lead to negative self-image and feelings of shame. (Johnsdotter & Essén 2016; Koukkula & Klemetti 2021, 40-42; WHO 2018, 352-352.)

With the help of sexual health education and support services, women who have undergone FGM can experience a satisfying sexual life and achieve orgasm. For instance, even though the external clitoris is excised, large areas of the clitoris remain under the scar tissue and remain intact. Deinfibulation has also shown positive results in women’s sexual life (African Care ry 2021, WHO 2018, 346).



## 2.4 Deinfibulation and reconstructive surgeries

Deinfibulation is a simple surgical procedure, sometimes referred as reversing infibulation, where the genital scar tissue is opened by laser or diathermic technique. According to WHO (2018) the procedure can be performed any time, but commonly during the second trimester of pregnancy or during labour. Deinfibulation is often needed to overcome physical health complications of women who have undergone FGM Type 3 as well as to facilitate intercourse and childbirth (Berg, Taraldsen, Said, Sørbye & Vangen 2017). In Finland the recommendation is to have the deinfibulation procedure in adolescence, before becoming sexually active or during the first pregnancy. Deinfibulation is always recommended if there are health complications due to FGM but should always be the personal choice of the women. (Koukkula & Klemetti 2021,44-46; WHO 2018, 204-205.)

Reconstructive surgeries include clitoral reconstruction and vulvar surgeries. The clitoral reconstruction strives to improve sexual well-being, by preventing chronic clitoral pain and dyspareunia as well as to support sexual identity and self-confidence are essential (Koukkula & Klemetti 2021, 46). Vulvar surgery is indicated when there are severe problems related to FGM, for instance painful scar tissue, cysts, and keloids, which typically causes pain and damage. Thus far, there is some evidence showing the effectiveness of the surgery in improving women's sexual health (Berg et al. 2017). However, there are also reports of negative outcomes such as the need of re-operations and reduced clitoral sensitivity (WHO 2018, 376-378).

Cultural constraints and community pressure against the deinfibulation procedure are common, which is why the procedure is often preferred to be performed during labour and therefore can be better reasoned for the benefit of the new-born as well as the wellbeing of the mother (Berg et al. 2017). Thereby, it is important to acknowledge the multiple constraining factors for women to seek guidance for the deinfibulation process and take them into consideration when discussing the benefits and timing of the procedure (Koukkula & Klemetti 2021,44-46).

## 2.5 FGM in Finland

FGM has been an increasingly relevant issue in Finland since the early 1990s, when the number of refugees and migrants from FGM prevalent countries started to increase. The continuously growing level of immigration requires continuous assessment of culturally diverse needs, especially in the health care sector.

According to Statistics Finland (n.d.) the number of people with foreign background (meaning a person whose both parents, or the only parent known, has been born abroad) has increased in three decades from 40,000 people up to the current 450,000 people, which is equivalent to

eight per cent of the total population in Finland. It is noteworthy that people with at least one parent born in Finland are considered to have Finnish background and are not listed in the statistics of people with foreign background. In 2020 around 450,000 people with foreign background were residing in Finland, out of which 76,614 were born in Finland and 367,417 were born abroad (Statistics Finland n.d.) The statistics from 2020 show increasing migration from FGM prevalent countries such as Iraq, Somalia, Turkey, Iran, Syria, and Nigeria (Statistics Finland n.d.; THL 2021a; WHO 2021.)

Statistics from 2020 show that most people with foreign background reside in Helsinki: circa 111,000 people (16.5 per cent of the population in Helsinki), which constitutes one quarter of the total population with foreign background in Finland. 50 per cent of the total number of people with foreign background lives in the Uusimaa region, which includes Helsinki as well as the surrounding Vantaa and Espoo cities among others. (Statistics Finland n.d.)

In addition to the growing migration, the historical peak of asylum applications to Finland occurred in 2015 (32,477 applications in total). The number of applications has however decreased since 2015 to approximately 4,000-5,000 applications per year. Since the beginning of the COVID-19 pandemic in 2020, the number of asylum applications has further decreased, in 2020 a total of 3,209 applications and in 2021 2,297 applications. In 2021 most applicants for international protection were citizens from Iraq, Afghanistan, and Somalia, after which came Russian, Turkish, Syrian, Nigerian, and Iranian citizens. Among the 20 largest nationalities applying for asylum were also Cameroon, Gambia, Ethiopia, which all have significant FGM prevalence in addition to the previously mentioned countries. (Finnish Immigration Service 2021; THL 2021a; WHO 2021.)

According to the estimation made by the Ministry of Social Affairs and Health for their Action plan for the prevention of female genital mutilation (Koukkula & Klemetti 2021), the number of girls and women in Finland who have undergone FGM is around 10,000. In addition, there are 11,620 girls between the ages 0-18 from FGM prevalent countries in Finland. The low-risk scenario of FGM (only girls born abroad will undergo FGM) is 6 per cent or 645 girls in total. In the high-risk scenario (girls born abroad and in Finland will undergo FGM) the number goes up to 27 per cent or 3,075 girls in total. These scenarios are calculated by the European Institute for Gender Equality (EIGE) guidelines for FGM risk estimation. (Koukkula & Klemetti 2021, 20-22.)

## 2.6 Research on FGM in Finland

There are several studies made on FGM prevalence in Finland, however they all suggest low accuracy of self-reported FGM mainly due the various barriers of discussing the sensitive issue. Additionally, girls and women might not consider or recognize the procedure done to them in their childhood as FGM, nor do they wish to discuss it due to fear of stigmatization

and legal issues, which leads to further studies with underreported prevalence. Majority of the studies in Finland have been conducted among Somali and Kurdish communities.

A study on migrant health and wellbeing from 2012 (Koponen & Mölsä 2012) reported also on FGM prevalence among women of Somali and Kurdish origin in Finland. The results show that FGM prevalence is more often underestimated. Approximately 70 per cent of the Somali women and 30 per cent of the Kurdish women who were interviewed told that they had been subjected to FGM. However, the report suggests suspicion of underestimation in the number of Kurdish women with FGM, since some Kurdish areas are known to have more than 70 per cent prevalence of FGM. In addition, the gender of the interviewer was seen as a barrier to discuss FGM openly (Koponen & Mölsä 2012, 141-144). Another survey conducted in 2014 on work and well-being among people of foreign origin showed FGM prevalence of 19 per cent among women who were from FGM prevalent countries (Castaneda et al. 2015, 18).

A study by Koukkula, Keskimäki, Koponen, Mölsä and Klemetti (2016) examined prevalence, socio-demographic determinants as well as health effects associated with FGM among women of Somali and Kurdish origin in Finland. The study showed older age and lack of education to be a significant factor for FGM prevalence as well as marriage in the Somali community and practice of Islam in the Kurdish, respectively. The conclusion of previous underestimations of the prevalence of FGM in Finland was found in the study as well (Koukkula et al. 2016).

In a study on asylum seekers' health and wellbeing in Finland, one out of ten women who participated in the study reported to have undergone FGM and one third out of the women who originated from southern parts of Africa, including for example Somalia, Nigeria, Angola, Cameroon, Ethiopia, and Eritrea (Koukkula & Klemetti 2019, 174). The asylum seekers who were interviewed for the study had arrived in Finland in 2018 (Koukkula & Klemetti 2019, 17).

A more recent report from 2020 (Koukkula & Klemetti 2020, 131-134), where people of foreign background and their health and wellbeing was studied (FinMonik-study 2018-2019), showed similar low reported rates on FGM as in previous Finnish surveys, and suggests low accuracy. However, women from Middle East and African countries showed to have clearly higher prevalence of FGM (8 to 18 per cent of the women interviewed).

Acquiring accurate information on the prevalence of FGM in Finland has proved to be challenging. More systematic ways of recording data have been developed in the maternity and child health services as well as in school health care. Also, information on FGM has been collected systematically through the health examination protocol in the asylum process. (Koukkula & Klemetti 2021, 20-21.) By normalizing the inquiries on FGM especially in the health care setting, will surely provide a space for open discussions and more accurate data on the current prevalence of FGM in Finland as well as increased awareness of its health consequences.

However, the attitudes on FGM are changing rapidly among immigrants the longer they have lived outside the country of origin. Nevertheless, the risk of FGM and positive views towards the tradition are still high among migrants who have recently arrived from FGM prevalent communities. The emphasis on awareness raising campaigns and proactive discussions in health care and reception centres is crucial in the prevention work. (Koponen & Mölsä 2012, 141; Koukkula et al. 2016; Johnsdotter & Essén 2016.)

## 2.7 Human rights and legislation on FGM

FGM is a grave violation against human rights and the right to health. There are several international human rights treaties, to which also Finland is committed to. The most relevant international treaty addressing FGM is the Council of Europe's Convention on preventing and combating violence against women and domestic violence; the Istanbul Convention 2015. It offers legally binding standards for governments to criminalize excising, infibulation or performing any other mutilation to the female genitalia and highlights the criminalization of assisting in the procedure. In addition to the Istanbul Convention, the UN Universal Declaration of Human Rights (1948), the UN Convention on the Elimination of Discrimination against Women (1979) and the UN Convention on the Rights of the Child (1989) are the most relevant international agreements addressing FGM. (Koukkula & Klemetti 2021, 25; THL 2021a.)

In addition to human rights treaties and policies condemning FGM practices, many countries have also created national laws against FGM. Some countries, including Finland, use existing laws related to assault and child abuse for criminalizing FGM instead of enacting specific laws on FGM (THL 2021a; WHO 2018, 396). However, WHO (2018) emphasizes the importance of specific laws addressing FGM for several reasons. Firstly, it facilitates the health care professional's justification of opposition to the tradition and refusal to perform FGM when requested. Legislation also supports the individuals as well as their families who wish to abandon the tradition. National laws with public awareness raising activities as well as culturally sensitive education on FGM, discourages the continuation of the tradition. Laws regarding specifically FGM, reminds of the legal protection from FGM and that it is available and relevant. National legislation addressing FGM also shows commitment to end the practice of FGM. (WHO 2018, 397.)

FGM is a punishable crime in Finland. It is seen as an assault or aggravated assault under the Criminal Code of Finland, with the maximum penalty of 10 years in prison. A family member who arranges or provides assistance for FGM, may also be found guilty of crime. Furthermore, if FGM is committed abroad by a Finnish citizen or foreigner residing permanently in Finland, it is a punishable crime, although FGM would not be considered as crime in the country in question. (Koukkula & Klemetti 2021, 25; THL 2021a.) According to Koukkula and Klemetti

(2021, 26) by 2021 there has not been any prosecutions due to FGM in Finland. However, according to a report by Ahmed, Ylispangar and Daham (2017) there are cases of girls who have been taken abroad for the procedure and that the risk of future cases is still present.

Health care professionals are obliged by law to report to the police a suspicion of risk of FGM or that a girl has been subjected to FGM while living in Finland. Regardless of the secrecy obligation of health care professionals, health care professionals are required to report threats against life or health of a person or a risk of violence, in order to prevent the act. (Koukkula & Klemetti 2021, 26; THL 2021a.)

FGM is required to be addressed also in the asylum process. The threat of FGM as well as the serious physical and psychological complications related to FGM are in most cases sufficient grounds to be granted an asylum, which is why FGM is addressed in the reception systems' statutory health examination. Girls and women who experience a threat of being mutilated or complications due to already performed FGM, are strongly encouraged to address the issue in the asylum unit's interview. (Koukkula & Klemetti 2021, 51-52.)

## 2.8 Prevention of FGM in Finland

There has been FGM prevention and advisory work in Finland for over two decades. In addition to legislation, policies and international agreements, action plans and guidelines have been made for the health care sector, social work, early childhood education, schools and other educational institutes as well as the reception and asylum systems. Also, guidelines for the media have been provided. Many non-governmental organizations have been active in FGM prevention work, especially the Finnish League for Human Rights, African Care ry and more recently Fenix Helsinki ry. Research on FGM in Finland is encouraged and several multisectoral projects including universities of applied sciences have been active in FGM prevention work. Also, training on FGM is included in health care professionals' education. (Koukkula & Klemetti 2021, 31-36.)

Women and families with Somali background have been earlier the main target group for FGM prevention campaigns and projects (Koponen & Mölsä 2012, 141), having been the most numerous migrant groups from FGM prevalent countries in Finland. However, today the increasing need for a wider target group due to growing migration from also other FGM prevalent countries and communities is highlighted (Koukkula et al. 2016). The preventive measures and information should also be adjusted to particular communities and their beliefs as well as to the driving reasons of the tradition. Interventions including accurate information and health education related to FGM for both women and men has been shown to be most efficient (Amasanti, Imcha & Momoh 2016; Koukkula & Klemetti 2021, 29-30; O'Neill et al. 2017; Waigwa, Doos, Bradbury-Jones & Taylor 2018).

The role of men from FGM practicing communities is extremely important in ending FGM in both the diaspora communities as well as in the countries of origin. Research has shown that especially after migration the attitudes are changing towards the tradition. (O'Neill et al. 2017.) A recent report on the awareness and perceptions of FGM among Somali men in the Helsinki region (Hassan Mohamed & Latvala 2020) show that the attitudes are mainly against the tradition. The main findings show that Somali men are aware of the adverse consequences of FGM and are considerate of the health complication of women related to FGM as well as sexual and reproductive health issues. Regarding FGM as a prerequisite for marriage was not seen necessary, and a preference of marrying a woman who had not been subjected to FGM was highlighted. Most importantly the men see themselves having a role in ending FGM and protecting their daughters from the procedure, which has increased their engagement also in awareness raising in their community and relatives in Somalia. However, the study showed some ambiguity towards the *sunna* procedure, which according to previous research by Elmusharaf et al. (2006) could be perceived as any type of FGM. The findings urge great emphasis on preventive and awareness raising discussions with both men and women in the health care sector (Hassan Mohamed & Latvala 2020).

### 3 The role of health care professionals in addressing FGM

There is a clear need for addressing FGM and related health issues in the health care services. Health care professionals especially in primary health care play an important role in the prevention of FGM as well as in the provision of quality care and guidance for women who have undergone FGM.

According to studies on self-perceived health issues of women with FGM show significant sexual, reproductive, and psychological complications in comparison with women without FGM (Andro, Cambois, & Lesclingand 2014; Koponen & Mölsä 2012, 141-144; Koukkula et al. 2016). In addition to the fact that women themselves find it difficult to bring up the topic as well as the evidently high level of health complications, emphasizes the need for specially developed, evidence based and sensitive care for women with FGM related health issues as well as a need to train health care professionals on FGM (Andro et al. 2014; Reisel & Creighton 2015).

However, previous studies made in Europe, North America and Australia, areas with an increasing level of immigration from FGM prevalent countries, show that there is a significant lack of knowledge, skills and guidelines regarding FGM in the health care sector (Koukkula et al. 2016; Molina-Gallego et al. 2021; Simpson, Robinson, Creighton, & Hodes 2012; Ogunsiyi 2015; Turkmani, Homer, Varol & Dawson 2018; Vissandjée, Denetto, Migliardi, & Proctor 2014). Health care professionals need a culturally sensitive approach to the discussion as FGM

can be a complex matter for the patient with consequences on personal, community and legal levels (Vissandjée et al. 2014).

Barriers to bring up and discuss FGM with women are many. These challenges occur due to multiple different reasons, however in most cases health care professionals lack the experience and competence on the topic, which further decreases the confidence in being able to provide appropriate care and guidance. Common guidelines at workplaces are also often lacking. Additionally, the belief of FGM being a cultural and private family matter prevents open discussions between health care professionals and patients. Fear of upsetting or offending women and challenges in bringing up a culturally sensitive issue in a way that promotes trust and empathy may end up in avoiding the topic completely, which has also been reasoned as an expression of respect. There is also fear that by reminding the women about a trauma such as FGM, will cause more distress than actual help. Also, mixed, and strong emotions concerning the topic challenges the health care providers further (Koukkula & Klemetti 2021; Johnsdotter & Essén 2016; Vissandjée et al. 2014). Furthermore, the emotive reactions on FGM are seen to also affect the confidence of health care professionals' abilities to bring up the topic. (Amasanti et al. 2016; Dixon et al. 2021; WHO 2018, 42-46.) Even neglect in bringing up the topic exists (Molina-Gallego et al. 2021).

Moreover, studies examining women who have undergone FGM and their experiences in the health care sector, show a lack of trust in the health care providers and their competencies on the topic as well as fear and discomfort of their reactions and attitudes. These factors decrease the willingness of seeking help for FGM related issues and increase further the feeling of shame and fear of being judged or stigmatized. Discussing FGM is often considered a taboo and therefore creating discomfort as well as embarrassment in women, especially with male health care professionals or interpreters present. Therefore, the need for proactiveness of the health care providers is strongly preferred by women who have undergone FGM. Distrust of confidentiality issues and fear of legislative consequences prevents women to bring up FGM as well as the fear of their own community reaction when discussing FGM to outsiders (Simpson et al. 2012; WHO 2018, 43, 45). Culturally sensitive care and communication skills are emphasized to create a trusted relationship. (Amasanti et al. 2016; Ahmed et al. 2017; Dixon et al. 2021; Kawous, Allwood, Norbart & van den Muijsenbergh 2020; Vissandjée et al. 2014.) Lastly, the unwillingness of being identified as a victim prevents bringing up the topic (Amasanti et al. 2016).

For being able to provide proactive and culturally sensitive care, it is important for health care providers to understand the socio-cultural constraints, which might hinder sexual and reproductive health knowledge of women with migrant backgrounds (Metusela et al. 2017). Health consequences of FGM are numerous and interrelated, including physical, psychological, sexual, and social issues. The awareness regarding FGM related health issues is

not necessarily shared in the communities where FGM is practiced. Due to cultural reasons FGM, and especially gynaecological and sexual complications, are considered taboos and therefore are not discussed within the community or friends and family (O'Neill et al. 2017). Therefore, cultural sensitivity and competence on the issue is key for discussing FGM (Kawous et al. 2020; THL 2021b). Bringing up FGM is a delicate balance between respect for cultural values and addressing FGM and its harmful consequences without alienating the patient (Vissandjée et al. 2014; Atkinson, Ottenheimer & Mishori 2019; Simpson et al. 2012). Terminology may also be perceived judgmental and stigmatizing for women with FGM, which is why it is recommended to use sensitive and context dependent terms (Johnsdotter & Essén 2016; WHO n.d.).

Amasanti et al. (2016) has suggested an effective yet compassionate approach to tackle FGM and its challenges in three steps: 1. training of health care professionals, 2. educating women and girls and 3. implementing a mandatory antenatal screening. Among other studies, this approach highlights the importance of the role of health care workers and their ability to a proactive and confident approach on addressing FGM and related health issues.

### 3.1 Importance of addressing FGM in health care settings

To bring up FGM with female patients is important not only for the provision of care and information of possible treatments, but to support and provide an opportunity for the women to share and process their thoughts (WHO 2018, 42-43). With accurate information women are empowered to make independent and informed decisions on their health. Health care professionals are in the frontline to influence and change attitudes concerning FGM as well as women's bodies and rights by addressing FGM and its consequences. Bringing up the issue without judgment, emotional reactions (e.g., expressing shock), or trivialization of the topic, is crucial for decreasing feelings of distress, shame, and guilt in women. (Dixon et al. 2021; Kawous et al. 2020; Koukkula & Klemetti 2021, 38-39; WHO 2018, 46-47.)

It is crucial to create a safe and non-judgmental space when addressing FGM and related issues in the health care setting. This requires competencies and understanding of the practice as well as the underlying factors of it. Being proactive and confident in a culturally sensitive way when bringing up and discussing FGM is highly recommended for better results in the prevention of FGM and provision of care, support and guidance for women who have undergone the procedure. (Dixon et al. 2021; Ahmed et al. 2017.)

Girls and women with FGM related physical health issues do not necessarily seek help for multiple different reasons. Difficulties in access to care is one reason, however some women might experience shame to seek help for their symptoms (Kawous et al. 2020). Also, unawareness of the relation of the symptoms and FGM might result in recurrent and long-term conditions without seeking help. Often women learn to live with the complications, as other



women in their communities also endure similar symptoms that are thereby considered normal (WHO 2018, 117). However, North American studies have shown frustration in women, when the initial issue for seeking help is disregarded and excessive focus is put on FGM (Johnsdotter & Essén 2016).

WHO (2018, 258-259) recommends addressing mental health issues in primary health care especially due to the idea that a holistic view of health is the best approach to health care as well as the fact that receiving help and support in primary health care setting is considered to be more comfortable and less stigmatizing. However, time and sensitivity are key in creating trust and better results. As FGM has many adverse effects on mental health, WHO (2018, 240) stresses the fact that there are other factors in life to create a range of emotions and it is also important to acknowledge intersectional determinants of mental health effects, and that not all psychological issues are directly related to FGM. For instance, sociodemographic factors, migrant background, acceptability of FGM in the surrounding society as well as attitudes of health care professionals can have a negative impact on mental health (WHO 2018, 240).

Discussing FGM related sexual health issues is highly recommended and research shows that women often find the opportunity to discuss sexual health positively when it is proactively addressed and brought up by health care professionals (Johnsdotter & Essén 2016). According to Johnsdotter and Essén (2016) false assumptions on FGM and sexual health might have a negative impact on women's self-esteem and body image, due to which health care professionals play an important role in providing accurate information and support. It has also been shown that communication on sexual health between patients and health care providers has improved the wellbeing of the women (WHO 2018, 349). Additionally, the lack of sexual education and open discussions within family, friends and the community create a need for a safe space to discuss the issues. Most importantly, women may consider it challenging or shameful to bring up and discuss sexual health issues due to beliefs and cultural norms (WHO 2018, 350). Also, the contradictions between values and rules of different cultures, are critical to be aware of as a health care provider, to be able to address FGM related sexual health issues as well as to provide culturally sensitive sexual education (Koukkula & Klemetti 2021, 40-42; WHO 2018, 352). Due to cultural reasons, it is important to consider the health providers' gender when addressing sexual health related issues, and if necessary, refer to a female health care professional if possible. (WHO 2018, 349-350)

It is recommended to address sexual health with FGM patients even if feeling hesitant. Addressing sexual health with a positive attitude and respect for the women perspective without pressuring or using terminology which might seem judgmental as well as reassuring confidentiality is key (Johnsdotter & Essén 2016; WHO 2018, 352). Accurate information on

benefits and realistic expectations should be given also on surgical interventions (Berg et al. 2017).

Lastly, it is essential not to assume that all women who have undergone FGM are experiencing sexual health problems. Nonetheless, should health care professionals be aware of the risks and the possibility of issues related to FGM in order to address the health care needs appropriately (WHO 2018, 323).

### 3.2 Language barriers, interpreters, and cultural mediators

Language barriers may create additional challenges to bring up and discuss sensitive issues. Interpreters and cultural mediators are recommended in consultations to reduce misunderstandings (Dixon et al. 2021). To facilitate the discussion, flash cards and pictures are also found useful (Amasanti et al. 2016; Koukkula & Klemetti 2021, 39).

When using an interpreter, cultural factors need to be considered. For instance, the gender of the interpreter as well as personal perceptions and attitudes towards FGM are important to be clarified before the consultation. Furthermore, it is imperative to make sure that there is no relation between the patient and interpreter as well as ensuring that the woman agrees and feels comfortable with the given interpreter and trusts the confidentiality of the situation (Dixon et al. 2021). Family members should preferably not be present and never be used as interpreters when bringing up FGM (WHO 2018, 59).

Kuusio, Vehko and Aalto (2020, 170) emphasize the importance of prolonged appointment times when interpreters are used, to enhance the results as well as the experience of the health services. The opportunity to use interpreters in Finland has been reported to be low. However, Kuusio et al. conclude that the possibility for interpretation is strongly country specific. Every fifth person with background from Middle East and Northern Africa and every third from Sub-Saharan Africa reported having been provided with interpreters in health care appointments. (Kuusio et al. (2020, 170.)

### 3.3 Cultural sensitivity as a facilitator for sensitive discussions

Cultural competence and cultural sensitiveness go hand in hand. Cultural competence is defined as respect and non-discrimination of all people from all cultural backgrounds. It also refers to accessibility of services, in a way that the different needs of people with diverse backgrounds are considered. Cultural competence of health care professionals is awareness, knowledge, skills, motivation as well as encountering of cultural diversity, by reflecting one's own cultural values and customs with the others (Koukkula & Klemetti 2021, 38; THL 2021b).

Cultural sensitivity, on the other hand, refers to interpersonal competence as well as verbal and non-verbal communication in a respectful way (THL 2021b). According to Foronda (2008)

cultural sensitivity includes the attributes of knowledge, consideration, understanding, respect and tailoring as well as the antecedents of diversity, awareness, and an encounter. In between these attributes and antecedents, cultural sensitivity is formed (Figure 2). Through combining the different factors, it will result in effective communication and interventions as well as satisfaction (Foronda 2008).

A culturally sensitive approach facilitates to work with culturally diverse people. It requires a sensibility as well as an ability and will to understand people coming from various backgrounds. Considering health care provision, cultural sensitivity does not necessarily mean detached services, but a flexibility in meeting the needs of different individuals and groups. Awareness of the diverse needs for reaching a more holistic approach and meeting the long-term needs of a specific group of people will improve the results of the health provision. (Foronda 2008; Koukkula & Klemetti 2021, 38; THL 2021b.)

Female genital mutilation is a complex phenomenon which affects women on a personal, community and legal level. Therefore, a culturally sensitive approach is seen to be crucial for creating a considerate, trusted, and non-judgmental space in health care settings when raising the topic with women (Vissandjée et al. 2014).

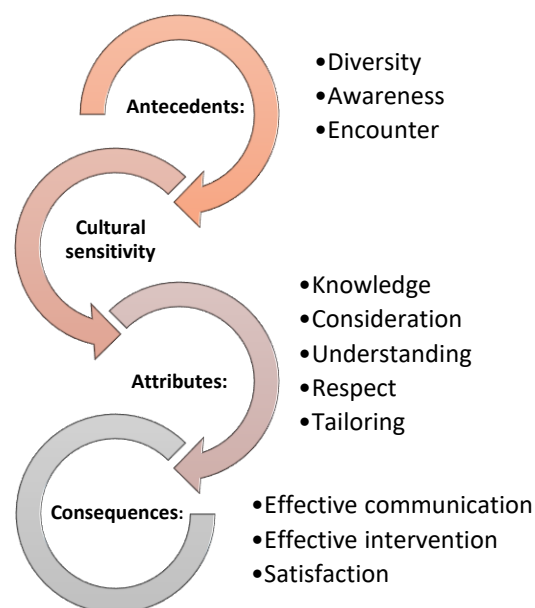


Figure 2: Definition of cultural sensitivity (adapted from Foronda 2008)

#### 4 Goal, objectives, and research questions

The goal of this thesis was to examine the perspectives and experiences of health care professionals in primary health care concerning FGM. The primary objective was to identify

the preventing and facilitating factors in bringing up and discussing FGM being a culturally sensitive topic in their work. The secondary objective was to provide recommendations for health care providers based on the identified development needs in the research, which could further improve recognizing the risk of FGM, identifying girls and women who have previously undergone FGM and being able to provide quality treatment, support, and guidance in a culturally sensitive way.

The thesis answered the following research questions:

1. What kind of perceptions and experiences do health care professionals in primary health care have concerning FGM and cultural sensitivity?
2. What factors prevent or facilitate health professionals to bring up and discuss FGM?
3. What are the development needs of health care professionals' competencies and skills in addressing FGM?

## 5 Methods

### 5.1 Qualitative research

This study used a qualitative approach with the goal to examine the informants' experiences, thoughts and views of the phenomenon in question. Qualitative research aims to interpret social reality, which is usually very context dependent, subjective and non-numerical. The analysis of qualitative data depends heavily on the researchers personal understanding of the context and setting. (Bhattacharjee 2012, 110,113). According to Tuomi and Sarajärvi (2009, 65-66) qualitative studies are aiming to understand and make sense, while quantitative studies to explain and predict a phenomenon.

The phenomenon of female genital mutilation and barriers to bring up culturally sensitive issues in health care settings, guided the author to choose the qualitative approach to gain information and perspectives with as broad spectrum as possible. A quantitative approach might have led to a higher number of informants. However, to avoid overlooking experiences, attitudes and thoughts that has not previously surfaced in research led to the choice of a qualitative approach.

Semi-structured face-to-face interviews are most commonly used for data collection in qualitative studies (Grove & Gray 2019, 77). However, in this study due to the sensitive topic as well as the ongoing COVID-19 pandemic, an online questionnaire was chosen as the data collection tool.

Bhattacharjee (2012, 20) emphasizes the importance the exploration phase of qualitative studies, where the researcher identifies the research questions and conducts a literature review on the topic. The purpose of the literature review in qualitative studies is firstly to view the current state of research on the topic, secondly to identify key authors, theories, articles, and findings and lastly to identify the gaps in knowledge in research.

The theoretical framework for this thesis consists of a wide review of the phenomenon of female genital mutilation (FGM) and related health issues as well as the importance of proactive discussions in primary health care concerning the topic. The intention was to introduce the topic of FGM as a global health issue. The history and reasons behind the tradition as well as the global prevalence of FGM and the significance of population growth, migration as well as the changing attitudes on the issue are essential for understanding the importance of the phenomenon as a whole. Also, the classifications of FGM and related terminology as well as the various health complications are essential. Furthermore, it was important to examine the health care professional's central role in the prevention of FGM and provision of care, including its challenges and facilitators.

The data acquisition for the theoretical framework was done through Google Scholar as well as CINAHL, PubMed and Cochrane. The reference lists of publications, theses, and other appropriate reports have also been carefully examined. Search terms caused some difficulties as the terminology for female genital mutilation has changed over the past few decades and still today, depending on the context and researcher, the terminology varies. The term female genital mutilation (FGM) was chosen to be used in this thesis. However, in the data search, several different words describing the same phenomenon, such as female genital cutting and female circumcision, were used.

## 5.2 Research setting

The goal of this study was to examine the perspectives and experiences of health care professionals in a primary health care setting concerning discussions on FGM with female patients. Previous research on the topic showed a lack of studies made in primary health care. Health care professionals' knowledge, awareness, and skills on FGM and related health issues have had more attention among midwives as well as in obstetrics settings. Therefore, this study aimed to examine registered nurses' as well as public health nurses' experiences on the topic specifically in primary health care.

Nurses and other health care professionals in primary health care have an important role in identifying, providing information and support for women who have undergone FGM. According to previous research made from both health care professionals' as well as women's perspective, primary health care setting is generally considered to be less stigmatizing as well as having a lower threshold to seek help and guidance in comparison with specialized care.

Nurses in primary health care face diverse health issues, including concerns of physical, mental and sexual health. Urological and gynaecological issues as well as family planning are common. Primary health care is also responsible for giving guidance and support for further services and referrals to secondary health care. (Head nurse, Personal communications 2022.)

Kuusio, Lumme and Koponen (2020, 154) conclude based on a broad study made in Finland (FinMonik-study 2018-2019) that women with foreign background utilize more services in health centres in comparison with the whole population of Finland. Generally they also have less access to private clinics and occupational health, which is why health centre services are essential. Furthermore, access to health services according to the same FinMonik-study was concluded to be difficult: only one third of the women with foreign background experienced getting an appointment to the health services fairly easy (Kuusio, Vehko & Aalto 2020, 164.) The higher usage of public primary health services as well as the access issues, shows the importance of acknowledging culturally specific needs in health centres.

The decision to conduct the data collection in a primary health care setting in Helsinki was based also on the fact that the majority of people with foreign background in Finland live in the capital area of Finland (Statistics Finland n.d.). Therefore there should be enhanced awareness, knowledge and guidelines among the health care professionals in the capital area to be able to address a variety of culturally specific needs, including FGM and related issues.

The data collection of this study was implemented in three different units at a health centre in Helsinki, which is part of the public health care services of Helsinki. Due to the sensitive topic, the health centre is not going to be named in this study according to the terms of the research permit granted by City of Helsinki as well as to ensure full anonymity and confidentiality of the informants.

The target group for the questionnaire were registered nurses and public health nurses, who work with adult patients in the three units at the health centre. Also midwives working with primary health care nursing tasks were included in the study, as the context of the setting was considered to be more important for the study, rather than the informants' previous education and work experience. Nurses and midwives working at maternity and child health clinics were not included in the target group. There were approximately 70 nurses working in the three units at the moment of the data collection (Head nurse 2022. Personal communication). It was emphasized that no previous experience of encounters with women who have undergone FGM was needed to answer the questionnaire, as this study aimed also to examine the situations where the topic might have been avoided or neglected due to unawareness or knowledge of the existing issue. The intention was to receive answers from a wider group of nurses, not only those who are experienced with FGM and related issues.

### 5.3 Data collection

Data collection in qualitative research can be done in multiple ways. Interviews are most commonly used for data collection in qualitative studies (Tuomi & Sarajärvi 2009, 71), but due to the ongoing COVID-19 pandemic as well as the sensitive topic of this study, and online questionnaire was chosen as the data collection tool. Also the intention was to make the questionnaire easily approachable and provide a more flexible way to participate, which was hoped to increase the number of informants. However, motivating nurses to participate in the questionnaire showed to be more challenging than expected.

The questionnaire (Appendix 2) was formulated with a fixed set of open-ended questions, where the participants were invited to respond in their own words. To encourage more participants to take part in the study, the questionnaire was created to be as easily approachable as possible, with understandable open-ended questions (Punch 2003, 35). Semi-structured interview with a set of fixed open-ended questions and no fixed answers was used in this study (Grove & Gray 2019, 77), to obtain insights on the participants experiences and views on the topic. Whereas in face-to-face interviews there is a possibility for the interviewer to obtain more information from the participants with additional probes, in an online questionnaire, where this possibility is not present, the questions must be carefully formulated and through piloting the process, ensure the understandability. (Grove & Gray 2019, 77-78; Punch 2003, 34-35.)

The research questions of this study as well as literature within the theoretical framework have been guiding the conceptualization of the questionnaire questions (Punch 2003, 30-31). The initial intention was to create a questionnaire with less than ten questions and the time to answer would require a maximum of thirty minutes. The final form of the questionnaire had six questions and according to the feedback from piloting, the response time was 10-20 minutes.

The research questions of the thesis were: 1. What kind of perceptions and experiences do health care professionals in primary health care have concerning FGM and cultural sensitivity? 2. What factors prevent or facilitate health professionals to bring up and discuss FGM? 3. What are the development needs of health care professionals' competencies and skills in addressing FGM? Aiming to answer these three research questions, six fixed questions were formulated for the questionnaire (Appendix 2). The first two questions approached the topic of facilitators and barriers of bringing up a culturally sensitive issue, which is typically a taboo in many communities. The third question enquired how nurses consider a culturally sensitive approach being present in their daily work and in relation to discussions on FGM. The fourth question dealt with language barriers and the use of interpreters in culturally sensitive discussions. The fifth question aimed to enquire how nurses see their role in promoting well-

being of women who have undergone FGM and what means could facilitate it. The last question enquired the development needs on the topic from the nurses' point of view and free comments regarding the issue.

The data was collected anonymously through an online-form (e-lomake by Eduix Ltd. 2021). No personal data was collected during the data collection and the IP address of the informant's computer was secured by the online form, which further ensured anonymity. The questionnaire (Appendix 2) was provided in both English and Finnish languages. The participants could use either language for answering the questionnaire. To ensure equivalence in meaning, quality and trustworthiness of the data, the translations of the questions were done from Finnish to English and back to Finnish, respectively, by the author.

The questionnaire was piloted with three nurse colleagues, who have experience working in the primary health care, but are not affiliated to the study setting in question. The piloting phase is important for testing the clarity and comprehensiveness of the questions, for the length, time and difficulty of the questionnaire to be completed as well as to ensure the accessibility and functionality of the entire data collection process and tools (Punch 2003, 34). After the piloting phase the questionnaire and related appendices were revised. Wording as well as the number of questions were edited according to the feedback.

Participants for the study were recruited through the head nurse at the health centre, who kindly agreed being the work life contact person for this study. The author has communicated via email with the contact person during the process, concerning the research permit application as well as to inform the intended schedule and data collection issues. One meeting in person was held before initiating the data collection.

The recruitment of the participants was done as follows. A short invitation letter was sent by email to the target group in the agreed units of the health centre. The email was sent by the contact person, to ensure anonymity as well as to avoid bias in informant selection. The invitation letter included the link to the online questionnaire (Appendix 2). The questionnaire included both the information letter (Appendix 3) and the informed consent form (Appendix 4). The informed consent had to be approved to be able to submit the answers. All information was given in both Finnish and English. The informants did not receive any payment or other benefits for participating in the study.

The data collection was implemented after the research permit was approved by the city of Helsinki. There was initially two weeks' time given to answer the questionnaire, however due to national holidays and a low response rate, the time was prolonged by one additional week. After the initial invitation letter, several reminders were sent through the contact person. Finally 14 informants shared their thoughts through the online questionnaire. All informants answered in Finnish. The number of informants ended up being fairly low, but due to the time



limit of the thesis process as well as the data saturation in the answers, it was considered to be a sufficient amount of data for this study. According to Fusch and Ness (2015) as well as Tuomi and Sarajärvi (2009, 87) data saturation can be reached faster in smaller studies and is reached when further coding in the analysis no longer feasible, when there is enough information to replicate the study and when there is no additional new information surfacing.

#### 5.4 Inductive content analysis

Inductive content analysis was applied for the analysis of the data of this study. Content analysis is a technique, which can be used for both qualitative as well as quantitative research approach and is widely used especially in nursing and public health studies. It can be utilized to analyse communication messages in written, verbal or visual form. Through systematic and objective means, content analysis aims to describe and quantify phenomena by conceptualizing and categorizing it. (Elo & Kyngäs 2008.)

An inductive content analysis was used in this study, due to its possibility to systematically conceptualize and describe broadly the phenomenon of the research. Elo and Kyngäs (2008) recommend an inductive approach when there is a lack of earlier research on the topic, or it is fragmented. The outcome of the analysis are either concepts or categories, which are used to create a model or a conceptual map or categories (Elo & Kyngäs 2008).

According to Elo and Kyngäs (2008) description, the method of content analysis includes three phases; 1. preparation, 2. organizing and 3. reporting (Figure 3). Starting with the preparation, it is essential to decide what to analyse and in what detail, as the sample data must be representative of the data and context. Preparation phase includes also understanding the data as a whole. The next phase of organizing the data includes open coding, grouping and categorization of the data. In the abstraction process the general description of the phenomenon is categorized, which will then be used for reporting of the results. Categories are divided into main categories, generic categories and sub-categories. (Elo & Kyngäs 2008.)

The content analysis for this thesis begun according to the recommendation and analysis phases of Elo and Kyngäs (2008). After the data collection was completed, the acquired data was transferred to a Word-document and translated to English. During the preparation phase of the analysis, the data was firstly organized by each informant and secondly question by question. The data was read through multiple times to familiarize and make sense of the whole. After understanding the data as a whole, selection of meaning units for the analysis begun, by underlining similar expressions and phrases with different colours.

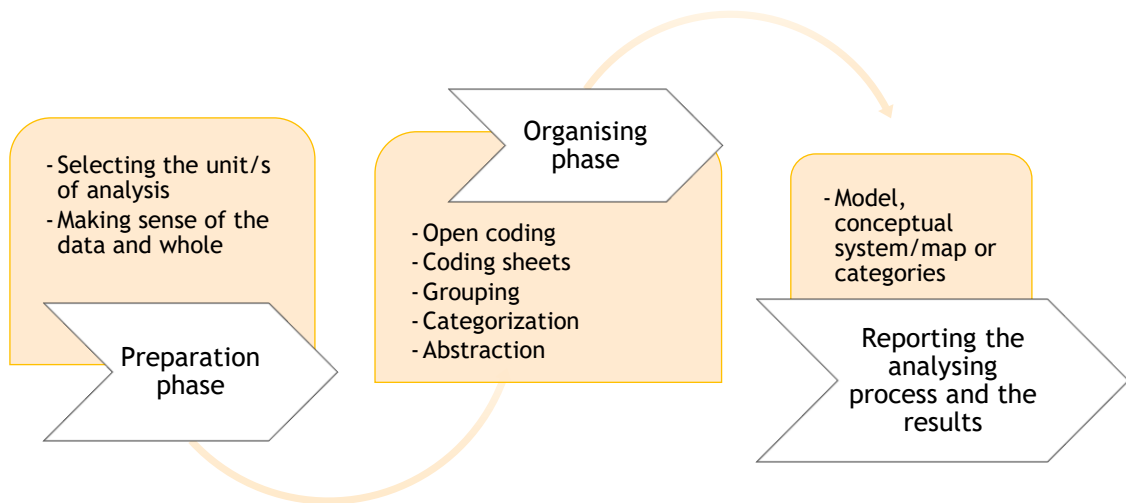


Figure 3: Content analysis phases (adapted from Elo & Kyngäs 2008)

The second phase of the analysis, the organising phase, started with initial coding of the different meaning units, and listing them. The informants' answers were mostly very concise, and therefore the coding and grouping of the meaning units was found to be fairly logical. However, both Elo and Kyngäs (2008) as well as Tuomi and Sarajärvi (2009, 110) emphasize the importance of carefully reading through the original expressions and phrases as well as the grouped meaning units, as the analysis process is not always proceeding in a linear fashion. After the selected meaning units were coded and grouped, they were organized under sub- and main categories. Out of the 149 meaning units and 42 initial codes, the data was grouped under 12 sub-categories and five main categories. The generic category for all categories was defined as perspectives on addressing FGM in primary health care. An example of the content analysis process and categorization is presented in Table 2. In the abstraction phase the importance lies in the relevant information of the data and how the used expressions are conceptualized within the theoretical framework of the study (Tuomi & Sarajärvi 2009, 111). The last phase of the content analysis aims to define the final categories and the findings in a logical manner (Elo & Kyngäs 2008). The results of the thesis were reported according to the five main categories of the analysis.

Meaning unit	Initial code	Sub-category	Main category	Generic category
“The presence of relatives can occasionally be a challenge if the patient does not want to discuss the topic in front of her family members.”	Lack of privacy and family present	Compromised privacy and time issues	Barriers for bringing up FGM	Perspectives on addressing FGM in primary health care
“When using an interpreter you often go through only the so-called mandatory issues.”	Challenges with interpreters	Language barriers	Barriers for bringing up FGM	Perspectives on addressing FGM in primary health care
“Facilitating factors are when women themselves bring up the topic.”	Nurses preferring proactive patients	Need for justification to raise the topic	Facilitators for bringing up FGM	Perspectives on addressing FGM in primary health care

Table 2: Example of the content analysis process of this study

## 6 Results

The results of this study are presented by following the five main categories and 12 sub-categories that emerged from the analysis of the data (Figure 4). Quotes from the informants' responses are utilized to illustrate the content of the data. The informants who participated in this study were working as registered nurses or public health nurses at the research setting. However, answers show that some informants may have a background also in midwifery. Out of the 14 participants, only a few considered having experience and sufficient competencies to confidently address issues related to female genital mutilation (FGM) in their current work tasks. Some informants stated not having any experience or knowledge on FGM whatsoever. Although the experiences and knowledge of the 14 informants varied largely, similarities in the perspectives on the topic were found.

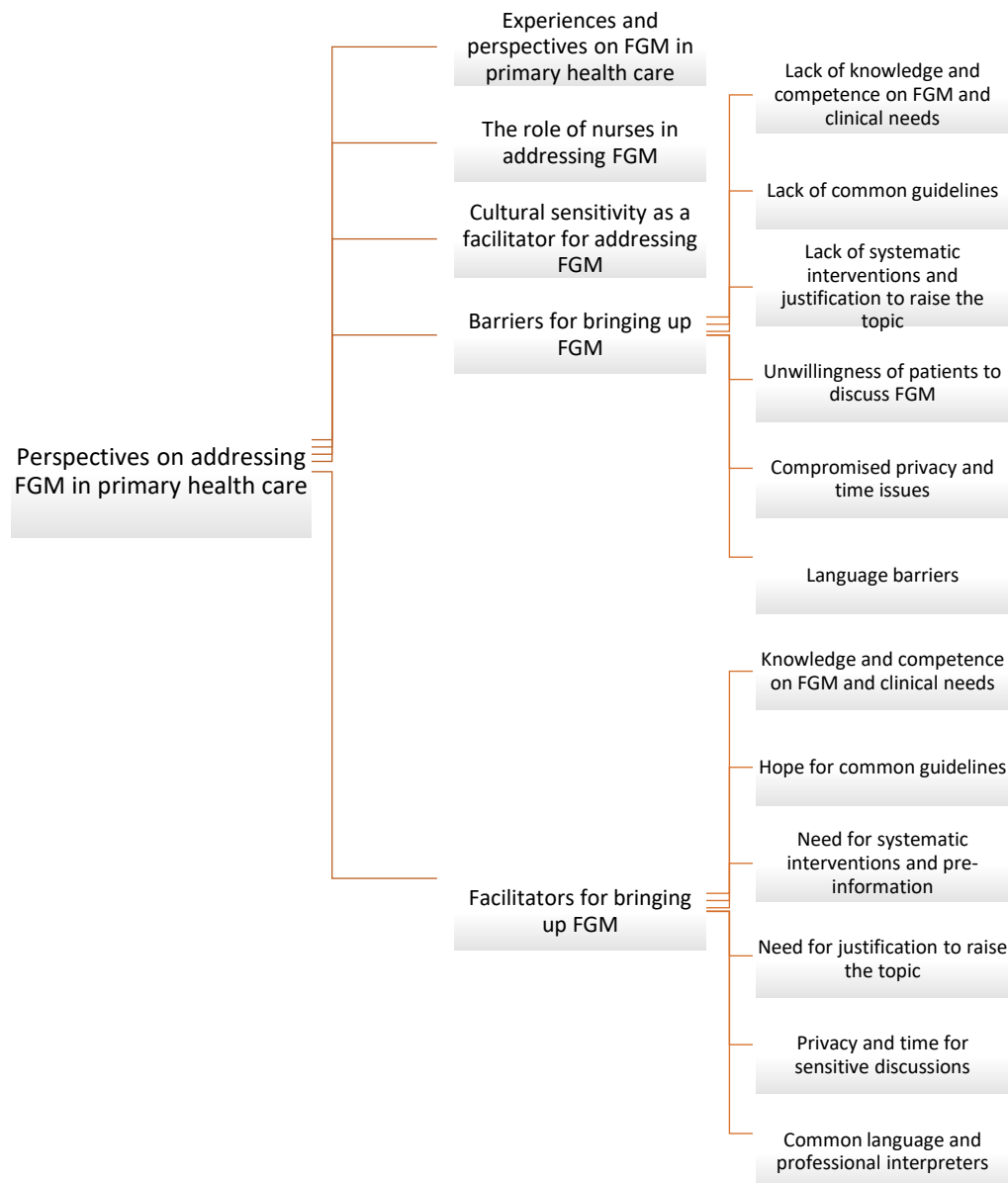


Figure 4: Synthesis of the results

### 6.1 Experiences and perspectives on FGM in primary health care

Most of the informants had no previous experience in encountering women who have undergone FGM at their work in primary health care. The lack of experience, knowledge and competencies in bringing up a sensitive topic was considered decreasing the confidence in health care professionals. The answers showed clearly how the topic was unfamiliar for most informants, therefore creating barriers in taking a proactive role in discussions on FGM with female patients. Most informants stated that they had not encountered women who have

undergone FGM at their work, however, all these particular informants also considered having significantly insufficient knowledge and competencies on the topic.

There has not been situations in my work, where there would have been a need or that it would have been natural to bring up FGM.

I have not yet been in a situation in my career, where the issue would have been topical.

There were few encounters that were shared in the answers. Some of the informants brought up the surprise and incapability to hide negative reactions from patients. One informant shared a previous experience on how the surprise of encountering a woman with FGM had caused strong emotions and surprise in the informant, which then created unnecessary discomfort for the patient due to the reaction and lack of knowledge of the nurse.

I have once seen a patient, who had been mutilated as a child. The patient was already an adult and came for an appointment due to genital symptoms. She did not mention that she had been mutilated. I completely froze when I saw her genitalia. It felt really bad as a professional to cause her discomfort due to my ignorance.

Negative emotions and preconceptions towards the tradition were also shared by the informants. One nurse said that the phenomenon rises a lot of emotions due to the idea of men being responsible for the ongoing tradition. Another informants' answer emphasized the perception of women as victims, by giving an example of raising the issue by concentrating on the procedure, which has been done against the person's will.

The topic causes a lot of emotions in me. I think it is incomprehensible how men cause unnecessary pain in all kinds of ways and with all kinds of excuses and use power on women.

[...]“hey, I noticed that your genitalia has been cut, has it been done against your will or when you could not express your will?” and then continue the conversation from there...

One informant pointed out the importance of acknowledging one's own reactions and attitudes towards FGM and how it facilitates the understanding of the complex phenomenon as well as addressing the issue with patients.

Also familiarizing yourself with your own attitudes and reactions as well as the reasons that influence behind them, helps to understand your own reactions and what causes the difficulty of discussing difficult topics with other people. So first you have to learn to understand and accept yourself before you can accept and understand others and their life choices and situations.

## 6.2 The role of nurses in addressing FGM

Even if the majority of the informants did not have experiences of encountering women who have undergone FGM at their work, most considered the role of health care professionals in

primary health care important. Informants stated that primary health care should provide a proactive approach on FGM and related health issues as well as inform women of available services and specialized care such as surgeries and deinfibulation. Informants also considered that it should be the nurses' role to identify women who have undergone the procedure and promote their wellbeing.

The task of primary health care is to be the primary place to bring up FGM. If we do not bring up the topic, who will? If we do not provide information on surgeries/deinfibulation, no one will do it. Our task is to tell about health consequences and possibilities as well as to write the referrals to secondary health care.

The nurse has a significant role in identifying and finding victims of FGM and promote their wellbeing in all ways.

The role of the nurses in primary health care was also seen as an important provider of psychosocial support. Providing a confidential space to share thoughts and experiences on the topic for women was considered essential.

I see that the role is important. As professionals we should provide information and guidance for patients, so that they will not be left alone with the issue.

Bringing up [the topic] would certainly help them to process the abuse[...]

The patient should be able to discuss the topic confidentially at any point when she needs the primary health care services.

There were also some informants who did not consider the role being significant. However, some said that better competencies, experience and knowledge on the topic, would make the health professionals feel that they could engage in a bigger role in promoting health and wellbeing as well as enable them to share accurate information and guidance. Lack of confidence in raising the topic was seen as a barrier for having a more significant role in primary health care.

The role could be more significant, if there would be more knowledge and experience on the topic[...]

The role [of nurses] is quite small.

That you do not have enough information, nor knowledge on how to help the patient with the problems that have been caused by FGM.

### 6.3 Barriers for bringing up FGM

There were several different preventing aspects found for bringing up FGM in primary health care (Figure 5). The most common reason preventing discussions on FGM was the lack of knowledge and competence on the topic. Also, the lack of common guidelines on further services and specialized care was highlighted in the answers. Informants were also looking for

justification to bring up the topic or pre-information from the patients. Cultural issues and the impression of women not wanting to discuss the topic was also mentioned as a barrier for raising the topic at the appointments. Privacy issues and time pressure was also seen as barriers as well as lack of common language and different matters concerning interpretation.

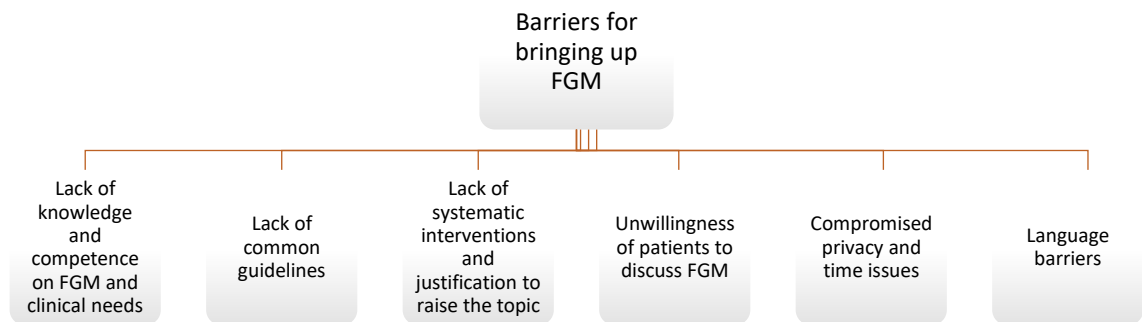


Figure 5: Barriers for bringing up FGM

Almost all participants stated having a lack of knowledge and competences on the topic of FGM and related clinical needs, thereby preventing them to bring up the issue with women. The lack of knowledge also affected their confidence to discuss it with women.

It is an area, on which I do not have any knowledge.

[with more knowledge and experience] I believe that then the nurse would have more confidence to bring up the topic.

The need for training on FGM and related issues was brought up by most informants, which shows the lack of competencies and confidence on tackling the topic. Almost all informants stated that they needed more knowledge to be able to bring up and support women with issues related to FGM.

The topic is relatively unfamiliar, and I would hope for more material on the subject, on how to encounter and bring up the topic, if I would face it in my work.

Further education is needed.

Also, informants who had previous experience with women who have undergone FGM, found it necessary for their colleagues to have further trainings.

I have sufficient knowledge and expertise related to FGM, but I would hope for further training on FGM and bringing up the topic for my colleagues.

The lack of common guidelines on clinical needs as well as for further services, support systems and specialized care prevented informants to bring up and discuss the issue with

women. Many considered it un-called for to bring up FGM with women when they did not have the means to help them further.

How to justify why I am asking if the patient has undergone FGM. And what do I do with this information, do I for example refer [the patient] to psychosocial support, because if I ask about it I must have also something more concrete to give the patient.

Lack of systematic interventions and justification to raise the topic emerged as a barrier in multiple answers. Many of the informants stated that it was difficult to raise the topic when they did not have previous medical history or other pre-information on the patient. Many also hoped for systematic interventions or a routine questionnaire, that would clarify if women had undergone the procedure or not. The informants found that this way it would be easier and justified to bring up FGM and the discomfort of bringing up a sensitive topic in vain could be avoided.

If there is no information on has it [FGM] been done or not [creates barriers to bring up the topic].

Many also stated that the fact that there is no clear reason to bring the topic prevents nurses to bring up FGM with women. Reasons that the informants considered to justify raising the topic were for instance gynaecological and urological symptoms as well as family planning.

When there is no clear reason to bring up the topic [creates barriers to bring up the topic].

There were several answers where informants described the unwillingness of the patients to discuss FGM as a barrier. For instance age and cultural differences were said to be a barrier to raise the topic as well as the idea that women would not find FGM as a wrongdoing. Also one informant mentioned that women might not dare to discuss sensitive topics with health care professionals due to cultural reasons.

If the patient does not want to talk about the topic.

Age and cultural differences [as barriers]. If the patient does not see it to be wrong.

Also in different cultures things can be “bashful”, and therefore [they] do not dare to have discussions with health care professionals.

Compromised privacy and time issues were considered being significant barriers to bring up FGM and related health issues with women. Many informants described the lack of privacy at the appointment creating challenges for raising sensitive issues with women. For instance women may often have their children, husband or other relatives accompanying them at the appointment.



The presence of relatives can occasionally be a challenge if the patient does not want to discuss the topic in front of her family members.

Women often have their husband accompanying them at the appointments and even as interpreters.

Also the presence of other family members can hamper discussions about certain issues.

Additionally, time issues was a concern for starting discussions on difficult topics.

[...] there should then be long enough time reserved beforehand [for discussions on sensitive topics].

All informants confirmed language barriers being a significant preventing matter in bringing up FGM and other sensitive topics at nurses' appointments. Language barriers often lead to challenging and perfunctory discussions at the appointments.

If the language skills of the patient is not sufficient.

It is difficult if there is no common language.

For example the lack of a common language complicates going through [sensitive issues].

The importance of interpreters at the appointment was highlighted in the answers. One informant stated experiencing frustration when the patients refuse to have an interpreter present even if there is no common language between the patient and health care professional. It was mentioned that being unable to discuss sensitive topics in depth prevents starting the conversation in the first place.

The lack of an interpreter hampers the communication, so there should always be an interpreter present.

Occasionally I feel frustrated, when the patient does not want an interpreter when I ask but tries to communicate at the appointment with weak Finnish/English language skills.

Language barriers has created issues for most of the informants at their work in primary health care. Informants describe it being common that family members attend the appointments as interpreters. Family members, sometimes husbands, children or other relatives, as interpreters was consistently considered as a barrier to address sensitive issues, which also raised the question of confidentiality and privacy. Informants felt that it would not be natural to bring up sensitive issues, such as FGM, if family members were present.

Often husbands or even the children are used as interpreters. At those times it is obviously not natural to bring up FGM.

The patient comes to the situation so that the husband acts as an interpreter.

If the interpreter is the patients' husband, it is challenging and raises thoughts of confidentiality.

Professional interpreters were highlighted as necessary in most situations. However, informants also considered the presence of interpreters to create barriers for raising sensitive issues at the appointment. Several informants stated that having an interpreter present decreases the feeling of confidentiality, and therefore patients may not want to open up about sensitive issues.

Of course having the interpreter in between decreases the mutual atmosphere and confidentiality.

Several informants mentioned also women's distrust towards the interpreters and the fear of sensitive and private issues spreading in the patients' own community, where language groups may be small. Informants also described situations where the patient refused to discuss certain sensitive issues in front of the interpreter.

With the interpreter present one does not necessarily open up the same way as when being one-on-one. Distrust in the interpreter, fear that the information spreads in the patients' community.

Some patients would not want an interpreter present at the appointment, because they fear that private matters will be revealed to others.

The patient refused to talk about her situation in front of the interpreter.

Many informants mentioned the importance of having female interpreters at the appointments. Having a male interpreter present when discussing sensitive issues with women has caused challenges for both the patient as well as the interpreter according to some informants.

Sometimes there has been problems, that only male interpreters has been available, and it has seemed to cause difficulties for both the interpreter and the female patient.

Informants also mentioned that when using interpreters at the appointment, nurses often deal with only the most necessary issues. There were also mentions that interpretation over the phone was considered challenging and made it more difficult to read the overall situation.

When using an interpreter you often go through only the so-called mandatory issues.

I have noticed with interpreters, that it is more difficult to interpret the narration of the patient, especially if the interpretation is organized via telephone. Situations can be challenging.

One nurse mentioned the danger of the interpreters' personal attitudes towards culturally sensitive issues, and how it can affect the tone of the discussions.

The attitude of the interpreters may sometimes influence the discussion and in those cases, you have to be alert yourself, so that I can notice the tone of the conversation.

Additionally, dialect issues with certain languages were mentioned causing further barriers in the discussions.

Interpreters occasionally have different dialect than the patients, even if the language is the same.

#### 6.4 Facilitators for bringing up FGM

Informants brought up different facilitating factors for bringing up FGM and culturally sensitive issues (Figure 6). Most highlighted again the importance of knowledge and competences on the topic as well as the availability of common guidelines for possible services and support systems. Additionally many informants mentioned information targeted for patients and routine questionnaires, which would include questions on FGM. Informants felt that they needed a clear reason to justify bringing up FGM or otherwise preferred the women to bring up the issue proactively. Common language, professional interpretation, privacy and time were seen as facilitators for most informants. The majority of the informants considered trainings and information being essential to increase confidence in bringing up the topic.

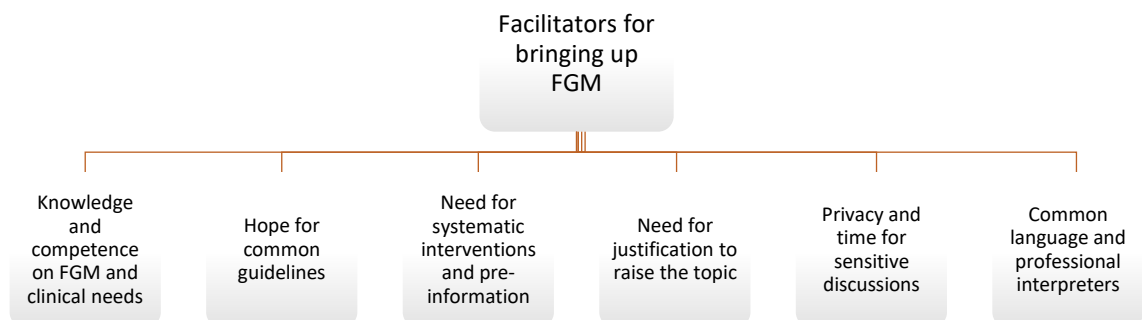


Figure 6: Facilitators for bringing up FGM

As already mentioned above concerning the barriers for bringing up sensitive issues, the importance of knowledge and competence on FGM and the clinical needs as well as further trainings were considered as facilitators by most informants. Knowledge was seen to be one of the key factors to facilitate bringing up the topic with women. Several informants recognized the connection between the lack of knowledge of the phenomenon and the challenges to bring up the topic.

Knowledge facilitates bringing up [the topic] and discussing it.

I would hope for more knowledge on FGM, its consequences and means to bring up the topic.

Training and guidance to identify and bring up [the topic].

Informants mentioned specific areas of the phenomenon for further trainings, which they considered to be useful for their work. Many stated the need for further information and trainings concerning physical health issues related to FGM, long-term mental health issues, effects on sexuality as well as general information of the prevalence of FGM.

Topics [for further training] could be: Identifying physical complications in acute care. In long-term care relationships identifying the possible long-term trauma symptoms and how to find the correct support systems. The global current state of FGM, the risk of FGM for girls living in Finland (trips to countries of origin or Europe).

Knowledge on FGM and its impact on sexuality.

Only one informant stated having sufficient knowledge and experience on FGM and related health issues. Another informant considered that registered nurses and public health nurses should have the basic knowledge on health promotion and health issues related to FGM, however, the need for specialized trainings on FGM is needed. One informant brought up the competencies of midwives on sexual health and related issues, which was seen to facilitate bringing up sensitive topics with patients.

Public health nurses and registered nurses are trained for expertise in women's health (including pregnancy, sexual health, birth control, other health promotion). The basic knowledge should be there, however further education is needed.

Midwives' delivery ward competencies facilitate discussions on sexuality with patients.

One informant mentioned the importance of acknowledging your own expertise in health promotion was seen to facilitate discussions on challenging topics. Getting to know your own reactions and attitudes towards certain sensitive issues was also seen as a facilitator to understand why it is challenging to bring up sensitive issues such as FGM with patients.

Also acknowledging and recognizing your own expertise facilitate bringing up all kinds of difficult topics, not only [issues] related to sexuality.

Acknowledging the important role of the health care professionals in primary health care in providing information and guidance for women who have undergone FGM was also seen as a facilitator for bringing up the issue.

A hope for common guidelines was shared by many informants. Several felt that it would be easier to bring up FGM if they had clear guidelines how to proceed and information on support systems and specialized care available.

I would hope for comprehensive common guidelines.

Information on where to refer the patient in different situations.

[...] that there would information of places, where the patient could be referred to.

Many answers highlighted the need for systematic interventions or pre-information such as previous medical records on FGM and related issues. Informants stressed the importance of making inquiries of FGM a routine procedure.

It would be good to have a pre-information form, with the question of FGM, would help bringing up [the topic].

Bringing up [the topic] would be easier if it would be a routine and if there would be directives on how to bring up a difficult issue and how to guide [the patient] forward.

Bringing up [the topic] could be made easier if one could ask for information on the patients' health beforehand and that would also include a question on FGM.

Some informants brought up the possibility to provide information for women at the health centres in several languages as a form of indirect intervention. Leaflets or other written material was considered beneficial to facilitate bringing up the topic and discussing it further with patients.

It would be good to provide patients leaflets and information of places where women can get help in the health care facilities.

[...]information on FGM, brochures in Finnish, English and Arabic, maybe also in French.

Need for justification to raise the topic emerged multiple times in the answers. Many of the informants stated that one of the key elements in being able to naturally bring up sensitive topics with women would be to have a clear reason for it. By a clear reason informants meant for instance gynaecological or urological issues, contraception guidance and family planning. Also pregnancy and maternity care were mentioned several times.

If the patients' issue is gynaecological. There is a clear reason to approach the topic.

If a woman is at the appointment due to gynaecological issues or birth control. Additionally during pregnancy monitoring and labour among other things.

It would probably be natural to bring up [the topic] during gynaecological examination [...]

For example when planning on intrauterine system would be a situation, where it would be natural to discuss FGM.

Gynaecological symptoms, urinary tract symptoms. Family planning. Maternity care. When discussing pregnancy, labour.

Many felt that it was easier to discuss culturally sensitive topics if women proactively brought up the issue or related health consequences, such as gynaecological issues. This was considered to justify raising the sensitive topic of FGM.

Facilitating factors are when women themselves bring up the topic.

If the patient herself is willing to talk.

If the patient herself brings up for instance a gynaecological issue.

Privacy and time for sensitive discussions was highlighted by the informants. Most stated that privacy and a calm environment was necessary for sensitive discussions. Many also stated that family members should not be present while discussing FGM related issues and that ideally only the patient and health care professional should be present. Also, the importance of reserving sufficient time for the appointment when discussing sensitive topics, especially when working with interpreters, was raised in the answers.

I would imagine that the situation would be easier with a calm, private environment, where there is a possibility to discuss one-on-one with the patient.

Women should be asked to come for the appointment without their husbands and husbands should definitely not act as interpreters.

Privacy. If possible, without a guardian or husband or other family members present. Only the interpreter and the health care professional discussing the personal matter.

Common language or professional interpreters were considered as requirements for a successful discussion on sensitive topics. Informants also stated that nurses need to actively assess the common understanding.

In my opinion the most important is having a common language, if there is none, then a professional interpreter must be used, so that we are on the same wavelength concerning the topic.

One should ask same questions multiple times with variation if there is a suspicion that the patient has not understood the matter as you have meant it.

Informants had positive experiences with professional interpreters and highlighted the need for female interpreters when discussing sensitive issues such as FGM. Also, on-site interpretation was considered more convenient for all parties.

In my opinion the situations have gone well. The interpreters I have used are all professionals and aware of these sensitive issues.

A good on-site interpretation and a female interpreter.

When discussing FGM, it is absolutely necessary to use a female interpreter.

It would be beneficial also for the patient, that the interpreter would be on-site (usually via telephone), and that issues could be clarified on both sides.

#### 6.5 Cultural sensitivity as a facilitator for addressing FGM

Cultural sensitivity was consciously a part of most of the nurses' daily work. However, four informants did not know how to describe cultural sensitivity and how it was present in their work whatsoever. Several informants described cultural sensitivity being competences and knowledge on different cultures, but mostly it was seen as respect and individuality in the encounters.

Cultural sensitivity probably means that everybody are met similarly, nonetheless understanding their backgrounds. The backgrounds may probably influence the individuals' use of services and how they reach out for services among other things.

My whole job description is to be culturally sensitive[...] Cultural sensitivity is not about knowing cultures but understanding individuality and the influence of the individual life situation of the patient in regard to their health.

Every patient is encountered as equals and everyone is respected. [Cultural sensitivity] means paying attention to the cultural background of the patient in the planning and implementation of the care.

In relation to cultural sensitivity and sensitive issues such as FGM many saw the importance of same gender health care professionals as well as interpreters.

Taking into consideration the different cultural backgrounds of the patients[...] I ask, when necessary, if it makes a difference that the examining doctor is male or female.

Two informants highlighted the need to listen in intercultural encounters. Encouraging agency and engaging the patients in the decision making was also mentioned in several answers. Also, curiosity was seen as a trait that facilitates intercultural encounters and discussions.

Emphasis on listening, no direct propositions from the viewpoint of the Finnish culture. One can talk about the means of care that are available and then ask, what kind of they thoughts rises in the patient. Cultural factors should not be dismissed.

I give space for the patient to go through the matters from their own point of view, by discussing the issue and by listening. As a person who is interested in cultures it is easy to keep up a conversation from that point of view. Encouraging the patient to learn new things.

Consideration of one's own reactions, attitudes and feelings towards other cultures or cultural traditions was considered to be a part of cultural sensitivity. Informants pointed out that people may link cultural sensitivity with prejudice or stereotypes. However, seeing people as individuals with individual needs, regardless of coming from the same cultural

group was highlighted. Also, understanding the changing cultures within families and generations was seen important by the informants.

By being culturally sensitive one takes into consideration the patients' own cultural tradition without an attitude. Discussing issues without emotional bursts.

Cultural sensitivity is easily related to prejudice. Everyone who comes from the same culture are still individuals and for instance the differences between families and generations are sometimes substantial.

Many informants considered cultural sensitivity being helpful in primary health care. It was also seen as competences on different cultural beliefs and attitudes on health care. However, the importance of individual needs and proactive discussions on sensitive topics by the health care professionals was considered more important for effective communication and results.

Feels like cultural sensitivity would be helpful. I would need more information on the habits and paradigms of different cultures. For example the care of acute issues are in many cultures totally different than in Finland, so it would be good to understand better their thoughts. However, I feel that I am able to read people and try to also consider the culture. For instance by discussing more on what their needs are and by explaining more than typically why things are done as they are.

Even if the concept of cultural sensitivity was unfamiliar for some informants, most considered it to be a facilitator for discussions on culturally sensitive topics and additional training on the culturally sensitive approach was requested.

## 7 Discussion

In this chapter the results of this thesis will be discussed reflecting on previous research on the topic. After the discussion of the results, the limitations and trustworthiness of the study will be examined as well as the ethical considerations regarding the entire thesis process.

### 7.1 Discussion of the results

The goal of this thesis was to examine the perspectives and experiences of health care professionals in primary health care concerning FGM, with the primary objective to identify the different barriers and facilitators to bring up culturally sensitive issues and secondly to provide development recommendations for health care providers. The thesis answered the following research questions: 1. What kind of perceptions and experiences do health care professionals in primary health care have concerning FGM and cultural sensitivity? 2. What factors prevent or facilitate health professionals to bring up and discuss FGM? 3. What are the development needs of health care professionals' competencies and skills in addressing FGM?



The results are discussed following the five main categories of the findings. Firstly, addressing nurses' experiences and perspectives on FGM in their work. Secondly, perceptions on the nurses' role in FGM issues in primary health care. Thirdly, the barriers and facilitators of bringing up FGM are discussed together and lastly, how nurses consider cultural sensitivity to be a part of their daily work and a facilitator in raising sensitive topics.

The results of this thesis show that the importance of the topic is widely acknowledged among nurses in primary health care, however most of the informants were not confident with their knowledge and competences on issues related to FGM. There is a gap between nurses' experiences on FGM and related discussions in primary health care. Almost all the informants stated not having encountered women who have undergone FGM at their work. However, it was shown in the results that nurses with confidence and knowledge on FGM, had also experiences on bringing up the topic and were proactive in their discussions with women. Therefore, it can be questioned whether nurses who stated a significant lack of knowledge on the topic, have been able to identify the possible encounters with women who have undergone FGM. Similar results have been found in earlier studies among health care professionals in areas where FGM prevalence has increased due to migration (Molina-Gallego et al. 2021; Simpson et al. 2012; Ogunsiji 2015; Turkmani et al. 2018; Vissandjée et al. 2014). Lack of awareness and competencies on FGM often lead to ignorance and neglect of the issue and related health consequences. Knowledge and experience, on the other hand, increases health care professionals' confidence and proactive approach in discussions with women.

According to previous research, women with FGM endure health issues significantly more than women without FGM, including psychological, sexual, and reproductive health consequences (Andro et al. 2014; Koponen & Mölsä 2012, 141-144; Koukkula et al. 2016), which is why it is relevant for nurses to address FGM proactively. Many informants reported not having faced situations where bringing the topic would have been natural or necessary. If the women did not bring up the issue themselves or if there was no clear reason, which informants generally considered a gynaecological symptom, the nurses did not feel the need to bring up FGM. This perspective is however problematic according to previous studies, as women who have undergone FGM prefer not to bring up the topic themselves with health care professionals for several reasons. For instance, lack of trust in health care providers' competencies on the topic as well as fear and discomfort of attitudes and emotional reactions prevent women to proactively bring up FGM in health care settings (Simpson et al. 2012; Amasanti et al. 2016). These type of reactions, strong emotions as well as negative preconceptions towards the tradition, emerged also in the results of this thesis. It is essential to create a safe and non-judgmental space when there is a need to discuss the topic with women (Kawous et al. 2020; Vissandjée et al. 2014).

Health care professionals should also consider the different socio-cultural constraints which may hinder women to bring up FGM with nurses (Dixon et al. 2021; Johnsdotter & Essén 2016; Metusela et al. 2017). A culturally sensitive approach facilitates bringing up FGM by acknowledging the complexity and concerns on personal, community and legal levels of the issues for women (Vissandjée et al. 2014). Understanding the phenomenon and the variety of reasons behind it as well as the diverse clinical needs that may arise due to FGM, also facilitates trustworthiness in the discussions (Metusela et al. 2017). Furthermore, the importance of getting to know your own attitudes and feelings towards the difficult topic, which increases confidence in raising the issue without judgement, emotional reactions, nor trivialization of the topic (Molina-Gallego et al. 2021; Dixon et al. 2021), was also mentioned by the informants in this study.

Nurses in primary health care have an important role in addressing FGM with patients and they are in the frontline of FGM interventions. Both prevention of FGM as well as provision of quality health care and guidance for women who have undergone FGM are needed. (Berg et al. 2017; Johnsdotter & Essén 2016; Dixon et al. 2021.) The constantly growing level of immigration from FGM prevalent countries as well as the higher level of primary health care service utilization among women with foreign backgrounds (Kuusio et al. 2020, 154) stresses the need to train health care professionals on FGM issues.

The results of this thesis showed that most informants considered the nurses' role crucial, however some considered it being less important. The more knowledge and experience the informant had on the topic, the more important they considered the role of the nurses to be, especially in primary health care. Importance was given to providing a confidential space for women to share and process their experiences and thoughts. Most informants saw the possibility to be in the frontline to discuss, support and provide guidance for women in primary health care, however, the lack of knowledge prevented them to engage in a bigger role.

The results demonstrated similar barriers and facilitators for bringing up and discussing FGM as have been found in earlier studies. The lack of knowledge, as already mentioned above, was the major barrier for addressing FGM with women. However, the results showed a strong motivation to learn and understand the phenomenon and its consequences. The need for further trainings and education were mentioned in most answers. The lack of trainings is systematically found being one of the greatest barriers in bringing up FGM in the health care sector (Amasanti et al. 2016; Andro et al. 2014; Reisel & Creighton 2015; Molina-Gallego et al. 2021; Dixon et al. 2021).

Some informants reported not having any knowledge on the topic, which implies the impossible task of identifying situations, where raising the topic as well as providing women

support and guidance would be essential. Increasing awareness and knowledge through further trainings among nurses in primary health care is a key solution to enable proactive interventions on FGM issues and health promotion for women who have undergone the procedure.

Additionally, a request for common guidelines and means to bring up sensitive topics proactively with patients was highlighted in the results. The lack of common guidelines was seen as a barrier for addressing the issue, as nurses felt raising the issue useless when they did not have knowledge or means to support and guide the patients to further care. Common guidelines were seen as an important way to facilitate the discussions, enabling nurses to provide women with something concrete if needed. Previous studies have showed similar outcomes with the lack of guidelines in health care settings (Dixon et al. 2021; Johnsdotter & Essén 2016; Vissandjée et al. 2014).

Systematic interventions and routine protocols for enquiring women of their FGM status was also brought up in the results as facilitators. Systematically raising the issue could eventually normalize asking about FGM. A routine protocol for bringing up FGM with women has been considered essential also in previous studies and would lower the threshold for health care professionals to bring up the sensitive topic (Andro et al. 2014; Reisel & Creighton 2015; Molina-Gallego et al. 2021). Related to common guidelines and systematic interventions, many informants considered information targeted for women at the health care facilities beneficial to address the issue. This could be seen as a sensitive way of raising the issue indirectly and show that they are prepared to discuss the issue if needed.

Many reported the difficulty in bringing up the sensitive topic when they were not certain if the patient had undergone FGM or not. Informants found it more justified to raise the topic if the patient had attended the appointment for instance due to a gynaecological issue. Clearly the topic was considered so sensitive that it could not have been asked just as a routine question among other issues. The answers also show the lack of knowledge on the variety of health issues and clinical needs that FGM may cause. Informants considered FGM issues being related mainly to gynaecological complications and family planning. However, FGM has various health and social consequences that should be considered. The health consequences are also often interrelated, including physical, psychological, as well as sexual issues and the awareness regarding the relation between FGM and health is not necessarily shared in FGM prevalent communities due cultural reasons (O'Neill et al. 2017). On this point as well, knowledge and further training facilitate conversations and increases confidence in bringing up culturally sensitive topics in different situations.

The need for pre-information and proactive approach from the women, were highlighted in the results as a facilitating factor. The hesitance to approach the topic proactively also shows

the lack of confidence and knowledge on FGM. Realizing that pre-information is available only if someone has already raised the issue earlier, may facilitate and normalize raising the topic among nurses. The importance of primary health care being the setting where this information should be addressed, was also reported by the informants. One informant emphasized the view that if health care professionals in primary health care will not bring up the issue, then who will?

Preconceptions of cultural differences and whether the women find FGM being “wrong” or not, was considered also as a barrier to bring up FGM proactively with women. Also, respect for the patient, by not addressing the issue, emerged in the answers. Cultural preconceptions and the view of FGM being a cultural and private family matter have been noted as a barrier to discuss FGM in health care settings also in previous studies (Amasanti et al. 2016; Dixon et al. 2021). The fear of upsetting or offending women by asking about FGM seemed to prevent nurses to raise the issue and has been reported in previous studies as well (Johnsdotter & Essén 2016; Vissandjée et al. 2014). However, due to cultural reasons, FGM as well as gynaecological and sexual issues, are considered taboos in many FGM prevalent communities (O’Neill et al. 2017). Consequently, this emphasizes yet again the importance of providing a space for sensitive discussions and provision of accurate information on the topic with a proactive approach. According to Johnsdotter and Essén (2016) the opportunity to discuss for instance sexual health issues in health care settings is perceived positively by women and is highly encouraged.

In the results of this thesis there were references of victimizing women due their experience of FGM. According to Amasanti et al. (2016) women’s experiences on being identified as a victim in health care settings decreases the willingness to bring up the topic. By understanding the complexity of the phenomenon while being sensitive to the needs of the individual will create a trusted environment for women to discuss FGM in health care settings. Previous studies also state that women’s confidence in discussing FGM with health care professionals is decreased when there is a fear of judgement or stigma as well as distrust in the health care professionals’ awareness of FGM and related health needs (Dixon et al. 2021). In the results of this study some informants highlighted the lack of awareness of the phenomenon as well as the clinical needs that may be caused by FGM. Also, negative preconceptions towards the tradition was found. Therefore, raising awareness and knowledge on FGM issues as well as emphasizing culturally sensitive approach in the daily work, would facilitate discussions on culturally sensitive topics.

Privacy issues emerged in many answers. The fact that many informants reported women, who they considered having a background in FGM prevalent communities, attending the appointments often accompanied by their husbands, children, or other relatives. This is

considered a significant barrier for discussions on sensitive issues. Even professional interpreters were considered hampering the confidentiality and trust of the conversation.

Language barriers often create various difficulties in conversations on sensitive topics. When the topic is considered a taboo in many cultures, misunderstandings may result in negative impressions, distrust, and reduced engagement with health care professionals. Informants reported that family members are often used as interpreters in health care settings, which was seen as preventing sensitive discussions.

The results showed that professional interpreters were occasionally seen as a barrier for sensitive discussions. Many language groups are small and close communities, which according to the informants has led to a fear of sensitive matters spreading to others in the community. Women have even refused to talk with the interpreter present. According to Dixon et al. (2021) and Simpson et al. (2012) discussions on FGM creates often discomfort and embarrassment in women, especially when male health care professionals or interpreters are present. Similar experiences on the importance of being sensitive towards gender issues were shared and reported also in this study. Therefore, it is essential to ensure that the patient accepts the interpreter and feels comfortable in the situation. The importance of gender was also emphasized by most informants as well as the interpreters' attitudes on sensitive topics. Nonetheless, most informants valued the professional interpreters and saw them as a facilitator for culturally sensitive conversations. In previous research interpreters has been seen also as cultural mediators, who may provide valuable information for health care professionals regarding different phenomena (Dixon et al. 2021). This aspect of value was however, not raised in the informants' answers.

The results of this thesis showed a gap in the knowledge on cultural sensitivity among the informants. Most informants saw cultural sensitivity being important and necessary in their daily work. Several informants, however, did not know how to describe cultural sensitivity or how it could be part of their daily work whatsoever. Cultural competence as a concept was more highlighted in the answers and was confused with cultural sensitivity, but also a strong knowledge of the difference between these two concepts was demonstrated among the informants. Cultural competence and cultural sensitivity go hand in hand, however, cultural sensitivity refers to interpersonal competence as well as respectful verbal as well as non-verbal communication skills (Foronda 2008). Additionally, training on culturally sensitive approach and intercultural encounters was underlined and considered to be very useful in bringing up cultural taboos.

As cultural sensitivity is considered as one of the key aspects in addressing FGM in health care (Metusela et al. 2017; Kawous et al. 2020; Vissandjée et al. 2014), it should be a priority to train nurses further on the topic while intercultural encounters will only become more

frequent. However, fear of offending the patient in the name of cultural sensitiveness might also hinder addressing the issue at all (Ahmed et al. 2017; Dixon et al. 2021). Nevertheless, by increasing the knowledge among health care professionals as well as developing means to address FGM and provide guidance, will also help to overcome the intercultural challenges of raising the topic of FGM proactively.

## 7.2 Limitations of the study

As for most studies, also this thesis has had its limitations. Female genital mutilation is a difficult topic considering culturally sensitive aspects as well as the low awareness of the phenomenon among health care professionals. FGM is also a very complex phenomenon, which has impacts on personal, community and legal levels (Vissandjée et al. 2014). Previous studies on FGM exist in Finland, however they are mostly related to prevalence or obstetric settings. Therefore, there is a need to address FGM and related issues in research from wider perspectives.

The goal of this study was to examine the perspectives and experiences of a diverse group of nurses in primary health care, not only those who have previous knowledge on the topic, but also nurses who face the barriers of bringing a sensitive topic. For this reason, as well as the ongoing COVID-19 pandemic, an anonymous online questionnaire was chosen for the data collection method rather than face-to-face interviews. This data collection tool, however, did not motivate the informants to elaborate their thoughts in depth. Most responses were short and concise. Qualitative approach for this study was seen as necessary to examine the topic from the specific perspective and as the goal was to understand a phenomenon (Tuomi & Sarajärvi 2009, 65-66). However, in retrospect face-to-face interviews could have generated more elaborated answers with deeper reflections on feelings, attitudes and other barriers preventing proactive discussions on FGM with women.

The online questionnaire did neither motivate a large number of participants and only 14 nurses answered the questionnaire. Even though data saturation was considered reached (Fusch & Ness 2015; Tuomi & Sarajärvi 2009, 87), the number of informants was not as high as initially hoped for. Low rate in replies may have also been a consequence of the author's inexperience in conducting a data collection. Having a larger target group for the data collection could have been considered initially. However, due to the research permit process from the City of Helsinki, it was decided not to apply another permit for a larger research setting while the data collection was already ongoing.

## 7.3 Trustworthiness

The evaluation criteria will guide as well as facilitate the quality of the thesis process. Qualitative research aims to interpret social reality, which is usually very context dependent

and subjective (Bhattacharjee 2012, 110). According to Lincoln and Guba (1985) criteria of trustworthiness is seen as the key factor in the evaluation of the value of the study. Credibility, transferability, dependability, and confirmability must be established for reaching trustworthiness and quality in research outcomes as well as to judge the rigor of qualitative studies (Bhattacharjee 2012, 110). The original criteria of Lincoln and Guba (1985) is still seen as a pragmatic tool to ensure the acceptability and value of research (Nowell, Norris, White & Moules 2017). These criteria have been applied during the entire thesis process.

By credibility a researcher aims to guarantee authentic representation of experience. Credibility in a study will be met when the reader recognizes the experience (Nowell et al. 2017), which they are confronted with in the text and find it believable (Bhattacharjee 2012, 110). It is recommended to use for instance researcher triangulation, data collection triangulation, persistent observation as well as external debriefings to ensure credibility in the study (Lincoln & Guba 1985). Even if the number of informants was quite low and elaboration in their answers was concise, the similarity of their experiences could be concluded, and data saturation reached. The context of the study in relation to previous research has been justified with the aim to guarantee the credibility of the outcomes. The entire thesis process has been overseen by the appointed supervisor to ensure further credibility.

Transferability aims to generalize the findings, in order to possibly transfer them to contexts outside of the study situation (Nowell et al. 2017). Often the findings are, however, time and context-bound experiences, but to ensure quality in research a thorough description and reporting of the context, informants as well as the data collection and analysis is required. This provides the reader sufficient knowledge to assess the transferability of the outcomes to other settings (Bhattacharjee 2012, 111). This thesis has aimed to provide a wide description on both the research setting and context as well as the group of informants. Also, the data collection and analysis phases are described in detail to ensure the possibility to assess the transferability of the findings.

Dependability aims to demonstrate consistency and repeatability of the findings and interpretations (Bhattacharjee 2012, 110). By logical, traceable, and detailed reporting of methods and process as well as the context and phenomenon itself, will provide dependability in research (Nowell et al. 2017). In this thesis dependability has been acknowledged by a thorough and comprehensive presentation of the theoretical framework of the phenomenon of FGM as well as a detailed reporting of the results. The aim has been to provide a logical and traceable report.

Through confirmability the researcher pursues neutrality in the process and outcomes (Guba & Lincoln 1985). Biases as well as personal interests and perspectives on the interpretations

of data can be avoided by clearly demonstrating the reasons for methodological and analytical choices as well as how conclusions have been drawn (Nowell et al. 2017). Additionally, participants' agreement on the inferences of the study will increase confirmability (Bhattacharjee 2012, 110-111). To avoid interpretations on personal preconceptions of the results, the discussion has been reflecting on previous research on the topic. The results showed similar outcomes as previous studies, which increases the confirmability of this thesis. A challenge in this thesis has been the translations of some central concepts, such as the Finnish expression "puheeksi ottaminen". It has been translated in this thesis as *bring up*, *raise* and *address a topic*.

#### 7.4 Ethical considerations

The fundamental principles of research integrity create the framework for good research practices. Firstly, reliability will ensure quality in the design, methods, analysis and use of data. Secondly, honesty through the whole research process will provide transparent, fair and unbiased results. Thirdly, respect will guide the researcher to consider colleagues, environment, society, and cultural heritage as well as the informants and participants of the study in a sensitive way. Lastly, accountability for the management of the process as well as the wider effects of the research is essential. (All European Academies ALLEA 2017, 4.) The guidelines of Laurea University of Applied Sciences have been guiding the work to strictly avoid any plagiarism or research misconduct in the process (Laurea UAS 2020, 12-15). The General Data Protection Regulation (GDPR) as well as the Finnish Data Protection Act 1050/2018 was followed and considered throughout the data collection and management process (Regulation (EU) 2016/679; Data Protection Act 1050/2018), however choosing to avoid any collection of personal data.

According to the Rectors' Conference of Finnish Universities of Applied Sciences (Arene) guidelines the author familiarized herself well with the topic of the thesis as well as the guidelines of research ethics. Basic principles of conducting a responsible and well-planned research as well as the guidelines of research ethics, Responsible Conduct of Research (RCR), have been and will be used during the entire thesis project. (Arene 2019, 9; Finnish National Board on Research Integrity TENK 2019, 48-49.) An ethical review of research was not required, as this study is not medical research neither does it include research on vulnerable groups or minors, cause any threat, mental harm, involve physical interventions nor deviation from the principle of informed consent (Arene 2019, 9-10). However, as the data collection and questionnaire were conducted at a public health centre, a research permit from the City of Helsinki was required (City of Helsinki 2022b).

Anonymity in the data of the informants has been a priority. The contact person at the health centre delivered the information letters to all possible participants, so that the author would



not have access to the personal data. To ensure confidentiality, the consent form did not require personal data, but had to be approved by the participant to get access to the questionnaire. The consent form and information letter with clear instructions and details of the thesis project, was provided in both English and Finnish language. All possible participants were clearly informed that participation in the research was voluntary and that the informants had the right to withdraw their participation at any time. The anonymity and data protection has been carefully considered to ensure honest and thorough answers from informants, as the topic itself is sensitive and may provoke emotions for and against.

Data collection and the online questionnaire with open-ended questions for health care professionals at the study setting was conducted with relevant precautions concerning data management, storage, and protection. The anonymous data collected from the questionnaires was stored on the authors personal computer with secured access control. Hard copies of the data has been stored securely in a locked space in the authors home, with only the authors' access to them. The supervisor of the thesis did have access to the anonymous data through the author, to ensure reliability of the study. The data has not been transferred outside of the European Union nor the European Economic Area (EEA). The software programs and file formats used for storage of the data has been addressed. Hard copies of the data have been destroyed after the thesis was accepted. Electronic data will be destroyed by overwriting two years after the thesis has been published, to ensure possibility for potential research integrity assessments.

The study and data collection method itself was not considered to involve risks or disadvantages for the participants. The data collection tool was anonymous and required no personal data. The participants were instructed to avoid any kind of personal data in the answers, securing both their own and their patients' anonymity. The online survey platform enabled the possibility to avoid registering of the computer IP address, which enhanced the confidentiality further.

No conflict of interest has been recognized to jeopardize the impartiality of the results. The thesis process did not require any external funding. The time needed for informants to answer the questionnaire during work hours was discussed with the work life contact person (Head nurse 2022. Personal communication). A written thesis project agreement was made between the author and the contact person at the health centre, to clarify the responsibilities and copyrights of the study.

## 8 Conclusions

The results of this thesis demonstrated registered and public health nurses' lack of experiences on encountering and addressing female genital mutilation (FGM) in primary health care. Lack of knowledge on the topic affected the perspectives, awareness and confidence to bring up the sensitive topic with female patients. The role of health care professionals in primary health care was considered to be important, however, the lack of knowledge and common guidelines prevented nurses to engage in a bigger role in the prevention of FGM as well as a provider on support, guidance and information. Cultural sensitivity was generally acknowledged as a facilitator for addressing FGM and related issues with patients, but often confused with cultural competences.

The results showed various preventing factors to bring up and discuss FGM, most importantly the lack of competence and knowledge on FGM as well as related health issues and clinical needs. Lack of common guidelines, systematic interventions and justification to raise the topic. Also the patients' unwillingness of discussing the issue was seen as a barrier. Compromised privacy and limited time was preventing to raise the sensitive topic. Additionally, language barriers as well as interpreters caused challenges in bringing up as well as discuss the topic in depth with mutual understanding.

Facilitators for bringing up FGM and related health issues were enhancing nurses' competences and knowledge through further trainings. A hope for common guidelines, systematic interventions and pre-information was needed, to justify and facilitate bringing up the culturally sensitive topic. Privacy and sufficient time to discuss FGM was seen important. Additionally, common language and professional interpreters were considered a crucial factor for an effective and respectful discussion.

Based on the results of this thesis there is a great need for further training on FGM and related issues for nurses working in primary health care. In addition to the demand for trainings, common guidelines and means to bring up the topic of FGM are needed. Professional interpreters as well as sufficient time for the appointments need to be available for sensitive discussions. Further trainings on cultural sensitivity would also be beneficial for health care professionals working in primary health care. Awareness of FGM prevalence was shown to be low, which decreases the possibilities to provide support, care and accurate information for women who have undergone FGM. By increasing awareness on FGM among health care professionals and helping them to engage in a proactive role, will also normalize discussions on topics that may seem sensitive or even taboos in many communities.

## 9 Recommendations

Health care providers, especially in primary health care, should engage in a proactive role in the prevention of FGM as well as provision of support, guidance and accurate information for women who have undergone FGM. Further trainings on FGM and related health issues as well as clinical needs are necessary. Common guidelines for health care professionals, including further support systems as well as available surgeries and deinfibulation, should be developed. A culturally sensitive approach should be addressed in health care settings more widely.

Furthermore, it would be beneficial to study health care professionals' competencies on FGM and their abilities to address culturally sensitive topics more extensively. A valuable perspective on the topic would be to examine the perspectives of women who have undergone FGM and how they experience interactions with health care professionals concerning the topic. This thesis was a small-scale study on one specific perspective on FGM, however hopefully it will inspire larger research on the topic.

## References

- Abdalla, S. & Galea, S. 2019. Is female genital mutilation/cutting associated with adverse mental health consequences? A systematic review of the evidence. Article in *BMJ Global Health*, 4 (4). Accessed 30 January 2022. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6666816/>
- African Care ry. 2021. Silpomisen vastaisen toiminnan materiaalipaketti. Accessed 2 January 2022. <https://www.africancare.fi/julkaisut/>
- Ahmed, U., Ylispangar, E. & Daham, M. 2017. Report on circumcision of girls born in Finland. Accessed 30 January 2022. <https://www.fenixhelsinki.com/l/report-on-circumcision-of-girls-born-in-finland/>
- All European Academies (ALLEA) 2017. The European Code of Conduct for Research Integrity. Accessed 22 January 2022. <https://www.allea.org/wp-content/uploads/2017/05/ALLEA-European-Code-of-Conduct-for-Research-Integrity-2017.pdf>
- Andro, A., Cambois, E. & Lesclingand, M. 2014. Long-term consequences of female genital mutilation in a European context: Self perceived health of FGM women compared to non-FGM women. Article in *Social Science & Medicine*, 106, 177-184. Accessed 17 January 2022. <https://www.sciencedirect.com/science/article/abs/pii/S0277953614001002>
- Andro, A. & Lesclingand, M. 2016. Female Genital Mutilation. Overview and Current Knowledge. Article in *Population*, 71 (2), 217- 296. Accessed 20 January 2022. [https://www.cairn-int.info/article-E\\_POPU\\_1602\\_0224--female-genital-mutilation-overview-and.htm?contenu=article](https://www.cairn-int.info/article-E_POPU_1602_0224--female-genital-mutilation-overview-and.htm?contenu=article)
- Amasanti, M.L., Imcha, M. & Momoh, C. 2016. Compassionate and Proactive Interventions by Health Workers in the United Kingdom: A Better Approach to Prevent and Respond to Female Genital Mutilation? Article in *PLoS Medicine*, 13(3). Accessed 11 February 2022. <https://journals.plos.org/plosmedicine/article/file?id=10.1371/journal.pmed.1001982&type=printable>
- Atkinson, H., Ottenheimer, D. & Mishori, R. 2019. Public Health Research Priorities to Address Female Genital Mutilation or Cutting in the United States. Article in *American Journal of Public Health (AJPH)*, 109 (11), 1523-1527. Accessed 2 January 2022. <https://ajph.aphapublications.org/doi/10.2105/AJPH.2019.305259>
- Berg, R.C., Taraldsen, S., Said, M.A., Sørbye, I.K. & Vangen, S. 2017. Reasons for and Experiences with Surgical Interventions for Female Genital Mutilation/Cutting (FGM/C): A Systematic Review. Article in *The Journal of Sexual Medicine*, 14 (8), 977-990. Accessed 5 February 2022. <https://pubmed.ncbi.nlm.nih.gov/28666656/>
- Berg, R.C. & Denison, E. 2013. A Tradition in Transition: Factors Perpetuating and Hindering the Continuance of Female Genital Mutilation/Cutting (FGM/C) Summarized in a Systematic Review. Article in *Health Care Women International*, 34 (10), 837-895. Accessed 12 February. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3783896/>
- Berg, R.C. & Underland, V. 2018. Immediate Health Consequences of Female Genital Mutilation/Cutting (FGM/C). Knowledge Centre for the Health Services at The Norwegian Institute of Public Health (NIPH), Oslo, Norway. <https://europepmc.org/article/nbk/nbk464798>
- Bhattacharjee, A. 2012. *Social Science Research: Principles, Methods, and Practices*. Accessed 5 February 2022. [https://digitalcommons.usf.edu/cgi/viewcontent.cgi?article=1002&context=oa\\_textbooks](https://digitalcommons.usf.edu/cgi/viewcontent.cgi?article=1002&context=oa_textbooks)

- Castaneda, A., Larja, L., Nieminen, T., Jokela, S., Suvisaari, J., Rask, S., Koponen, P. & Koskinen, S. 2015. Ulkomaalaistaustaisten psyykinen hyvinvointi, turvallisuus ja osallisuus - Ulkomaista syntyperää olevien työ ja hyvinvointi -tutkimus 2014 (UTH). Accessed 20 January 2022. [https://www.julkari.fi/bitstream/handle/10024/127023/URN\\_ISBN\\_978-952-302-535-6.pdf?sequence=2](https://www.julkari.fi/bitstream/handle/10024/127023/URN_ISBN_978-952-302-535-6.pdf?sequence=2)
- City of Helsinki. 2022a. Health Stations. Accessed 6 February 2022. <https://www.hel.fi/en/health-and-social-services/health-care/health-stations>
- City of Helsinki. 2022b. Tutkimusluvut. Accessed 18 January 2022. <https://www.hel.fi/sote/fi/paatoksenteke/tutkimus/tutkimusluvut/>
- Data Protection Act 1050/2018. Accessed 22 January 2022. <https://www.finlex.fi/en/laki/kaannokset/2018/en20181050?search%5Btype%5D=pika&search%5Bkieli%5D%5B0%5D=en&search%5Bpika%5D=data%20protection>
- Dixon, S., Duddy, C., Harrison, G., Papoutsi, C., Ziebland, S. & Griffiths, F. 2021. Conversations about FGM in primary care: a realist review on how, why and under what circumstances FGM is discussed in general practice consultations. Article in *BMJ Open*, 11 (3). Accessed 20 January 2022. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7986780/>
- Eduix Ltd. 2021. Manage online forms and electronic services with E-LOMAKE. Accessed 27 January 2022. <https://e-lomake.fi/en/>
- Elo, S. & Kyngäs, H. 2007. The qualitative content analysis process. Article in *Journal of Advanced Nursing*. 62(1), 107-115. Accessed 5 February 2022. <https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1365-2648.2007.04569.x>
- Elmusharaf, S., Elhadi, N. & Almroth, L. 2006. Reliability of self reported form of female genital mutilation and WHO classification: cross sectional study. Article in *BMJ*, 333 (124). Accessed 15 January 2022. <https://www.bmj.com/content/333/7559/124.full>
- End FGM European Network, Equality Now & US End FGM/C Network. 2020. Global Report - FGM/C: a Call for a Global Response. Accessed 5 January 2022. <https://www.endfgm.eu/content/documents/FGM-Global-ONLINE-PDF-VERSION-07.pdf>
- Finnish institute for health and welfare (THL). 2021a. Prevention of female genital mutilation (FGM). Accessed 1 January 2022. <https://thl.fi/en/web/migration-and-cultural-diversity/immigrants-health-and-wellbeing/sexual-and-reproductive-health-of-immigrants/prevention-of-female-genital-mutilation-fgm->
- Finnish institute for health and welfare (THL). 2021b. Kulttuurisensiitivinen työote. Accessed 1 January 2022. <https://thl.fi/fi/web/maahanmuutto-ja-kulttuurinen-moninaisuus/tyontueksi/hyvia-kaytantaaja/kulttuurisensiitivinen-tyoote>
- Finnish Immigration Service. 2021. Statistics. Accessed 17 January 2022. <https://tilastot.migri.fi/index.html#applications/23330?l=en>
- Finnish National Board on Research Integrity (TENK). 2019. The ethical principles of research with human participants and ethical review in the human sciences in Finland - Finnish National Board on Research Integrity TENK guidelines 2019. Accessed 22 January 2022. [https://www.tenk.fi/sites/tenk.fi/files/Ihmistieteiden\\_eettisen\\_ennakkoarvioinnin\\_ohje\\_2019.pdf](https://www.tenk.fi/sites/tenk.fi/files/Ihmistieteiden_eettisen_ennakkoarvioinnin_ohje_2019.pdf)
- Foronda, C. 2008. A Concept Analysis of Cultural Sensitivity. Article in *Journal of Transcultural Nursing*, 19 (3), 207-212. Accessed 5 February 2022. <https://pubmed.ncbi.nlm.nih.gov/18411414/>

Fusch, P. I. & Ness, L. R. 2015. Are We There Yet? Data Saturation in Qualitative Research. Article in *The Qualitative Report*, 20 (9), 1408-1416. Accessed 28 April 2022. <https://nsuworks.nova.edu/tqr/vol20/iss9/3/>

Grove, S. K. & Gray, J. R. 2019. *Understanding Nursing Research - Building an Evidence-Based Practice*. 7<sup>th</sup> edition. China: Elsevier, Inc.

Hassan Mohamed, A. & Latvala, J. 2020. Female genital mutilation (FGM) Awareness and perceptions of Somali men in the Helsinki region, Finland. *Finnish League for Human Rights*. Accessed 15 January 2022. <https://ihmisoikeusliitto.fi/wp-content/uploads/2020/09/FGM-Awareness-and-perceptions-of-Somali-men-in-the-Helsinki-region.pdf>

Iavazzo, C., Sardi, T.A. & Gkegkes, I.D. 2013. Female genital mutilation and infections: a systematic review of the clinical evidence. Article in *Archives of Gynecology and Obstetrics*, 287 (6), 1137-1149. Accessed 12 January 2022. <https://link.springer.com/article/10.1007%2Fs00404-012-2708-5>

Johnsdotter, S. & Essén, B. 2016. Cultural change after migration: Circumcision of girls in Western migrant communities. Article in *Best practice & research Clinical obstetrics & gynaecology*, 32, 15-25. Accessed 20 January 2022. <https://pubmed.ncbi.nlm.nih.gov/26644059/>

Kawous, R., Allwood, E., Norbart, E. & van den Muijsenbergh, M.E.T.C. 2020. Female genital mutilation and women's healthcare experiences with general practitioners in the Netherlands: A qualitative study. Article in *PLOS ONE*, 15 (7). Accessed 5 January 2022. <https://doi.org/10.1371/journal.pone.0235867>

Koponen & Mölsä. 2012. Naisten ympärileikkaus. In: Castaneda, A., Rask, S., Koponen, P., Mölsä, M. & Koskinen, S. (eds.) *Maahanmuuttajien terveys ja hyvinvointi - Tutkimus venäläis-, somalialais- ja kurditaustaisista Suomessa*. Accessed 12 January 2022. <https://www.julkari.fi/handle/10024/90907>

Koukkula, M., Keskimäki, I., Koponen, P., Mölsä, M. & Klemetti, R. 2016. Female Genital Mutilation/Cutting among Women of Somali and Kurdish Origin in Finland. Article in *Birth*, 43 (3), 240-246. Accessed 12 January 2022. <https://onlinelibrary.wiley.com/doi/abs/10.1111/birt.12236>

Koukkula, M. & Klemetti, R. 2021. Action plan for the prevention of female genital mutilation (FGM). Ministry of Social Affairs and Health. Accessed 2 January 2022. <https://julkaisut.valtioneuvosto.fi/handle/10024/162904>

Koukkula, M. & Klemetti, R. 2020. Naisten sukuelinten silpominen ja miesten ympärileikkaus. In: Kuusio, H., Seppänen, A., Jokela, S., Somersalo, L. & Lilja, E. (eds.) *Ulkomaalaistaustaisten terveys ja hyvinvointi Suomessa - FinMonik-tutkimus 2018-2019*. Accessed 12 January 2022. <https://www.julkari.fi/handle/10024/139210>

Koukkula, M. & Klemetti, R. 2019. Sukuelinten silpominen ja ympärileikkaukset. In: Skogberg, N., Mustonen, K.-L., Koponen, P., Tiittala, P., Lilja, E., Ahmed Haji Omar, A., Snellman, O. & Castaneda, A. (eds.) *Turvapaikanhakijoiden terveys ja hyvinvointi - Tutkimus Suomeen vuonna 2018 tulleista turvapaikanhakijoista*. Accessed 12 January 2022. [https://www.julkari.fi/bitstream/handle/10024/138298/URN\\_ISBN\\_978-952-343-351-9.pdf?sequence=1&isAllowed=y](https://www.julkari.fi/bitstream/handle/10024/138298/URN_ISBN_978-952-343-351-9.pdf?sequence=1&isAllowed=y)

Kuusio, H., Vehko, T. & Aalto, A. 2020. Pääsy terveystalouteen, niiden laatu ja sujuvuus. In: Kuusio, H., Seppänen, A., Jokela, S., Somersalo, L. & Lilja, E. (eds.) *Ulkomaalaistaustaisten terveys ja hyvinvointi Suomessa - FinMonik-tutkimus 2018-2019*. Accessed 28 April 2022. <https://www.julkari.fi/handle/10024/139210>

Kuusio, H., Lumme, S. & Koponen, P. 2020. Terveyspalvelujen käyttö, koettu tarve ja riittävyys. In: Kuusio, H., Seppänen, A., Jokela, S., Somersalo, L. & Lilja, E. (eds.) *Ulkomaalaistaustaisten terveys ja hyvinvointi Suomessa - FinMonik-tutkimus 2018-2019*. Accessed 28 April 2022. <https://www.julkari.fi/handle/10024/139210>

Laurea University of Applied Sciences (Laurea UAS). 2020. Guidelines by Laurea University of Applied Sciences for the prevention of fraudulent activity and processing of alleged fraud. Accessed 22 January 2022. <https://www.laurea.fi/globalassets/laurea/documents/prevention-of-fraudulent-activity-and-processing-of-alleged-fraud.pdf>

Lincoln, Y. S. & Guba, E. G. 1985. *Naturalistic Inquiry*. United States of America: SAGE Publications.

Metusela, C., Ussher, J., Perz, J., Hawkey, A., Morrow, M., Narchal, R., Estoesta, J. & Monteiro, M. 2017. "In My Culture, We Don't Know Anything About That": Sexual and Reproductive Health of Migrant and Refugee Women. Article in *International Journal of Behavioral Medicine*, 24, 836-845. Accessed 25 December 2021. <https://link.springer.com/article/10.1007/s12529-017-9662-3>

Molina-Gallego, B., Mordillo-Mateos, L., Melgar de Corral, G., Gómez-Cantarino, S., Polonio-López, B. & Ugarte-Gurrutxaga, M.I. 2021. Female Genital Mutilation: Knowledge and Skills of Health Professionals. Article in *Healthcare*, 9 (8), 974. Accessed 2 January 2022. <https://doi.org/10.3390/healthcare9080974>

Mulongo, P., McAndrew, S. & Hollins Martin, C. 2014. Crossing borders: Discussing the evidence relating to the mental health needs of women exposed to female genital mutilation. Article in *International Journal of Mental Health Nursing*, 23 (4), 296-305. Accessed 15 January 2022. <https://onlinelibrary.wiley.com/doi/full/10.1111/inm.12060>

O'Neill, S., Dubourg, D., Florquin, S., Bos, M., Zewelde, S. & Richard, F. 2017. "Men have a role to play but they don't play it": A mixed methods study exploring men's involvement in Female Genital Mutilation in Belgium, the Netherlands and the United Kingdom, Men Speak Out against FGM. Accessed 12 February 2022. [https://www.researchgate.net/publication/321214035\\_Men\\_have\\_a\\_role\\_to\\_play\\_but\\_they\\_don't\\_play\\_it\\_A\\_mixed\\_methods\\_study\\_exploring\\_men's\\_involvement\\_in\\_Female\\_Genital\\_Mutilation\\_in\\_Belgium\\_the\\_Netherlands\\_and\\_the\\_United\\_Kingdom\\_Men\\_Speak\\_Out](https://www.researchgate.net/publication/321214035_Men_have_a_role_to_play_but_they_don't_play_it_A_mixed_methods_study_exploring_men's_involvement_in_Female_Genital_Mutilation_in_Belgium_the_Netherlands_and_the_United_Kingdom_Men_Speak_Out)

Nowell, L., Norris, J. M., White, D. E. & Moules, N.J. 2017. Thematic Analysis: Striving to Meet the Trustworthiness Criteria. Article in *International Journal of Qualitative Methods*, 16 (1). Accessed 6 February 2022. <https://journals.sagepub.com/doi/full/10.1177/1609406917733847>

Ogunsiji, O. 2015. Female genital mutilation (FGM): Australian midwives' knowledge and attitudes. Article in *Health care for women international*, 36 (11), 1179-1193. Accessed 20 January 2022. <https://pubmed.ncbi.nlm.nih.gov/25558808/>

Punch, K. F. 2003. *Survey Research - The Basics*. Cornwall: SAGE Publications Ltd.

Rectors' Conference of Finnish Universities of Applied Sciences (Arene). 2019. Ethical recommendations for thesis writing at universities of applied sciences. Accessed 22 January 2022. [http://www.arene.fi/wp-content/uploads/Raportit/2020/ETHICAL%20RECOMMENDATIONS%20FOR%20THESIS%20WRITING%20AT%20UNIVERSITIES%20OF%20APPLIED%20SCIENCES\\_2020.pdf?t=1578480382](http://www.arene.fi/wp-content/uploads/Raportit/2020/ETHICAL%20RECOMMENDATIONS%20FOR%20THESIS%20WRITING%20AT%20UNIVERSITIES%20OF%20APPLIED%20SCIENCES_2020.pdf?t=1578480382)

Regulation (EU) 2016/679. EU General Data Protection Regulation (GDPR): Regulation 2016/679. Accessed 23 May 2022. <https://op.europa.eu/en/publication-detail/-/publication/3e485e15-11bd-11e6-ba9a-01aa75ed71a1>

- Reisel, D. & Creighton, S.M. 2015. Long term health consequences of Female Genital Mutilation (FGM). Article in *Maturitas*, 80 (1), 48-51. Accessed 12 January 2022. <https://www.sciencedirect.com/science/article/abs/pii/S0378512214003260>
- Rushwan, H. 2013. Female genital mutilation: A tragedy for women's reproductive health. Article in *African Journal of Urology*, 19 (3), 130-133. Accessed 20 January 2022. <https://www.sciencedirect.com/science/article/pii/S1110570413000520>
- Simpson, J., Robinson, K., Creighton, S. M. & Hodes, D. 2012. Female genital mutilation: the role of health professionals in prevention, assessment, and management. Article in *BMJ*, 344. Accessed 20 January 2022. <https://www.bmj.com/content/344/bmj.e1361.full>
- Statistics Finland. No date. Maahanmuuttajat ja kotoutuminen. Accessed 17 January 2022. <https://www.stat.fi/tup/maahanmuutto/index.html>
- Tuomi, J. & Sarajärvi, A. 2018. Laadullinen tutkimus ja sisällönanalyysi. Helsinki: Kustanneosakeyhtiö Tammi.
- Turkmani, S., Homer, C., Varol, N. & Dawson, A. 2018. A survey of Australian midwives' knowledge, experience, and training needs in relation to female genital mutilation. Article in *Women and birth: journal of the Australian College of Midwives*, 31(1), 25-30. Accessed 20 January 2022. <https://pubmed.ncbi.nlm.nih.gov/28687260/>
- United Nations (UN). No date. Sustainable Development Goals - Gender equality and women's empowerment. Accessed 1 January 2022. <https://www.un.org/sustainabledevelopment/gender-equality/>
- United Nations Children's Fund UNICEF. 2021. FGM. Accessed 1 January 2022. <https://www.unicef.org/protection/female-genital-mutilation>
- United Nations Population Fund UNFPA. 2022. Female genital mutilation. Accessed 15 May 2022. <https://www.unfpa.org/female-genital-mutilation#readmore-expand>
- United Nations Population Fund UNFPA. 2020. Female genital mutilation (FGM) frequently asked questions. Accessed 17 January 2022. [https://www.unfpa.org/resources/female-genital-mutilation-fgm-frequently-asked-questions#who\\_performs](https://www.unfpa.org/resources/female-genital-mutilation-fgm-frequently-asked-questions#who_performs)
- United Nations Population Fund UNFPA. 2018 Brief on the medicalization of female genital mutilation. Accessed 15 January 2022. <https://www.unfpa.org/resources/brief-medicalization-female-genital-mutilation>
- Vissandjée, B., Denetto, S., Migliardi, P. & Proctor, J. 2014. Female genital cutting (FGC) and the ethics of care: community engagement and cultural sensitivity at the interface of migration experiences. Article in *BMC International Health and Human Rights*, 14 (13). Accessed 6 January 2022. <https://bmcinthealthhumrights.biomedcentral.com/track/pdf/10.1186/1472-698X-14-13.pdf>
- Waigwa, S., Doos, L., Bradbury-Jones, C. & Taylor, J. 2018. Effectiveness of health education as an intervention designed to prevent female genital mutilation/cutting (FGM/C): a systematic review. Article in *Reproductive Health* 15 (62). Accessed 8 February 2022. <https://doi.org/10.1186/s12978-018-0503-x>
- World Health Organization (WHO). 2018. Care of girls and women living with female genital mutilation - A clinical handbook. Accessed 9 January 2022. <https://www.who.int/reproductivehealth/publications/health-care-girls-women-living-with-FGM/en/>



World Health Organization (WHO). 2020. FGM - Key facts. Accessed 1 January 2022.  
<https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation>

World Health Organization (WHO). 2021. Female genital mutilation. Accessed 1 January 2022.  
[https://www.who.int/health-topics/female-genital-mutilation#tab=tab\\_1](https://www.who.int/health-topics/female-genital-mutilation#tab=tab_1)

World Health Organization (WHO). 2022. Sexual and Reproductive Health and Research (SRH). Accessed 13 January 2022. <https://www.who.int/teams/sexual-and-reproductive-health-and-research/key-areas-of-work/sexual-health/defining-sexual-health>

World Health Organization (WHO). No date. Empowering health care providers to prevent female genital mutilation. Accessed 1 January 2022.  
<https://www.who.int/activities/empowering-health-care-providers-to-prevent-female-genital-mutilation>

Unpublished

Head nurse. 2022. Head nurse in health centre. Email to the author. 9 February 2022. Personal communication.

## Figures

Figure 1: FGM classification (adapted from WHO 2018, 27-33) .....	9
Figure 2: Definition of cultural sensitivity (adapted from Foronda 2008) .....	27
Figure 3: Content analysis phases (adapted from Elo & Kyngäs 2008) .....	34
Figure 4: Synthesis of the results.....	36
Figure 5: Barriers for bringing up FGM.....	39
Figure 6: Facilitators for bringing up FGM .....	43

## Tables

Table 1: FGM prevalence in the 30 countries with highest FGM levels (End FGM European Network, Equality Now & US End FGM/C Network 2020, 21; WHO 2021; Finnish institute for health and welfare THL 2021a) .....	10
Table 2: Example of the content analysis process of this study .....	35

## Appendices

Appendix 1: Global FGM prevalence in smaller communities, and regions.....	68
Appendix 2: Questionnaire in English and Finnish .....	69
Appendix 3: Information letter for participants (English and Finnish) .....	70
Appendix 4: Consent form for participants (English and Finnish).....	74
Appendix 5: Thesis timetable .....	76

## Appendix 1: Global FGM prevalence in smaller communities, and regions

Country	Details	Country	Details
<b>Pakistan</b>	Bohra community (Type 1)	<b>Kuwait</b>	Research shows 38% prevalence
<b>India</b>	Bohra community 1 million people (Type 1) prevalence 75%, Sunni Muslim sect in Kerala	<b>Bahrain</b>	Anecdotal evidence
<b>Sri Lanka</b>	Moor, Malay and Bohra communities (Type 1 or 4)	<b>Qatar</b>	Anecdotal evidence
<b>Maldives</b>	Prevalence of 13% aged 15-49, but 1% aged 0-14 (Type 4)	<b>United Arab Emirates</b>	Survey results showing 34% prevalence of women subjected to FGM
<b>Singapore</b>	Malay Muslim community (Type 1 or 4)	<b>Oman</b>	Regional prevalence up to 78-95% (Type 1 and 2)
<b>Thailand</b>	Muslim communities	<b>Jordan</b>	Anecdotal evidence
<b>Brunei Darussalam</b>	Malay community	<b>Saudi Arabia</b>	Both indigenous and diaspora communities (Type 1,2,3)
<b>Philippines</b>	Muslim community in Mindanao region	<b>Colombia</b>	Type 1 of FGM is practiced by at least two different indigenous communities
<b>Malaysia</b>	Malaysian government estimates 83-85% of the Muslim baby girls have undergone medicalized FGM (Type 1 or 4)	<b>Ecuador</b>	No prevalence data available
<b>Russia</b>	Avar community in East Dagestan as well as the Andi people (Type 1 and Type 2)	<b>Panama</b>	No prevalence data available
<b>Georgia</b>	Avar community (Type 1)	<b>Peru</b>	No prevalence data available

(End FGM European Network, Equality Now & US End FGM/C Network 2020, 48-52; UNFPA 2020.)

## Appendix 2: Questionnaire in English and Finnish

Please avoid any personal data and descriptions that would jeopardize the anonymity of your patients in the answers, thank you!

Yritä välttää henkilötietoja sekä kuvailuja vastauksissasi, jotka voisivat vaarantaa potilaasi anonymiteetin, kiitos!

1. Female genital mutilation (FGM) and related health issues are often considered as a taboo in many communities. Please describe what kind situations or means make bringing up the topic easier with women who have undergone FGM. You may give examples of situations.

Tyttöjen ja naisten sukuelinten silpominen ja siihen liittyvät terveyshaitat koetaan monessa yhteisössä tabuiksi. Kuvaile minkälaiset tilanteet tai keinot tekevät aiheen puheeksi ottamisen helpommaksi silpomisen läpikäyneiden naisten kanssa? Voit antaa esimerkkejä tilanteista.

2. Please describe situations or things that make bringing up FGM with women challenging. You may give examples.

Kuvaile tilanteita tai asioita, jotka tekevät silpomisen puheeksi ottamisen naisten kanssa haastavaksi? Voit antaa esimerkkejä.

3. Culturally sensitive approach is seen to be key in bringing up sensitive issues, such as FGM, with patients. However it has been shown to have both positive and negative impacts on the challenges of bringing up FGM. How would you describe cultural sensitivity and how is it present in your work?

Kulttuurisensitiivinen työote on nähty ratkaisevaksi tekijäksi sensitiivisten asioiden, kuten silpomisen, puheeksi ottamisessa. Sillä on kuitenkin nähty olevan positiivisia ja negatiivisia vaikutuksia silpomisen puheeksi ottamisen haasteisiin. Miten kuvailisit kulttuurisensitiivisyyttä ja miten se näkyy sinun työssäsi?

4. Language barriers may sometimes create challenges for bringing up FGM with patients, which is why interpreters and cultural mediators are recommended. What kind of situations have you encountered with bringing up sensitive issues, such as FGM, and language barriers, interpreters or cultural mediators?

Kielimuuri saattaa joskus aiheuttaa haasteita silpomisen puheeksi ottamiseen potilaiden kanssa, jonka vuoksi tulkkeja ja kulttuuritulkkeja suositellaan. Minkälaisia tilanteita olet kohdannut sensitiivisten asioiden, kuten silpomisen, puheeksi ottamisen ja kielimuurin, tulkkien tai kulttuuritulkkien kanssa?

5. Please describe how you see the role of nurses in primary health care in promoting the well-being of women who have undergone FGM and how could the topic be brought up more easily?

Kuvaile minkälaisena näet hoitajan roolin perusterveydenhuollossa silpomisen läpikäyneiden naisten hyvinvoinnin edistämiseksi ja miten aiheen puheeksi ottamista voisi helpottaa?

6. What type of information or guidance would you hope for in the future related to the topic? You may also comment or share your thoughts on the topic freely.

Minkälaista tietoa tai ohjeistusta toivoisit jatkossa aihepiiriin liittyen? Voit myös yleisesti kommentoida tai jakaa ajatuksiasi aihepiiristä.

### Appendix 3: Information letter for participants (English and Finnish)

#### PARTICIPANT INFORMATION SHEET

##### Study title:

**Female genital mutilation (FGM) - addressing culturally sensitive issues in primary health care**

##### Invitation to participate in a research study

We would like to invite you to take part in our research study, where the purpose is to examine health care professional's perspectives and experiences on bringing up female genital mutilation (FGM) and its health consequences with patients.

We want to especially hear the perspectives of registered nurses and public health nurses in primary health care, because of the important role they play in the prevention and quality care of women with FGM. Therefore, we would like to hear Your views and experiences on encounters and conversations at your work related to FGM. All data will be collected anonymously, no personal data will be acquired.

This information sheet describes the study and Your role in it. Before you decide, it is important that You understand why the research is being done and what it would involve for You. Please take time to read this information and discuss it with others if You wish. If there is anything that is not clear, or if You would like more information, please ask us. After that we will ask You to approve a consent form to participate in the study.

##### Voluntary nature of participation

The participation in this study is voluntary. You can withdraw from the study at any time without giving any reason and without there being any negative consequences. If You withdraw from the study or withdraw Your consent, any data collected from You before the withdrawal can be included as part of the research data, because it will be impossible to recognize Your texts from the anonymous data.

##### Purpose of the study

The goal of this study is to examine and understand the perspectives and experiences of health care professionals in primary health care concerning FGM. The primary objective is to identify the preventing and facilitating factors in bringing up and discussing a culturally sensitive topic, such as FGM, in their work. The secondary objective is to provide recommendations for health care providers based on the identified development needs in the research.

##### Who is organizing and funding the research?

The study is conducted by Johanna Järvinen, registered nurse and master's degree student at Laurea University of Applied Sciences (degree programme in Global Health and Crisis Management). The supervisor of the study is [REDACTED] at Laurea UAS. The contact person [REDACTED] head nurse.

There is no identified bias or affiliation between the researcher and the study setting. No outside funding for the research is required.

##### What will the participation involve?

The data collection of the study will be done through an anonymous online questionnaire, e-lomake by Eduix Ltd. The questionnaire includes six open-ended questions, which will require maximum of 30 minutes response time. No personal information will be collected during the process. The recruitment of the participants will be done through the contact person in [REDACTED]. The researcher will not know the identity of the participants, nor will the contact person have access to the collected data. The consent form does not require personal data and the questionnaire will be answered anonymously. To ensure anonymity the IP address of the computer used for answering the questionnaire will be instructed to be secured on the online form. There will be two weeks' time to answer the questionnaire.

The study will use a qualitative approach, which is why we have chosen open-ended questions in the questionnaire. This approach will also provide an opportunity to examine deeper the participants experiences, feelings, and views on the topic. Due to the COVID-19

pandemic as well as the sensitivity of the topic, an online questionnaire was chosen instead of interviews. The results will be published by June 2022.

**Data management**

The data collection itself will be anonymous, therefore there will be no personal data register. The anonymous data will be stored on the authors personal computer and S-database provided and secured by Laurea, according to the EU data protection protocols as well as password access only. The data will not be transferred outside of EU or EEA. The supervisor of the thesis will have access to the anonymous data through the author, to ensure reliability of the study. Possible hard copies of the data will be stored securely at the authors home, with only the authors' access to them and will be destroyed by shredding immediately after the thesis report has been accepted. The electronic, anonymous data will be destroyed two years after the thesis has been approved, to ensure possibility for potential research integrity assessments.

**Possible benefits of taking part**

The results of the study will be published, and recommendations for health care providers will be given for future development needs concerning the topic. The results will be presented for the personnel in [REDACTED], when. It is possible that participating in this study will not directly benefit You. However, increasing the awareness of female genital mutilation and its health consequences in general is beneficial. The author aims to publish an article on the topic in cooperation with the supervisor after the thesis process is finished.

**Possible disadvantages and risks of taking part**

Participating in this study may cause some strong emotions due to the sensitive topic. If you have any questions or wish to share your thoughts, you are welcome to contact the researcher. Anonymity is a priority; hence no personal data will be collected. Answering the questionnaire will take around 30 minutes time.

**Financial information**

Participation in this study will involve no cost to You. You will receive no payment for Your participation.

**Informing about the research results**

The results and the thesis will be published by June 2022. The thesis will be found in the open access Theseus archive ([www.theseus.fi](http://www.theseus.fi)). Additionally, there will be a media release, and hopefully an opportunity to present the results in [REDACTED]

**Termination of the study**

The researcher conducting the study will make the best efforts to complete and conclude the results in a responsible way.

**Further information**

Further information related to the study can be requested directly from the researcher or supervisor of the study.

**Contact details of the researchers**

Researcher / Student

Name: Johanna Järvinen

Tel. number: [REDACTED]

Email: [REDACTED]

Supervisor

Name: [REDACTED]

Name of the organization: Laurea University of Applied Sciences, Tikkurila campus

Tel. number: [REDACTED]

Email: [REDACTED]

## TIEDOTE TUTKIMUKSESTA

### Tutkimuksen nimi:

**Female genital mutilation (FGM) - addressing culturally sensitive issues in primary health care (Tyttöjen ja naisten sukuelinten silpomisen puheeksi ottaminen perusterveydenhuollossa)**

### Pyyntö osallistua tutkimukseen

Teitä pyydetään mukaan tutkimukseen, jossa tavoitteena on tarkastella terveydenhuollon ammattilaisten näkemyksiä ja kokemuksia tyttöjen ja naisten sukuelinten silpomisen sekä siihen liittyvien terveyshaittojen puheeksi ottamisesta.

Arvioimme, että sovellutte tutkimukseen, koska haluamme erityisesti kuulla ja tarkastella perusterveydenhuollon sairaanhoitajien ja terveydenhoitajien näkemyksiä asiasta, heidän keskeisen roolinsa vuoksi silpomista ehkäisevässä työssä sekä laadukkaan hoidon, tuen ja ohjauksen tarjoajina. Siitä syystä haluaisimme kuulla teidän kokemuksistanne ja näkemyksistänne keskusteluista ja kohtaamisista työssänne silpomisen aihepiiriin liittyen. Tiedonkeruu tapahtuu anonymisti verkkokyselyn avulla, eikä henkilötietoja kerätä.

Tämä tiedote kuvaa tutkimusta ja teidän osuuttanne siinä. Perehdyttyänne tähän tiedotteeseen teillä on mahdollisuus esittää kysymyksiä tutkimuksesta, jonka jälkeen teiltä pyydetään suostumus tutkimukseen osallistumisesta.

### Vapaaehtoisuus

Tutkimukseen osallistuminen on täysin vapaaehtoista. Voitte myös keskeyttää tutkimuksen koska tahansa syytä ilmoittamatta. Mikäli keskeytätte tutkimuksen tai peruutatte suostumuksen, teiltä keskeyttämiseen ja suostumuksen peruuttamiseen mennessä kerättyjä tietoja voidaan käyttää osana tutkimusaineistoa, koska aineiston anonymiteetin johdosta on mahdotonta tunnistaa teidän vastauksianne tekstistä.

### Tutkimuksen tarkoitus

Tämän tutkimuksen tarkoituksena on tarkastella ja ymmärtää terveydenhuollon ammattilaisten näkemyksiä ja kokemuksia tyttöjen ja naisten sukuelinten silpomiseen liittyen perusterveydenhuollossa. Tavoitteena on tunnistaa kulttuurisesti sensitiivisten asian kuten silpomisen puheeksi ottamisen mahdollistajia ja estäjiä. Sekundaarinen tavoite on tuottaa suosituksia kehittämistarpeista terveydenhuollon tuottajille tutkimuksen tulosten perusteella.

### Tutkimuksen toteuttajat

Tutkimuksen toteuttaa Johanna Järvinen, sairaanhoitaja ja YAMK-opiskelija Laurea-ammattikorkeakoulusta (Master's degree programme in Global Health and Crisis Management). Opinnäytetyön ohjaaja on [REDACTED], Laurea-ammattikorkeakoulu. Yhteyshenkilö [REDACTED]

Tutkijalla ei ole tutkimukseen liittyviä sidonnaisuuksia. Tutkijan ja tutkimuksen yhteistyökumppanin välillä ei ole havaittu kytköksiä eikä tutkimuksen toteuttaminen vaadi ulkopuolista rahoitusta.

### Tutkimusmenetelmät ja toimenpiteet

Tutkimuksen tiedonkeruu toteutetaan anonymilla verkkokyselyllä (e-lomake, Eduix Oy). Kyselyssä on kuusi avointa kysymystä, joiden vastaamiseen kuluu noin puoli tuntia. Osallistujien henkilötietoja ei kerätä missään vaiheessa tutkimusprosessia. Tutkimukseen osallistujat rekrytoidaan [REDACTED] yhteyshenkilön kautta. Tutkija ei tule saamaan tietoonsa osallistujien henkilöllisyyttä, ja vastaavasti yhteyshenkilö ei tule saamaan tietoonsa osallistujien vastauksia. Suostumuslomake ei vaadi henkilötietoja ja kyselyyn vastataan anonymisti. Anonymiteetin suojaamiseksi vastaajia ohjeistetaan salaamaan käyttämänsä tietokoneen IP-osoitteen verkkokyselyssä. Vastaamisaikaa on kaksi viikkoa.

Tutkimuksessa käytetään laadullista metodia, jonka vuoksi olemme valinneet kyselyyn avoimet kysymykset. Tämä lähestymistapa antaa mahdollisuuden tarkastella osallistujien kokemuksia, tuntemuksia ja näkemyksiä aiheesta syvemmin. Verkkokysely valittiin tiedonkeruun työkaluksi haastattelujen sijaan, koronapandemian ja aiheen



sensitiivisyyden vuoksi. Tutkimuksen tulokset julkistetaan vuoden 2022 kesäkuun lopussa.

#### Aineistonhallinta

Tiedonkeruu itsessään on täysin anonyymi, joten henkilötietorekisteriä ei synny. Anonyymi aineisto säilytetään tutkijan henkilökohtaisella tietokoneella ja Laurea AMK:n tarjoamalla sekä EU:n tietosuojasetusten mukaisesti turvatulla S-asetuksen, salasanalla suojattuina. Tietoja ei siirry EU:n tai ETA:n ulkopuolelle. Tutkimuksen ohjaajalla on pääsy anonyymiin aineistoon tutkijan kautta, tutkimuksen luotettavuuden varmistamiseksi. Mahdolliset tulosteet säilytetään tietoturvasyistä tutkijan kotona lukitussa tilassa, johon pääsy on ainoastaan tutkijalla ja hävitetään silppurilla heti opinnäytetyön hyväksymisen jälkeen. Sähköinen anonyymi tutkimusaineisto hävitetään päällekirjoittamalla kaksi vuotta opinnäytetyön hyväksymisen jälkeen, tutkimuseettisten tarkastusten mahdollistamiseksi.

#### Tutkimuksen mahdolliset hyödyt

Tutkimuksen tulokset julkaistaan ja kehittämissuosituksia aiheeseen liittyen annetaan terveydenhuollon tuottajille tutkimuksen tulosten perusteella. Tulokset tullaan mahdollisesti myös esittelemään [REDACTED] henkilökunnalle. On mahdollista, ettei tutkimukseen osallistuminen tuota teille suoranaista hyötyä. On kuitenkin yleisesti hyödyllistä jakaa tietoisuutta silpomisen aihepiiristä. Tutkimuksen toteuttajan tavoitteena on julkaista myös artikkeli aiheesta opinnäytetyöprosessin valmistuttua yhteistyössä tutkimuksen ohjaajan kanssa.

#### Tutkimuksesta mahdollisesti seuraavat haitat ja epämukavuudet

Tutkimukseen osallistuminen saattaa aiheuttaa vahvoja tunteita aiheen sensitiivisyyden vuoksi. Jos sinulla herää kysymyksiä tai haluat jakaa ajatuksiasi, olet tervetullut ottamaan yhteyttä tutkijaan. Anonymiteetti on tutkimuksessa prioriteetti, jonka vuoksi henkilötietoja ei tulla keräämään. Kyselyyn vastaaminen tulee viemään noin puoli tuntia.

#### Kustannukset ja niiden korvaaminen

Tutkimukseen osallistuminen ei maksa teille mitään. Osallistumisesta ei myöskään makseta erillistä korvausta.

#### Tutkimustuloksista tiedottaminen

Tutkimuksen tulokset ja opinnäytetyö tullaan julkaisemaan avoimesti Theseus-tietokannassa kesäkuussa 2022 ([www.theseus.fi](http://www.theseus.fi)). Lisäksi tutkimuksesta julkaistaan mediatiedote ja toivon mukaan tilaisuus esittää tulokset [REDACTED] myös järjesty.

#### Tutkimuksen päättyminen

Tutkimuksen suorittaja tekee parhaansa viedäkseen tutkimuksen vastuullisesti loppuun.

#### Lisätiedot

Pyydämme teitä tarvittaessa esittämään tutkimukseen liittyviä kysymyksiä tutkijalle tai tutkimuksesta vastaavalle henkilölle.

#### Tutkijoiden yhteystiedot

Tutkija / opinnäytetyötekijä

Nimi: Johanna Järvinen

Puh. [REDACTED]

Sähköposti: [REDACTED]

Opinnäytetyön ohjaaja

Titteli: Yliopettaja

Nimi: [REDACTED]

Korkeakoulu: Laurea Ammattikorkeakoulu, Tikkurilan kampus

Puh. [REDACTED]

Sähköposti: [REDACTED]

## Appendix 4: Consent form for participants (English and Finnish)

### PARTICIPANT CONSENT FORM

**Title of the study:**

Female genital mutilation (FGM) - addressing culturally sensitive issues in primary health care

**Location of the study:** Online questionnaire

**Author:** Johanna Järvinen, [REDACTED] Master's Degree student in Global Health and Crisis Management, Laurea University of Applied Sciences

**Supervisor:** [REDACTED]

I have been invited to participate in the above online questionnaire, which has the aim to examine the topic of bringing up FGM and related health issues by health care professionals in primary health care.

I have read and understood the written participant information letter. The information letter has provided me sufficient information about above study, the purpose and execution of the study, about my rights as well as about the benefits and risks involved in it. I have had the opportunity to ask questions about the study and have had these answered satisfactorily.

Personal data is not collected during the study. I have been informed not to give any personal data in the questionnaire. It is also important to avoid describing patients so that their anonymity would not be jeopardized.

I voluntarily consent to participate in this study. I have not been pressurized or persuaded into participation.

I have had enough time to consider my participation in the study.

I understand that my participation is entirely voluntary and that I am free to withdraw my consent at any time, without giving any reason. I am aware that if I withdraw from the study or withdraw my consent, any data collected from me before my withdrawal can be included as part of the research data.

By approving this form, I confirm that I voluntarily consent to participate in this study.

### TUTKITTAVAN SUOSTUMUS

**Tutkimuksen nimi:**

Female genital mutilation (FGM) - addressing culturally sensitive issues in primary health care (Tyttöjen ja naisten sukuelinten silpomisen puheeksi ottaminen perusterveydenhuollossa)

**Tutkimuksen sijainti:** Verkkokysely

**Tutkimuksen toteuttaja:** Johanna Järvinen, [REDACTED] YAMK-opiskelija, Laurea-ammattikorkeakoulu (Master's Degree in Global Health and Crisis Management)

**Opinnäytetyön ohjaaja:** [REDACTED]

Minua on pyydetty osallistumaan yllä mainittuun e-lomakekyselyyn, jonka tarkoituksena on tarkastella tyttöjen ja naisten sukuelinten silpomisen ja sen aiheuttamien terveyshaittojen puheeksi ottoa perusterveydenhuollossa.

Olen saanut tiedotteen tutkimuksesta ja ymmärtänyt sen. Tiedotteesta olen saanut riittävän selvityksen tutkimuksesta, sen tarkoituksesta ja toteutuksesta, oikeuksistani sekä tutkimuksen mahdollisesti liittyvistä hyödyistä ja riskeistä. Minulla on ollut mahdollisuus esittää kysymyksiä ja olen saanut riittävän vastauksen kaikkiin tutkimusta koskeviin kysymyksiini.

Tutkimuksessa ei kerätä henkilö- eikä tunnistetietoja. Olen saanut ohjeistuksen välttää henkilötietojen kirjaamista kyselylomakkeeseen. Lisäksi vastauksissa on tärkeää välttää potilaiden kuvaamista niin, että heidän anonymiteettinsä ei vaarantuisi.

Osallistun tutkimukseen vapaaehtoisesti. Minua ei ole painostettu eikä houkuteltu osallistumaan tutkimukseen.

Minulla on ollut riittävästi aikaa harkita osallistumistani tutkimukseen.

Ymmärrän, että osallistumiseni on vapaaehtoista ja että voin peruuttaa tämän suostumukseni koska tahansa syytä ilmoittamatta. Olen tietoinen siitä, että mikäli keskeytän tutkimuksen tai peruutan suostumuksen, minusta keskeyttämiseen ja suostumuksen peruuttamiseen mennessä kerättyjä tietoja ja näytteitä voidaan käyttää osana tutkimusaineistoa.

**Hyväksymällä tämän suostumuksen vahvistan osallistumiseni tähän tutkimukseen.**

## Appendix 5: Thesis timetable

## THESIS TIMETABLE

DECEMBER 2021	<ul style="list-style-type: none"> <li>Defining the topic</li> </ul>
JANUARY 2022	<ul style="list-style-type: none"> <li>Thesis topic analysis presentation 11<sup>th</sup> January</li> <li>Agreement with work life partner</li> <li>Preparing the thesis plan, questionnaire, consent form and information letter</li> </ul>
FEBRUARY 2022	<ul style="list-style-type: none"> <li>Thesis plan presentation 23<sup>rd</sup> February</li> </ul>
MARCH 2022	<ul style="list-style-type: none"> <li>Piloting of the questionnaire</li> <li>Research permit application from City of Helsinki</li> </ul>
APRIL 2022	<ul style="list-style-type: none"> <li>Data collection</li> </ul>
MAY 2022	<ul style="list-style-type: none"> <li>Data analysis and synthesis</li> <li>Thesis presentation 30<sup>th</sup> May</li> </ul>
JUNE 2022	<ul style="list-style-type: none"> <li>Publication</li> </ul>