Female Genital Mutilation/Cutting among Women of Somali and Kurdish Origin in Finland

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ABSTRACT: Background: *The tradition of female genital mutilation/cutting (FGM/C) has spread in Europe as a result of immigration. Although it is known to have negative health impacts, the exact prevalence of FGM/C and its health effects in Finland are unknown. This study explores the prevalence of FGM/C, the sociodemographic characteristics associated with it, and its health effects among women of Somali and Kurdish origin in Finland.* **Methods:** *Data were obtained from the Migrant Health and Well Being Study carried out in 2010–2012. This study uses data from interviews with Somali (N = 165) and Kurdish origin (N = 224) women. The participation rate was 37 percent for Somali and 54 percent for Kurdish origin women.* **Results:** *The prevalence of FGM/C was 69 percent among those of Somali origin and 32 percent among those of Kurdish origin. Having no education and older age were significantly associated with FGM/C, as was marriage amongst women of Somali origin, and the practice of Islam among women of Kurdish origin. Reporting good self-perceived health was more common among women without FGM/C. Outpatient visits to medical doctors were less common among women of Somali origin with FGM/C, compared with women without FGM/C. About 26 percent of Somali origin and 39 percent of Kurdish origin women with FGM/C reported reproductive or other health problems because of FGM/C.* **Discussion:** *FGM/C is more common in Finland than previously assumed, particularly among women of Kurdish origin. Women with FGM/C need improved access to culturally competent health services to address the health impacts of FGM/C. Education and outreach to immigrant communities to prevent future FGM/C are also urgently needed. (BIRTH 43:3 September 2016)*

Key words: *female genital mutilation/cutting*

Female genital mutilation/cutting (FGM/C) includes all procedures that are performed for nonmedical reasons involving partial or total removal of the external female genitalia, or other injury to the female genital organs (1,2). An estimated 125 million girls and women live with FGM/C in the world today, and three million girls are at risk of being subjected to the practice every year (1,2). Most of the girls who have been subjected to the practice live in Africa, Asia, and the Middle East. As a result of immigration, the tradition has spread all over the world. It has been estimated that half a million girls and women in Europe have been subjected to FGM/C (3). The risk of FGM/C is still present after immigration to Europe. Although there is little current evidence that FGM/C is

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practiced within the area of the European Union, the daughters of immigrants form a large group who may be subjected to FGM/C while traveling outside the European Union. Estimating the prevalence of FGM/C in Europe is complex as no standardized methods and data have existed on this intimate phenomenon (4,5). It is assumed that 180,000 girls are at risk of FGM/C in Europe. Isman et al. estimated in their study that in Scandinavia there are 100,000 immigrants from countries where FGM/C is a tradition (6). Elgaali et al. showed in their quantitative study that 19 percent of the daughters of African immigrants in Scandinavia had been circumcised while living in Scandinavia (7). However, in Finland, like in many European countries, there are no precise estimates of the prevalence of FGM/C or the health impacts of FGM/C among immigrant women living in the country.

Studies on FGM/C, its health consequences and care requirements are scarce and are mostly concentrated on African countries (8). FGM/C has been internationally recognized as a violation of human rights (2,9). The ancient tradition also reflects inequality between the sexes and discrimination against women. The tradition violates children's rights and individuals' right to health, security, and physical sanctity.

FGM/C has several negative health impacts (2,8–10). Short-term impacts include severe pain, bleeding, and infections; while long-term impacts include painful menstruation and intercourse, cysts, and psychosocial problems. Childbirth complications such as prolonged labor, obstruction, perineal tears, and postpartum hemorrhage are common among women who have been subjected to FGM/C. The degree of cutting and the circumstances under which the procedure was performed also influence the severity of subsequent health impacts.

The number of migrants to Finland has been growing during the past decade. In 2012, over 220,000 citizens of foreign origin were living in Finland, with Russians, Estonians, Somalis, and Iraqis forming the biggest groups (11). FGM/C prevalence is known to be high among Somalis (12). However, there is little information on the tradition of FGM/C among Kurdish women, though it is known that in Iraqi Kurdistan, the prevalence of FGM/C is between 40 and 70 percent (13–15). In Finland, the Ministry of Social Affairs and Health has published a specific action plan on the prevention of FGM/C for the years 2012–2016 (16). Still, there is little information on the prevalence of FGM/C among migrants in Finland (3), and the experienced health effects have not been studied. The purpose of this study is to explore the prevalence of FGM/C and its perceived health effects. We also study whether FGM/C is associated with socio-demographic characteristics, self-perceived health, and outpatient visits to a medical doctor among women of Somali and Kurdish origin in Finland.

Methods

In Finland, the National Institute for Health and Welfare collected data on health, well being, use of services, and the living conditions of working-aged immigrants of Russian, Somali, and Kurdish origin in 2010–2012. The Migrant Health and Wellbeing Study consisted of a health examination and a health interview. The questionnaire was structured, and consisted of questions on migration history, living conditions, socioeconomic characteristics, health, health behaviors, and use of health services. The questionnaire was developed based on previous national health surveys among the general population, with some new modules added on specific migrant health issues (such as FGM/C). The feasibility and concept validity of the questionnaire was evaluated in focus groups with health care professionals and survey staff of Russian, Kurdish, and Somali origin, as well as in a pilot study. Among other reproductive health issues, FGM/C status was asked in personal interviews with women of Somali and Kurdish origin. The study has been described in more detail elsewhere (17).

Data were collected in six municipalities with the highest proportions of migrants, three in the metropolitan area (Helsinki, Espoo, Vantaa) and three in other parts of the country (Turku, Tampere, Vaasa). These areas covered 93 percent of Somali and 67 percent of Kurdish origin migrants who met the inclusion criteria in Finland in 2008. A sample of 1,000 persons from each ethnic group was randomly selected from the National Population Registry. Included women were 18–64 years of age, lived in Finland for at least 1 year, and were born in Somalia, Iraq, or Iran. A person with Somalia as the country of birth was defined as being of Somali origin. A person with Iraq or Iran as a country of birth and Kurdish Soran as the mother tongue was defined as being of Kurdish origin. The sampling method used was that of stratified random sampling by the municipality and ethnic group. The size of the migrant population defined the sample size in each of the six geographic areas.

An invitation letter was first mailed and was followed up with a telephone contact. If the person was not reached by telephone, home visits were made. This study uses data from the interviews, which were done either as a separate interview by an interviewer or as a part of health examination made by a nurse. The participation rate varied between the groups: 54 percent for Kurdish and 37 percent for Somali women. Bilingual interviewers and nurses implemented the interviews to ensure data quality. The mother tongue of the interviewers had to be Somali or Kurdish Soran. The interviewers had 2 weeks training before the study. The interviews took place at the home of participants, at the location of

the health examination (municipal health centre or temporary clinic), or some other place chosen by the participant (e.g., work place or library, if a private room was available). Since the theme is gender-sensitive the questions concerning FGM/C were instructed to be asked only by a female interviewer or nurse; for this reason, these sensitive questions were not asked of all women taking part in the interviews. If a male interviewer carried out the interview, this set of questions was asked by the nurse during the health examination. Responses were given to these questions by 85 percent of Somali and 97 percent of Kurdish female participants.

The Coordinating Ethical Committee of the Hospital District of Helsinki and Uusimaa gave ethical approval for the study (19.1.2010 325/13/00/2009). The participants gave their written informed consent for the health interview.

Interview questions included the participants' age, marital status (married, civil union, cohabitation, divorced, widower, unmarried), education (no education, primary, secondary or higher), and religion (none, Orthodox, Lutheran, Muslim, Jewish, other). Self-perceived health was also assessed (good, rather good, moderate, rather poor, and poor).

Reproductive health was measured by a series of questions as to whether they had had FGM/C (yes, no), problems during pregnancy or delivery as a result of FGM/C (yes, no), reluctance to give birth because of difficult delivery (yes, no), infections because of FGM/C (yes, no); pain as a result of FGM/C (yes, no); difficulties in marital life as a result of FGM/C (yes, no); other health problems (not specified) related to FGM/C (yes, no). Participants were also asked whether they had ever had a miscarriage (yes, no), whether they had visited a doctor within the last 12 months, and about their degree of satisfaction with their own health (very satisfied, satisfied, neutral, unsatisfied, and very unsatisfied).

Data analyses were conducted using Stata version 13.1 (STATA Corporation, College Station, TX, USA). Inverse probability weights were used to correct for the effects of nonresponse and different sampling probabilities to provide representative results for each migrant population (18). The different sampling probabilities and nonresponse were handled using inverse probability weights based on age group, sex, migrant group, study location, and marital status. Descriptive statistics and frequency distributions were used to describe the data, while cross-tabulations were used to explore the associations between the socio-demographic factors, self-perceived health, health care use, and FGM/C. The statistical significance of the differences was tested using Pearson's chi-square ($\times 2$), Fisher's test, or the Adjusted Wald test; statistical significance was set at $p < 0.05$.

Binary logistic regression analyses were used to describe the associations as odds ratios (OR) with 95% confidence interval (CI). The dependent variable in the logistic regression model was FGM/C (Yes = 1, No = 0). To control for possible confounding effects, the statistically significant explanatory variables from the univariate analysis were entered into a multivariate logistic regression analysis and the models were adjusted for age, marital status, education, and religion.

Results

The total number of women who answered the question about FGM/C was 165 of Somali origin and 224 of Kurdish origin (Table 1). The mean age among women of Somali origin was 34.3 years (range 18–63) and among women of Kurdish origin 35.8 (range 18–62). In the Somali origin group, all but one woman were Muslims and in the Kurdish origin group, 75 percent of women were Muslims. Of the women, 66 percent of Somali origin and 69 percent of Kurdish origin were married or in a civil union or in a registered partnership. About 33 percent of Somali and 18 percent of Kurdish origin women had no school education.

Most women of Somali origin defined their self-perceived health as good or rather good (82%), whereas women of Kurdish origin gave this rating less often (63%; Table 1). Women of Kurdish origin made outpatient visits to see a medical doctor somewhat more often than women of Somali origin. Almost all women of Somali origin were satisfied with their health, while 62 percent of women of Kurdish origin were satisfied with their health. After adjusting for age, the prevalence of FGM/C was 69 percent among women of Somali origin and 32 percent among women of Kurdish origin. Problems during pregnancy or delivery because of FGM/C were reported by 18 percent of the women with FGM/C in both groups. Other health problems because of FGM/C were reported by 9 percent of the Somali origin women and by 20 percent of the Kurdish origin women with FGM/C, including reluctance to give birth again because of difficult delivery, infections, pain, and difficulties in marital life.

Marriage or civil union was significantly more common among women of Somali origin with FGM/C than those without FGM/C (Table 2). Older women (of both Somali and Kurdish origin) more often had experienced FGM/C than younger women. Women of Somali origin with FGM/C significantly more often had no school education compared with those without FGM/C. Women of Kurdish origin with FGM/C were more often Muslims than women without FGM/C. Having no school education was significantly more common

Table 1. Socio-Demographic Characteristics, Self-Perceived Health, Outpatient Visits to Doctor, and Satisfaction with Health of Women of Somali and Kurdish Origin, Finland, 2010–2012

	Women of Somali origin N = *165*	*Women of Kurdish origin* N = *224*
Age	*N* (%)	*N* (%)
18–29	64 (40.5)	65 (29.9)
30–44	60 (37.7)	108 (48.1)
45–64	41 (21.8)	51 (22.0)
Religion		
Muslim	164 (99.4)	168 (74.5)
Other/none	1 (0.6)	56 (25.6)
Marital status		
Married/civil union	110 (66.0)	161 (68.5)
Unmarried/ divorced/widow	53 (34.0)	63 (31.5)
Education		
No formal education	63 (32.6)	42 (17.7)
Primary	76 (49.7)	87 (39.0)
Secondary/higher	24 (17.7)	94 (43.3)
Miscarriages (ever had at least one)	52 (30.1)	58 (24.9)
Self-perceived health		
Good or rather good	135 (82.3)	137 (62.7)
Poor or moderate	29 (17.7)	87 (37.3)
Outpatient visit to doctor in past 12 months	97 (59.5)	168 (74.7)
Satisfaction with own health		
Satisfied	151 (93.1)	137 (62.1)
Unsatisfied	10 (6.9)	87 (37.9)

Numbers may not add exactly to totals due to missing data.

among women of Kurdish origin with FGM/C than those without FGM/C.

Good self-perceived health was reported more often by women of Somali origin without FGM/C than with FGM/C (Table 2). Outpatient visits to a medical doctor were significantly more common among women of Somali origin without FGM/C than with FGM/C. The FGM/C status made no difference in satisfaction with health among women of Somali origin. Women of Kurdish origin with FGM/C were more often very satisfied or satisfied with their health than Kurdish women without FGM/C.

Logistic regression was used to model the likelihood of having FGM/C after controlling for age, marital status, education, and religion (Table 3). Separate models were run for women of Somali and Kurdish origin. Older age, being married or in a civil union, and having no school education were significantly associated with FGM/C for women of Somali origin (Table 3). Education was strongly associated with FGM/C among women of Kurdish origin; after adjustment for other variables, the odds ratio for FGM/C was 11.04(5.57–21.89) for women with no education, compared with women with a secondary or higher education. The odds ratio was 3.68(2.05–6.61) for women with primary education, when compared with higher educated women.

We also used logistic regression to examine whether FGM/C was associated with women's perceived health, and use of health services, after adjustment for age, marital status, and education (Table 4). Women of Somali origin with FGM/C made outpatient visits to a medical doctor less often compared with women without FGM/C. Compared with women of Somali origin with FGM/C, those without FGM/C were much more likely to report their health to be good. The FGM/C-status of women of Kurdish origin was not statistically significantly associated with health care use. The adjusted odds ratio for Kurdish women with FGM/C satisfied with their health was 1.81(1.03–3.18), when compared with Kurdish women without FGM/C.

Discussion

This study showed that the prevalence of FGM/C among ethnic minority women living in Finland is higher than has previously been assumed, particularly among women of Kurdish origin. Older age and having no education were strongly associated with FGM/C in both women of Somali and Kurdish origin. Also, among women of Somali origin, being married was strongly associated with FGM/C. Although FGM/C is not prescribed by any religion (2), being Muslim was associated with FGM/C among women of Kurdish origin. Muslim faith is more prevalent among the population groups that have a tradition of FGM/C; however, the tradition is not directly linked to the religion. The association of religion could not be studied among women of Somali origin, since nearly all the participants were Muslims. Among women of Somali origin, reporting good self-perceived health was more common among women without FGM/C than for those with. Outpatient visits to a medical doctor were also more common among women without FGM/C. The results show that one-fifth of women with FGM/C had experienced problems during pregnancy or labor, such as pain, which they considered was because of FGM/C.

In our study, having no school education was strongly associated with FGM/C, which is in line with previous studies (19,20). Refaat et al. showed that urban and educated women's daughters are less likely to undergo FGM/C (19). Saleem et al. found that children of uneducated mothers were eight times more

Table 2. Background Characteristics, Self-Perceived Health, Outpatient Visits to Doctor, and Satisfaction with Health of Women of Somali and Kurdish Origin with and without FGM/C, Finland, 2010–2012

	Women of Somali origin		*Women of Kurdish origin*	
	N = *165*		N = *224*	
	FGM/C % (n = *115*)	*No FGM/C %* (n = *50*)	*FGM/C %* (n = *71*)	*No FGM/C %* (n = *153*)
Age				
18–29	30.3	61.7*	22.1	33.7
30–44	42.5	27.7*	57.6	43.4
45–64	27.2	10.6*	20.2	22.9
Muslim	99.1	100	83.8	69.6*
Married/in civil union	74.4	50.1	74.5	65.7
No education	35.1	27.6*	33.9	9.3*
Miscarriages	31.4	26.7	23.1	25.9
Good self-perceived health	49.4	68.9*	39.5	41.3
Poor self-perceived health	3.6	12.7	11.4	9.5
Outpatient visit to doctor in past 12 months	53.3	72.0*	71.7	76.1
Very satisfied/satisfied with health	94.2	90.3	69.5	58.2*

**Statistically significant difference at* p < *0.05 level. FGM/C = female genital mutilation/cutting.*

Table 3. Adjusted Odds Ratios for FGM/C among Women of Somali and Kurdish Origin, Finland, 2010–2012

	Women of Somali origin OR (95% CI)	*Women of Kurdish origin OR (95% CI)*
Age		
18–29	1.00	1.00
30–44	**3.13 (1.51–6.48)**	**2.02 (1.16–3.51)**
45–64	**5.21 (2.09–13.0)**	1.35 (0.68–2.68)
Marital status		
Unmarried/ divorced/ widowed	1.00	1.00
Married/ civil union	**3.38 (1.73–6.59)**	1.31 (0.98–2.94)
Education		
Secondary/ higher	1.00	1.00
Primary	**2.91 (1.22–6.94)**	**3.68 (2.05–6.61)**
No education	**3.73 (1.49–9.36)**	**11.04 (5.57–21.89)**
Religion		
Other	NA*	1.00
Muslim	NA*	**2.02 (1.12–3.63)**

**Too few observations for statistical analysis. 95% CI = 95% confidence interval. Bolded odds ratios represent significant associations. FGM/C = female genital mutilation/cutting.*

likely to have FGM/C compared with children of mothers with over nine years of education (20). Both the education of the girl's father and the employment status of the girl's mother have been shown to be significant factors associated with FGM/C (21). FGM/C is usually performed in childhood, and may bear little relationship with current socio-demographic status. Still, the results indicate that women with low educational status need more information on FGM/C, as their daughters may be at higher risk of FGM/C. Previous research has found that mothers play an important role in decision-making about FGM/C (22). However, in Europe and even in Finland, attitudes toward FGM/C may have been changed among those who have lived longer in the new country (23). A systematic review of FGM/C studies in Europe by Exterkate (24) showed that daughters of an immigrant family (second generation) have somewhat little risk of undergoing FGM/C.

In some traditional societies, FGM/C is a requirement for getting married so it is not surprising that FGM/C is more common among older married than among unmarried women (1,20). Consistent with other studies (2,15), FGM/C was more common in older age groups, which shows the decline in the practice among younger generations. Preventive work both in Finland and in the countries of origin are also likely to have had some effect.

Use of outpatient medical care was more common among women without FGM/C in this study. Similar results were seen in the study of Norman et al. as women with FGM/C reported many barriers to health service use (25). In a United Kingdom study, women with FGM/C lacked knowledge about FGM/C, while poor communication skills among health care providers led to poor management of childbirth and women

Table 4. Odds Ratios for Health Outcomes among Women of Somali and Kurdish Origin with and without FGM/C, Finland, 2010–2012

Health outcomes	*Women of Somali origin with FGM/C*	*Women of Kurdish origin with FGM/C*	*Women without FGM/C*
Outpatient visit to doctor in past 12 months			
Model 1: OR (95% CI)	**0.26 (0.13–0.53)**	0.92 (0.54–1.58)	1.00
Model 2: OR (95% CI)	**0.36 (0.16–0.80)**	0.61 (0.34–1.10)	1.00
Self-perceived health good			
Model 1: OR (95% CI)	0.54 (0.22–1.28)	0.80 (0.50–1.28)	1.00
Model 2: OR (95% CI)	**0.36 (0.17–0.77)**	1.34 (0.75–2.38)	1.00
Satisfied with health			
Model 1: OR (95% CI)	1.39 (0.45–4.34)	1.42 (0.88–2.30)	1.00
Model 2: OR (95% CI)	1.88 (0.50–7.02)	**1.81 (1.03–3.18)**	1.00

Model 1: Unadjusted odds ratio. Model 2: Adjusted for age, marital status, education, and religion (Kurdish origin). Final multivariate model presents the forward step logistic regression analysis. Bolded odds ratios represent significant associations. 95% CI = 95% confidence interval. FGM/C = female genital mutilation/cutting.

feeling different or abnormal. These reasons can lead to under-use of health care services (23,26).

FGM/C has negative impacts on health and it can cause problems during pregnancy and delivery. These impacts need to be addressed in health services for immigrant women.

Strengths and Limitations

The strength of this study is that it is based on a random population sample. A population-based survey is a good tool for estimating the prevalence of FGM/C and it also enables the study of other outcomes and their associations with FGM/C. Studying migrants as a target population is known to be difficult because migrants do not tend to take part in demographic surveys, with language and culture often preventing their participation (27). The moderate response rate (37 and 54% for women of Somali and Kurdish origin, respectively) can therefore be considered reasonable for a migrant survey. Interviewers in the data collection phase were of the same origin as the participants, which allowed for communication with participants in their mother tongue, which helps to build trust and express understanding toward the respondents' cultures.

A limitation was that the subject of FGM/C is very sensitive. It is known that the self reporting of different forms of FGM is unreliable and underreporting is common (28) but also overreporting has been documented (21). While the FGM/C-status was not examined, only asked about, underreporting is more likely as is recall bias, as not all those interviewed would be able or willing to tell about their FGM/C situation in the interview. For 26 Somali and 6 Kurdish women, the question about FGM/C was not asked or the participants refused to answer the question. This may have led to an underestimation of the prevalence of FGM/C. Respondents may know that FGM/C is illegal in Finland, which might have meant that social acceptability bias led to underreporting of FGM/C. It is also possible that some women with FGM/C may not associate their health symptoms and discomforts as being because of FGM/C. Women also may be reluctant to view their FGM/C in negative terms as it might mean having negative feelings about their parents and family members who were responsible for the FGM/C. Thus, women with FGM/C often do not complain about the discomforts they have, negative health consequences can be underreported, and health sometimes can be perceived in a positive perspective.

Conclusions

This study shows that the prevalence of FGM/C was 69 percent among those of Somali origin and 32 percent among those of Kurdish origin. Education, marital status, and older age are the main sociodemographic factors associated with FGM/C in Finland. FGM/C is more common among migrant women living in Finland than was previously assumed, especially among women of Kurdish origin. Further studies and linking the data to the Medical Birth Register would enable the study of women's health during pregnancy and childbirth and possible associations to FGM/C.

As a result of the increasing number of migrants, actions against FGM/C are still needed, not only in migrants' countries of origin but also in Europe, as it violates human rights and has negative health impacts. Our results indicate that women with low educational status need more information on FGM/C, as their

daughters may be at higher risk of being cut. Professionals in health care, education, and immigration should be trained to address the issue, to focus on prevention, but also to give their support to women living with FGM/C or who are at risk of being subjected to the practice. Campaigns against FGM/C need to be targeted toward immigrant communities in Europe. This would serve to improve the health and well being of recent migrants, and also to indirectly influence attitudes toward FGM/C in their countries of origin.

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