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— ACTA COMMENTARY —

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# How to deal with female circumcision as a health issue in the Nordic countries

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The Nordic Network for Research on Female Circumcision (FOKO; Norwegian abbreviation: *FØrskning om Kvindeligg Omskæring*, <http://www.med.uio.no/ism/inthel/foko/>) was established in 2000 to bring scientific attention to female circumcision to health professionals and social workers in the Nordic countries. The purpose of FOKO is to provide knowledge, to dispel myths, and to encourage research. The participants in FOKO are engaged in clinical work or research regarding circumcision, either in their home country or in different African countries. The purpose of this editorial is to bring attention to female circumcision as a health issue in the Nordic countries and to inform readers about the research network FOKO and its next workshop in Sweden in September 2003.

Female genital mutilation (FGM) is the terminology used by the World Health Organization (WHO) and circumcision is the term used mainly by the population where the custom is practiced. In this article the term female genital cutting (FGC) is used as it is now recommended by FIGO, intending to cover the whole variety of procedures (1).

Roughly 100 000 immigrants in the Nordic countries originate from areas in Africa where the tradition of FGC is still well known. A majority of this immigrant group consists of Somali women and men (approximately 25 000 in Sweden, 16 000 in Denmark, 8 000 in Norway and 7 000 in Finland, less than 10 in Iceland;

national statistics figures). FGC in the Nordic countries became an issue in the 1980s. The civil war in Somalia caused many Somalis to leave their country in the early 1990s. The arrival of large groups of Somali families forced the Nordic societies to take a stand on the health issue of FGC.

Traditionally, Somali girls are infibulated, which involves excision of the clitoris, labia minora and stitching of the vaginal opening. Health providers and social professionals in the Nordic countries are therefore obliged to know how to handle this issue. The primary motives for FGC in Somalia are that the practice is experienced as a religious duty and a prerequisite of marriage (2). Based on clinical experience, the most common reaction to FGC in a Western country is one of disgust and rejection. However, in countries where FGC is practiced it is looked upon as the “normal” state, sometimes expressed in line with the following citations: “being smooth in the genital area without flaps is a beauty ideal,” “if the labia minora are not cut they will continue to grow,” “the clitoris and the labia minora have to be concealed in order to reduce sexual desire, to reduce the risk of promiscuity, promote fertility and make childbirth easier – or the girl will not become a woman,” “circumcision will ensure that the woman is a virgin as she gets married.” These examples of motives do not necessarily coexist in the same ethnic groups. Thus, FGC has deep and complex social and cultural roots that we cannot

ignore when discussing how to best deal with FGC as a health issue in the Nordic countries.

### Health problems in relation to FGC

Recently, academic scholars have discussed knowledge about FGC from a new perspective (3). Shell-Duncan and Hernlund have questioned earlier scientific conclusions and the proclamation of the international movements against FGC, especially the uncertainty of the methods and reliability of the research results. In the literature it is often stated that FGC health problems are dysmenorrhea, urinary tract infection, pelvic inflammatory disease, infertility and sexual problems. Childbirth complications are described as prolonged labor, fetal distress, mental retardation, epilepsy, perinatal death and maternal fistulas (4–7). Obermeyer reviewed the literature on the health consequences of FGC (8). Analysis of studies on infertility or urinary problems of FGC did not document significant differences between women who had undergone FGC and those who had not (9). Studies of delivery problems showed only significantly increased rates of cesarean section and episiotomy among circumcised women. Regarding obstetric complications, a large case-control study of obstetric consequence led by the WHO is now under way in six African countries (pers. commun., The Editor, Bulletin of WHO, Geneva).

A few studies have been performed on the long-term effects of FGC women who have migrated from low- to high-income countries (10–16). In the latter references from Sweden and Norway regarding perinatal mortality among immigrants from Africa's Horn, it was demonstrated that poor obstetric outcome might be a consequence of not providing the best care to circumcised women. It is therefore important to reevaluate earlier information so that the best care can be provided to circumcised women giving birth in the Nordic countries. Otherwise, there is a risk that strong emotional feelings against the practice of FGC may obscure the rational way of evaluating obstetric and gynecologic risks, and preempt the investigation of other factors that may play a causative role in morbidity among these immigrant women. The Scandinavian health authorities have put a lot of effort into prevention by means of disseminating information on FGC. Unfortunately, part of the information used among the Scandinavian health providers is based on statements linking FGC with perinatal mortality and obstructed labor even though studies with contradictory results on this topic based on Swedish data have recently

been published (14,15). In this context, more attention has to be devoted to scrutinizing the original source of information and determining whether the data presented suffer from bias as they often originate from low-resource countries where access to proper health care is limited.

### Is FGC performed in the Nordic countries?

Legislation of FGC exists in all Nordic countries but no legal action has ever been taken. In Denmark, no special law has been passed about FGC even though there have been several attempts to do so. A proposal of a law about this issue was rejected in 1996. The Department of Justice stated that FGC was to be considered under the law dealing with general bodily mutilation and that it can be punished by imprisonment for 4–8 years. The person who performs the mutilation and also the parents who allow it will be punished (17). There is not a specific law against FGC in Finland and it is punishable according to criminal law as a serious assault. The act of serious assault bears a prison sentence of a maximum of 10 years (pers. commun., Dr Erkki Kujansuu, University Hospital, Tampere, Finland). In Norway, a law forbidding FGC was passed in 1996. From the very beginning it included a prohibition against female circumcision of Norwegian girls abroad, even in countries where the practice is not criminalized (2). Immigrants from countries practicing FGC came to Sweden earlier than they arrived in the other Nordic countries. Sweden was the first country in the Western world to specifically condemn FGC in 1982. In 1998, the law was revised with a change in terminology, from "female circumcision" to "female genital mutilation," and more severe penalties were imposed. The law was further reformulated in 1999 to allow prosecution in a Swedish court against someone carrying out FGC even if the act was performed in a country where it is not declared criminal (2). In Iceland a law banning FGC is presently being discussed in the Icelandic parliament and is expected to be passed in the autumn of 2003 (<http://www.althingi.is>, pers. commun., Professor Reynir Geirsson, Reykjavik).

A survey of the occurrence of FGC of Africans in exile in the Western world showed that France is the only country where it is known that cases of illegal FGC have been brought to court. Since 1978, at least 25 prosecutions of West African circumcisers and parents have taken place (18). Studies conducted by Morison et al. and Dorkenoo suggest that circumcision of British African girls has occurred, but no figures were given (19,20). The organization FORWARD (Foundation for

Women's Health Research and Development) in the UK has information regarding one English gynecologist who in 1998 had his authorization withdrawn without trial after he had been video-filmed performing FGC.

### Does circumcision take place outside the Nordic countries?

As mentioned earlier, in 1999, the Swedish law was reformulated to include future cases of circumcision of Swedish girls taken abroad for the procedure. To date, no such case has been documented in Sweden (pers. commun., Sara Johnsdotter, EU DAPHNE Program, Lund University). Denmark has not removed the legal principle of double criminality, which means that no cases of FGC carried out in a country where it is legal can be taken to the Danish court. However, this has recently been discussed (<http://www.sm.dk/nyheter>), and this discussion has caused much anger and resistance in the Somali communities in Denmark. As no example of this practice has ever been proven it could hardly be justified to introduce such a law and it seems that the Danish national campaign against FGC has been successful (21). However, there are constant rumors in the groups concerned about young Danish African girls being circumcised. Yet there is no substantiated evidence in the form of court cases or social service documentation. In Norway, there has been one report to the police concerning circumcision, when a Gambian woman reported her husband. This report was, for unclear reasons, withdrawn. Rumors are frequent and a list with anonymous examples of Norwegian African girls said to have been circumcised has been edited by an organization working to support immigrants in Norway but no case has been taken to court (pers. commun., Sara Johnsdotter, Lund University, Sweden, and R. Elise B. Johansen, Oslo, Norway, at the state project against female circumcision; "Omsorg og Kunnskap"). In Finland, sending children abroad for circumcision is prohibited as well. There have occasionally been rumors regarding girls being circumcised in Africa during summer holidays, but no cases have been verified so far. Among Somalis, at least, the attitudes seem to be changing and many Somalis seem to be willing to give up all types of FGC (pers. commun. Dr Juha Määkinen, Turku, Dr Satu Suhonen, Helsinki, and Marja Tiilikainen, project manager, The KokoNainen-project, The Finnish League for Human Rights, Helsinki). In Iceland no cases of girls being taken abroad to be circumcised are known (pers. commun., Professor Reynir Geirsson, Reykjavik).

### Conclusion

In the Nordic countries, no legal action has ever been taken against FGC since this practice was made illegal. This does not mean that the rumors are false, only that they remain unverified. However, FGC is definitely an issue to be considered in the Nordic countries. In Norway and Sweden both anthropologists and obstetricians have been conducting studies on Somali immigrants especially with respect to the issue of FGC, its consequences and effects. In Finland and Denmark the work has concentrated more on intervention campaigns and community-based methods to ensure that knowledge and information about providing care to circumcised women is available through publications from the National Board of Health and Welfare. The research network of FOKO has previously arranged two workshops for anthropologists, sociologists, psychologists, medical doctors, nurses, midwives and social workers with special interest in this field. The first meeting was held in Gotland, Sweden, in 2000 and the second one in Oslo, Norway, in 2001. As mentioned, a third workshop is planned to take place in Malmö, Sweden, in September 2003. Two speakers are especially invited: social anthropologist Ylva Hernlund from the USA, dealing with the context and contingency regarding decision making around circumcision, and Dr Nahid Toubia from London, giving a lecture on FGC as a public health issue in the Western world.

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