Holy Hymen, the Might of a Small Membrane – Experiencers' Views About Virginity Testing

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2023 Laurea

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Global Health & Crisis Management
Master's Thesis
June, 2023

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Global Health and Crisis Management
Master of Health Care

Abstract

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Year 2023 Pages 60

This thesis' purpose is to answer to the World Health Organization's call to raise virginity testing awareness among health care and social work professionals by offering a voice to few people, whose lives virginity testing has relation to or has affected somehow. Virginity testing and virginity myths are global health issues. The test is specified to be invasive, unscientific and a form of gender-based and honor-related violence which happens all over the world.

This thesis is an independently conducted qualitative study. The theoretical framework includes the definitions of different forms of gender-based violence, virginity myths and cultural notions of honor, consequences of violence and prevention of violence.

The aim of this thesis was set to study and reveal the experiences and views of people, who have experienced virginity testing-related issues in their personal life. The objective was to construct customer-oriented recommendations for health care and social work professionals for addressing virginity testing in healthcare encounters based on the collected qualitative data.

The recruitment of participants was implemented using a recruitment poster that was disseminated for professionals who encounter the target group, stakeholders and possible participants. The data were collected through a completely anonymous online survey and analyzed using thematic analysis. There were five participants who produced 2567 words of their experiences, views and wishes. One collective narrative was formed to showcase their voices and different aspects to virginity testing. The findings are parallel and in line with WHO's and other health care and human rights organisations' definitions, petitions and guidelines.

Based on the results of this thesis it is recommended that more education about virginity testing, honor-related violence and violence in general is organized among professionals, communities and individuals. There is an unrecognised, hidden group of people in Finland who potentially have needs for health care, psychoeducation and other support due to their experiences. Experiences of virginity testing are not visible or obvious for the eye and clients and patients might not speak about them hence they need to be mapped by asking. Cultural sensitivity and trauma-informed approaches are suggested to be utilized.

Keywords: cultural notions of honor, gender-based violence, human rights, sexual health, virginity testing

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1 Introduction

What activity is defined as a human rights violation, a sexual assault, an unscientific examination and despite all of this carried out in the 2020s by some health care professionals and required by the close ones of the subject? The answer is virginity testing, and it is expected of and happens globally to people, who are assumed or identified as girls or women. Virginity testing is a gynecological examination and an old tradition which is falsely believed to determine if a girl or a woman has had vaginal intercourse. The term and concept of virginity is a cultural, social, and religious construct and there is no medical or scientific basis to examine it because the appearance or a lack of hymen is not a proof of vaginal intercourses. (WHO 2018a, 4.)

According to the World Health Organization, WHO, (2018b) there are many reasons why girls and women are globally subjected and even forced to undergo virginity testing. One reason for virginity testing is the social expectation that girls and women should remain virgins until marriage. Requests and demands for testing might come from parents, potential partners or even employers who want to evaluate a girl’s or a woman’s eligibility and chastity. According to WHO (2018a, 12) several medical professionals, health-care professionals, health-care associations and human rights organizations have explicitly condemned this practice and procedure as unscientific and harmful. WHO has pleaded that there is an urgent need to raise awareness among health professionals and communities about this topic and its short-term and long-term harmful mental, physical and social consequences.

The author has been working in the field of social work meeting people from different backgrounds in Finland for about 15 years and has encountered this issue only a few times which got her interested, because it does not mean that the issue is not there. It is more likely that it has been and is hidden for different reasons, as several professionals who encounter honor-related violence, are saying (Leppänen 2021). Based on the author’s personal experience and discussions with many health care and social work professionals she had noticed that often people thought virginity testing has nothing to do with Finland or does not happen in Finland and partly therefor they had not familiarized themselves with it more, but they got interested as well. As virginity testing has been documented in at least twenty countries all over the world (WHO 2018b) and immigration and globalization increases, it is crucial for both health care and social work professionals globally to be aware of this tradition. It benefits all parties if professionals can understand their clients’ needs, because it helps them to encounter, support and help them better.

The last ten years of the author's career focus has been in interpersonal and domestic violence. The fact that the author is relatively close to the themes of this thesis can be an advantage and disadvantage simultaneously. She has seen it might be dangerous or even lethal for a person to decline a request for testing their virginity let alone fail the test. She has noticed that it takes more effort and time to help a family in that situation rather than just to explain that the test is not valid. Additionally, the author has read from online discussion boards several personal stories of people who defend virginity testing and hence made conclusions that not all people who undergo the procedure consider themselves victims or oppressed. Some people seem to think quite the opposite and feel proud and honorable to go to the examination to prove their worth. It is important to recognize these aspects of this complex topic before educating people on the harmful consequences and bluntly requesting to eliminate a practice which symbolizes many things and has importance for the practitioners.

The purpose of this thesis is to answer WHO's call by raising virginity testing awareness among health care and social work professionals and offering a voice to few people, whose lives virginity testing has relation or has affected somehow. This is a qualitative study, and its aim is to gather data through an anonymous online survey for people who have been somehow subjected to virginity testing and objective is based on the collected data to construct recommendations for health care and social work professionals for addressing the virginity testing in healthcare encounters. The participants were mostly sought with the help of professional networks, different organizations, social media and influencers. The voices of experts by experience can benefit to build a better understanding of the multifaceted and global phenomenon and individual stories behind it. Their voices are in key position because they are the experts on their experiences, culture and families. They understand the possible pressure and danger and can tell what sort of support they wish for. The respondents' knowledge and guidance can help professionals to develop more appropriate, more professional and customer-oriented approach when they encounter virginity testing related themes.

2 Virginity testing as part of gender-based violence

On average in the world, every 11 minutes one woman or a girl is killed by their intimate partner or someone in their own family (UNODC 2021). In 2021 this meant approximately 45000 women worldwide. According to United Nations Office on Drugs and Crime, UNODC, there hasn't been major increases or decreases in these numbers, they are distinctly sex or gender-related killings and the outrageous and the most extreme result of gender-based violence. As boys and men are clearly overrepresented in the homicide statistics worldwide as

victims, those killings are mostly done in the public sphere, and includes killings done by people outside family. (UNODC 2022.)

UNODC's global estimates report from 2020 states, that in global data the effects of COVID-19 restrictions on annual gender-related killings of women are inconclusive and patchy. In Western Europe there was 11 % increase from 2019 to 2020 and in Southern Europe 5 %. In Northern Europe there was no detectable shift and in Eastern Europe there was a modest decrease. In Northern America the numbers increased by 8 %, in Central America 3 % and South America 5 %. According to UNODC these changes seemed like previous annual differences recorded during the past decade. UNODC's report states that in some countries there was a high monthly variability in national trends during October 2019 to December 2020, but overall family or intimate partner related homicide statistics remained relatively unaffected by COVID-19 lockdowns. (UNODC 2021, 3.)

Most often, a killing done by a family member is the continuum and escalated worst-case scenario of earlier interpersonal and domestic violence. Intimate partner violence or family violence includes different types of violence: physical violence, psychological or emotional violence, sexual violence, economic violence, digital violence, religious or spiritual violence, honor-related violence, disciplinary violence, stalking, maltreatment and neglect. These forms are described more in the chapter 2.1 Forms of violence. Women and girls are also overrepresented in human trafficking statistics. The terms gender-related killing, "femicide" or "feminicide", include also female targeted killings perpetrated by people who are not family. (UNODC 2021, 9.)

The UNODC's report from 2021 did not yet show outstanding shifts in the statistics, however the UNODC's report from 2022 introduces data and results from 25 countries in the Americas and Europe which indicate an increase in femicides in the private sphere during COVID-19 pandemic. The report states that these were driven primarily by increases in killings which were perpetrated by other family members than intimate partners. These increases in female family-related homicides were greater than any yearly observations since 2015. It is significant that four in ten female homicides globally remain unclassified which means they cannot be counted as gender-based killings even if they were gender-related. The true number of femicides is hard to evaluate as some homicides are not even recorded or reported. (UNODC 2022, 5-11.)

The United Nations has identified seven key strategies to prevent gender-based violence and created an acronym for the reference. The United Nations summarize in their "RESPECT" framework these strategies (Table 1) which are based on a systematic review of different prevention interventions. These interventions are:

R	Relationship skills strengthened: This strategy is about improving interpersonal communication, decision-making and conflict management skills of individuals, couples and groups of all genders.
E	Empowerment of women: This strategy means social and economic empowerment interventions e.g., inheritance and asset ownerships.
S	Services ensured: This strategy means any services provided to survivors of gender-based violence such as police, health and social services or legal services.
P	Poverty reduced: This refers to interventions that target women and households with the primary aim of alleviating poverty.
E	Environments made safe: This strategy is about the aims to create safe schools, workplaces and work environments, public spaces.
C	Child and adolescent abuse prevented: This strategy refers to actions that aim to build safe family relationships and nurture and implement parenting programs.
T	Transformed attitudes, beliefs and norms: This strategy means multidisciplinary interventions that question harmful gender stereotypes that keep current structure of male privilege and female subordination, give justification for gender-based violence and which stigmatize survivors.

Table 1: The United Nation's RESPECT framework 2021

The UNODC's reports remind that these strategies may and should be combined as wide-ranging approach and long-term commitment have the most prominent preventive and reductive influence on gender-related killings. This thesis touches on six of these strategies as its purpose is to answer the WHO's call by raising virginity testing awareness among health care and social work professionals and objective based on the collected data to construct recommendations for health care and social work professionals for addressing the virginity testing in healthcare encounters. Built awareness and recommendations can help to transform attitudes, prevent child and adolescent abuse, enhance safe environments and communication, ensure services and their quality and empower women. (UNODC 2021, 27.)

2.1 Forms of violence

Interpersonal violence means violence between individuals or small groups of individuals. Domestic violence means violence between individuals who are family members or in an intimate relationship, living together or closely related. Domestic violence is a global epidemic and considered as one the most serious problems of our society. Anyone might

encounter it during their lifetime as it is so common and no socioeconomic status, education, age, sex, religion or any other feature completely shield from it. Domestic violence always harms everyone involved. Domestic violence is very traumatizing in nature since the one who is hurting is someone dear and close to the victim. When violence happens in home or between family members, the meaning of family as a provider of safety and shelter can be lost. (Kytölä 2021, 14-19.)

In Finland it has been estimated that only 10% of intimate partner violence is reported to police and approximately every other woman has experienced violence done by their current or former partner. In the United States about 20 people are battered every minute by their partner. In Finland that same amount, 20 people die because of domestic violence every year. (Kytölä 2021, 15-16.)

There are many myths and misconceptions of domestic violence which makes it more difficult to recognize and seek help. Research indicates that there are some more vulnerable groups and individuals but, in the end, anyone can be a victim, survivor or a perpetrator. Both experiencers and professionals face the challenges of recognizing domestic violence. Finland has had several notes from the European Council on the Istanbul's Convention. The Istanbul's Convention focuses on the prevention of violence but also contains obligations to protect and help the victim survivors and hold perpetrators to criminal account (Ministry of Social Affairs and Health 2017, 11-12). Finland has had recommendations to organize mandatory education for police and prosecutors on gender-based violence and how to encounter victim survivors of violence. There is a lot of work to be done to support all the parties involved and prevent violence. (Kytölä 2021, 16-17.)

Psychological violence, sometimes called emotional violence or abuse is always included in all the other types of violence (Figure 1) listed further. It can be difficult to recognize because of its sometimes-abstract nature. According to Katja Kytölä an expert in work against domestic violence psychological violence can be e.g. shouting, intimidation, coercive control, sleep deprivation, blaming, accusations, belittling, humiliation, name-calling, disrespect, blackmailing and different threats, isolation from people, work, school or hobbies, ostracism (exclusion from a group) or maltreatment and neglect. Ostracism causes physical pain in the certain area of the brain. (Kytölä 2021, 20.)

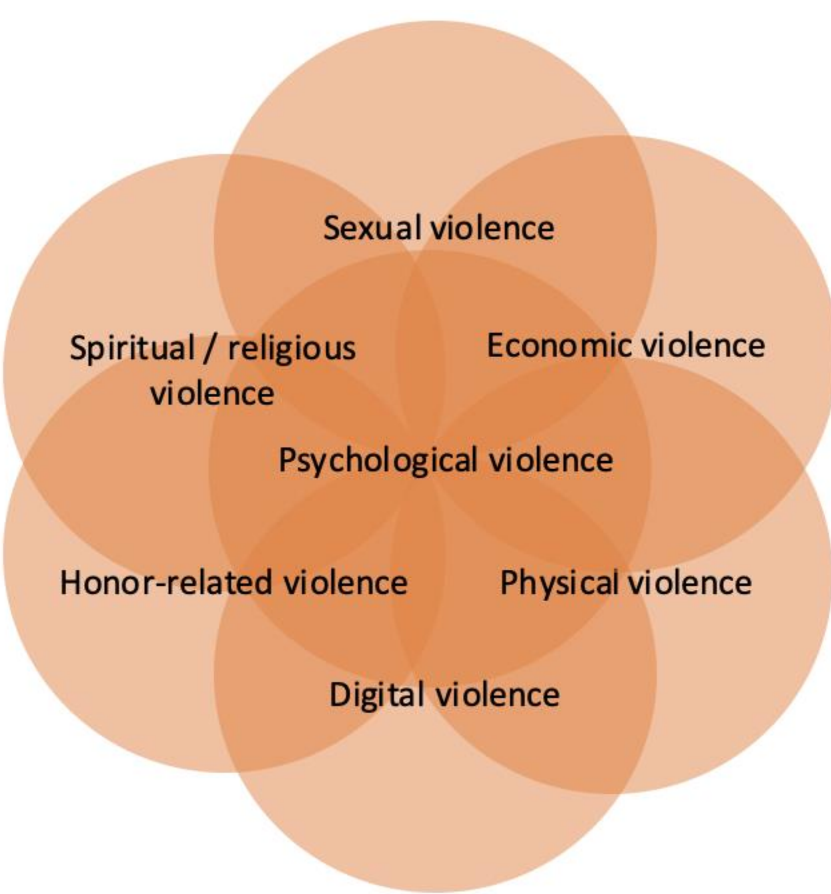

Figure 1: Forms of violence (Kytölä 2021, 19-23)

According to Kytölä (2021, 19-20) physical violence is often wrongly perceived as the only definition of violence. All physical hurting or breaking the integrity of another individual is considered as physical violence. Physical violence is more diverse than hitting and slapping e.g. biting, spitting, pulling, pressing, scratching, pinching, kicking, choking, strangulation, stabbing, cutting, slitting, burning, forcing or pressuring into sexual acts and rape, chemical violence (secretly or by force giving alcohol, drugs or medication), physical hurting of pets and children, preventing one's medical care, using guns or objects to hurt, throwing or breaking objects, speeding with a vehicle and acid attacks.

Rape is the extreme act of sexual violence but violence which insults one's sexuality is a variation of different physical and psychological acts such as touching without consent, pressure, blackmailing, forcing into sex or sexual acts, threats to rape or use sexual violence, using sexual acts as a tool to exercise power, name calling and insulting related to sexuality, sharing pictures or other material without consent, upskirting, voyeurism and filming without consent. Economic or financial violence is a group of psychological and physical acts which

hurt one’s economic situation. Exploitation and controlling are ways to use economic violence. One might make all the decisions of shared assets or finances or use the victim’s money without consent. The perpetrator may prevent the victim from earning own money, going to work or school or stop them from having an account of their own. Sometimes economic violence means forcing the victim to take a big debt or not telling them about big financial matters. In digital violence technology is a tool for the violence. The perpetrator might hack into the victim’s technological devices such as a computer or a smart phone, bank account, email or social media to monitor, control, harass and use psychological violence. Forcing to show one’s messages or emails is digital violence as well. Religious or spiritual violence is physical and psychological violence related to one’s religion or spirituality. It can be forcing into praying or precluding from practicing religion or spirituality. It can be forced conversion, mocking one’s religion, spiritual beliefs or spirituality or threats about the end of the world, hell or god’s punishment. Some spiritual or religious groups might use shunning, a form of ostracism, as a sanction against individuals who question or leave the community. (Kytölä 2021, 20-22.)

Stalking may or may not be part of post separation abuse. Post separation abuse means different acts of violence, such as harassment or parental alienation or alienation accusations, that happen or continue after divorce or separation. Stalking may happen even without any earlier relation between the victim and the perpetrator. Stalking includes following and spying the victim or trying to make constant contacts. Increasingly often technology is used: phones, email, social media, GPS, tracking devices, cameras and wiretaps. Stalking has been a crime in Finland since 2014. For an outsider’s eye it is not always scary threats, it could be even love notes, but stalking can cause the victim huge anxiety. (Kytölä 2021, 21-22.)

Violent discipline or disciplinary violence is common and widely accepted justification for violence against children. In Finland it has been forbidden by law since 1984 (Kytölä 2021, 50) but the Central union for child welfare’s yearly statements verify that the attitudes are still justificatory towards violent discipline and its practices are still in use. The most notable factor that influenced parents’ and caregivers’ attitudes were former experiences of being a target of violent discipline. The respondents who had experienced violent discipline from their parents related more positively towards using it and used it more themselves compared to respondents who had no former experience of violent discipline. Disciplinary violence is physical or psychological violence that a parent, another adult or potentially a sibling is using towards a child to cause physical, psychological or emotional hurt or pain for the child to punish them or regulate or control their behavior. It can be any type of violent acts mentioned earlier. In 2021’s statement 31% of adults said they had used grabbing or tossing around often or sometimes. (The Central union for child welfare 2021, 4.)

Even though the parent’s aim might be to “raise” and teach their children with violent discipline, it does not help to grow a conscience, but it grows a fear for punishments. Children might learn how to avoid certain behavior but not because they would understand why it is forbidden but because they do not want to get hurt. Physical or psychological punishments will not encourage children and it can do serious and long-lasting damage to their core self, identity and dignity and hence cause even more difficulties in their adulthood. (Kytölä 2021, 51.)

2.2 Cultural notions of honor and honor-related violence

In Kurdish and Turkish there are words “namus” and “shirif” which describe the concept of honor. Namus means the morality of a woman and shirif refers to a noble, respected, honorable man. Honor is something you can own and lose. According to patriarchal societies’ cultural notions of honor, a man’s honor is retained when he takes care that the family’s and extended family’s girls and women behave decently. Men’s homosexuality and bisexuality are viewed as indecent and dishonoring. Family’s honor is important to women too and therefor they can monitor the behavior of other women and men. If honor is lost, honor killing might be an attempt to recover the honor. Other custom can be that the dishonored family is ostracized, and they will need to move to another area. There are similarities with the Romani people’s concept of vendetta (verikosto) which is a part of old customs and causes duty to give way or yield in aim to prevent killings. (Ala-Lipasti 2009, 22-23.)

Honor-related violence means violence that is executed in order to restore the perpetrators’ or their family’s honor. It can be threats of violence and it is done as a punishment or admonishment for dishonoring the perpetrator’s, family’s or community’s reputation and honor. So-called “honor” killing means a murder of an individual who has brought shame to the family or relatives. It is contradictory that acts of honor-related violence aim to prevent honor killing and honor-related conflicts. There can be one or more perpetrators or killers and they can be a family member, or someone invited by the family or a member of community. It is possible that family members have different views about the punishment and only some relatives are a risk or a serious life threat to the victim. Domestic violence and familicides happen in every culture but honor-related violence and honor killings refer to patriarchal societies’ cultural notions of honor and the terms mean harmful traditions that can arise from them. Male-dominated, patriarchal society considers that a woman is man’s property. (Kytölä 2021, 23; Ala-Lipasti 2009, 17-19.)

In Finnish individualistic society the more communal society’s way of thinking of shared honor or collective shame might be challenging to comprehend or digest. Some still perceive cultural notions of honor as permanent, built-in culture and demand deportations of perpetrators, but this is obviously not a solution to stop honor-related violence or killings

from happening. Active education, discussion and work on attitudes and new learnt inner operation models can prevent honor-related violence. (Ala-Lipasti 2009, 9-10.)

Understanding honor concepts and mechanisms is crucial when migrant integration action plans are made. Raija Ala-Lipasti adduces and quotes Paulo Freire from 1977 about integration, here freely translated from Finnish: “Integration is the ability of an individual to adapt to reality and at the same time ability to choose and change reality. Here a person is a subject, not an object.” The author shares Ala-Lipasti’s interpretation that this quote describes that people who move to a new country should have the opportunity to change their reality, impact the society or their own thinking. The author has also seen that many migrants want to defend Finnish equality between genders. (Ala-Lipasti 2009, 21.)

Migrant families live very differently; some might choose the familiar way of living and even certain degree of isolation from the mainstream culture, some adopt the surrounding society’s new demands and norms and some combine these two manners or create new ones. The cultural habits of country of origin can become even more meaningful in the new country than they were in the country of origin. People might worry that they lose their cultural identity and humans tend to lean on familiar traditions in time of crisis or uncertainty. (Ala-Lipasti 2009, 27-28.)

2.2.1 Female genital mutilation

Female genital mutilation, FGM, is an old tradition with serious health risks and damage, and it is done in many different countries around the world where it is called female circumcision or cutting (Kytölä 2021, 23). FGM can be a partial or total removal of the external female genitalia or other injury to the female genital organs by cutting, pricking, piercing, incising, scraping, stitching, stretching or burning, and it has no medical reasons. It violates number of well-established human rights principles of equality and non-discrimination based on sex, the right to life and to freedom from torture or cruel, inhuman or degrading treatment or punishment. (WHO 2008, 1-8.)

FGM has no known health benefits, but many known short-time and long-time dangers and consequences for both physical and mental health. These consequences are severe pain, chronic pain, bleeding, urinary problems, vaginal problems, menstrual problems, scar tissue, psychological trauma, infection, problems with sex and sexuality, post-traumatic stress disorder (PTSD), dangers for childbirth, shock, or even death. Hundreds of millions of girls and women have gone through FGM but not all women are even aware if it is done to them or not. It is commonly stated that mutilation is a more correct term than circumcision since all its types, classified from Type I to Type IV, are radical compared to boy’s circumcision which is considered also an offense against boy child’s right to physical integrity. All UN agencies have agreed to use the term mutilation although practicing communities might have

associated the word mutilation negatively. This term was agreed because their purpose is to help communities to abandon this harmful practice by different communal, local and nation-level actions. There is a strong need for dialogue and educating on its risks and violation of girls' rights as well as organized diffusion, laws and policies. (WHO 2008, 1; WHO 2008, 22; Kytölä 2021, 23.)

Why is FGM continued to practice then? WHO states it is a manifestation of gender inequality deeply rooted in social, political and economic structures. FGM, child marriage, the practice of bride price or dowry and virginity testing all represent society's control over women. FGM is supported both men and women in the countries where it is widely practiced and considered as the norm. Those who depart from norm may encounter harassment, condemnation and ostracism. These rewards such as celebration and gifts and punishments such as stigmatization and rejection are influential in this practice's continuity. FGM is seen as essential rite of passage into adulthood in some societies and there might be peer pressure for the girls to undergo the procedure if they have a choice or say in it. According to WHO, FGM might have become even a meaningful part of the cultural identity of girls and women and a source of pride since it means acceptance and membership to community in those communities or families where it is the norm. (WHO 2008, 5-6.)

According to WHO some reasons and justifications for the practice are linked to girls' perceived marriageability and virginity. People have beliefs that FGM ensures that a girl is fit for marriage and stayed as a virgin as stiches would preserve virginity. Finished FGM is also linked to beliefs about increased sexual pleasure of men, girls' hygiene and beauty standards of women. The author has heard from an expert of experience and human rights activist that one broadly believed theory says that FGM started in ancient Egypt and one reason for it was to control women's sexuality and beliefs that it would prevent immodest behavior and unwanted pregnancies. (WHO 2008, 6.)

2.2.2 Virginity myths and testing

MacLachlan (2007, 6-11) narrates that virginity myths have a long and powerful history. In Europe the most famous virgins are possibly Virgin Mary the mother and Joan of Arc the martyr, from Christian narratives. However, the concept of virginity has even deeper roots as virginity was presumably invented in ancient Greece (MacLachlan 2007, 14).

Virginity is a cultural, social and religious construct meaning a condition of a person who has not had sexual intercourse. From a biological perspective, for a female person, this means vaginal intercourse. In general, the discussion on virginity is commonly from a quite narrow heterocentric point of view, penile-vaginal sex, even though sex is a wider concept. The hymen means a construct within the vulva. It is a thin mucosal tissue surrounding and partially covering the vaginal opening. There is not any known biological function of the

hymen, but one hypothesis suggests that it protects the vagina from contamination by faecal and other materials, especially at the early stage of life. All hymens are shaped differently, and some people are born without it. Some hymens are thicker as others are thinner and the elasticity varies. (Latva 2020, Sex Info Online 2019, WHO 2018b.)

It is still widely thought that a hymen, or the lack of it, determines if a person has been sexually active or not. This is because of a common belief that the hymen “breaks” in the first penetrative intercourse. However, it does not break but a tear or a stretch may happen for a various of reasons. Penetrative sex or masturbation, inserting a tampon, a gynecological examination or doing sports or other physical activities could cause a tear of the hymen. It is also a common belief that this always causes bleeding or spotting, but it does not happen to every individual, and many do not notice tearing to happen. Additionally, thanks to the elasticity, the hymen may stay intact after a female’s first sexual intercourse and even after a childbirth. Still, the misconception of the hymen’s role lives on. (WHO 2018b, Sex Info Online 2019.)

Virginity is important in several societies around the world in different scales, bigger and smaller communities for various reasons. “True love waits” campaign which originated in the United States is aimed at young people and the message is to stay virgin until marriage and abstain from any sexual conducts. In Finland the campaign is called “Tosi rakkaus odottaa” and it is supported by 20 Christian organizations and schools in Finland. Kirsi-Marja Isotalo has researched the campaign’s impact on life and sexuality and found that the ideology of virginity appeared for most of the respondents as a practice causing shame and guilt. (Isotalo 2017, 1-2.)

Guarding virginity has many aspects. In different cultures virginity is believed to bring honor to girls who remain virgins and to those girls’ families. In South Africa’s Zulu tradition, girl’s virginity can be used as a bargaining tool when families negotiate and decide about ilobolo, bride wealth. In Vietnam, the Vietnamese word for virginity, trinh tiết, withholds both the verbal reference for biological part hymen and the perceived chastity. “Virgin cure” is one of the virginity myths. In some African societies it is a current belief that sex with a virgin can cure HIV and Aids. This undeniably causes suffering for the girls who pass practiced virginity tests because they are in danger to get raped and HIV. Virginity is safeguarded by others but the girls and women themselves as well. An observational study by Ghandour et al. (2017) in Lebanon points out that 39,3% of their respondents protect their hymen from breaking by doing alternative sexual activities such as anal or oral while still feeling guilt, worry and pressure. (Rakubu 2019, 14-19.)

A virginity test, also known as “a two-finger test”, “hymen examination” and “per vaginal examination”, is a gynecological test done to females to determine if they are virgins. “Two-

finger" signals to the manner how examination is done in some cases to assess the size of the vaginal opening. Due to the reasons mentioned earlier about the differences of hymens, this test is unscientific and does not tell anything about virginity or sexual history, yet it is still in practice in many countries. WHO and various United Nations agencies have made statements about the ethical problems around virginity testing, why it is considered a harmful practice, a violation of human rights and have called for an end to the tests. Virginity testing was made illegal in England in November 2021 (Munsi 2022). According to WHO virginity testing has been documented in at least 20 countries spanning all regions of the world and that requests for the test and cases are emerging in other countries too. WHO claims virginity testing is likely underreported, especially in areas where it is not seen as desirable. (Crosby et. al 2020; WHO 2018a, 7.)

Online discussions can be found on different social media platforms, even a more professional platform LinkedIn, where people defend virginity testing. On some comments people explain how bad they feel about it, and some seem to take pride in proving that they are or were virgins. Even if some would be willing and happy volunteers to get the test done, it does not remove the fact that often it is done without a girl's or a woman's consent. World Association for Sexual Health (WAS), which is multidisciplinary and global group of scientific societies, non-governmental organizations and professionals in the field of human sexuality, has made a Declaration of Sexual Rights (2014). The WAS Declaration of Sexual Rights has 16 articles. Article five "The right to be free from all forms of violence and coercion" mentions virginity testing as sexuality related violence and coercion. Other articles reaffirm that virginity testing has aspects that are against sexual rights, as everyone has "the right to privacy" (Article 6) and "the right to autonomy and bodily integrity" (Article 3) which includes the right to free and informed consent prior to any sexually related testing.

Some have invented a way to go around this test or how to try to secure the preferred results. Hymenoplasty is a big business and one can find artificial hymens and hymen kits being sold online. In England hymenoplasty was made illegal in January 2022. Hymenoplasty does not guarantee blood in the next intercourse (IKWRO 2021, 7) and there is no research on the impacts of hymenoplasty on health, for example childbirth. The author has also heard stories of faked bleeding in white sheets after the wedding, when there has been a tradition of "sheet ceremony" where newlyweds have to show their sheets to relatives to prove the virginity of the bride and "a successful wedding night". (Munsi 2022.)

One can hear through the grapevine that virginity testing and hymenoplasty are frequently requested in Finland too. These demonstrative comments on the silent phenomenon have come from different interpreters and health care professionals. Ethical instructions of doctors in Finland say doctors should not conduct the tests. The author did not find any statistics how frequently virginity testing is requested. Hannu Halila has evaluated (Latva 2020) that yearly

a few dozens of both operations, virginity tests and hymenoplasty, are done in Finland. There is discussion whether the tests or surgeries should be done by doctors and some professionals are afraid that if professional doctors refused to do them, charlatans would do them. In 2021, hymenoplasty was done in few private clinics in Finland and the estimation was three times a year per clinic. In Sweden hymenoplasty slightly more common than in Finland. In 2021 hymenoplasty in Finland costed around 2500-3700 euros. In 2020 the evaluation of the price was up to 4000 euros. (Latvala 2021; Latva 2020.)

All of this leads the author to wonder: how a small membrane that a hymen is, has been able to preserve its might throughout the times that it still defines, saves or destroys a family's honor? Or save one's life, because having one intact could do that. (WHO 2018b.)

3 Consequences of violence

Violence has many effects on the health. It is always a threat to physical and mental health. Domestic violence is a risk to the attachment developing between a child and their parent whether the violence is towards the child from a parent or between parents and or inside the family and child is exposed to that. Dynamics in the family have effect on a child's physical, psychological and social development, function of the genes and neurophysiological maturation. Violence is always potentially traumatizing in its nature which means it does not always traumatize but is likely to do so. Violence is a significant stress factor and major stress has severe and permanent impact on the structure of brain, body functions and emotional life. Stress can even impact the size of the brain. Hippocampus, the area of the brain where memory and learning happen, is damaged and reduced in size. During childhood when the child's nervous system is in development, the brain is at the most plasticity state. This means the first two to three years of a child the growing environment has major influence. When traumatizing events have occurred in childhood it is called developmental trauma. (Kytölä 2021, 68-69.)

Kytölä highlights that a traumatic experience can stay in one's body for decades and increase the risk of different cardiovascular diseases, cancer, diabetes, Alzheimer and autoimmune disease. She states that a child's exposure to the risk of this magnitude is not taken into consideration seriously enough in society. (Kytölä 2021, 79-81.)

4 Prevention of violence

Domestic violence can be prevented (Kytölä 2021, 91) and it is better to catch it early on. New parents need support even before the child is born and Kytölä suggests parents get

widely information how new life changing situation will have impact on their lives and their relationship. If parents have traumatic backgrounds, they should have a possibility to get more intense support to prevent transgenerational traumatization. Safety skills and emotional skills for children can be taught starting from early childhood education and upskilling can happen during school years.

If an individual doesn't recognize or know they have experienced violence it is unlikely to seek help for it (Kytölä 2021, 17). People might ask support to variety of problems violence has caused them, for example financial issues, and seek medical treatment because of somatic problems. Heli Siltala's dissertation for University of Jyväskylä (2021) brought valuable findings about the effects and costs of domestic violence in Finnish health care. Some of the main findings were that victims of domestic violence use health care services frequently because of mental health problems, physical injuries, unclassified symptoms, genitourinary problems, diseases of the respiratory system and nervous system, neurological problems and pregnancy complications and that they use up to 80% more health care services than average population. It is startling that according to those findings less than 1% of the victims are recognized in health care settings. The health costs were higher for victims than the general population until their identification. These results indicate that early identification of domestic violence in health care could reduce the health problems and financial burden it places on health care services. (Siltala 2021, 44-46.)

It would be ideal if victims of domestic violence could get all services from one desk; one unit that coordinates prevention of domestic violence at different levels: preventive work, recognizing, reporting, service coordination to other services, gathering information, guidance, tracking, preparing for preliminary hearing and after-care. There should also be an option to the common practice where the victim must hide and most often leave their homes to shelter, when it could be that the perpetrator is obligated to let the victim stay at home in peace. It is also the perpetrator's right get some help and guidance for their own violent behavior. (Hirsi Ali 2005, 141.)

4.1 Cognitive biases

A cognitive bias is considered "a systematic bias in the outcomes of decisions people make", simple mental strategies for making judgements and decisions. There are over hundred cognitive biases named, but few are highlighted here. Confirmation bias is one of the most fundamental biases. This bias means situations where an individual puts more weigh on the evidence which is supporting the view they already have. It can be challenged by trying to think the opposite and search also evidence which could change their mind. (Lockton 2012, 2-3.)

In status quo, the present state bias people tend to make decisions or not make decisions to keep things as they were, unchangeable and current state of things. It is humane resistance to change. It helps all professionals to be aware of this as they evaluate their actions on violence prevention and adopt and develop new manners of approach. (Lockton 2012, 6.)

When doing research, it is good to be aware of biases and practice self-reflection of own biases. The author has a bias from looking through her professional frame work's glasses and having certain expectations on the results or might have a blind spot thinking there are no blind spots or biases. One can't know what one doesn't know. She neither is immune to the widely accepted social norms of the society she is in and can experience cognitive dissonance where beliefs and attitudes conflict. Dan Lockton presents in his article Robert Cialdini's set of six "weapons of influence", techniques for influencing behavior. The set of techniques have been listed based on research on biases and heuristics. These techniques are called reciprocation, commitment and consistency, social proof, liking, authority and scarcity. These techniques can be used dealing with biases and recognizing them is helpful in personal and working life. Many of these techniques are widely used in e.g. marketing, sales and fundraising. (Lockton 2012, 11-12.)

4.2 Anti-racist social work

Baldwin et al. (2014, 5-6) explain some of the reasonings why we all should learn about intercultural communication. Intercultural communication is a form of communication when culture, a way of life, has an impact on the communication between individuals or within a group of people. Groups of people from different cultures might have different cultural symbols, values or behaviors with each other and this can affect the messages exchanged. Global problems need intercultural and cross-cultural dialogue. This requires learning about different cultures as well as one's own. Cultural knowledge can help to be flexible and absorb new ways of thinking, feeling and reform even behavior wise.

Hansen et al. (2016, 36) state about the special remarks of the ethicalness of a study, that involves immigrants and people with different or diverse cultural backgrounds. In their broad statement about honor-related violence in Finland, Hansen et al. state that public discussion around different cultures and habits tends to categorize people to "us" and "them". Even though virginity testing is done globally it is mostly practiced among people from certain cultural backgrounds so raising this issue might cause some people to stigmatize and generalize these groups or communities even more. This could have been a concern for potential informants, and contradictory as this study aims to be empowering by nature, not othering. Again, virginity testing is not practiced only in a homogenous group of people, and honor-related violence as a phenomenon has many factors and surroundings. Culture should

not be seen as the only factor as individuals with the same cultural background might relate very differently to virginity testing and other honor-related violence.

According to Lena Dominelli (2018, 8) it is essential to understand the dynamics of racialized oppression to promote world peace and non-violent relations between and among people from different cultures, ethnic groups and nationalities. Racism is a social distress everywhere in the world and social work is not exempted from different levels and forms of racism such as personal, institutional and cultural racism in its policies, practices and theories. Anti-racism is a bridge formed of active operations and initiatives between racist and non-racist social relations. According to Dominelli anti-racism comes unnecessary in a non-racist space or context where racism has vanished but denying the existence of racism does not make it disappear. Dominelli points out that social workers assume that their personal tolerance and commitment to professional ethics which are rooted in equality does enable them to work in non-oppressive manner, but racialized people's experiences of their interventions and several studies demonstrate that this is not the case. (Dominelli 2018, 9-12.)

Human rights activist and writer Ujuni Ahmed has publicly spoken on the importance of representation and against the problems of so-called white feminism. She claims several women's rights activists are promoting only white women's rights and are silent on the topics that are relevant to women like herself. She emphasizes that the needs of families and youth from migrant backgrounds cannot be defined from the outside without hearing the families and youth themselves. Ahmed raises FGM as an example and says it is a form of gender-based violence that is not bound to a certain culture or religion and that FGM and many other issues are not merely a problem of immigration or social integration. She says that she has often seen that people are afraid to take a stand because they do not know the culture but that it is insignificant when it is about equality and the human rights of children, women and minorities. Ahmed says silence maintains the oppressive structures and in the worst-case white feminism leads to minorities' state's weakening. She says the silence of white feminism is in fact about individual's own convenience and comfort. She states that silence does not mean holding space for her and it is not a favor to her but to the person being quiet themselves. (Pirilä 2023.)

5 Aims and objective

The aim of this thesis was set to study and reveal the experiences and views of people, who have experienced virginity testing related issues in their personal life. The objective was to construct evidence-based customer-oriented recommendations for health care and social work professionals for addressing the virginity testing in healthcare encounters.

The study seeks answers to the following questions:

1. How to recognize actually or potentially virginity tested person
2. How to recognize virginity test related risks
3. How to encounter and support a client or patient who brings up virginity testing
4. How to bring up virginity testing in discussion with a client or patient
5. How to recognize the need and responsiveness to guidance

6 Methods

6.1 Study design and research setting

This thesis was carried out in Finland as a qualitative study with purposeful sampling and the focus was on the experiences of people who have been experiencing virginity testing related themes in their personal life. An anonymous online survey was selected as a data collection method which was executed using e-lomake. Anonymous online survey enables to participate from anywhere and habitation is not surveyed which means the informants might live in different settings, in their own home by themselves, with a spouse, with other family members, friends, in a shared apartment or in an accommodation center. The informants have different cultural backgrounds. Some might have been born in Finland, and some might be migrants, asylum seekers or maybe just visiting.

6.2 Data collection

The recruitment of respondents was executed mainly through the author's network and utilizing social media platforms such as Facebook, Instagram, Tiktok and anonymous message app Jodel. Well over 200 governmental and non-governmental organizations, Helsinki based private companies and professionals which are working towards to end domestic violence nationally and honor-related violence were approached, such as accommodation centers, DIDAR, Monika Multicultural Women's Association and SOPU work just to name a few. Some organizations were not from health care or social work settings but cultural sector actors. All were given information on the thesis, its topic and invited to participate by putting the recruitment poster on display to help with data collection. The thought was that the poster could be visible to possible participants who could then choose freely if they want to take part in the online survey.

Helsinki based private companies such as Hyvinpitely Oy and We Encourage Oy LTD helped with respondent recruitment by sharing the recruitment poster in their social media. The author is involved with both companies but does not have a conflict of interest as she does

not know the potential informants through any clientship, which might have jeopardized the author's impartiality or informant's anonymity. There was no dependency between respondents and the author. There is no economic gain for the author or these companies for spreading the recruitment poster online for their followers. Some organizations reached out and told they had put the poster on display somewhere safe their clients could see. Few replied that their customers do not face virginity testing, or it has not come up and therefor they have evaluated that they could not help. Some influencers commented their willingness to disseminate the poster and survey link to their networks.

The recruitment poster (Appendix 1) was evaluated to not have name of the researcher for safety reasons and responses were directed to the anonymous online survey. This is because there could be parties who condemn the neutral, yet the UN's human rights acknowledged research of virginity testing experiences and views. The poster was used for snowball-sampling by (Hirsjärvi & Hurme 2018, 59) encouraging the respondents delivering the research invite to people who would be interested about the research.

The setting was likely to have informants who are cisgender girls and women, but gender was not asked and therefor did not exclude other genders from participating. Cisgender means a gender when gender identity corresponds with the sex identified as having at birth. Other genders in this thesis' framework could mean persons who are identified as trans men, meaning men who were assigned females at birth, or non-binary people, meaning persons who do not identify themselves female or male. It is less recognized that persons belonging to gender minorities might have also had experiences about virginity testing if they have been assumed to be females and treated as cis.

The criteria for partition were following:

- Respondents must be over 18 years old
- Respondents have experience of their own or their close one's of virginity testing, but this was not strictly limited
- Respondents understand English
- Respondents are voluntarily participating and understanding the anonymity and sensitivity and ethics of the study and reporting
- Respondents have given their informed consent in the e-lomake

This way the respondents are in active role, and they create meanings for the study. As mentioned earlier, the topic of virginity testing is controversial, since it is classified harmful, but still practiced (WHO 2018b) for different reasons and some practitioners might aim to do good without understanding the risks of virginity testing. The topic is intimate, delicate and vulnerable, so it may raise diverse emotions. Hirsjärvi and Hurme (2018) point out that some

researchers prefer anonymous survey forms in these settings. According to Hansen et al. (2016) there are always power dynamics at play in an interview between the author and informant, which is important to acknowledge.

The online survey questions (Appendix 5) are open ended and formed from the themes of which have been sketched to enable factual and opinion-based data. Fact based questions can be linked to public knowledge or more private, family or certain situation related facts. The topic of this study is virginity testing, so all questions can be seen delicate as they touch and dive into topics such as respondent's sexuality related experiences and physical and mental abuse. This might require different ways of asking or approaching the topic. (Hirsjärvi & Hurme 2018, 106-115.)

The questions were divided under three different chapters; "Background questions", "If you have experienced virginity testing or if you have been persuaded into one or if you want one" and "Wishes for the future". The questions in the first background segment had questions related to respondent's personal experiences and general feelings about virginity testing and their thoughts on other people's views on virginity testing. The second segment focused more on respondent's views on health care and social work professionals' knowledge and action related to virginity testing. The last, wishes segment oriented the respondent to share their views how health care and social work professionals should encounter and support those who have experienced virginity testing. There was also a question that surveyed the respondents' wishes related to the future of virginity testing. Participants were not technically forced to answer to every question in the e-lomake and they had the option to leave a question unanswered for any reason. There were 12 blank answers out of 80 individual answers.

The online survey was open from October 2022 to May 2023 in total. The recruitment of participants was continued months at a time to gather more data and more stakeholders were contacted to utilize their networks as well. All informants participated during March 2023.

6.3 Data analysis

The author chose thematic analysis for the data analysis method. The analysis phase was immediately started after the data collection ended. First the author familiarized with the collected data by reading it many times according to Hirsjärvi and Hurme's recommendations (2018, 135-140). According to Nowell et al. (2017) a trustworthy thematic analysis has six phases. Phase one is familiarizing yourself with your data which means spending time and engagement with it. Phase two is generating initial codes. Phase three is searching for themes. Phase four is reviewing themes. Phase five is defining and naming themes and phase six producing the report.

It is necessary to read the data to analyze it. The reading phase is not just passive reading but active reading which means it can be read "interactively" to get a better understanding of it. The reader can present simple questions to the data such as "Who?", "What?", "When?", "Where?" and "Why?". Attention can be drawn into contentual themes e.g., conditions and context, definitions, processes, regular habits, events, strategies, relations and framework. (Hirsjärvi & Hurme 2018, 143.)

After interactive reading, initial codes were generated, then themes searched and reviewed. Lastly themes were defined, named and interpretated. After thematization, a categorization (Figure 2) was done to better demonstrate a summary of the data collected.

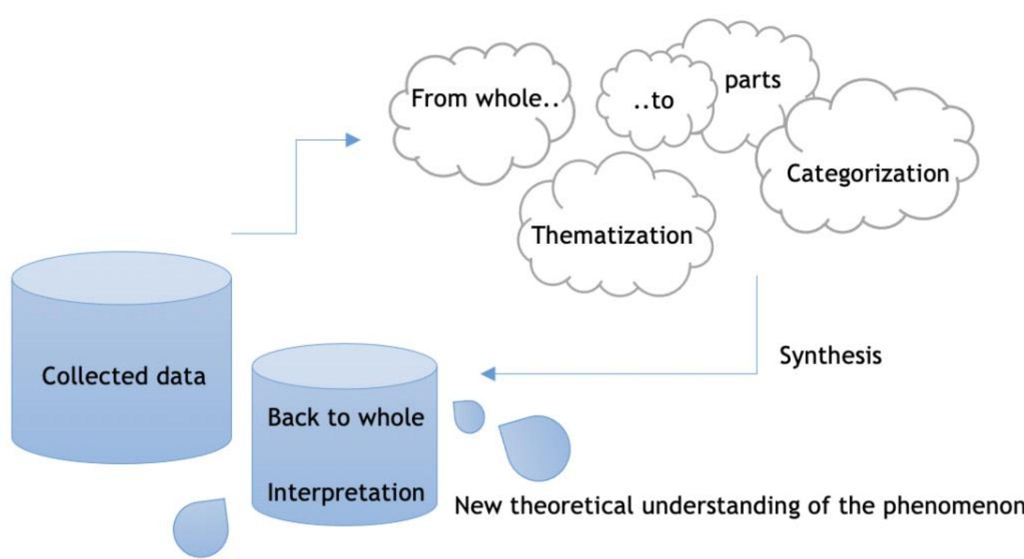

Figure 2: Data processing from analyze to synthesis after Hirsjärvi & Hurme (2018, 144)

6.4 Ethical considerations and risk assessment

All European Academies, ALLEA, has determined good research practices that are based on fundamental principles of research integrity. These principles are reliability, honesty, respect and accountability. The European Code of Conduct for Research Integrity is a document of guidelines that is updated regularly. The conduct guides researchers to commit and practice good research ethics. (ALLEA 2020, 4.)

The author followed Laurea University of Applied Sciences' guidelines (2020) for the prevention of fraudulent activity, which means activity that is intentional dishonesty or dismiss of scientific and study practices. Ministry of Education and Culture in Finland appoints

The Finnish Advisory Board on Research Integrity, TENK (Tutkimuseettinen neuvottelukunta) to promote research integrity and prevent research misconduct in Finland. The Advisory Board has formulated guidelines called Responsible conduct of research and procedures for handling allegations of misconduct in Finland, or the RCR guidelines, which were additionally followed and reflected. (TENK 2012, 30.)

As TENK (2019, 9-11) recommends, the author familiarized herself with the topic of virginity testing, virginity myths and honor-related cultures in advance to avoid causing unnecessary harm to informants. Recruitment criteria was that respondents are at least 18 years old. The participants were informed that the survey is completely anonymous, and they have been advised not to deliver any information from which the respondents or other persons could be recognized. The data collected cannot be removed afterwards because the answers and respondents cannot be connected. There is a data management plan in Appendix 3. The informed consent was collected anonymously in the e-lomake. The author wanted to create a qualitative survey with respectful and open questions, but it does not remove the fact that in a study informants' sensitive experiences turn into data that the author analyses and interprets. After publishing the thesis, the results might be intentionally interpretated by certain groups in ways that could be harmful to the different groups the informants represent. (Hansen et al. 2016, 36-37.)

Ethical and legal consideration is prominently present throughout the thesis because of several ethical issues around the sensitive topic. An ethical review statement was applied for the research project from The Human Sciences Ethics Committee of the Helsinki Region Universities of Applied Sciences. The statement was required because the research is focused on humans and "the research involves the risk of causing mental harm that exceeds the limits of normal daily life to the research participants" and "the research could pose a threat to the safety of the research participants or the researchers". The confidentiality and anonymity are important to any study and with respondents considered a vulnerable group because of their experiences with violence, it is crucial for their safety. First, the Human Sciences Ethics Committee of the Helsinki Region Universities of Applied Sciences' review statement asked some clearance and repairs related to the data collection and target group. The original plan with thematic interviews was pivoted to anonymous online survey and the target group was limited to adults. The supplemented research plan was reviewed, and the committee's preliminary assessment was positive after alterations were made to the research plan. (The Human Sciences Ethics Committee 2020.)

There are always some risks when using internet. There is no way to know or control how the participants use the survey or if their phones, tablets or computers are being controlled by a family member. There was a reminder in the beginning of e-lomake about clearing browser history after filling the survey. Professionals from EDUIX were consulted about e-lomake and

IP-addresses. There is an information letter in Finnish (Appendix 6) for professionals, who were encouraged to invite participants, about the thesis, recruitment criteria and safety instructions.

No funding for this thesis was needed. The Finnish National Board on Research Integrity (2012) defines some of the criteria for reliability and validity and guidelines provided were committed to follow. Project report is available to the participants and the great public online in Theseus. The collected data was analyzed, reported, published and disseminated according to Laurea UAS Thesis guidelines.

7 Results

This chapter presents the results of the thesis. It has been divided into two subchapters: first the collected and analyzed data's themes are described so the reader can have an understanding about data content and how it was analyzed. This is followed by the recommendations. The recommendations are based on the analyzed data that is reflected on the theoretical framework and background of the thesis.

Even though the sample size is small the answers seem to describe and cover quite well different aspects to virginity testing. All the respondents were against virginity testing although one stated that they did not care if the patient was over 16 years old and had consent. Respondents did not claim to have personal experience of someone testing their virginity but almost all of them had lived in a setting where virginity and potentially virginity testing was important to the people around them; friends or young women they were helping. One of the respondents had experience of checking a hymen. Unfortunately, it was impossible to revise did the respondent mean they had checked another person's hymen or had their own hymen been checked. One of the participants defined that they did not have any personal experience of virginity testing but as they regardless chose to participate in a survey that was aimed for people in that situation, it would be problematic to disregard their contribution based only on an assumption that there was no personal interest in the matter and because their reasons are unclear, their participation is part of the analysis.

7.1 Themes

The author interpretated the data and found five themes which answer to the questions of aims and objective. The data was reflected to this thesis' theoretic background and themes related to gender-based violence, consequences of violence, cultural notions of honor and prevention of violence. The five themes which rose from the questions, theory and data are following:

- Gender-based violence
- How virginity testing is seen
- Consequences of virginity testing
- How to support and help
- Prevention of virginity testing

Themes	Main findings	Quotes
Background questions: **1.** Gender-based violence **2.** How virginity testing is seen **3.** Consequences of virginity testing	**1.** All respondents recognized and verbalized GBV aspects of virginity testing and most seemed very enlightened about human rights and virginity test's unscientific nature. **2.** Most respondents did not accept virginity testing and seemed to feel strongly against it. Respect for different world views and valuing freedom of choice was verbalized. There were variations how significant religion or culture was seen for the practice and there were some worries about discrimination. **3.** Honor killings and violence were seen as a serious threat. Forced suicide and rebuilding of hymen were mentioned. Potential trauma and traumatization were repeated as a result of breaking boundaries.	**1.** "We were taught that women were responsible for mens' behaviour" **2.** "I have seen a few young women willing to take the test while believing that is something to make their family proud or it is their duty be "clean" for their husband. But I believe this is very wrong in very core level while respecting their decision." **3.** "Lot of girls who want to be sexually active end up doing anal eben if they dont want to just so they wont lose virginity."
Views of experts by experience on health care and social work professionals' operations: **4.** How to support and help **5.** Prevention of virginity testing	**4.** All respondents had ideas how professionals should encounter and support clients who experience or might experience honor-related violence. Two respondents offered opposed opinions whether professionals should ask directly about virginity testing or not. **5.** Only one respondent seemed indifferent if virginity tests are banned or not. Most felt that the test is outdated and should not exist anymore.	**4.** "Its very important that professionals do not make assumptions. Wait until the person brings it up." VS. "Ask directly" **5.**"Give it to them if they want" VS. "People will not tell them the reasoning behind requesting a test. Many young women will communicate as they are doing it willingly but actually case is mostly different."
Wishes for the future: **6.** How to support and help **7.** Prevention of virginity testing	**6.** The needs for support seemed well recognized. Therapy and other support services were verbalized. **7.** The hopes for virginity testing to be banned or made illegal was repeated. The meaning of education was addressed too.	**6.** "…the first concern should be whether the client or patient is in a safe situation, and then to ascertain what their thoughts are about it." **7.** "…would forbid it, but I would also put so much effort on working with people who see this as necessity for girls. Parents should understand the impacts of it."

Table 2: Some examples of analyzed data

From the themes and categories, the author wanted to form one longer answer, sort of a story whereas if all the participants' voices were describing their views simultaneously by an

imaginary character. The author used the idea of combining different answers to form, not a stereotype, but an understanding. This narrative was thought to demonstrate the results but also give more room to the respondents' speech and diverse yet shared experiences around the topic. The author chose example quotes from all participants' answers to different questions and put them together. The quotes are not in chronological order in any way, but all the themes have fitted in the narrative. The sentences might have been shortened and few sentences combined so that the narrative could proceed with a nice flow and the whole set would be more balanced, but no words have been added, meanings or grammatical tense changed. Some clear typos were corrected.

Aim with the narrative was to paint a picture using participants' brushes and colors. The result includes answers that were repeated often, and it includes also individual answers. Some answers which describe specified religion or religious groups were left out from the narrative. All the data cannot be in this story, and it is not to be interpretated too much because the sentences have moved places inside their context. The narrative is not a full story of one person, but it is full of experienced reality and views of real people. The author has noticed that when it comes to stories about violence, many have the experience that the words peers use feels so familiar that they describe it as it could be from their own mouth. Perhaps readers can identify to this story somehow, be curious about the topic and feel empathy towards people behind the text or in similar situations.

> I don't know. I don't think about hymens that much. Checking if there is a hymen. It doesn't respect boundaries. It should not be done. Weird, bad, scary, condescending for females. Disgusting, traumatizing, invasive and humiliating. For many it is a traumatic experience. I have no idea. Therapy. Therapy. Therapy if needed. Group therapy.
>
> I lived in a country where this was very common and many of my family and friends have done it. Young women who are forced to get the test, by their parents or by husband-to-be. We were expected to bleed on our wedding night, and if we didn't, we could go to the doctor to try to prove that we were still virgins. In some of the groups I was involved in, it was celebrated to abstain from even kissing, hugging, and holding hands, and women who did those things would be shamed. Women and men are not seen as equals. The culture was very homophobic, so the concept of virginity didn't apply to anyone but women. Maybe the healthcare industry could figure out a better way of testing men for virginity and it might not be such a big deal anymore.

However, I do not believe it is a culture or religion thing. This is a practice forced by mainly group of men, sometimes religious leaders. Consider communities, some sell this idea as part of their religious culture, some not at all consider or practice it, even some are openly against to it. There are so many doing work against this, and telling this is not part of the religion, culture etc. There is no medical reason.

I have seen terrified young women when they were forced to split their legs to prove they are "clean". I have seen doctors refusing to perform it. I also have heard doctors shaming girls for not being virginity before getting married. I saw a father abusing his daughter because the doctor refused to perform the test. My friend was refused to get health care service from gynecologist as she was single, and the doctor said he could perform only virginity test for her. The men or even some women made them believe they are "dirty", not worth of anything. They should take a patient-centered approach and be especially careful to be informed it should not exist anymore. The people who did it should be arrested. This was illegal in the country.

Most people nowadays think that it's a relic of a cis-heteronormative misogynistic culture. A lot of conservative politicians and lawmakers in particular don't understand science and have been systematically stripping away reproductive rights and healthcare rights. That is not easy. Its only purpose is to control and subjugate women and I think it's horrible that some people are in real danger because of it. I find it disrespectful and unfair towards women.

It has to be different in Finland. Its constantly decreasing which is good. Please remember that Finland is very diverse. Everyone's experience is different. What I am mostly afraid is people discussing about this as part of someone's culture or advocating it as a right as in practicing a cultural or religious necessity. It is not correct, no culture or religious should be used as disrespecting women body, their choices or used to define them as "clean" or "dirty".

It could be part of taking a history with a new client or patient, in the same way that a medical history asks specific questions with a list of possible health concerns. But it should also be optional, as it could be unsafe to bring up in a domestic violence situation. It violates human rights to bodily autonomy.

7.2 Recommendations

In this chapter the results are compared to aims and objective of this research and recommendations are formed. The group of participants was compact, but they answered quite long, and the material was interesting. As seen from the results they are very much in line with the theoretic background. Almost all were clearly against virginity testing, and they respected human rights, autonomy and bodily integrity and recognized the potentially traumatizing effects of the test. One participant seemed to have less of a clear stance on the matter as they stated they do not understand the test and it is “f-cked up” but their other answers gave the impression that they did not want to ban it from those who wanted to have it. The author got a feeling from one participant’s answers that maybe they knew less about virginity testing as they answered to few questions that they do not know and comments such as “ehh” could express insecurity on their answer. Their participation is still valid and useful data as it gives some variation to the data and reflects many similar views.

The author’s background and world views affect to her biases, and it is difficult to perfectly avoid all assumptions. On the other hand, it would have been interesting to analyze data which reveals opinions and views supporting virginity testing. Maybe if the sampling would have been bigger the views would have been more diverse. It is also possible that the phrasing of questions had impact on the respondents. What caused the sample to be so small? The author wanted the survey to include several questions, because she had only one chance to ask questions from participants and so that the possible small sample would have been as rich as possible. Sometimes people understand questions differently and it can be a good thing there are different questions on the same theme. The survey was very long and maybe it was too long. Long survey might have caused some to skip questions or leave the survey before submitting. The informed consent and other information letters were so long that the participants had a lot to read even before the survey itself.

When professionals were contacted, they were asked to let the author know if they would disseminate the poster, but of course it is possible that they might have done so even if they did not say it. Only four professionals and other stakeholders out of a bit over 200 told they would. Three said maybe and that they will consider. Six said they can’t because of policies or that they did not see it useful for the thesis or for their clients. The number of professionals and possible participants who saw the poster is difficult to evaluate precisely but they were posted into online groups which have thousands of members. Either way the response rate is small compared to the amount of people this topic is or has been close to.

After analyzing the data, it was realized that it was quite hard to find the target group for this survey. It could be that it would have been easier for the participants to build trust in face-to-face contacts and a possible interview. Maybe few face-to-face contacts with

stakeholders did help to get the word around. Based on the feedback from stakeholders, there could have been potential under 18-year-old respondents but as one of the criteria to participate was adulthood their answers could not enrich the data. During the data hunt it was learned that the author would have found few informants through at least one contact person, but the person told they cannot read and did not speak English or Finnish. It possibly could have helped, if they would have had a chance to use interpreters but then again, it would not have been completely anonymous, private survey to participate. Or if the author had translated the survey to Finnish, which she did not do because of her schedule.

Other positive side to online survey among anonymity is that it probably helped the author to move further away from the role of a violence prevention worker. Other reasons for the response rate can be that people who might not be feeling so well do not necessarily have the resources to participate. Or maybe they are alone somewhere and hard to contact in general. It could be that this survey's participants are active in general and interested in this area already. New ideas whom to contact while writing the results were born, but it was already too late for those contacts and adding new possible data to this thesis.

This thesis aimed to find answers to questions, which are presented here separately and reflected the connections between questions and this thesis' findings.

1. How to recognize actually or potentially virginity tested person:

The findings did strongly second that virginity tested, potentially virginity tested person or those who are pressured to do the test cannot be recognized merely based on their culture, religion or a country of origin. Both Muslims and Christians were mentioned in the answers evenhandedly and virginity testing happens also at least in Catholic and Orthodox Judaism (Latva 2020).

If a person is asking for hymenoplasty it is a red flag for health care and social work professionals as it hints, there might be a pressured need for an intact hymen. Also, if a person mentions they are experiencing or have experienced domestic violence or any kind of honor-related violence it is an indicator of different forms of honor-related violence. Person might not name violence and it is possible they use the word problem instead of violence when they describe their situation with family.

If virginity testing is seen by health care and social work professionals as an important risk factor that should be mapped, there should be guidelines on how to map, ask and support. Another harmful old practice, FGM, has been mapped longer in Finland and good, working practices with FGM mapping could be applied here.

2. How to recognize virginity test related risks:

When virginity testing was recognized as part of gender-based violence and control on sexuality, the respondents seemed to know the risks up to death. It is recommended to learn about honor-related violence and cultural notions on honor and how patients and clients navigate through the service system with these risks and how it might affect if virginity testing as a topic stays unnoticed and a taboo.

From a professional perspective it also helps to know yourself. Who are you, what do you like, what do you dislike, what are your boundaries, your values, beliefs and attitudes? How do you see violence and what do you consider violence? Who can be a victim and who can be a perpetrator? How do they look? How do they make you feel and react? If one is clueless where they stand or have a lot of misconceptions or misinformation it is harder to help others with these issues. Luckily, we can always learn more if we are willing. As it was mentioned in the data, people have experiences of professionals who behave inappropriately and even violently as they shame their patients. This is due to strong biases and possibly lack of knowledge, recognition and self-reflection.

3. How to encounter and support a client or a patient who brings up virginity testing and
4. How to bring up virginity testing in discussion with a client or a patient:

The findings provided few concrete gems which fit The United Nation's RESPECT framework (UNODC 2021, 27.) There were suggestions of patient-centered approach, asking directly but at the same time making sure the patient or the client is safe and alone when the topic would come up. The importance of words was recognized, and professionals should be careful and respectful with their wording. The right to autonomy was emphasized and professionals are guided to not to do anything the patient does not agree with. There was a suggestion to support the person with reporting. All participants seemed to recognize the possible needs for psychological help and therapy, and they suggested professionals would remind people that abuse is not their fault and that they could need to build self-confidence.

There was one suggestion that maybe professionals should learn to do the test safely, which is interpreted to refer to the possibility that the test itself can break hymen which of course could mean trouble for the patient. There was also a comment saying "give it to them if they want" referring to the test but the subject is seen more complex. Based on the other findings and many countries' decisions on law the author would abstain from any suggestions that encourage professionals to perform the test which can cause serious harm on so many levels. There are stories of professionals in some countries, who write a document about patient's health, and it works as a "virginity certificate". The author is more careful to take a stance with this custom. In the results we see that not getting a test or certificate is a risk for the clients and patients, so admittedly the problem is bigger than the test itself. In some cases,

the test could normalize the situation in the family for the girl or woman, but there is a risk the test would cause the girl or woman to be in a more vulnerable or dangerous situation than before the test. There has been controversy if the test should be banned but the debate should not be a barrier for professionals to help and support those who need help.

This part caused also more inner controversy discussion in the analyzing phase because one informant expressed that the theme should not be asked straightforwardly. It was interpretated from the context that this was referring to a situation when a person is asked about virginity testing just because they would be assumed to come from certain countries, and it came with a reminder that Finland is diverse. This sounded like they were talking about ethnic profiling and assuming which can surely be tiring for minorities or marginalized groups. If a professional adopts anti-racist social work as an approach, it protects the clients from harmful practices such as ethnic profiling.

Another respondent stated that it should be asked straightforwardly. If everyone is systematically asked about their opinions or beliefs about virginity as part of sexual health, it becomes more equal. It is reasoned as the risk is not seen from the looks of a person. Virginity testing happens all around the world and those who experience it do not look alike or come from identical backgrounds. Sexual health is an important part of human health and perhaps public health nurses are few of the professionals who could get to do early intervention at schools. As any type of violence causes shame, it is typical that people do not want to speak about it and it could be that they cannot answer or that they lie, but at least they would know it is possible to talk about it and there is help available later when the time is right. Or maybe they crave to speak but they do not know where they could do that and are silent.

Another great advice was to not force people to talk or forcibly change their minds. A respondent shared personal experience where they tried their best to change one girl's mind about virginity test, which she wanted to have. Their friend helped them to see that they should let go of the trying because the girl was believing she wanted to do the test for a reason. The respondent said some can refuse to see the impact of the test as self-protection, a self-survival mechanism. The respondent described that afterwards they did not try to argue but they made clear that it is their right to refuse the test, they are not obligated to prove anything and if they are not safe, they can get help. They added that if they would want to do the test, they were there to support.

5. How to recognize the need and responsiveness to guidance:

The author has noticed that trauma-informed model of care or trauma-informed approach has been trending lately. Creating safe physical, social and emotional environment is in line with the UN's RESPECT framework (Table 1). There is a need for education about violence but

about psychological trauma too. As Siltala (2021) mentions early identification can reduce the health problems violence and trauma causes. Siltala's findings are in line with what Higgins et. al (2016, 7) argued, that people with previous traumatic experiences generally report their physical health issues and that survivors of child maltreatment were in greater risk to have hepatitis, diabetes, heart disease, cancer, a stroke and to have surgery and chronic pain symptoms. Child sexual abuse survivors were more likely to have different conditions such as irritable bowel syndrome, asthma, arthritis and digestive problems. Especially pressured or forced virginity test fills the criteria of sexual abuse which is one of the most intimate, hurtful and traumatizing form of violence, particularly when the perpetrator or perpetrators could be close ones or somehow involved in the violence for example being the one who orders the act. Considering this, trauma-informed approach seems a suitable approach encountering those who have experienced virginity testing or pressure for the test. Trauma-informed approach is needed also if a client or a patient does not bring up the topic their selves, but the professional has a concern and bringing it up.

Higgins et. al (2016, 9) describe the concept of "Four R's", the key assumptions originally identified by Substance Abuse and Mental Health Services Administration (SAMHSA), which are the basis of trauma-informed approach: Realisation, Recognition, Response and Resist of re-traumatization. Realisation means realization at all levels of an organization about trauma and its impacts on individuals, families and communities. Recognition means recognition of signs of trauma. Response means the response a program or organization responds by utilizing the principles of a trauma-informed approach. The last R, Resist is about resisting re-traumatization on both clients as staff as well.

With virginity testing this could mean learning about the phenomenon, admitting it is happening and how it effects on people. In a hospital setting this means a variety of different professionals who potentially meet people who have encountered virginity testing or who are potentially forced or pressured to do the test later. It can be the person who books appointments, nurses, doctors, surgeons, institutional cleaners, psychologists, psychiatrists, social workers, counsellors and others. As they have different duties at work, they can still use the same approach within their framework. The author thinks the trauma aware, and trauma sensitive states (Figure 3) are the minimum every health care and social work professional should master so it would be less likely for them to retraumatize the clients more. Clients have cultural needs and different backgrounds, and trauma-informed approach includes processes which notice cultural stereotypes and biases.

Besides the Four R's, SAMHSA has introduced six key principles for the approach. The principles are safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, voice and choice and lastly, cultural, historical and gender issues. Safety means the safety of everyone, including staff and the people they serve. It means both

psychological and physical safety. Transparency about operational and decision-making of the organization builds trust. Peers mean psychological trauma survivors and experts by experience. Collaboration means sharing power and ensuring collaborative approach to healing. Empowerment, voice and choice describe well the strengths-based nature of trauma-informed approach. Individuals have a choice and control of their lives and treatment. The approach also includes processes which notice and cover cultural needs, cultural stereotypes and biases. (Higgins et. al 2016, 9.)

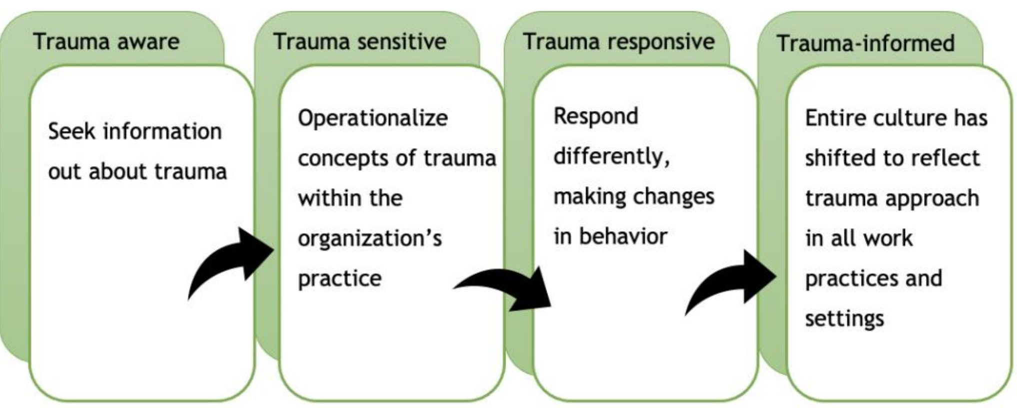

Figure 3: From trauma aware to trauma-informed (Higgins et. al 2016, 5)

8 Discussion

The different dimensions of trustworthiness, transferability, credibility, confirmability, dependability and ethics of this study were evaluated. Lincoln and Guba's (1985) have formed criteria for qualitative research's trustworthiness and those four dimensions are credibility, dependability, confirmability and transferability. Credibility's purpose is to determine if the findings, from participant's view, are true and credible. This was not possible to ask from participants, but their answers and messages were repeated in the data and constructed narrative. Dependability ensures that findings are stable and repeatable if the study setting is similar. Confirmability increases the confidence in the findings which other researchers would confirm. The results and theory were compared, and they are in line. Transferability means findings can be generalized or transferred to different settings, time or contexts. These criteria were used to enhance the quality of the study and data saturation was used in defining the sufficiency of the data. Reporting of this thesis was evaluated by the CASP Checklist as well.

The aim of this thesis was set to study and reveal the experiences and views of people, who have experienced virginity testing related issues in their personal life. Five participants provided the data of 68 individual answers in total. Those answers formed four and a half pages of text from 2567 words in total. At least four participants reported some personal experience on the topic through close ones, friends, community or work. Their data seemed homogenous even though they described their unique experiences, and clear repetition of views was seen.

If other individuals would have participated in this research, the results could have slight or huge variation since the individuals were asked to tell their personal experiences. The findings of the thesis were the author's interpretations from the content of the data. The author aimed to paint a realistic picture with the narrative with their wording, but it is possible there are opinions of it being a failed attempt. On the thesis' results' defense, there are several official, evidence-based statements, pleas and action plans published and the small, yet fruitful sample confirms that those global guidelines are there for a reason.

It could be that this thesis' results slowly start filling a gap in Finland because during the data search the author could not find stories of virginity testing by the experts by experience. It would be interesting to learn how common of a topic virginity testing is in Finland. Even if there wouldn't be many tests done, there are several women who have experienced it and might have the need for support. If we do not ask, we do not know. When we do not know, we assume. We might assume it does not concern our clients or patients. In the future it would be interesting to find a quantitative study on the frequency of virginity tested people in Finland, frequency of hymenoplasty or considering of it and a broader sampling on the experiencers' side.

The sample size in this research was five participants in total. The sample size was smaller than the author expected and aimed for. After having a quiet reaction for the invite from the organizations, the dissemination was expanded, with the acceptance of Ethics Committee, into social media, closed online groups, social media influencers and human rights activists which all seemed to bring a better result rate. No background information such as age, sex or religion were gathered so those features were not emphasized in the analysis either.

One of the questions that remain is, where are the voices of people who have gone through a virginity test with their free will or pressured and are still in favor of it. Few comments are visible on LinkedIn, but commentators' full stories are not known, and they seemed biased. The author is open for arguments that are challenging her to change her views about this issue and how it should be encountered. The data reinforced the comprehension she had got through the literature and her work. It would be interesting to read also the views of people who advocate virginity testing. Maybe research that is focusing on the practitioners' beliefs

and values would help with the work against violence and to promote human rights and health. Additionally, more research on the views, attitudes and knowledge of professionals would be needed. Maybe it would give commentary on the quietness around the topic and reasoning for the next steps of precautionary work. Professionals should never be the bottleneck for their clients to get help.

As earlier mentioned, a tiny purposeless membrane that hymen is, can define the honor of individuals and whole families. It is almost as hymen has supernatural powers as it has power beyond its capabilities or even existence. It is a tissue that gets praise even though its presence cannot be reliably proven. For those who this is not a norm, the discussion around hymen can seem to have almost religious traits. In fact, the concepts related to virginity testing are sometimes referred as virginity myths and hymen myths. Additionally, there is undeniable contradictory in the belief that a woman must be a virgin before marriage if some think that for men it is even preferred to have sexual experience before marriage. Without further explanations it seems to be paradoxical since homosexuality is not approved either. How do they get the experience? Surely there are many ways, but it seems to be a taboo.

The author has heard that there are communities where sex education is not wanted because there is a belief that it results in dirty and unchaste thoughts. If sex education and sexual counselling are accepted as a part of human’s health care, it can prevent many health hazards. As Finland is diverse, it has become even more important to have sex education at schools because sexual health is everyone’s right. Are there guidelines what should happen if children are not allowed to take part in those classes? Is it a red flag for the personnel at school? If a child is always “sick” during sex-ed, maybe it should be. Cultural sensitivity is an approach that can be used in sex education and to map honor-related violence.

In different phases of the thesis, the author questioned her motives and even the right to conduct this research but mostly before the beginning and during the data collection and data analyze. After reading Ujuni Ahmed’s comments on white feminism the author found a correlation between her reasoning and the multifaceted aspects to holding space for minorities in Finland versus not staying silent about the difficulties or human rights violations they are facing. It is crucial to listen to be able to build an understanding from the inside out. Active listening and not speaking on behalf of anyone does not mean to not speak at all, but it takes some discretion to understand when and how.

It would not be ethical if the author would define how the experiencers of virginity testing are feeling without asking them. Even when it was asked through this survey, the author cannot state the results are the whole truth since it depicts the views of five people. The author believes that from different cultures, religions and countries she can learn the most from the people who have first-hand experience, but it is good to remember that people are

always representing themselves too. Everyone is unique and their unique thoughts, beliefs and attitudes rarely if never can be a summary of their whole culture, religion or a country.

By doing this thesis the author wanted to deepen her knowledge on this narrower, specific segment of gender-based violence yet it was confirmed that it is indeed wider and very complex than one might first think. It is hard to evaluate how invariable the results are. Now it seems definitions of the human rights or the common concepts of gender-based violence will not change soon.

When in spring 2021 the author started to search virginity testing news, medical articles and guidelines in Finland there were not much Finnish material to be found or information about virginity tests in Finland. Now two years later this still seems to be the case. The aim of this master's thesis was set to study and reveal the experiences and views of people, who have experienced virginity testing related issues in their personal life. The objective was to construct customer-oriented recommendations for health care and social work professionals for addressing the virginity testing in healthcare encounters based on the collected qualitative data.

It was found that virginity testing is seen and experienced as humiliating, traumatizing, confusing, invasive, disgusting and unreliable yet its meaning as a source of pride in "honor culture" was recognized. The risk of being killed was well recognized and the need for learning more about the reasons behind the test and its consequences in several areas. Clients, patients and even professionals themselves seem to benefit from the trauma-informed approach in the encountering of people who have virginity test related experiences. Education on virginity testing and honor-related violence is needed. As honor-related violence and killings are causing life threatening situations, physical and psychological safety are topics everyone should review in their work environments, client work and collaboration with others.

It is challenging that violence is so common and it means many professionals share personal experiences of violence themselves. It is an interesting and philosophical discussion that should it be mandatory for professionals to somehow work on their own possible trauma. Working on one's own trauma history can be very triggering, and individuals have different preparedness and resources for that. Autonomy includes that dealing and healing own traumas should always be voluntary, yet it can be very challenging for a professional to help others with things they do not recognize in their own lives. Trauma aware, trauma sensitive and trauma responsive are steps before trauma-informed.

While this thesis was brewing, in fall 2022 historical protests blew up in Iran after a 22-year-old woman called Mahsa Amini or Jina Amini was allegedly murdered by the Guidance patrol, Iran's governmental and religious morality police. Her suspicious death started a huge wave

of protests globally, in Iran too. Even more women were arrested in Iran, they disappeared or were found dead. This means honor-related violence is “alive and well”. Number of small organizations in Finland are already doing great work on preventing honor-related or honor-based violence with projects like VIGOR in 2018-2021 and Pro Youth in 2021-2023, but their resources are limited and the responsibility of answering the need should not be merely on their shoulders. The cake is big enough for everyone and all are encouraged to participate on the work against any form of violence. Health promotion is not promoting health if it does not acknowledge the darker side of health concerns and threats. The silence around this topic during data collection was loud. If earlier mentioned ostracism is reflected on that, silence can be a form of violence as well.

We should not let people suffer. If we close our eyes, ears and mouths like the three wise monkeys, will we be wiser monkeys? Hopefully this thesis’ success to raise few voices of experts by experience is a tiny spark among other actors to fuse discussion in the field of Finnish health care and social work on virginity testing. In addition, build awareness and update their procedures if virginity testing and honor-related violence are not yet taken into consideration in the guidelines as should.

9 Conclusions

Statistics show that Finland is a violent country which presumably also affects in a way that violence is so normalized in Finnish society that it is not recognized well enough. There has been numeral studies and theories why domestic violence is such a big problem in Finland. Few comments are related to long-lasting and transgenerational traumas from war, suppressed emotions and culture of obmutescence. From one Finnish point of view there is violence that in Finland is perhaps considered as more normal, such as disciplinary violence, and then again violence which is generally more condemned and less disapproved such as honor- related violence. One way to interpret this is, that it has to do with biases and is a psychological phenomenon, a defense where sometimes it is easier for an individual to see bad or something fixable in others, other groups, other cultures and habits than in self and one’s own community.

Both forms of violence mentioned are nonetheless violence and provably harmful, traumatizing and re-traumatizing behaviors for every party involved. The motives behind these behaviors might target something well from the perpetrator’s position, such as that the child would behave and grow up to be a “right kind”, honorable of an individual that is accepted by the community as well. This is similar in justifications for disciplinary violence and honor-related violence. From an evolutionary aspect, to end up outside of the tribe, family or community was fatal and human brain has developed to still take this as a serious

threat. It is humane to try to avert from anything unpleasant or dangerous, but this should not be done at all costs. There is a huge lack of knowledge about the real consequences of violence among both public and professionals, which maintains harmful and traumatizing practices by well-intentioned close ones.

Obviously, violence does not consistently come from a place of good intentions and others' best interests in mind. Violence is also power and dominance that is taken by force. It is important to break the cycle of violence as early on as possible, because if it does not happen there is a greater risk that it continues to pass on for the next generations and so forth. Violence is violence despite the cultural context. If physical punishment is used, how much does it matter in general whether the instrument of the offence is a birch or a shoe? In individualistic or communal point of view, it can naturally have significant meaning that should not be belittled. Then again, the more we understand different and specific forms of violence and their root causes, the better we can prevent them and promote healthier ways to show up for others and ourselves.

In Finland too there is an unrecognised, hidden group of people who potentially have needs for health care, psychoeducation and other support. Having virginity test related experiences is not visible or obvious for the eye and clients or patients might not speak about it so it needs to be mapped by asking just like other forms of violence if a worry arises or as a part of routine questions. The results suggest that cultural sensitivity and trauma-informed approaches should be utilized to recognize virginity testing, virginity testing related risks and the need and responsiveness to guidance. Approaches are useful in encountering and supporting a client or patient who brings up virginity testing themselves and also for the professional to bring it up in a discussion with a client or patient. Abuse is never a victim's fault and it is a phrase any professional can learn to understand, remember and repeat for their clients.

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Appendix 1: The participant recruitment poster

Appendix 1: Participant information

PARTICIPANT INFORMATION

Study title: Holy hymen, the might of a small membrane – Views about virginity testing

Invitation to participate in a research study
You are warmly welcomed to take part in this research study! It is a Master's thesis which is part of author's studies in Laurea University of Applied Sciences in a degree programme called Global Health and Crisis Management.

The purpose of this qualitative research is to study the experiences and views of people, who have experienced virginity testing related issues or topics in their personal life.

This information 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, please consider your participation again. After this information, please click your consent to participate in the study into the e-lomake. Your active consent is necessary for you to be able to continue in the e-lomake survey.

Voluntary nature of participation
The participation in this study is voluntary and anonymous.

Purpose of the study
The purpose of this qualitative study is to study the views and experiences of people, who have experienced virginity testing related issues or topics in their personal life. The purpose is to raise awareness of virginity testing among health care and social work professionals by lifting the voices of people who the topic concerns and enable tools for professionals so they could develop their actions in their everyday work. One of the main themes is what should professionals know about virginity testing and how should they encounter and support people who experience or might experience it.

Who is organizing and funding the research?
The responsible researcher and organizer is Ellimari Kortman. The study is her Master's thesis in a degree programme called Global Health and Crisis Management in Laurea University of Applied Sciences. This thesis is supervised by PhD Teija-Kaisa Aholaakko. No funding is needed, since there are no expected expenses. Neither there are any financial gains of this study.

What will the participation involve?
Participation means answering this anonymous online survey once. The research study will be finished in fall 2022. All the survey answers are anonymous and still very confidential, so all information from which you or other persons might be recognized will be removed before the data will be analyzed. After two months from the publication of this study, all the survey data will be destroyed by overriding the texts and deleting the e-lomake data. The author is the responsible researcher, and the only one who handles the raw data. The supervisor of this thesis might examine only the anonymized and coded data. The researcher is Native Finnish speaker and fluent in English. There is no need for translators so she will be the only one handling data.

Possible benefits of taking part
There are no certain nor straightforward personal benefits for the participant. Indirect potential benefits are expected, when people in the situation where they are or might be exposed to virginity testing, seek help, and the social and health care professionals have learned about virginity testing through the shared experiences in this study. In that way taking part and contributing to knowledge, might bring benefits to the wider community as virginity testing awareness increases.

Possible disadvantages and risks of taking part
Virginity testing is a topic, which may raise many different emotions. Taking part in this survey might bring uncomfortable feelings, memories and thoughts. If so, please contact to professionals or for example the Nollalinja (Phone 080 005005), which is a free of charge, 24-hour phoneline to call, if you need further discussion with a professional.

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 research will be published in thesis database Theseus when it is ready and information about the study is shared through a press release. The results of the study are anonymous, and you cannot be identified from any report or publication placed in the public domain.

Termination of the study
The researcher conducting the study can also terminate the study if acute personal or national crisis happens.

Further information

Further information related to the study can be requested from the researcher / person in charge of the study

Contact details of the researchers

Researcher / Student Name: Ellimari Kortman

Tel. number: +358

Email: ellimari.kortman@student.laurea.fi

Person in charge of the study / Supervisor Name: Teija-Kaisa Aholaakko

Email: teija-kaisa.aholaakko@laurea.fi

Name of the organisation / Faculty: Laurea University of Applied Sciences

Appendix 2: Appendix to the Participant Information: A Privacy Notice for Applied Research

Appendix to the Participant Information: A Privacy Notice for Applied Research

Within this study, your personal data will not be processed (according to the European Union General Data Protection Regulation (679/2016) and current national regulation.)

Data controller of the study and a contact person for matters related to the not processing of personal data:

Data controller: Ellimari Kortman

Organisation: Laurea University of Applied Sciences

Telephone: +358 [redacted] Email: ellimari.kortman@student.laurea.fi

Types of personal data that will not be collected:

Name, date or place of birth, address, occupation, voice, IP-address of the computer, or related data will not be collected. Some data that is considered as sensitive is gathered anonymously, such as sexuality related information related to virginity testing. Other sensitive data (e.g., race, ethnic origin, political opinions, religious or philosophical beliefs) will not be collected. There is no voluntary, statutory or contractual requirement to provide your personal data (see above), your anonymous participation is entirely voluntary.

Personal data will not be collected from other sources.

Personal data protection principles:

The data will not be collected so there is no need to process or protect the following personal data in the information systems:

☐ user ID ☐ password ☐ user registration ☐ access control (physical location) is not needed in e-lomake with anonymous access.

X other methods are not used.

No personal data will be processed. The purpose of this qualitative study is to study the experiences of people, who have experienced virginity testing related issues or topics in their personal life anonymously.

Legal basis of processing personal data is not relevant to defined for the anonymous data.

In this Masters' Thesis, the legal basis for processing the personal data is not relevant to define for the anonymous data. The informed consent is granted only for the participation in the anonymous e-lomake survey by the participant.

Nature and duration of the research (no personal data exists to be processed):

☒ One-time research ☐ Follow-up research

Duration of the research:

= time frame needed for collecting and analyzing the data and for the publication of the study is 6 months (plus two years for possible reclamations about the research integrity, results and time needed to respond to them).

Data transfer outside of research registry:

No personal data will be collected.

Your data will not be transferred outside of the EU or the EEA.

Your rights as a data subject:

You can exercise your rights by contacting the data controller of the study.

No personal data will be collected in this study so there is no personal data to be used for automated decision-making.

Pseudonymisation and anonymization:

All information collected from you will be handled confidentially and according to the legislation. Individual participants will not be recognized because no personal data is available. Individuals can't be identified. The qualitative data will not be given to people outside the research group. The final research results will be reported in aggregate form, and it will be impossible to identify individual participants.

Appendix 3: Consent form

PARTICIPANT'S INFORMED CONSENT FORM

Title of the study: Holy hymen, the might of a small membrane – Views about virginity testing

Location of the study University: Laurea University of Applied Sciences, Master's Thesis

Researcher: Ellimari Kortman

Phone: +358

Email: ellimari.kortman@student.laurea.fi

Supervisor: Teija-Kaisa Aholaakko, teija-kaisa.aholaakko@laurea.fi

I have been invited to participate in the above research study. The purpose of the research is to raise awareness of virginity testing related issues among health care and social work professionals and help to form customer-oriented approach by hearing the voice of people, who have been exposed to virginity testing related issues.

I have read and understood the written participant information. The information 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.

My personal data will not be collected during the study, and this is informed in the Privacy Notice.

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 have had sufficient information of the collection, processing and transfer of the study data. I understand that my participation is entirely voluntary and that I am not able to withdraw my data after sending e-lomake, because the survey is **completely anonymous**, and my answers cannot be connected to me anymore.

The informed consent

*I have read the participant information and privacy notice documents above. Yes / No

*I am 18 or older and I confirm that I voluntarily consent to participate in this study.
Yes / No

Please note, that if you choose "No" and proceed to answer, your answers cannot be used in this research and will be deleted immediately.

Appendix 4: Anonymous online survey questions

Background questions

- Would you please tell me, what kind of experiences you have about virginity testing?
- How do you feel about virginity testing?
- What do you think other people know about virginity testing?
- How do you think people within your culture see virginity testing?
- How do you think people outside your culture see virginity testing?

If you have experienced virginity testing or if you have been persuaded into one or if you want one

- Would you please tell me, if there is something else you would like to share about your personal experiences with virginity testing?
- What kind of encounters related to virginity testing have you had with health care and social work professionals?
- How do you think the health care and social work professionals recognize actually or potentially virginity tested person?
- How do you think the health care and social work professionals recognize virginity test related risks?
- How do you think the health care and social work professionals should encounter a client or a patient who brings up virginity testing?
- How do you think the health care and social work professionals should support a client or a patient who brings up virginity testing?
- How do you think the health care and social work professionals should bring up virginity testing in discussion with a client or a patient?

Wishes for the future

- What do you think the health care and social work professionals should know about virginity testing?
- What do you think, what kind of support those who have experienced virginity testing might need?
- What do you think, what kind of encountering would help those who have experienced virginity testing?
- If you could decide, what would be the future of virginity testing?

Appendix 5: Information letter for professionals

Hyvä ammattilainen,
Kiitos, että olet kiinnostunut jakamaan kutsua YAMK-opinnäytetyöhöni liittyen!

Opinnäytetyöni aihe on neitsyystestaus. Opinnäytetyö pyrkii tutkimaan ja tuomaan esiin niiden ihmisten kokemuksia ja näkemyksiä, jotka ovat kokeneet neitsyystestauksen tai siihen liittyviä aiheita henkilökohtaisessa elämässään. Opinnäytetyön tavoitteena on muodostaa asiakaslähtöisiä suosituksia sosiaali- ja terveysalan ammattilaisille anonyymin verkkokyselyn avulla kerätyn aineiston pohjalta. Aineistosta nousee mahdollisesti vastauksia näihin kysymyksiin:

- Kuinka tunnistaa neitsyystestauksen kokenut tai potentiaalisesti kokenut henkilö
- Kuinka tunnistaa neitsyystestaukseen liittyviä riskejä
- Kuinka kohdata ja tukea potilasta tai asiakasta, joka ottaa neitsyystestauksen puheeksi
- Kuinka ottaa neitsyystestaus puheeksi potilaan tai asiakkaan kanssa

Verkkokysely toteutetaan englanniksi e-lomakkeella, johon pääsee käsiksi linkin (shorturl.at/oABCF) kautta tai oheisen posterin QR-koodin avulla. E-lomake sisältää tarkemmat tiedot osallistujille heidän oikeuksistaan, opinnäytetyön tarkoituksesta ja aineiston käsittelystä. Henkilökohtaista dataa ei kerätä, sillä kysely on täysin anonyymi. Neitsyystestaus on aiheena hyvin intiimi ja voi nostaa epämukavia tunteita tai muistoja pintaan. Vastaajat saavat e-lomakkeella Nollalinjan numeron, mikäli he kokevat tarvitsevansa tukea. Vastaajia neuvotaan poistamaan internetin selaushistoria kyselyyn vastaamisen jälkeen. Mikäli vastaajan internetin käyttöä seurataan hänen omalta laitteeltaan, vastaaja tulee ohjata toisen, turvalliseksi todetun laitteen ääreen täyttämään kysely.

Kriteerit osallistumiseen ovat:

- 18 vuoden ikä ja englannin kielen taito
- Vapaaehtoinen osallistuminen tutkimukseen sekä tutkimuksen ja raportoinnin anonymiteetin, sensitiivisyyden ja eettisyyden ymmärtäminen
- Henkilökohtaiset kokemukset joko omasta tai läheisen elämästä neitsyystestaukseen tai siihen liittyviin teemoihin liittyen
- Tietoon perustuvan suostumuksen antaminen e-lomakkeella

Jos teillä tai vastaajalla herää mitä tahansa kysyttävää tutkimukseen liittyen, vastaan erittäin mielelläni.

Ystävällisin terveisin, Ellimari Kortman
Global health and crisis management degree programme in Laurea University of Applied Sciences