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MUTILAZIONI GENITALI FEMMINILI IN EUROPA:
PROBLEMI E PROPOSTE PER L'ERADICAZIONE DI UNA PRATICA CULTURALE
Roma, 10 - 11 dicembre 2004

Female Genital Cutting Among Immigrants in European Countries: Are Risk Estimations Reasonable?

Background: risk estimations

How many immigrant girls in European countries are at risk of being subjected to FGC? Estimated numbers vary, as well as the modes of calculation. Often it is not stated how the figures were reached: "It has been estimated that 20,000 girls in Britain may be at risk of FGM" (Eke & Nkanginieme 1999:1084), with no further comment.

In Sweden, the figures vary from 8,000 (Olsson 2000) to 12,000 (Esken et al 2001). The basic mode of calculation seems to be counting the number of girls having at least one parent born in a country where FGC is practised.

Another way to present figures in relation to FGC is to state the number of all immigrants from countries where FGC exists:

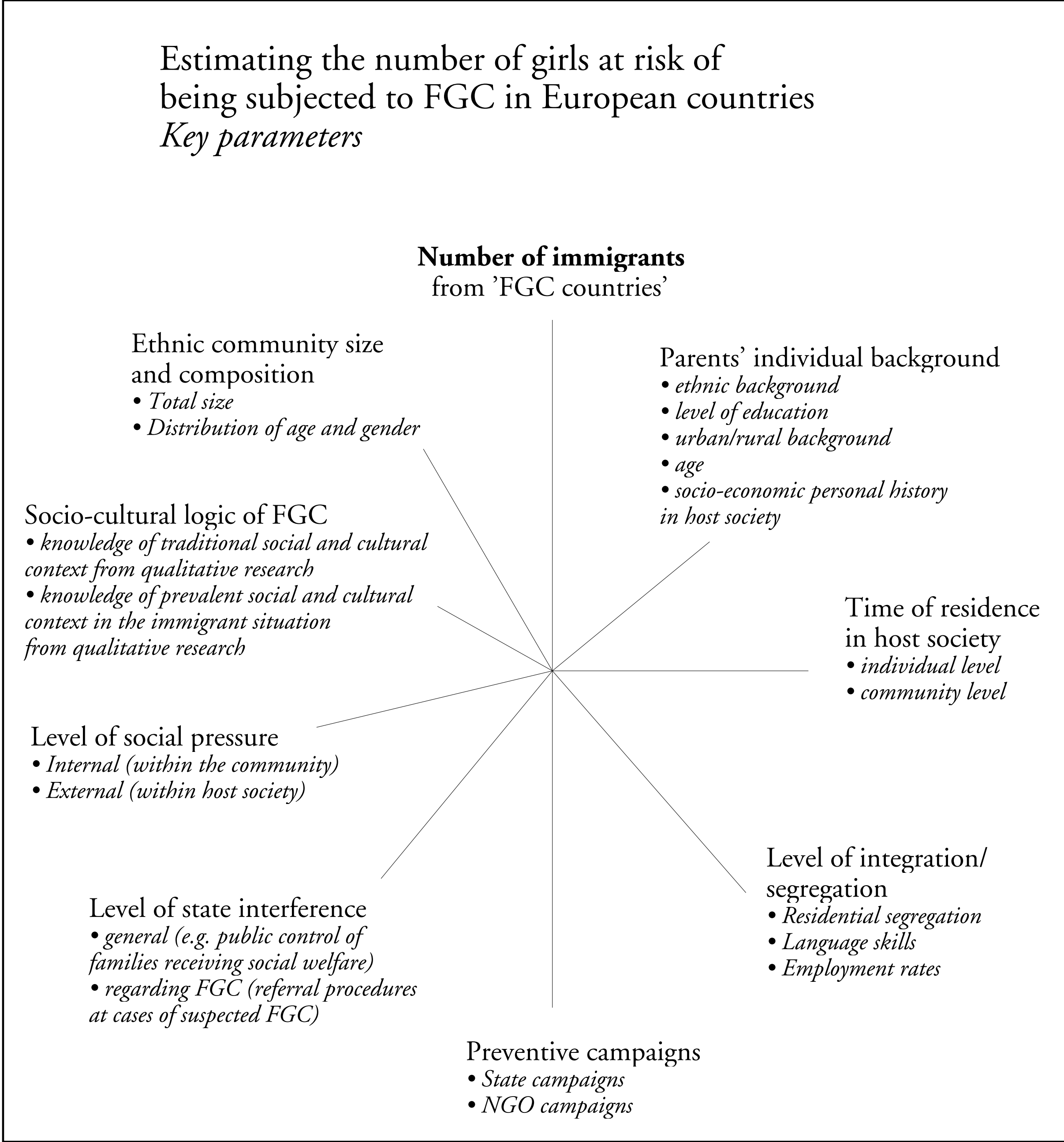
> … the number of migrants coming from FGM risk countries is the highest in the UK counting more than 300 000 individuals, France with almost 200 000 women immigrants from those countries, followed by Italy and Germany with 133 847 and 77 795 women immigrants respectively [Diamantopoulou 2000:2].

Yet another presentation of numbers includes all women and girls supposed to have been subjected to FGC (sometimes with an addition of those who may be at risk of being subjected in the future): GAMS in France states that 27,000 women and girls in France are concerned (Tortorelli 2002); in Italy, 30,000 women are said to be concerned (Bonessio et al 2000, Bonessio et al 2001, from abstracts); in the US, "an estimated 168,000 females with or at risk of FGM" (Eke & Nkanginieme 1999:1084). Sometimes there is a distinction made between women already affected and girls said to be at risk:

> In Italia vivono 40mila donne infibulate e, ogni anno, 6mila bambine, tra i quattro e i dodici anni, con genitori provenienti soprattutto dai paesi dell'Africa sub-sahariana, rischiano di essere sottoposte a questo rituale [Persiani 2004].
>
> *40,000 infibulated women live in Italy, and every year 6,000 children aged four to twelve years, with parents coming from the sub-Saharan countries, risk being subjected to this ritual.*

In a Daphne report (Leye & Deblonde 2004) including five European countries, numbers of girls at risk are estimated using various modes of calculation, depending on access to statistics and the countries' various ways of categorising immigrants.

What factors or parameters ought to be included at risk estimations?[1] Below a suggestion will be made. There is no intention to offer a new mathematical formula to calculate numbers of girls at risk of FGC, but rather to remind of that dealing with figures of "risk" is risky business.



[1] The issue seems to have been discussed in Italy at a seminar in Rome (22 June, 2004): "Como calcolare le dimensioni del fenomeno in Africa e nei paesi di immigrazione?" ("How calculate the dimensions of the phenomenon in Africa and the countries of immigration?") it is asked in an invitation to the seminar **Mutilazioni dei genitali femminili: Una giornata internazionale di reflessione.** Unfortunately, I have not been able to find any further documentation of this seminar.

Parameters in risk estimations

Number of immigrants from 'FGC countries'
This factor is emphasised in the model, since this is the mode seemingly most used at estimating numbers of girls at risk. A technical way to calculate is, for instance, to look for the number of girls aged 0-15 born in/with citizenship of a certain country, and then divide that figure in relation to prevalence of FGC in country of birth. (For examples, see Leye and Deblonde 2004, figures concerning Sweden by me on page 25). However, the official number of girls at risk in Sweden is based on the view that **all** girls (0-20 years) with one or both **parents** born in a country where FGC is practised by at least 60% of the population are to be considered "at risk".

Ethnic community size and composition
The size of the ethnic community is of crucial importance. There are good reasons to assume that girls in a community embracing more than 20,000 Somalis are at higher risk than girls in a community of less than 300 people from Senegal (where the number of girls aged 0-15 does not exceed 15 individuals in Sweden). The distribution of age and gender in a certain community may also be of importance at risk assessment.

Socio-cultural logic of FGC
To be able to assess the level of risk, we need to have access to qualitative studies describing the traditional logic(s) of FGC in the country of origin. In some local settings the practice of FGC seems to be deeply interwoven with many aspects of social life (religion, gender relations, initiation and adult status, aesthetics, etc.). In others, the practice seems to be more or less redundant, or be perceived as a "tradition" but in lack of a 'deeper' meaning.

Likewise, we need to get hold of the internal debate within the community in the context of immigration. How have views changed, due to migration? Traditional reasons for FGC in the country of origin are always *context-specific*, which means that migration experiences and everyday life in a new social environment will force immigrants to reassess their views – their reasons for being advocates or opponents of FGC will still be context-specific, but the logic will have gone through some kind of change due to the new life circumstances.

An example of an abrupt abandonment of FGC in exile is presented by Grisaru et al 1997:

> Ethiopian Jews give up RFGS [ritual female genital surgery] immediately on arrival in Israel. They see themselves a part of a Jewish society without RFGS. No signs of distress or nostalgia for the custom were expressed. […] Rapid cultural change without evident distress may be possible if individuals or a group consciously accepts a new identity [Grisaru et al. 1997:214].

The results of medical (genital) examinations of 113 Jewish Ethiopian women aged 16-47 in the same study were surprising, since a much lower number of women than expected was circumcised: as many as 71 women (63%) showed no traces of any cutting. Considering the fact that migration to Israel took place as late as in the 1980s and 90s, more older women "ought to" have been circumcised.[2] Nevertheless, the genital examinations fully supported the claim of abandonment stated in the qualitative interviews.

When it comes to qualitative analyses of socio-cultural context of FGC in exile, studies are few. Among them is McGown (1999) who has a focus on Somalis in London and Toronto. Johnsdotter et al (2000, Johnsdotter 2002) discuss cultural change in this field among Somalis in Sweden, and Pasquinelli (2000) has conducted qualitative research to map the internal discussion and socio-cultural context of FGC among Somalis and Nigerians in Italy.

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[2] About 85,000 Ethiopian Jews live in Israel today. Most of them were transferred by the Israelian state during Operation Moses in 1984-85, Operation Salomo in 1991, and Operation Quara in 1999 (Wymark 2003).

Within the scope of the Daphne project hosting this conference, Johnsdotter et al (forthcoming) conducted a qualitative study aiming at understanding the internal discussion of FGC among Eritreans and Ethiopians in Sweden.

Qualitative studies show that the level of risk of FGC is unequally distributed among and within the concerned ethnic communities. The implications of this fact will be further discussed below.

Level of social pressure

To assess the level of social pressure within the community, we need insights of in-group relations. Here, again, the size of the community probably is of importance, but also the level of segregation (see below). Social pressure can work both ways: either to promote a persistence of tradition, or a general in-group view that the practice ought to be abandoned.

When it comes to external social pressure, there are obvious differences between European countries. Compare, for instance, Sweden and Belgium: Sweden has a high level of attention and alertness in the FGC field, while Belgium seems to lack both public discussion and referral procedures (Leye & Deblonde 2004). It is likely that the existence or lack of public debate and campaigns play a role when it comes to social pressure.

The mass media plays a tricky role. On the one hand, public attention to the FGC issue spurs internal debates and may speed up the process of change. On the other hand, sensational framing of the issue, presenting allegations about persistence of the practice in the host society, may have negative consequences in terms of social pressure. Those immigrants who are ambivalent to FGC may "tip over" and believe that "everybody else" in their community sticks to tradition. In this particular situation, there is reason to believe that exaggerations in the mass media may increase the level of risk.

Level of state interference

When we try to establish how many girls who are at risk of being subjected to FGC, we need to consider the level of state interference, or the multi-faceted relations between the immigrant communities and the state institutions. Among the Somalis in Sweden, there is a prevalent idea that the Swedish state is omnipotent, leaving ordinary parents with little power to run their families, and with a strong desire to control the private life of its citizens (Johnsdotter 2002, 2004). A widespread understanding is that the Swedish state can take over the custody of children by compulsion, for almost no reason at all. (Sweden has traditionally had one of the highest per capita rates in the world of forced taking of children into custody.) This description of the situation is confirmed by empirical examples in other studies. Here an elderly woman replies to the researcher, who is met with statements from her Somali informants that FGC is a tradition which has been abandoned by the Swedish Somalis:

> People do it in Canada or the USA… there the system does not interfere with FC as is the case here in Sweden [Ahlberg et al 2004:60].

There is an interface between general state interference and the existence of FGC referral procedures. Again using Sweden as an example: there are several cases of rejection of social welfare allowances as a response to suspicion of planned FGC. There are also examples of reports regarding suspected performed or planned FGC from most sectors in society (but no case has reached court). Generally the FGC referral procedures work well in the Swedish society (Johnsdotter 2004).

This situation is different from the contexts of e.g. the UK and France, where larger groups of illegal immigrants live. This is mentioned as an obstructive factor when it comes to implementation of the legislation in France – some cases of FGC will remain unnoticed by society thanks to lack of social control:

- There have been a lot of illegal entries in the country the last couple of years. […] And we know that there are groups of the population who escape from all social control. You cannot trace them [prosecutor interviewed, in Weil-Curiel 2004].

Preventive campaigns
The level of risk is likely to be affected by the existence or lack of campaigning. The UK, Denmark and Sweden are among the countries that have a long history of anti-FGM campaigns. In the UK, FORWARD is an activist organisation with longstanding experience of national campaigning. Today the organisation is a key actor in cases of suspected performed or planned FGC, in close cooperation with the police and the child protection authorities (Kwateng-Kluvitse 2004). Sweden initiated a national campaign against FGM in the beginning of the 1990s, Denmark started their campaign a few years later. Belgium, again, is an example of a country where no national campaign of FGC has been launched.

Level of integration/segregation
There is reason to assume that immigrants living in segregation in the host society are more prone to view FGC in a positive way, than immigrants who are integrated or assimilated into the host society. Here we have to include residential segregation, language skills and employment rates, among other factors in the same vein.

This parameter is closely related to ethnic community size, level of social pressure and time of residence in host society. In Sweden, we can see a clear difference between the internal debates among Somalis on the one hand, and Eritreans and Ethiopians on the other hand. Most Eritreans and Ethiopians, in total less than 20,000 in Sweden, arrived in Sweden in the 1970s. Generally speaking, the groups are very well integrated: they arrived in a period when Sweden had a strong economy and good opportunities to integrate foreigners into the labour market. The Somalis arrived in Sweden at the time of, or shortly after, a period of strong economic recession. A large majority of the Somalis have been denied access to the labour market and are forced to live on social welfare. To a high extent, Swedish Eritreans and Ethiopians share a "western" view of FGC, repudiating all forms of it with fervour; while many Swedish Somalis express views of FGC which do not accord with the public view of FGC in Sweden (Johnsdotter & Essén 2004, Johnsdotter et al. forthcoming, Johnsdotter 2002).

Time of residence in host society
This parameter is closely related to the one above, concerning level of segregation. The point is that we deal with time of residence at two levels: at the individual level and the community level. Individuals who have stayed in the host country for, say, ten years are more likely to oppose to FGC than individuals who arrived very recently from a local setting where FGC is completely acceptable and even honoured.

However, many individual migrants arrive into already existing ethnic networks in the host society, where they may be influenced by values prevailing. That is, an Eritrean who arrived in Sweden last year may be more willing to openly dissociate himself from FGC, as a result of discussions with his fellow countrymen in Sweden, than a Gambian arriving in the new society years ago, if most of his fellow countrymen still have a positive view of FGC (a hypothetical example; nobody has yet studied the internal views of FGC among Swedish Gambians). It is reasonable to believe that the longer a group has lived in a society, the more the general views within the group will be in accordance with those of the host society. (This does not hold for processes of negative integration, i.e. when a community creates its own institutions within but without relations to the host society, see e.g. Carlbom 2003.)

Parents' individual background
At the presentation of numbers of girls said to be at risk of FGC, all parents are implicitly equally prone to have their daughters circumcised. In reality, there is an immense difference in attitudes within these groups.

When it comes to ethnic background, some ethnic groups from an 'FGC country' may not practice FGC at all. If a society hosts a Ghanese community, the level of risk varies depending on whether these persons come from the north or the south of Ghana.

Similar considerations have to be made when it comes to level of education, age and whether the person comes from a rural or urban area (we can expect differences in attitudes of people coming from Addis Ababa compared to people from very distant rural areas of Ethiopia).

Every individual has his or her personal "journey" in the host society, when it comes to social, psychological and socio-economic aspects. We can expect that persons who have lived for some time in the host society and are residentially segregated, unemployed and with experiences of discrimination, are more inclined to view FGC positively than persons who were soaked into the host society soon after arrival – those who are employed, interact in arenas of the host society and who develop a sense of belonging to their new society.

Does it matter? Can't exaggerations be useful?

The point of this discussion is to highlight the fact that "being at risk of FGC" is a highly complex category, and a strictly context-specific one. In France, more than 25 cases of FGC have been taken to court (e.g. Weil-Curiel 2004). This has a lot to say about the situation of *West Africans* in *France* – but very little to tell about, say, *East Africans* in *Denmark*. Drawing conclusions about persistence of FGC in all of Europe, using the French trials as an example, is a grave incident of jumping to conclusions. It is a bit like trying to say something about Norwegians in the United States, by exemplifying with the situation of Russians in Australia. Yet, in many texts there is an understanding of the phenomenon assuming a general persistence of FGC traditions among the African immigrant groups in Europe:

> FGM is also reported to exist in Denmark, England, Finland, France, Germany, Italy, the Netherlands, Sweden etc. [Ras Work 2001:8].

> In industrialized countries, genital mutilation occurs predominantly among immigrants from countries where mutilation is practised. It has been reported in Australia, Canada, Denmark, France, Italy, the Netherlands, Sweden, the UK and USA [Amnesty, undated website, accessed 2 December 2004, *http://groups.msn.com/AmnestyInternationalCenter/femalegenitalmutilationfgm.msnw*].

Finland has no documented illegal case of FGC (Essén & Wilken-Jensen 2003), nor has Sweden or Denmark (ibid, Johnsdotter 2004). In England there is still not a single documented case of unlawful female circumcision, even if the study conducted by Morison et al. (1998) suggests that there have been, and maybe still are, instances of girls being circumcised abroad or at British clinics. To the best of my knowledge, there are also no documented cases in e.g. Germany and the Netherlands.

At the non-existence of documented cases, most actors in the field restrict themselves to statements about girls *at risk* of FGC – which is a very extensible category, and one that does not need to be exemplified with documented cases.

There seems to exist a bit of anxiousness in risk estimations. The numbers are rather exaggerated than toned down considering all factors pointing at decrease of risk. There seems to be a general, but implicit, understanding in this field that exaggerations are harmless and done for the moral good. Rather include every possible girl or group in these estimations, than to downgrade the issue and risk to be perceived as insensitive or wanting in empathy.

Also, we must not dismiss the fact that a social problem must be presented as alarming and of a sizeable scope to be able to attract attention and funding. Activists, politicians, experts, journalists and officials all have good reasons to maintain a public discourse holding that FGC is a serious and widespread phenomenon in the African immigrant groups (Johnsdotter 2002).

When it comes to exaggerations regarding risk estimations and allegations of a widely persisting practice of FGC in the European countries, the price is paid by individual members of the immigrant communities. A few examples:

> [A woman in her 30s from Eritrea:] - *I have felt really bad about it sometimes when I have watched a documentary [on television]. I didn't dare to leave the house almost. Since I am veiled too, I felt stared at, even if it [the things said in the documentary] had nothing to do with me. I felt horrible at the broadcasting of that program… Okay, it's a good thing too, the broadcasting of programs like that, we also need to know about what's going on. But not in that way, because there is such a stigmatisation following* [Johnsdotter et al. forthcoming].

> [A circumcised young woman from Somalia:] - *The Swedes see it as a big deal, and talk about it and sometimes exaggerate. That is the main source of pressure and discrimination for the circumcised girl* [Ahlberg et al. 2004:59].

> [A Somali woman in her 40s] expressed her feelings of embarrassment when there are articles in Swedish newspapers or reports on television about female circumcision. She says she can imagine how Swedes perceive of the tradition: *"'How can they do these terrible things to their own daughters?'… They don't understand… and I can see why".* This feeling of being abashed at the existence of the tradition, looking at it with the eyes of the Swedes, appears to be one of the reasons behind some Somalis' strong reactions when their fellow countrymen have appeared in the mass media talking about circumcision: 'Do they have to insist on paying attention to this practice?' Continuous attention will create a bad image of the Somalis in Sweden: portraying them as monstrous people torturing their own flesh and blood [Johnsdotter 2002:131].

A man from Ethiopia is of the opinion that the FGC debate in Sweden has been very vulgar. He suggests that he FGC issue works as an instrument for Swedes, or westerners, to canalize a self-righteous attitude of moral goodness, and that there is a latent racism lurking in it:

> [A man in his 40s from Ethiopia, with irony:] - *You are not supposed to say nigger, but you can say this [about FGC], because that is so well substantiated, isn't it? I am sure that some people have the best intentions, but I think this is a fraudulent debate. "God, we are so good", and so on. Those who are concerned have reason to feel deeply offended* [Johnsdotter et al, forthcoming].

The question then is if the possibility – and actually, the probability – that there are girls in Europe who are subjected to FGC, can defend the exaggerations. If a moral panic (see e.g. Goode & Ben-Yehuda 1995) leads to measures that save some girls from suffering, is it worth the price to stigmatise whole groups to achieve it?

A new approach: alertness and scepticism combined

The exaggerating attitude seems to imply a conflict between alertness and scepticism (or reasonable risk estimations). It appears as if many people believe that the construction and maintenance of referral procedures regarding FGC in a society depend on a view of a large-scale practice among African immigrants. The perceived horror of the FGC crime seems to outface our ordinary sense of reason, leaving scepticism and accuracy aside. At least in Sweden, any rumour about traditional circumcisers touring the country is taken as fact, even if the story lacks substantiation. Without any further commentary, a journalist gives the following depiction of Swedish Africans (Somalis) in an editor's column in Sweden's most important daily paper:

> It is not Anders and Greta Svensson [names representing 'typical Swedes'] who have their five-year-old daughter circumcised on the kitchen table, by a Somali circumciser on tour in Sweden [Dagens Nyheter, 11 October 2002].

The origin context of the idea was a speculative and manipulated documentary broadcast on Swedish national television in 2001. Few people reacted to the weakness of the argument, but accepted the statement as an established truth. A former minister of the government went public

condemning the atrocities alleged to be committed: "Circumcisers are flown into Sweden to perform mutilations".[3] This allegation about African circumcisers touring Sweden is highly improbable simply on the grounds that Swedish regulations regarding tourists from Africa are extraordinarily strict. It is practically impossible for an African person, resident in Africa, to obtain even a short tourist visa to Sweden. Further, rumours of circumcisers operating in Sweden have been investigated by the police, who did not find any evidence of such an activity (Johnsdotter 2004).[4]

To some groups it is a kind of symbolic violence to include them in risk statistics. When it comes to Eritreans and Ethiopians in Sweden, many of them regard it an offence to be included in these figures:

> I: - *When numbers of girls at risk of FGC is mentioned [in Sweden], then daughters of Eritreans and Ethiopians are included…*
> [An Ethiopian woman in her 60s:] - *That they would be at risk…?*
> I: - *Yes, they are included in the risk group…*
> [Upset, doubtful:] - *Is it true…?*
> I: - *Yes.*
> [Starts laughing incredulously:] - *That's bizarre… that's bizarre!*
> [Johnsdotter et al, forthcoming].

Her attitude, and the themes dominating the study of internal views of FGC among Swedish Eritrean and Ethiopians, point at a complete abandonment of FGC in these groups (Johnsdotter et al 2000, forthcoming). This is supported by the fact that all police reports on FGC and hearsay cases in the field concern only Somalis in Sweden (Johnsdotter 2004).

It is reasonable to believe that some girls in Sweden are at real risk of being subjected to FGC, as in several other European countries. However, it is not reasonable to believe, given the empirical evidence of cultural change and the non-existence of documented cases, to believe that FGC activities in Sweden occur at a large scale, or that traditional circumcisers tour the country. The same probably holds for many countries in Europe: some girls are at real risk, while others are at no risk at all of FGC, even if their parents were born in 'FGC risk countries'. We have reason to question estimations like the one suggested by the British Medical Association; that 3,000-4,000 British girls are being subjected to FGC *every year* (BMA 2004). If that would be true, it is likely that at least *one* case of illegal FGC during all these years would have been within reach for documentation, given the long history of campaigning and state interventions in the UK.

The field of FGC is a perfect breeding ground for rumours, 'witch hunting' and appearances of contemporary legends (or 'urban legends', see e.g. Goode and Ben-Yehuda 1995). Therefore, official figures of risk estimation and official statements about persistence of FGC practices need to be well-founded and formulated with accuracy.

Conclusion

An optimal official attitude would be to construct and maintain a societal structure prepared to deal with suspected cases of FGC with a high level of alertness; and to combine such an alert system with a healthy sceptical attitude toward rumours and exaggerations.

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[3] Maj Britt Theorin, "Prosecute the Swedish mutilators", *Aftonbladet*, 6 September 2001.

[4] In one case, they had even the address of the alleged circumciser. The origin of the rumour was that a social worker overheard an immigrant woman (from the Middle East) stating that her Somali neighbour was a circumciser. The social worker reported this statement to the police immediately, including the address in question. The police took the report seriously but their investigation gave no result (Police investigation K221441-99).

References

Alhberg, Maina Beth, with Ingela Krantz, Gunilla Lindmark, and Marian Warsame (2004)
'It's only a tradition': Making sense of eradication interventions and the persistence of female 'circumcision' within a Swedish context. *Critical Social Policy* 24(1):50-78.

BMA; British Medical Association (2004)
Female genital mutilation - caring for patients & child protection: The UK. Website, accessed on 3 December 2004, *http://www.bma.org.uk/ap.nsf/Content/FGM~UK*.

Bonessio L, Bartucca B, Bertelli S, Morini F, and Spina V (2000)
Female genital mutilation and legislation [Article in Italian, abstract in English]. *Minerva Ginecol.* 52(11):485-489.

Bonessio L, Bartucca B, Bertelli S, Morini F, Aleandri F, and Spina V (2000)
Female genital mutilation: FGM patients treated at the "Umberto I" polyclinic of Rome: 1985-1996 [Article in Italian, abstract in English]. *Clin Ter* 152(3):171-177.

Carlbom, Aje (2003)
The Imagined versus the Real Other: Multiculturalism and the Representation of Muslims in Sweden. Doct diss. Lund Monographs in Social Anthropology 12, Lund University.

Diamantopoulou, Anna (2000)
Female Genital Mutilation: What Europe Should and Can Do. Speech in the European Parliament, Brussels, November 29, 2000.

Eke, Ndu & Kanu E.O. Nkanginieme (1999)
Female Genital Mutilation: A Global Bug That Should Not Cross the Millenium Bridge. *World J Surg* 23:1082-1087.

Esken, Piret, with Jamila Said Musse and Lars Adarve (2001)
Respektera flickors hälsa [Respect girls' health]. *Göteborgs-Posten*, 7 September 2001.

Essén, Birgitta & Wilken-Jensen, Charlotte (2004)
How to deal with female circumcision as a health issue in the Nordic countries. *Acta Obstetricia et Gynecologica Scandinavica* 82(8):683-686.

Goode, Erich, and Nachman Ben-Yehuda (1995)
Moral Panics: The Social Construction of Deviance. Oxford, Cambridge: Blackwell.

Grisaru, Nimrod, with Simcha Lezer and R. H. Belmaker (1997)
Ritual Female Genital Surgery Among Ethiopian Jews. *Archives of Sexual Behavior*, 26(2): 211-215.

Johnsdotter, Sara (2002)
Created by God: How Somalis in Swedish Exile Reassess the Practice of Female Circumcision. Doct. diss. Department of Social Anthropology, Lund University.

——— (2004)
FGM in Sweden: Swedish Legislation Regarding "female genital mutilation" and implementation of the law. EC-Daphne project. Research Report in Sociology 2004:1. Department of Sociology, Lund University.

Johnsdotter, Sara, with Aje Carlbom, Ali Elmi, and Asha Omar (2000)
Som Gud skapade oss: Förhållningssätt till kvinnlig omskärelse bland somalier i Malmö [As we were created by God: Attitudes to female circumcision among Somalis in Malmö]. Malmö: Program Sexuell hälsa.

Johnsdotter, Sara, with Rishan Aregai, Aje Carlbom, Kontie Moussa, and Birgitta Essén (Forthcoming)

Kvinnlig omskärelse i Sverige: Etiopier och eritreaner [Female Genital Cutting in Sweden: Ethiopians and Eritreans]. Research report. Stockholm: Save the Children, Sweden.

Johnsdotter, Sara and Birgitta Essén (2004)
”Sexual Health among Young Somali Women in Sweden: Living with Conflicting Culturally Determined Sexual Ideologies”. Paper presented at the conferense *Advancing Knowledge on Psycho-Sexual Effects of FGM/C: Assessing the Evidence*. Alexandria, Egypt. October 10-12, 2004.

Kwateng-Kluvitse, Adwoa (2004)
National report: United Kingdom. Research report, Daphne project Evaluating the impact of existing legislation in Europe with regard to female genital mutilation. Ghent: ICRH, Ghent University.

Leye, Els & Jessika Deblonde (2004)
Legislation in Europe regarding female genital mutilation and the implementation of the law in Belgium, France, Spain, Sweden and the UK. Ghent: ICRH, Ghent University.

McGown, Rima Berns (1999)
Muslims in the Diaspora: The Somali Communities of London and Toronto. Toronto: University of Toronto Press.

Morison, Linda, with S. Dirir, J. Warsame, A. Dirir, and S. Elmi (1998)
Experiences, Attitudes and Views of Young, Single Somalis Living in London, on Female Circumcision. A collaborative project between the London Black Women's Health Project and the London School of Hygiene and Tropical Medicine. London: London School of Hygiene and Tropical Medicine.

Olsson, Iréne (2000)
Bred kamp mot kvinnlig könsstympning: Uppemot 8 000 flickor beräknas vara i riskzonen [Struggle on a broad front against female genital mutilation: Nearly 8,000 girls in Sweden are estimated to be at risk]. *Läkartidningen*, 97(42):4694-4695.

Pasquinelli, Carla (2000)
Antropologia delle mutilazioni genitali femminili. Una ricerca in Italia. AIDOS.

Persiani, Gabriella (2004)
Mutilazioni genitali femminili. Tradizione e orrore. Ma qualcosa sta cambiando. *Il cassetto*, online media, *http://www.ilcassetto.it/notizia.php?tid=5*, accessed 2 December 2002.

Ras Work, Berhane (2001)
Cultural reasons which condone FGM. *Female Genital Mutilation (Wiebliche Genitalverstümmelung) – ein "harmloser" Brauch oder ein tiefgehender Schaden für Frauen?* Dokumentation der Veranstaltung Wiebliche Genitalverstümmelung (FGM), 8.5.2001. Wien: Österreichen Gesellschaft für Familienplanung.

Tortorelli, Maria Antonietta (2003)
MGF, la donna negata. *Obbiettivo*, Collegio Ipasvi, Firenze 1/2003, pp. 27-32.

Weil-Curiel, Linda (2004)
French legislation regarding female genital mutilation and the implementation of the law in France. Ghent, Belgium: ICRH.

Wymark, Ewa (2003)
Från främling till bror [From stranger to brother]. *Menorah*, nr 4.