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FGM in Sweden: current policies and debates

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1. Introduction

1.1. Country context

Sweden, with a total population of some 10 million people, has an estimated number of about 38,000 women with FGM; among them some 7,000 girls younger than 18 years. They originate primarily from Somalia, Eritrea, Ethiopia, Egypt and Gambia, and arrived in Sweden already circumcised (the Swedish Board of Health and Welfare, 2015). Some 19,000 girls in Sweden were born in families originating from countries in which some form of FGM is a traditional practice.[1]

The largest group is the Somali, with the first wave of immigration in the 1990s. This is also the group with the highest number of newly arrived immigrants. The other immigrant groups from FGM-practising countries are smaller in size, the majority of them arrived many years ago, and they are generally better integrated into the Swedish society than many Somalis.

1.2. Legal framework

In 1982, Sweden legislated against FGM and was the first Western country to do so.

Beside the ban on FGM,[2] there is a comprehensive legal framework including the *Social Services Act*, regulating how children should be protected, and the duty for professionals to report knowledge or suspicions about abuse of or other crimes against a child.[3] Further, there are specific regulations making it possible to breach professional secrecy between authorities in cases of suspected pending or performed FGM,[4] and it is also possible to have a girl genitally examined without consent from her parents.[5] Finally, also relevant in this field is the *Discrimination Act*,[6] which prohibits any kind of discrimination of people of a certain ethnic background.

Sweden has a nationwide system of personal identification numbers, which facilitates for authorities to 'monitor' individuals and families (in contrast to some other European countries where it is more difficult to have public control over residents).

[1] These estimates do not include the Kurdish Iraqi residents in Sweden, since there is presently little research about FGM in this area (The Swedish Board of Health and Welfare, 2015).
[2] Act Prohibiting Female Genital Mutilation (1982:316).
[3] Social Services Act (2001:453). There is also the Care of Young Persons Act (1990:52) permitting the social authorities to take a young person into care using compulsion. The law can be applied when there is no other way of protecting a girl from suspected pending FGM.
[4] Public Access to Information and Secrecy Act (2009:4).
[5] Act regarding Special Representative for a Child (1999:997).
[6] Discrimination Act (2008:567). Technically, it suffices that ethnic background has been a contributory cause for specific treatment in order to say that discrimination has taken place.

Since the law came into effect in 1982, some 70 reports on suspected FGM have reached the police.[7] Some of these were groundless (some were based merely on rumours without a specific suspect, etc.). In some cases, the suspected family had moved to another country, while in others the genital examination showed that no FGM had taken place. Two cases have been taken to court and ended up in custodial sentences, both in 2006. Both cases concerned families of Somali origin; in one case the father of the girl was found guilty and in the other case the mother. In both cases the FGM act is said to have been performed in Somalia (Johnsdotter & Mestre i Mestre, 2015).

1.3. Policy background

Since the first years of the 1990s, there have been recurrent policy initiatives from the government in order to prevent FGM and to provide the best care possible for already circumcised girls and women in Sweden (Johnsdotter, 2004; 2009). One of the latest efforts was the publication of a research survey (NCK/Johnsdotter & Essén, 2011). In 2013, the Ministry of Health and Social Affairs established a government commission 1) to estimate the number of concerned girls and women in Sweden (prevalence study); and 2) to increase the competence among health care professionals who treat girls and women with FGM, and also to find good practices for how to implement preventive efforts in the health care sector (the Swedish Board of Health and Welfare).[8] The Ministry of Education established another commission to map the experiences among concerned women and girls, and also among concerned professionals, with the aim to improve existing guidelines for prevention and adequate care (the Östergötland County Administrative Board).[9] Both these commissions have been completed and final reports have been published, although some material – such as updated guidelines for healthcare staff – is still underway.

2. Policy debate

2.1. 'Dare to see'

The Östergötland County Administrative Board published a report, named 'Våga se' [Dare to see], as a deliverable of the government commission. As the title suggests, the report builds on the assumption that cases are scarce because professionals in general do not 'dare to see' cases of FGM, and the report instructs on how to raise the issue in different arenas.

At the launching of the project, an activity loosely connected to the project ended up in a newspaper article in which it was claimed that 60 girls with FGM had been 'discovered' in a single school class, a strange claim that swiftly became global news.[10] In the debate that followed, it was argued that policy initiatives to give

[7] Johnsdotter's research archive of police reports, police inquiries and court documents. The exact number in October 2010 was 46 police reports/inquiries. The request for documents regarding reported suspected cases handled by the police and prosecutor between 2010 and the present is currently being attended. A rough estimate is that, in sum, there will have been some 70 reports/ inquiries in the police system at a national level up until today.

[8] S2013/6130/FS. 2013-09-06.

[9] U2013/5292/JÄM. 2013-09-06.

[10] '60 cases of female genital mutilation discovered in Swedish school' (the news agency Reuters, 20 June, 2014). It originated from an article in a provincial newspaper in Sweden, Norrköpings Tidningar,

attention to FGM need to be balanced and well-grounded in order to avoid further stigmatisation of the concerned women and girls.

Further, the perspective that the scarcity of cases is due to professionals' failing to identify and act upon suspected cases of FGM has been challenged. It may well be the case that the scarcity of cases to a high extent can be explained by the fact that attitudes to FGM change after migration (e.g., Johnsdotter & Essén, 2016).

2.2. Genital modifications: law, medicine, and ethics

Legislation and policy making regarding FGM have been discussed in relation to other genital modifications that are accepted in European countries. Most of these debates have concerned circumcision of boys. More and more activists and debaters argue that male children should have the same legal protection as girls as regards their genital integrity.[11]

FGM legislation has also been discussed in relation to cosmetic genital surgery. Since the FGM Act in Sweden is applicable regardless of age, a situation presents itself in which the lawfulness of genital modifications in adult women becomes a question of ethnicity or colour of skin (and thus the law is discriminatory in how it is (not) applied). However, FGM activists regard these remarks as academic hair-splitting.[12]

A future debate about reconstructive clitoral surgery for circumcised women can be expected, in Sweden as well as in other European countries. The technique is well established in France (Foldès et al., 2012), while the procedure meets with scepticism in other countries.[13] In Sweden, a medical team, allied with the NGO *Desert Flower Scandinavia*, has started performing the operation. A future question for Sweden and other EU Member States is whether such a procedure is acceptable from a medical perspective and, if so, whether it should be subsidised as an element in the care of women with FGM.

'More and more genitally mutilated girls are discovered', published the same day. The piece built on the misapprehension of 'discovery' of circumcised girls. Only one who does not know that many young girls arrive in Europe already circumcised will be surprised at finding them in ordinary schools. Thus, the word 'discovered' hinted toward criminal activities. The news spread all over the world in a few hours, and was reported by, for example, The Independent, La Gaceta, The Times of India, The New Zealand Herald and many more.

[11] For example, in 2011, the Ethics Board of the Swedish Society of Medicine [Svenska Läkaresällskapet] published a text in which they argued that circumcision of boys without their consent is unethical.

[12] Noteworthy, with similar FGM legislation in Sweden and Denmark, the official interpretations differ. In contrast to statements from the Swedish Board of Health and Welfare, the Danish board asserts that the Danish FGM Act is applicable also in cases regarding Danish (white) women, and thus cosmetic genital surgery in women is outlawed in Denmark (personal communication with representatives of the Danish Board of Health and Welfare at a seminar organised by the Nordic Council of Ministers, Copenhagen, 18 April 2013).

[13] For example, The Royal College of Obstetricians and Gynaecologists in the UK maintains that "clitoral reconstruction should not be performed because current evidence suggests unacceptable complication rates without conclusive evidence of benefit" (2015:4).

2.3. Balancing promptitude in action and risk of discrimination

A compulsory genital examination of a Swedish Somali 11-year-old girl in Uppsala in 2005 resulted in a court case about discrimination. In 2010, the Supreme Court decided that the municipality of Uppsala had to pay damages to the girl and her parents since the suspicions about FGM primarily had to do with the ethnic background of the family. More cases of compulsory genital examination (none of them proving FGM) have been reported to the government body Diskriminerings-ombudsmannen [the Ombudsman against Discrimination].

This case demonstrates the difficulties for professionals to balance expectations, on the one hand, to act swiftly when they suspect that FGM has been illegally performed or that a girl might be at risk, and, on the other hand, not to act in ways that can be deemed discriminatory.[14]

3. Transferability of good practices (UK, Italy)

3.1. Legislative framework

It seems that what can be achieved in terms of child protection and prosecution in the UK and Italy can also be achieved in Sweden within existing legal framework. Further, professionals' duty to report suspicions of illegally performed or pending FGM is in place in Sweden.

The FGM Protection Orders described in the UK Discussion Paper have no equivalent in Sweden. A girl at risk of pending FGM can be protected through the *Care of Young Persons Act* permitting the social authorities to take a young person into care. However, there is no system in place to take a variety of measures similar to the FGMPOs.

3.2. Care for women and girls with FGM

There have been FGM protocols and guidelines within the healthcare sector in Sweden since the 1990s, during the last decades administered by the Swedish Board of Health and Welfare. The board works continuously with updates of these resources. Recently, the board introduced a web-based course, which offers an introduction to the subject and provides tools to work with FGM prevention in the healthcare sector.[15]

There are also some clinics specialised in care for women and girls with FGM. The most established one is AMEL in Stockholm, with five gynaecologists and one counsellor.[16]

[14] Needless to say, it is not a crime to have a certain ethnic background, or to let minor girls spend holidays in FGM-practising countries. Yet, these circumstances have been crucial in many cases of suspected FGM (Johnsdotter, 2009).

[15] Available at https://utbildning.socialstyrelsen.se/enrol/index.php?id=35

[16] http://www.sodersjukhuset.se/Avdelningar--mottagningar/Mottagningar/Mottagning-for-konsstymade/

3.3. Involvement of concerned immigrant communities

The UK and Italy Discussion Papers give examples of projects involving immigrant communities. This approach in preventive work has not been in focus in government initiatives for quite some years in Sweden. Here is room for improvement, and the obvious constraint would be lack of funding. If funding is available in the future, the next step would be selecting receivers of funding and, at a later stage, dealing with difficulties in evaluating the outcomes of the projects.

Currently, the Swedish Migration Agency has a web training on honour-related violence and oppression, including forced marriages and FGM. The Swedish Board of Health and Welfare has developed material that includes FGM as a topic of discussion, aimed at being used by so called 'community communicators' when lecturing newly arrived about the Swedish society.

3.4. Government funding

What stands out when one compares Sweden with Italy and the UK is the volume of government funding for FGM-related projects. Funding to projects in Sweden has been more modest, especially compared to Italy. The last two government commissions had budgets of SEK 1.5 million and SEK 2 million (ca. EUR 165,000 and EUR 218,000, respectively).

However, in addition, there are government grants for NGO activities and projects in the social welfare field,[17] and also funding for activities on the global arena. Through SIDA (Swedish International Development Cooperation Agency), the Swedish government supports the organisation Tostan, connecting FGM to human rights issues in a broad perspective, and Nafis, a Somali women's organisation working to combat FGM. In 2014, the Swedish government allocated SEK 40 million (ca. EUR 4,3 million) to a global anti-FGM programme monitored by UNICEF and UNFPA. In a broader effort, the government supports a strategy aimed at strengthening African women's and children's health, including work to combat FGM (ca. EUR 307 million in a five-year-period).

4. Recommendations for actions

4.1. Giving attention to the issue of FGM while avoiding arbitrariness and discriminatory measures

As pointed out in the UK Discussion Paper, too strong a focus on legislative measures takes away focus from other important aspects of FGM prevention. In Sweden, we have experienced that an emphasis on prosecution, and too strong willingness to identify illegal cases, may result in discrimination. The rightful care and support these girls are owed according to legislation (social support according to the *Social Services Act* and the right to have access to care on equal terms according to *the Health and Medical Services Act*), may be jeopardised if professionals meeting these girls focus too strongly and too singularly on the issue of FGM and whether the girl has been illegally circumcised or not. Complementary

17 E.g., www.socialstyrelsen.se/statsbidrag/aktuellastatsbidrag/Documents/dnr-11217-2015-fordelning-sociala-organisationer-2016.pdf.

social or medical evils that the girl suffers from, or other personal problems she has, may be overlooked by social workers trying to find out if she has been unlawfully subjected to FGM, or by medical professionals focusing inappropriately on FGM.

If any professional meets an African parent and starts thinking about the risk of FGM, we have a hypothetical situation where practically all parents from FGM-practising communities risk being reported to the social authorities or to the police.[18] This is not the current situation: relatively few cases of suspicion are actually reported. However, we can draw the conclusion that there is a big risk for arbitrariness within this topic. Indeed, parents are not reported because of substantial information to support suspicion; parents are reported because they have happened to meet professionals who, for some reason or another, have come to think about the possibility of FGM. There is a clear and great hazard here, regarding which families become objects for investigation. If professionals are sensitised toward FGM while not simultaneously being offered relevant guidelines or protocols on the best way to handle suspected cases, the threat for arbitrariness is further heightened. Therefore, FGM sensitising campaigns directed toward professionals must always be accompanied by relevant knowledge and proper guidelines.

4.2. Being careful about the framing

The UK Discussion Paper includes an interesting paragraph (p. 12) about an interview study, in which a cut young girl reacts against the language and messages in FGM campaigning. Policy makers and campaigners may want to reconsider some messages and wording in campaigns in order not to be rejected by immigrant communities – which are important potential allies in preventive efforts.

Further, there is an inherent risk in placing the FGM issue under broader umbrella concepts such as 'honour violence'. Theoretically, the phenomena must be understood separately, and a merging can be misleading and pose difficulties for professionals who try to grasp the situation and act upon suspected cases adequately.

Concurrently, there is also a risk in singling out FGM too strongly. It needs to be clarified from the government bodies that the suspected cases of FGM should be handled in the same way as other suspected cases of abuse or maltreatment of children. Singling out FGM as a particularly reckless form of child abuse may have the effect that ordinary protocols are abandoned and the cases are handled in imperfect and questionable ways.

4.3. Mobilising established immigrant communities

While not claiming that the figures are statistically significant in any way, it might be worth noting that the two court cases in Sweden were initiated by the girls themselves, who turned to Swedish authorities – while the numerous compulsory genital examinations in suspected cases have not ended up in any single court case thus far. This situation may have something to say about the importance of trust

[18] According to the Social Services Act, it suffices with a suspicion that a child is being abused, or is at risk of being so, to invoke the duty to report (to the social authorities) for professionals. The social authorities, in turn, should hand over the case to the police if there is a suspicion that a crime against a child has been committed.

building between concerned immigrant communities and authorities in the host countries.

In addition, there is room for better use of the competence among well-established community members with adequate language skills and knowledge about how to best persuade newly arrived peers about why FGM must be abandoned. The 'cultural change' perspective, increasingly discussed in the international field of FGM,[19] could be a powerful tool in preventive campaigns – using the inherent power in the public message that 'most others' among those who have migrated from FGM-practising communities to Western host societies have abandoned the practice.[20]

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[19] E.g., Johnsdotter, 2002; Farina & Ortensi, 2012; Belmaker, 2012; Gele et al., 2012, 2015; Exterkate, 2013; EIGE, 2015; Johnsdotter & Mestre i Mestre, 2015; Johnsdotter & Essén, 2016.
[20] This approach, built on social convention theory, has been suggested as a key strategy by UNICEF (2005, 2010).

Dissemination of lessons learned and capacity building of actors in legal and para-legal fields.")

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