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FGM in Sweden: Swedish Legislation Regarding ”Female Genital Mutilation” and Implementation of the Law.

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Sara Johnsdotter

FGM in Sweden

Swedish legislation regarding "female genital mutilation" and implementation of the law

EC Daphne project
Evaluating the impact of existing legislation in Europe with regard to female genital mutilation
International Centre for Reproductive Health
Ghent University, Belgium
January - December 2003

Research Report in Sociology 2004:1. Department of Sociology, Lund University.

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Foreword

In 2002, an EC Daphne project on FGM, suggested and formulated by Els Leye and Jessika Deblonde at the International Centre for Reproductive Health (ICRH) at Ghent University in Belgium, was approved by the European Commission.

The project has been monitored by Leye and Deblonde and has included partners from four other European countries. The following persons have formed a steering group for the project:

• Els Leye, Jessika Deblonde	ICRH, Ghent University, Belgium
• Adwoa Kwateng-Kluvitse	FORWARD, United Kingdom
• Linda Weil-Curiel	CAMS, France
• Sara Johnsdotter	Dept. of Social Anthropology; Lund University, Sweden
• José Garcia Añon, Ruth Mestre i Mestre	Centre of Studies on Citizenship, Migration and Minorities; Universidad de Valencia, Spain

The objectives of the project were to

1) establish the nature of existing laws applicable to FGM in all EU member states;
2) analyse the implementation of such legislation in five member states;
3) evaluate the impact of existing legislation;
4) formulate recommendations for an EU strategy on legal actions towards FGM.

Each of the five partners (Belgium, France, United Kingdom, Sweden, and Spain) has conducted research in their own respective countries during the spring, summer, and autumn of 2003 to meet objectives 2) and 3).

The methodology used by the five country partners has focused on analyses of suspected cases of FGM, on legislation with regard to FGM (Acts on FGM, child protection legislation, secrecy legislation, etc.), on the mapping of referral procedures when it comes to suspicions about performed FGM or fear of future performance, and on interviews with key informants in the field. Further, the partners have collected data on national or local preventive efforts, population statistics, and other relevant aspects for an understanding of the obstructing and encouraging factors for the implementation of the existing legislation in the various countries.

This publication, "FGM in Sweden", concerns only the fieldwork done in Sweden to meet with objectives 2) and 3) as mentioned above. A comprehensive report including results from the fieldwork in all five countries, in addition to the results of the analysis of FGM relevant legislation in all EU member states, will be published in Ghent in 2004.

Thanks to the steering group members, Maria Malmström, Mats Palmgren, Birgitta Essén, Aje Carlbom, and Siv Hamring for valuable critical comments on earlier drafts of the report.

Lund, November 2003

Sara Johnsdotter

1. Background

The background to the 1982 legislation

The issue of female circumcision was raised in Sweden in 1979 by a series of three articles in a weekly magazine (*Vi* 1979). The issue was highlighted and described as a tradition in parts of Africa. A Swedish gynaecologist and head physician was named and interviewed, stating that he, among others, performed circumcisions on immigrant women in Sweden. He said cases were few, but classified by him and his colleagues as regular labia alterations also performed on Swedish women who desired such genital changes.

A media storm broke out and a law against female circumcision was suggested. A governmental bill proposing a new law was presented in March 1982 (Prop. 1981/ 82:172). The new legislation came into force on July 1, 1982.

The Göteborg Project

In 1993, the Swedish Board of Health and Welfare initiated a three-year-project called "Health promoting measures for women and children: Prevention of female genital mutilation". The project was in answer to accelerating needs from officials and school staff, health care staff, and other professionals who came in contact with a growing number of immigrants from countries where female circumcision is practised (above all, Somalis).

The project, run by the immigrant service administration of Göteborg, had the aim of creating methods for prevention of FGM and working for adequate care of circumcised women in Sweden. During the 1990s, the Göteborg Project distributed information to health care staff, social welfare officers, pre-school and school teachers, policemen, and any other group affected by and interested in this issue. There have also been continuous activities aimed at moulding opinion, especially in the Somali group.

The Swedish Board of Health and Welfare: Commission to work against FGM

In 1998, the Swedish government allocated 2,7 million crowns (about 295 000) to further preventive work and educational measures over three years. Cooperation has developed between concerned cities and regional institutions. The Institute for Public Health, the State Board of Integration, the State Board of Migration, and the State School Board have all been involved.

Guidelines for social welfare offices, schools, maternity clinics, child welfare clinics, and other institutions have been formulated and distributed, with background information about the phenomenon and also practical information for all the specific target groups of officials.

Information in several languages about the Swedish legislation, harmful consequences of the practice, etc., has been distributed among concerned immigrant groups.

The Ministry of Health and Social Affairs: A national action plan against FGM

In June 2003, the Ministry of Health and Social Affairs presented the governmental action plan against FGM and allocated 3 million crowns (about 328 000) for the realisation of the project. The aims of the action plan are:

- To work for a total abolition of FGM among girls who live in Sweden
- To give adequate support to girls and women in Sweden who are already circumcised

The action plan is expected to be implemented by a variety of actors: the government, various kinds of authorities, regional and local governments, and NGOs. These are also target groups, in addition to the concerned immigrant groups, and officials and professionals in all relevant sectors (the health care sector, the school and pre-school sector, the social sector, the police, and the prosecution departments).

NGOs

Several small groups of activists have worked with the issue for many years. The most influential group through the years has been RISK, an NGO giving training courses to African women (and also men), who are now working as health advisors and moulders of opinion among their fellow-countrymen.

Cooperative networks

In many cities specific cooperative networks [*samverkansgrupper*] have been formed to handle the issue of female circumcision. Information about the phenomenon is distributed and hypothetical and real suspected cases, and guidelines for action, are discussed in recurrent meetings. In its typical form, a cooperative network consists of representatives from the police, the social welfare sector, the health care sector, the school sector, and NGOs.

Mass media coverage

The issue of FGM is often discussed in the mass media. During one week in September 2001, the mass medial attention was immense, due to a documentary on FGM in Sweden, broadcast on Swedish state television ("The Forgotten Girls", SVT1, 6 September, 2001), based on clips recorded with a hidden camera. The highlighting of the question of FGM further raised the level of alertness among citizens and professionals in this field in Sweden.

Implementation of the law

A few cases of suspected FGM have reached the prosecution authorities, but none have been taken to court, because of a lack of evidence.

2. Immigrant communities in focus

The largest group of immigrants associated with female circumcision in Sweden is from Somalia: some 19,000 Somalis live in Sweden. (31 December 1999: 18 801 persons living in Sweden were either born in Somalia (12 692) or born in Sweden with at least one parent born in Somalia (6 109). Figures from Statistics Sweden [*SCB*], 22 November 2000.) If people from Djibouti, Kenya, and Ethiopia, classifying themselves as Somalis, are added to these figures, an estimate is that Somalis in Sweden amount to well over 20,000 persons. The largest groups live in Stockholm and Göteborg, while a few more than one thousand live in Malmö, the third largest city in Sweden.

The second largest immigrant group in Sweden, originating from a country where female circumcision is performed, is composed of Ethiopians. However, some of these categorise themselves as ethnic Somalis and many of them are Eritreans (who were born while Eritrea was a region of Ethiopia). Another large group is composed of immigrants from Eritrea. West Africans are few.

Foreign-born persons in Sweden by country of birth, year 2002

[Included: countries where female circumcision is practised by at least 20% of the population. Prevalence estimations from WHO. Population figures from Statistics Sweden, *www.scb.se*, accessed 28 August 2003. Not included in this list: Persons born in Sweden with at least one parent born in a foreign country, so called "second generation immigrants".]

East Africa	
Djibouti	58
Eritrea	3,943
Ethiopia	11,409
Kenya	1,402
Somalia	14,005
Sudan	793
West Africa	
Benin	24
Burkina Faso	39
Gambia	2,681
Ghana	1,084
Guinea	129
Guinea-Bissau	86
Ivory Coast	347
Liberia	609
Mali	53
Mauritania	23
Nigeria	825
Senegal	273
Sierra Leone	367
Other countries	
Central African Republic	26
Chad	26
Egypt	2,279
Yemen	187

The immigrants most strongly associated with FGM in Sweden are the Somalis. Practically all cases of suspected FGM discussed in the section below involve Somalis. Most cases of suspected FGM are reported from the Stockholm and Göteborg districts. Malmö is the third largest city. The tables below show how many Somalis live in these areas. (Not included: So-called "second generation immigrants".)

Population by citizenship and by municipality
Dec. 31, 2001

The Stockholm county [Stockholms län]			
Africa	11 261	Somalia	3 853
The City of Stockholm			
Africa	7 418	Somalia	3 257
The Westcoast county [Västra Götalands län]			
Africa	4 226	Somalia	2 195
The City of Göteborg			
Africa	3 252	Somalia	1 802
Skåne county [Skåne län]			
Africa	2 178	Somalia	818
The City of Malmö			
Africa	1 116	Somalia	526
Sweden			
Africa	**23 998**	**Somalia**	**9 570**

Foreign-born persons by country of birth and by municipality
Dec. 31, 2001

The Stockholm county [Stockholms län]			
Africa	27 915	Somalia	5 412
The City of Stockholm			
Africa	17 303	Somalia	4 414
The Westcoust county [Västra Götalands län]			
Africa	10 027	Somalia	3 209
The City of Göteborg			
Africa	7 450	Somalia	2 662
Skåne county [Skåne län]			
Africa	5 397	Somalia	1 282
The City of Malmö			
Africa	2 670	Somalia	853
Sweden			
Africa	**57 316**	**Somalia**	**13 489**

3. Legislation

Sweden passed the first act prohibiting female circumcision in 1982, thereby becoming the first western country to legislate against the practice. In 1998 the law was revised with a change in terminology, from "female circumcision" to "female genital mutilation", and more severe penalties for breaking the law were imposed. The law was further reformulated in 1999, to allow for prosecution in a Swedish court of someone performing female genital mutilation even if the act has been performed in a country where it is not considered criminal (removal of the principle of double incrimination).

Act Prohibiting Female Genital Mutilation

[*Lag (1982:316) med förbud mot könsstympning av kvinnor*]

Section 1: Operations on the external female genital organs which are designed to mutilate them or produce other permanent changes in them (genital mutilation) must not take place, regardless of whether consent to this operation has or has not been given.

Section 2: Anyone contravening Section 1 will be sent to prison for a maximum of four years.
If the crime has resulted in danger to life or serious illness or has in some other way involved particularly reckless behavior, it is to be regarded as serious. The punishment for a serious crime is prison for a minimum of two and a maximum of ten years. Attempts, preparations, conspiracy and failure to report crimes are treated as criminal liability in accordance with section 23 of the Penal Code.
[Quoted from Rahman & Toubia (2000:219).]

Section 3: A person who violates this law is liable to prosecution in a Swedish court, even if Section 2 or 3 of Chapter 2 of the Penal Code is not applicable.

According to a legal expert at a public prosecution authority, sections 2 and 3 of Chapter 2 of the Penal Code concern nationality and residency. It does not matter whether the offender or the victim are Swedish citizens. If the crime has been committed in Sweden, any person (asylum-seeker, illegal, etc.) may be prosecuted in a Swedish court. If the crime has been committed abroad, the victim does not have to be a Swedish citizen for prosecution to take place, and neither does the offender. However, they should be or have been residents of Sweden.

In a literal reading of the law, it states that all procedures which "produce […] permanent changes" are prohibited. However, the official position is that the prohibition also includes ritual procedures which do not lead to permanent changes: "According to the law all types of female genital mutilation are illegal, ranging from the most extensive, where large parts of the genitals are cut away and the vaginal opening is stitched together (infibulation), to pricking of the clitoris with a sharp or pointed object" (information sheet from the Göteborg Project, my translation from Swedish; see also Omsäter 1996:13, 23, 40, and the government bill Prop. 1998/99:70, page 8.) However, it remains unclear whether it would be possible to take a case including a symbolic pricking to court, based of the wording of the FGM law (interview with prosecutor).

Further, it is unclear what the official stand is toward cosmetic genital surgery, so called "designer vaginas". As the Swedish law does not mention age or ethnic background, and considers consent irrelevant, the Act on FGM ought to outlaw genital changes also in non-African women. So far there has not been a legal case against plastic surgeons or gynaecologists for violating the Act on FGM when performing cosmetic (not medically motivated) genital surgery on women in Sweden. The issue was raised by a Swedish news paper after a conference on FGM in Malmö in September 2003 (*Sydsvenskan*, 10 October, 2003; 15 October, 2003), and the Swedish Board of Health and Welfare has now declared that they will take a closer look at the Act on FGM and how it is applied.

In summary: **The Act on FGM prohibits all forms of FGM. Further, performance of, participation in, facilitation of, attempts at, or procuring for FGM services, and also failure to report information concerning and knowledge about performed or future FGM is punishable.**

Social Services Act

[*SoL, Socialtjänstlagen*]

Chapter 1. The objectives of social services

Section 2: When measures affect children, the requirements of consideration for the best interest of the child shall be specially observed. A child is any person aged under 18 years.

Chapter 2. Municipal responsibilities

Section 2: The municipality is ultimately responsible for ensuring that persons staying within its boundaries receive the support and assistance they need.

This responsibility does not imply any restriction of the responsibilities incumbent on other mandators.

Chapter 3. Tasks of the municipal social welfare committee

Section 1: The tasks of the municipal social welfare committee include the following:

– …

– assuming responsibility for the provision of care and service, information, counselling, support and care, financial assistance and other assistance for families and individuals in need of the same.

Section 5: […] When a measure affects a child, the child's attitude shall be clarified as far as possible. Allowance shall be made for the child's wishes, with regard to its age and maturity.

Chapter 5. Special provisions for various groups

Children and young persons

Section 1: The social welfare committee shall

– endeavour to ensure that children and young persons grow up in secure and good conditions,

– promote, in close co-operation with families, the comprehensive personal development and favourable physical and social development of children and young persons,

– be especially observant of the development of children and young persons who have shown signs of developing in an unfavourable direction,

– …

– ensure, in close co-operation with families, that children and young persons in danger of developing in an undesirable direction receive the protection and support which they need and, where justified by consideration of the young person's best interests, care and upbringing away from home […].

[Selection of sections by the Swedish Board of Health and Welfare 2002:44; translation by the Ministry of health and social affairs 2003a].

In a discussion about the Social Services Act in relation to the issue of FGM, the Swedish Board of Health and Welfare gives guidelines to officials in the social sector concerning action and measures in a variety of situations: "If there is an impending risk of that FGM is about to be performed", "If the parents have a positive attitudes toward FGM", "If there is a suspicion that FGM has been performed", etc. (The Swedish Board of Health and Welfare 2002:49f).

Chapter 14. Reporting of abuses

Section 1: Any person receiving information of a matter which can imply a need for the social welfare committee to intervene for the protection of a child should notify the committee accordingly.

Authorities whose activities affect children and young persons are duty bound, as are other authorities in health care, medical care and social services, to notify the social welfare committee immediately of any matter which comes to their knowledge and may imply a need for the social welfare committee to intervene for the protection of a child. The same applies to persons employed by such authorities. The same duty of notification also applies to persons active within professionally-conducted private services affecting children and young persons or any other professionally-conducted private services in health and medical care or in the sphere of social services. Where couples counselling services are concerned, the provisions of subsection three shall apply instead.

It is the duty of persons employed in couples counselling to notify the social welfare committee immediately if in the course of their activity it comes to their knowledge that a child is being sexually abused or maltreated in the home.

It is the duty of public authorities, officials and professionally active persons as referred to in subsection two to furnish the social welfare committee with all particulars which may be material to an investigation of a child's need of protection.

The provisions of Section 3 of the Children's Ombudsman Act (1993:335) apply concerning reports by the Children's Ombudsman.

Staff at schools and in children day care, and ordinary citizens have a duty to report any suspicion of FGM to the social authorities. An official who fails reporting commits breach of duty and may be prosecuted. In the guidelines published by the Swedish Board of Health and Welfare, it is stressed that a citizen suspecting performed or future female circumcision has an obligation to report it: "Note that it is not a matter for the person suspecting FGM to investigate 'to know for sure' before reporting it" (The Swedish Board of Health and Welfare 2002:32). It is possible for citizens to turn in a report anonymously.

In summary: **All citizens have a duty to report knowledge of performed or fear of future FGM to the social authorities.**

Care of Young Persons (Special Provisions) Act

[*LVU, Lag (1990:52) med särskilda bestämmelser om vård av unga*]

Section 6: The social welfare committee may decide to immediately take someone under the age of 20 years into custody, if:
1. it is likely that the young person needs care under the auspices of this law, and
2. awaiting a court decision concerning care poses a danger to the young person's health or development, or because the investigation may be made seriously more difficult or further measures may be obstructed.

Social services have the opportunity to use compulsion

Social service interventions for children and young people must primarily be provided in voluntary form with the support of the Social Services Act. Only where this is not possible can the Care of Young Persons (Special Provisions) Act (LVU), be applied. LVU is a supplementary protective act which regulates the circumstances in which a young person can be taken into care or protected without his or her consent. LVU is used when the young person has a need for care or protection which cannot be met by means of voluntary solutions.

The social welfare committee does not only have the authority to intervene to protect a minor but also an obligation where the criteria set out in LVU are met. The application of LVU does not require that voluntary interventions have previously been attempted.

For LVU to be applied, three criteria must be met:

– A deficiency must exist in the young person's home environment (what are known as environment cases) or the young person's own behaviour (what are known as behavioural cases);

– The deficiencies must lead to there being a manifest risk of damage to the young person's health or development;

– The necessary care cannot be given by voluntary means.

In certain emergency situations the social welfare committee can immediately take a minor into care temporarily while awaiting a final decision on the care issue.

The aim of care under both the Social Services Act and LVU is for the minor to be able to return to his or her home or own accommodation. In other words, care is to be seen as a temporary measure.
(The Swedish Board of Health and Welfare 2000:32.)

In their guidelines to different groups of professionals, the Swedish Board of Health and Welfare points out that the LVU can be used if there is a clear risk that a girl may be circumcised and there is no other way to protect her (2002:49).

When there is a suspicion that FGM has been performed, a genital examination by a physician is recommended by the Swedish Board of Health and Welfare, but such a procedure requires a cooperative attitude from the parents. An immediate intervention applying the LVU must not take place, if its *only* purpose is to have a genital examination performed (2002:49-50). If the parents do not allow a medical examination, a prosecutor may apply for a special representative for a child, in accordance with the law 1999:997 described below (Swedish Board of Health and Welfare 2002:50).

In summary: **The LVU law, permitting the social authorities to take a young person into care using compulsion, can be applied when there is no other way of protecting a girl from pending circumcision.**

Secrecy Act
[*Sekretesslag 1980:100*]

Professionals in the social welfare sector and in the health sector are bound to observe secrecy in their work. Secrecy applies if disclosure of the information will presumably cause significant harm to the person to whom the information relates or to a person close to him.

Professionals working in the health care sector are obliged to report any suspicion of child abuse, or any knowledge that a child's welfare is threatened, to the social authorities, according to the Social Services Act.

The social welfare committee is prevented by the Secrecy Act from reporting crime to the police, unless there are specific circumstances allowing such reporting. Some crimes involving children negate the duty to observe secrecy, and an extended interpretation of the passages accounting for these crimes may include the crime of FGM, according to the Swedish Board of Health and Welfare (2002:50). Further, there is the more general option of reporting crimes to the police which can lead to a minimum of two years in prison (ibid.).

If the social authorities suspect that FGM has been performed, they can open an investigation and decide to report the case to the police ("A report to the police shall be done without a standpoint regarding guilt from the social welfare committee: It is not up to the committee to take a stand and investigate this", 2002:50).

There is no absolute obligation for social authorities to report serious crimes to the police authorities. In case of a crime involving a child, "the social welfare committee shall consider if it is appropriate to make a police report, based on what is regarded as the best interests of the child" (The Swedish Board of Health and Welfare 2002:50). However, when it comes to suspicion of FGM, reporting to the police seems to be the procedure recommended by most local social welfare offices (interviews; for further discussion, see below).

In summary: **Health sector professionals have a *duty* to report cases of FGM to the social authorities. Social authorities *may* report some cases of FGM to the police. Local guidelines may state that such cases should be reported to the police authorities** (see section 6 below).

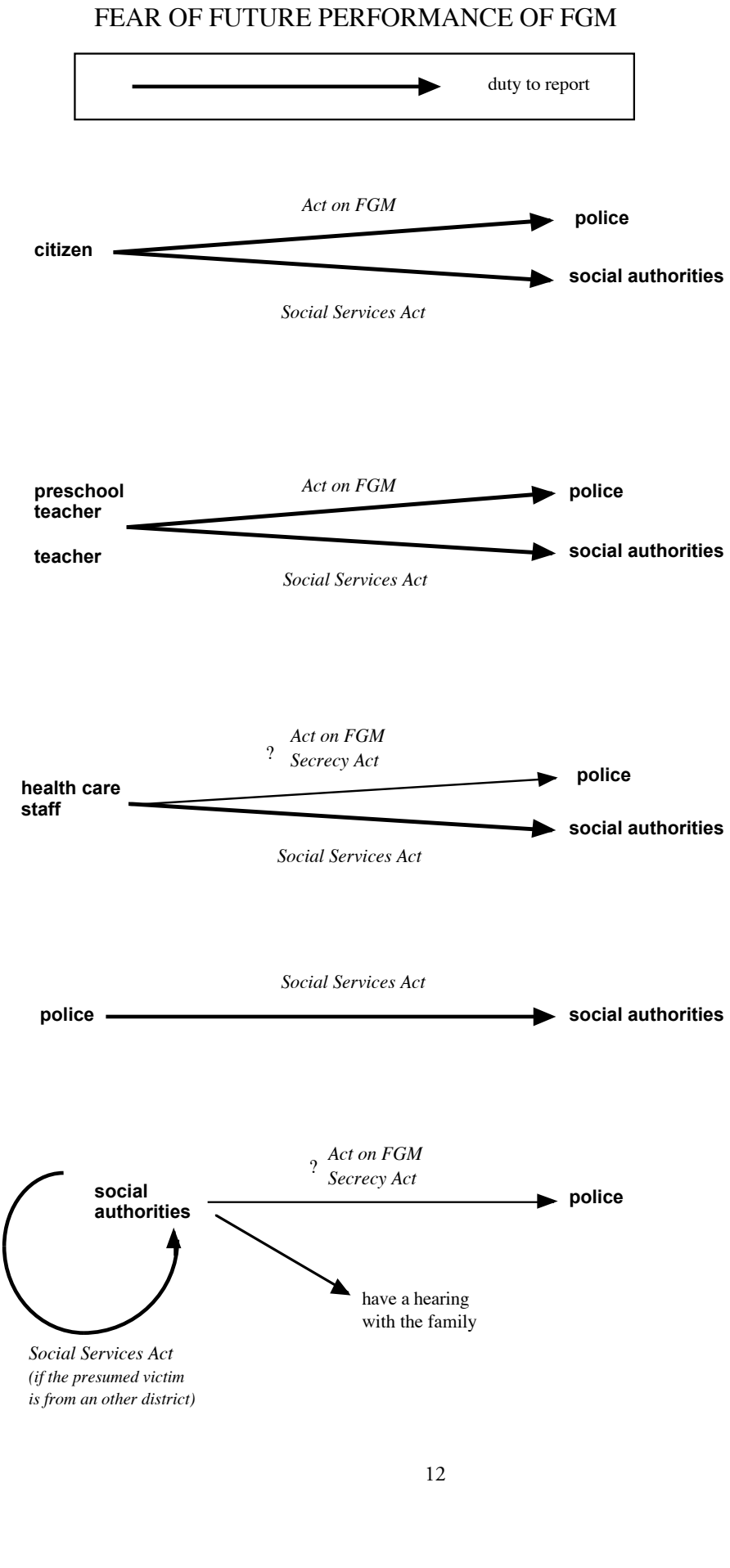
Act regarding Special Representative for a Child
[*Lag (1999:997) om särskild företrädare för barn*]

> Section 1: When there is reason to believe that a crime, the punishment for which can lead to a prison sentence, has been committed against someone who is younger than 18 years of age, a special representative for the child shall be appointed if
> 1. a custodian is suspected of having committed the crime, or
> 2. it may be feared that a custodian, because of his or her relationship to the person suspected of having committed the crime, will not safeguard the rights of the child.

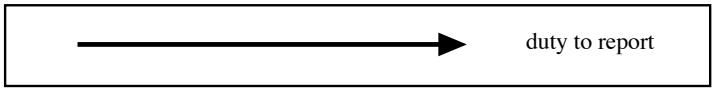
A special representative for a child is appointed by the prosecutor heading the police investigation. Such a representative (lawyer) can allow a medical investigation of a child, even when the child's parents refuse to grant permission for such an examination (Wilhelmsson 2003).

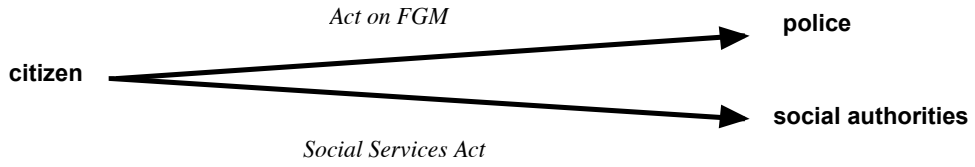
In summary: **This law enables a genital examination by a physician, even if the child's parents object to such an examination.**

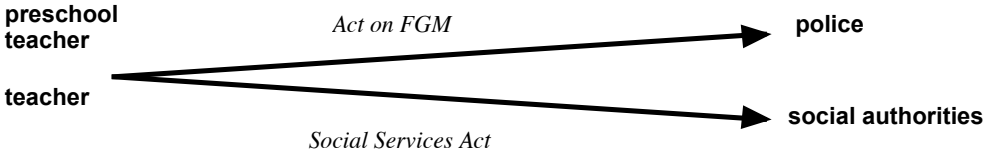
4. Model of the referral system

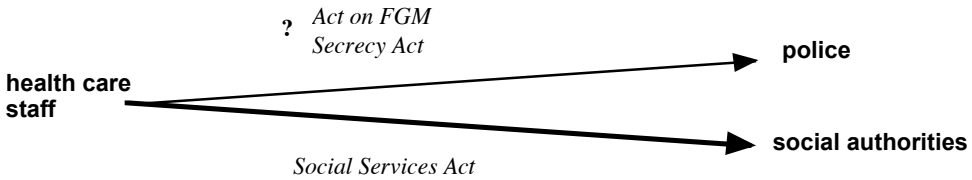


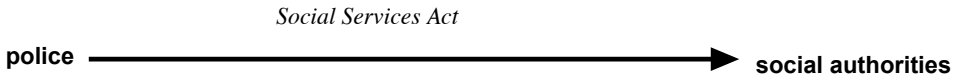
SUSPICION OF PERFORMED FGM

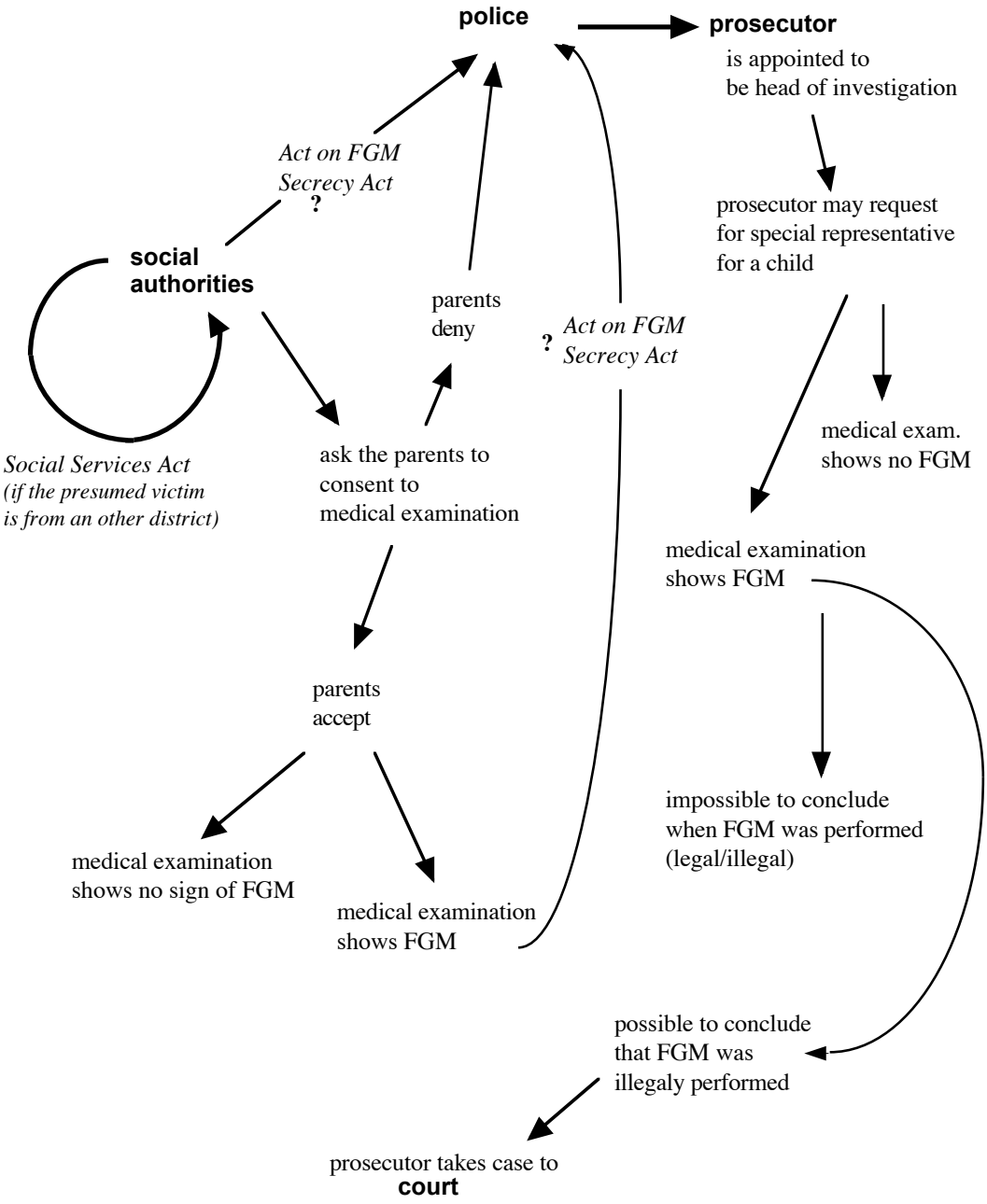












NOTE:

? Act on FGM / Secrecy Act

The relation between the Act on FGM and the Secrecy Act is not clear. However, authorities bound by secrecy:

… have an option of reporting to the police any crime which may lead to a minimum of two years in prison,

… have an option of reporting also milder forms of [planned] FGM to the police if the purpose is preventing crime.

A state committee on secrecy is currently reviewing the possibility of reporting to the police any form of FGM in minors.

Source: An appellate judge of appeal at a state committee revising the Secrecy Act

5. Cases

Two categories of cases are reported below. First, all the cases ever reported to the police in Sweden. All cases should have been covered. The method used to identify these was telephone calls to all 21 police districts in Sweden, asking if they had ever had a report on FGM. (The police authorities have a duty to provide information on the existence of reports, according to the principle of transparency in Swedish society; see Ministry of Justice, 2000).

Further, many of these cases have been reported in the mass media and could be identified in that way. Practically all existing reports and police investigations were requested for the purpose of this study. According to the Secrecy Act, exceptions from the secrecy rules can be made by authorities (e.g. police authorities) to facilitate research. The researcher is then, in turn, bound to observe confidentiality in accordance with the Secrecy Act.

The second category concerns "hearsay cases". Those are cases mentioned in interviews with key informants and others during this study. A few of these cases were already described in category I, since they had been reported to the police; the other cases never involved the police authorities.

I.) All cases reported to the police in Sweden

STOCKHOLM

Case A: 1998.
Staff at a day care centre report suspicion of performed FGM to the social authorities. A Somali woman's 3-year-old daughter had been absent for a period of time, and this day the little girl seemed ill and her bottom was reddish. The staff at the day care centre booked an appointment with a doctor and notified the mother that the girl was not well. When the mother arrived at the day care centre, she was called to a meeting with the staff before she could see her daughter. At this meeting she was informed about the suspicion of unlawful circumcision and the planned genital examination. The mother was upset and refused to have the girl examined under these circumstances. She said that she herself was willing to take her daughter to a doctor for genital examination. The social worker insisted on an examination the very same day, in the presence of one person from the social welfare office and one from the day care centre.

Problems arose when the girl was taken to genital examination. According to the mother's reports to the police (for calumny) and DO [the ombudsman working against discrimination], she was not offered an interpreter and was not properly informed about the suspicions. The examination was performed in spite of her daughter's cries. The examination showed that no FGM had been performed, but that the girl probably suffered from vaginitis. A general skin irritation in the area was probably a result of former threadworm.

Source: Governmental bill 1998/99:70. Police investigation. DO case 454-98.
Status: No FGM performed.

Case B: 1999.
A social worker reports to the police that an immigrant (non-African) woman has told her, during a group discussion with immigrant women, that there is a Somali woman from her neighbourhood who frequently goes to Rinkeby [a suburb of Stockholm with a large immigrant population] to perform FGM. The woman stating this said that the Somali woman was her neighbour. Circumcisions were said to be performed in the localities of immigrant organisations. The Somali woman was said to have described her work to her neighbour saying that 'she cuts'. When the Swedish project managers were upset at hearing this, the woman became silent "and understood that she had 'let the cat out of the bag'." The address of the woman and her neighbour is included in the report to the police.

Source: Police report.
Status: Searching gave no results; no formal investigation opened.

Case C: 2001.
Reports were handed in (by several observers) to the police in Stockholm referring to general information given in the documentary "The Forgotten Girls", broadcast on the national television channel, SVT1, on September 6, 2001. All "religious leaders" exposed in the program were collectively reported. (However, much of the information about these "religious leaders" given in the documentary was heavily biased and unreliable. See Johnsdotter [2002] for a critical review of the allegations.)

Source: Police reports.
Status: No investigation opened, since no crime had been committed.

Case D: October 2001.
A young girl (X, aged 16) reports to the city district team working with youth that she has gone through FGM during a stay in her native country, Somalia. The district team reports the case to the social authorities according to the Social Services Act. They, in turn, report the case to the police. X says during a hearing with the police that an operation has been performed, but its extent remains unclear.

X came to Sweden when she was 3 years old. She grew up here, believing that the woman she lived with was her biological mother. When she goes to Somalia in May 2000, she finds out that her "mother" in reality is her paternal aunt. She is left at her biological father's farm and stays there for 20 days. She asks him for his permission to return to Sweden, and he takes her to her stepmother's (aunt's) house in Mogadishu. Her stepmother has returned to Sweden, after having warned X against spending time with her grandmother and biological mother. These two women tell her one day that she should come with them to take a shower, but instead she is put to sleep with an injection and circumcised by a male circumciser. (According to an investigation note: "The mutilation seems to have been of a milder form, so called pricking." From reading the notes one understands that this conclusion is drawn on the basis of information from medical records.)

Source: Police report and investigation.
Status: Police investigation closed, with the prosecutor's explanation: "It appears that there is no reason to suspect that any person resident in Sweden has participated in any form of assistance at reported genital mutilation in Somalia during autumn 2000."

Cases E, F, and G (for details, see below): 2001.

The prosecutor closes the police investigations in February 2002, giving a summary. The investigations were opened due to the BO-list handed in anonymously in year 2000. [BO is the Ombudsman for children. An anonymous list was sent to BO in 2000, but placed aside. In September 2001, a television team was given a tip about the list, and the BO office was publicly accused of violating their duty to report the list to the authorities according to the Social Services Act and the Act on FGM. The BO office immediately delivered the list to the police. In the list three or four family names are mentioned, while a few remain unclear: "2 girls from town X", etc. All in all, eleven girls are mentioned, most of them with insufficient information to enable identification, said to have been circumcised in Somalia during the summer of 2000.]

The prosecutor sums up: "The anonymous information has been checked as far as possible, through contacts with the social authorities and other sources. The investigation shows that it is possible that six girls in three families have gone through FGM. Four of the girls do not live in Sweden any longer – in some cases they have not lived in Sweden for a long time. [---] When it comes to the remaining two girls, the investigation shows that they have gone through FGM, but the information brought forward about time and place of the operations makes prosecution impossible, since the operations have been carried out before the principle of double incrimination was removed on July 1, 1999. Furthermore, even disregarding this fact, there is no person resident in Sweden who can be reasonably suspected of a crime."

Case E:
X is in her 50s, illiterate, from Somalia, mother of at least eight children (a note says that "she has sent her six youngest children to Somalia to familiarise them with Somali traditions"; eight names are mentioned

during interrogation). Six years earlier, one of her sons was taken into custody by the social authorities, unclear for what reason. The longest part of the interrogation concerns the fact that she has for a long time received government child benefit payments for children who are no longer resident in Sweden.

She states that she is very upset about the allegation that she would have had her daughters circumcised. She says that, as far as she knows, her daughters have not gone through circumcision. She says she is an opponent of this tradition, that female circumcision is prohibited by her religion, and that nobody would dare to do this to her daughters without her permission, not even older relatives. She says that the allegations are unfounded and made out of malevolence. If her daughters ever come back to Sweden, she will welcome the authorities examining their genitals.

Her daughter Y (born in 1986) reported her mother in year 1998 (for maltreatment). It remains unclear if she reported her mother to the police or to the social authorities, but the case ended up in a police report. Her other younger daughters involved in this investigation about FGM were born in the beginning of the 1990s.

Source: Police report and investigation.
Status: Presumptive victims are not resident in Sweden; unclear if FGM has been performed.

Case F:
A is in her early 30s, from Somalia. She says during interrogation at the police station that she has been questioned by the social authorities at least three times about whether she has had her daughters circumcised or not. When confronted with these allegations, she says she told the social authorities that she wanted them to prove that the girls had been circumcised after migration to Sweden.

Her younger daughter C (born in early 1990s) went to Somalia during the summer of 1999 to visit her father and returned to Sweden about one year later. That was when the social authorities accused A of having had her daughter circumcised. A states that C was already circumcised in 1997 (a mild form, "sunni"), before she came to Sweden, and that her older sister B (born in early 1990s) can verify that. Her older sister was circumcised in the early 90s, while living with her grandmother. The older sister says that she too was only circumcised according to sunni, but she has not let her mother A control that. A says that there was not so much to be said about it when the operations took place, since such operations are commonplace in Somalia, but that she has become an opponent of FGM after having lived in Sweden. She does not think that many girls are sent to Somalia for FGM ("when you live in Europe, most people change their minds about FGM"), but most girls have already been circumcised before they come to Sweden, she thinks.

The police got this information from the social authorities: B came to Sweden a year earlier, after having lived with her grandmother (April 2000, according to register records). Her mother (A) does not know when her oldest daughter was circumcised. C was circumcised (a mild form) by a doctor in Somalia in 1997, according to her mother (C came to Sweden in August 1997, according to register records).

The social authorities held a hearing with the younger sister (C), who claimed that she wanted to be circumcised, since all her friends were circumcised, and that she felt like an outsider. She claims that she did not find it painful. She has not called on the school nurse.

Source: Police investigation.
Status: Suspicion of illegal circumcision being performed; circumcision admitted, but alleged to have been performed before migration to Sweden.

Case G:
A Somali mother in her early 40s and a 17-year-old-daughter (married) were sought by the police after anonymous information (the BO list) claiming that the daughter had been unlawfully circumcised. According to the social insurance office, the family left Sweden in October 2000. Searching for these persons at former addresses did not produce any results.

Source: Police investigation.
Status: Presumptive victims are no longer resident in Sweden; unclear whether a crime has been committed or not.

GÖTEBORG

Case H: 1995. "The Göteborg case".

31 May 1995. A pre-school teacher reports to the social welfare office that he suspects that a six-year-old girl (born in Sweden) has been circumcised during a one-month-trip to Stockholm. The family travelled to be close to a relative giving birth. The pre-school teacher says that the girl, when asked about her trip, answered that she was told by her mother not to tell anyone about their trip. A small change in the girl's behaviour was noticable: she was more taciturn than before.

October 1995. An investigation is initiated at the local social welfare office. According to a later police report, the parents do not show up at the first notice. The second time the girl's father shows up at the social welfare office. He denies that any of his daughters are circumcised, and says that he knows it is prohibited. He does not want to answer when asked about what they would have done if the family had still lived in Somalia.

February 1996. A police report is made.

March 1996. The county administrative board [Länsstyrelsen] is informed.

April 1996. The girl's father is interrogated by the police. He says that the social authorities have reported the case to the police without any kind of evidence, which he thinks is wrong. He does not want to permit a medical investigation of his daughter(s) unless there is evidence of the suspicions. When a police officer explains the possibility of having the girl examined on the basis of the legislation, the father changes his mind and says that he will allow an examination. He says he is a Muslim and that according to Islam, girls are to be circumcised according to "sunnah", but that this procedure is optional. He prefers his own daughters to be uncircumcised, since he does not find the way it is performed to be "good". Furthermore, he says that neither he nor his wife have forbidden the girl to talk about what happened in Stockholm – where they went to help his sister when she was about to have a baby – and he does not think that his daughter has changed in any way. He does not know what position he would have had concerning FGM if still in Somalia (he got to know about the Swedish Act on FGM in 1991), and he considers the question irrelevant today, when he would not let any of his daughters undergo circumcision.

May 1995. The girl's mother is interrogated by the police. When confronted with the suspicions of FGM, "she smiles and states, 'No, she has not' [undergone FGM]." She says she is opposed to female circumcision and does not wish her daughters go through it. Her husband, she says, thinks their daughters should undergo a sunnah form of circumcision. According to her own faith as a Muslim, there is no requirement of female circumcision. Therefore, she says, her daughters will not go through it. She denies that the girl was told not to talk about the trip to Stockholm, and states that she has not noticed any changes in her daughter. She was informed about the legal ban on FGM by pre-school staff about a year ago. She does not object to having her daughters genitally examined.

20 January 1997. The investigation at the social welfare office is closed. No medical examination of the girl's genitals has yet been performed.

April 1997. The case is opened again at the local social welfare office.

1 July 1997. Two specialists in gynaecology examine the girl. The examination is performed during a period of one hour and 20 minutes, and the girl's genitals are photographed. One of the doctors writes a certificate [rättsintyg]: "An examination of the outer genitals shows that both labia minora are missing."

The prosecutor finds it difficult to take action on the basis of such a brief certificate and asks for supplementary examinations.

October 1997. The gynaecologist responsible for the certificate writes that the girl on two occasions has been summoned for an additional examination, but that she has not appeared at the hospital. She then writes a new certificate, on the basis of the examination performed some months earlier, stating: "There is no known malformation where the labia minora are missing and where the clitoris and urethra appear normal. From the fact that the labia minora are missing one may therefore conclude that they have been removed."

November 1997. According to the girl's father, the family has not been summoned to the hospital at any point after July 1. In November, the family turns to a private pediatrician. He examines the girl and writes a certificate stating that inner and outer labia are completely normal and show no signs of scars. He also writes that the girl's mother finds the suspicions troublesome, because she is a religious person, and devoted Muslims are prohibited from practicing female circumcision.

January 1998. After a request from the police, the same pediatrician writes another certificate. After having seen the first certificate written by a gynaecologist, he states: "We cannot have seen the same girl."

The conclusion drawn by the police and the prosecutor is then that the family has presented another girl to the private paediatrician's clinic.

June 1998. The social authorities close the case for the second time: "investigation has not thrown any light on what has happened." The girl continues her schooling and is described as a happy and lively girl by her teacher.

The police keep the investigation open. The police officer in charge continues to send requests to the social welfare office to have the girl and her sisters examined by a physician.

March 1999. The girl's mother makes a phone call to the police, asking for such an examination. She wants the family to be cleared of suspicion. But no further examination occurs. The gynaecologist at the hospital states that she sees no point in examining girls about whose identity she can't be positive. The social authorities see no way to assure the identity of the girls. The police state that the school and the day care centre could have made a positive identification at the collecting of the girls. They are very critical of the way the social authorities have handled the case.

The girl's parents keep assuring the authorities that they have not had any of their daughters circumcised. They were the ones who contacted the media to tell their story, since they feel harassed by the authorities. Finally the case is closed, because the statute of limitations has run out.

The family today lives abroad.

Source: Police investigation. Newspaper article (*GP*, 14 July 2000), referring to medical records, the police investigation and the investigation done by social authorities.
Status: Suspicion of performed illegal circumcision; the statute of limitations for the crime has run out.
Commentary: A new law came into force on January 1, 2000*: Act (1999:997) regarding a special representative for a child*. This law enables a medical examination of a child even if its parents refuse to give permission for such an examination. The child's legal representative, appointed by a court after a formal request from a prosecutor (the head of the police investigation), can make the formal decision to allow an examination. However, such a measure requires a cooperative attitude from the social authorities, and such an attitude was missing in this case, according to the police officer in charge (telephone conversation). The case was closed in the summer of 2000.

Case I: 1999.
January. A 5-month-old baby girl is hospitalised due to an infection. An experienced nurse discovers that the genitals of the girl have been circumcised. Her inference is supported by two experienced colleagues [she states later, during the police investigation]. She is convinced that this has been discovered earlier – as the changes of the genitals were so "striking" – so she restricts her actions to writing a note in the medical case record.

17 February. One and a half months later a chief physician discovers the note in the case record. He writes a report to the social welfare office of the district where the girl's family lives. The social welfare office reports the case to the district police office (26 February).

5 May. A detective inspector makes the decision to act in this case.

17 May. Police, social authorities, and a physician make a house call. The parents are informed that they are under suspicion of plotting regarding severe genital mutilation. The girl (at the time, ten months old) is taken to a clinic for genital examination. The other children of the family are taken into custody. The parents are taken separately to police headquarters where they are further informed about the serious charges. Both parents deny these insistently and indignantly, and cannot understand why anyone could think they would harm their own child in this way. Later the same day, the (two) physicians declare the girl's genitals to be completely normal. Neither of them could find signs of any kind of violence or of an operation.

Source: A newspaper article (*GP*, 26 May 1999) referring to the police investigation in detail.
Status: Suspicion of performed illegal circumcision; suspicions unfounded.

Case J: 2001.
The two daughters of the woman exposed in the documentary "The Forgotten Girls". In this documentary it was alleged that a 13-year-old girl had been circumcised during a trip to Africa, and that her younger sister was to be circumcised abroad during the summer of 2002.

The local social authorities sent some information to the local police and an official police investigation could be initiated. The social authorities and the police each had their own investigations, but maintained continuous communication.

The older sister was examined by a physician on the initiative of the social authorities, and it was established that her clitoris had been removed. In addition, she was described as a healthy and normal 13-year-old girl.

During a police interrogation, her mother stated that the girl was circumcised at the age of three or four and that the circumcision had taken place in Africa, on the initiative of the girl's maternal grandmother.

During a police interrogation with the 13-year-old-girl, she gave an account of the circumstances of her own circumcision, practically identical to her mother's account. However, the interrogator claims that some information given by the young girl seemed well prepared and – possibly – expressed in a vocabulary unfamiliar to most children of her age. An example: the girl said that she was given a pain-relieving substance at the operation and that she could go to school soon afterwards. At a question about whether such small children go to school in Somalia, the girl was at a loss for a reply. According to the police, "The girl's verbal language told one story, while her body language told another."

The younger sister was examined and was intact. A new examination took place after the summer, and the girl was still intact.

Source: The police memo (Palmgren 2002), referring to police investigations.
Status: 1) Suspicion of performed illegal circumcision; circumcision verified, unclear at what point in time (whether it was illegal or not).

2) Misgivings about future circumcision; so far not performed (August 2002).

Case K: 2001.
A family in Hjällbo was mentioned in the BO-list. Two daughters in the family were said to have been circumcised.

At the time of the report to BO and the media attention, the entire family moves to Great Britain. According to rumours, the family have secretly visited relatives in Sweden. After questions among Somalis and door-to-door inquiries in the neighbourhood, the police come into contact with an older sister in October 2002.

Two sisters now live in Sweden. Their mother and five siblings live in a suburb of London. The older sister tells the police that all daughters are circumcised and that all these circumcisions were performed in Somalia in the 1980s, before the family moved to Sweden. The police claim that her story is coherent when it comes to the data about her and her older sisters, but that it is incoherent regarding her two younger sisters (e.g., point in time, age of the girls at circumcision). The police conclude that it is possible that the girls were circumcised during summer holidays spent in Somalia in the years 1999-2001.

Source: The police memo (Palmgren 2002) referring to police investigations.
Status: The police estimate that demonstrating the crime is difficult, but establish that there exist family members who can be interrogated and perhaps provide more information.

Case L: Spring 2002.
Information to the police, but no official report, from a local child welfare clinic. An African woman stated that she did not care about the Swedish Act against FGM, and that she had the intention of having her newborn girl circumcised. Social authorities were contacted. The family was called to a meeting at the local social welfare office. The family was informed about the contents of the law and also about the danger that their daughter could be taken into custody by the social authorities. The parents replied that such decisions are in the hands of God, but that they had abandoned their plans to have their daughter circumcised. It remains unclear if the authorities have had any further contact with the family.

Source: The police memo (Palmgren 2002).
Status: Misgivings about future circumcision; outcome unclear.

Case M: Summer 2002.
The police recieve information about a case, similar to case L above, but no official report. According to this information, the social authorities had conversations with a family and reached the conclusion that there was no basis for further intervention.

Source: The police memo (Palmgren 2002).
Status: Misgivings about future circumcision; outcome unclear.

JÖNKÖPING

Case N: 2001.
According to the list sent to BO, a girl from Gislaved (in the Jönköping district) was said to have been circumcised during a trip to Somalia in the summer of 2000. No name was mentioned, however. The social authorities decided not to open an investigation because the information was so "vague". However, they did report the vague information to the police and declared that they would be interested if the police could find any substantial information.

The police acted in August 2001, contacting a Somali health advisor in the district who has worked with the issue of female circumcision for a year or so. The health advisor could tell the police that some families in Gislaved (114 Somali citizens live in Gislaved; 166 persons born in Somalia) are very traditional and prefer not to talk about female circumcision. "H has to date not heard of any family who has gone to Somalia or any other place to have FGM performed. She knows of many families who have gone to Somalia for vacations. One of H's tasks as a health advisor is to notify the police if she receives information about the performance of FGM, which she of course will do."

Source: Police report.
Status: General suspicions, no particular suspect.

HELSINGBORG

Case O: 1999.
Someone asked a 13-year-old immigrant girl if certain celebrations they were talking about was a wedding feast, and received the answer: "No, we are celebrating a circumcision." According to the person who reported to the police, the people at the party were "dressed in a Muslim fashion". The policeman investigating found out that the party was arranged by Kurds, who were celebrating a male circumcision. The physician who performed the circumcision at a Swedish hospital could verify the information.

Source: Police officer reading aloud from the police report.
Status: No formal investigation opened, since the police found that no crime had been committed.

II) Hearsay cases reported in the interviews

Case 1.
At the present moment the social welfare office in Rinkeby [a suburb of Stockholm with a large immigrant population] is investigating a report of suspected circumcision. They have not yet contacted the family under suspicion, since the source of information is considered unreliable, but they have questioned people who know the girl (school nurse, teachers, etc.) to see if there are further reasons to investigate.

Case 2.
The head of the social authorities' unit for children in Spånga-Tensta [a suburb of Stockholm with a large immigrant population] claims that they receive a few reports every year about suspicion of performed FGM or suspicion of future performance of FGM. Last year they had two cases:
1) Report of suspected performed FGM. A social worker had a conversation with the mother of the girl. The mother claimed that no circumcision had been performed and herself suggested a genital examination to prove it. The social worker considered the woman to be trustworthy and did not insist on having a genital examination performed.
2) Two sisters, not very young, were sent back to Somalia. It was suspected that the girls were sent back for FGM and the case was reported to the police. The police closed the investigation because the girls have not returned to Sweden (should be referring to Case E, as described above).

Case 3.
A social worker in Gunnared [a part of Göteborg with a large immigrant population] tells about a case she was involved in: A child welfare clinic reported a fear of future performance of FGM to the social authorities. A social worker went to the clinic and had a lengthy conversation with the Somali mother. The mother claimed that her daughter was too young (two years) to go through a circumcision, and that she had no such plans. She agreed to have her daughter genitally examined after the trip to Somalia, and so occurred. No FGM had been performed.

Case 4.
A gynaecologist reports that a Somali woman, 16 years old, came to the clinic to undergo an abortion. Health staff at the clinic (who had recently watched the documentary "The Forgotten Girls") were concerned about her being circumcised and wondered if it had been performed illegally. The young woman stated that she was already circumcised when she arrived in Sweden, at the age of five. The gynaecologist points out that due to the worries about the circumcision, the health care staff failed to complete the care plan suggested, e.g., giving the woman sufficient pain-relief drugs during her abortion.

Case 5.
A school doctor gets information about a girl who was circumcised immediately before she left for Sweden. The girl was born and spent her first years in Somalia, and her mother was to be married to a Somali man living in Sweden. The mother made sure that the girl was circumcised before her future husband came to Somalia to take them to Sweden.

The discussion arising from this case concerns the question: Can the stepfather be held responsible and prosecuted for not having foreseen this situation? Had he a duty to protect this girl from FGM? (In the preparatory work of the Act on FGM in Sweden [Prop 1998/99:70, pp. 11-12] it is stated: "There may also be cases, where the connection to Sweden was weak at the time of the crime, but where there nevertheless may be a reason to prosecute, e.g., when the family prior to it's arrived in Sweden spent a long period of time in another country where genital mutilation is unacceptable, and therefore the parents must have been informed about the reprehensibility of the deed.")

To my knowledge, the doctor discussed the matter with a legal expert, but did not report the case to the police.
The same case was described in two of the interviews with key informants.

Case 6.
A woman younger than 18 came to the women's clinic to have an operation performed, probably due to infection. It was suspected that she had been circumcised recently. A nurse talked to a colleague about her suspicions and said that the suspicions had been reported for further investigation.
The same case was described in two of the interviews with key informants.

Case 7.
In May 2003, I (Johnsdotter) received a phone call from a teacher in Malmö. She was worried about a 14-year-old girl who was going to spend the summer in Somalia. The girl was going to spend the summer at her grandmother's, and the teacher was worried, knowing about older generations' general support for the tradition of FGM. She had talked to the girl's mother about her fears, and been told that the girl was in no danger of FGM. Now the teacher did not know whether she should press the case further and asked for advice. I mentioned the possibility of turning to the social authorities and advised her to talk to a Somali health advisor in Malmö, who could speak to the woman in Somali and in a culturally sensitive manner.

This advisor told me later that she did not think there was reason to worry. The woman had understood the teacher's worries and sympathised with them. She claimed she was only sunnah circumcised herself, a sign of her mother's resistance to the tradition. The mother felt safe that nothing would happen to her daughter during the summer.

I do not know what happened further in this case.

Case 8.

A school nurse in Rosengård [a neighbourhood in Malmö with a large immigrant population] states that she has not come into contact with the issue during her three years in the area. However, she remembers a note in a medical record: a student (aged about fourteen) had left some blood in her chair. It was feared that a circumcision had been performed. Staff at the school contacted the social authorities, whose staff talked to the mother.

This story seems to be identical to the one told by one of my Somali informants (whose daughter was a student at this school):

[Omar interprets]: - *She has a daughter, sixteen years old. Once she [the daughter] left school because she had a headache. When she came back the next day she was told that there had been blood. They had seen this blood the day before when she had gone home. Now they asked her if the blood was hers, 'is this yours?' and the girl said no. She said she had only had this headache and left because of that. And then they asked her if she had had circumcision. They suspected that she had been circumcised here in Sweden.*
[E fills in:] - *But that was really wrong, you know, to ask her that … How could I have circumcised her here in Sweden? There are no traditional doctors here and I can't do it myself … They sent me to 'socialen' [the social welfare office] and they called us and so on. Why did they do that? Did I kill somebody?*
[Johnsdotter 2002:139].

My impression after the interview was that her daughter arrived in Sweden already circumcised.

Case 9.

A social worker in Rosengård [a neighbourhood in Malmö with a large immigrant population] says that they have not had any investigations concerning FGM. The only case she knows about was when there was a suspicion that some girls in a Somali family were going to risk circumcision during a summer trip to Somalia. A Somali woman, mother of both daughters and sons, was about to go to Somalia – but was taking only her daughters with her. The social welfare office, which under certain circumstances allows financing of trips to someone's country of origin (e.g. in repatriation projects), denied this family financial support to travel to Somalia. The entire family stayed in Sweden during summer holidays.
This case was described in one of the interviews with key informants, and in one telephone interview with a social worker.

Case 10.

A social worker in Biskopsgården [a part of Göteborg with a large immigrant population] states that the guidelines in cases of suspected FGM are very clear. So far, in this area, they have only had one case of suspicion, where an investigation was opened. Someone reported fear of future performance of FGM, as a girl was about to travel to Somalia during her summer holidays. A social worker talked to the parents, who were considered trustworthy. After the summer vacation, it was confirmed that the girl had never left Sweden during the summer.

Case 11.

A school nurse in Malmö says there was a case of suspicion of performed FGM several years ago. A girl at the school went to the toilet very often and showed other signs of having been through a circumcision. In addition, she had recently been on a trip to her parents' native country. The school contacted the family for a conversation. The mother gave her permission for a genital examination and the school doctor established that the girl showed no signs of FGM.

Case 12.

A midwife in Malmö states that a nurse from a child health clinic feared that a couple of Somali girls risked FGM during a trip to Somalia. It seems as if the nurse made a house call to talk to the parents about the risk of FGM, but the parents denied any such plans. Those girls never returned to Sweden. As of now, three or four years later, it seems as if the girls are still not back in Sweden.

Case 13.

A Somali girl, in the sixth or seventh grade, placed in foster-home care in southern Sweden, had problems urinating. A gynaecologist was called to ask if her problems could have anything to do with circumcision. An examination showed no signs of FGM. The girl's problem was bedwetting.

Cases 14 and 15.

In Malmström (1999), ten informants at two multiethnic schools in Göteborg are interviewed regarding the issue of FGM. Two of them claimed that at some point they had suspected FGM. In the first case, a teacher suspected FGM when a Somali girl started walking in a different way, but she was not sure, since the girl was in a period of growth. Because the girl was very reserved, the teacher never brought up the issue with her. Her suspicions were never reported.

The other case also concerned a Somali girl: she came back after a holiday, seemed to be in an irritable mood, and walked differently. The teacher suspected FGM, but did not know to whom to turn to with her suspicions.

Discussion

An overall look at the cases described above indicates that there are few cases which actually end up in reliable conclusions about performed FGM. Many of the cases, especially the hearsay cases, are about fear of future performance of FGM.

When it comes to cases involving suspicions of performed FGM, the suspicions were unfounded in many cases (the most obvious were Cases A, I, and 11, but also others). In other cases it has not been established whether or not FGM has been performed, but under the circumstances it seems unlikely. A few cases show the difficulty of proving whether FGM has actually been performed, due to uncertainty in the range of what can be regarded as "normal" genitals. In some cases FGM has been admitted by a parent, but alleged to have been performed abroad before the change of the law in 1999 and, thus, not illegal.

The cases described above present a picture of a system which is quite alert, and of professionals willing to deal with suspected cases. This will be further discussed in the following section.

6. Implementation of the law

The general public

The public in Sweden may not be well informed about the issue, but most people seem to be aware of the existence of a tradition of FGM. The phenomenon has been described occasionally in the mass media over many years, and the mass medial attention was immense after the broadcast of the television documentary "The Forgotten Girls" in 2001, with the daily newspapers, the tabloid press, and radio debates covering the issue and treating it as an issue of fervent topicality.

"Public opinion" seems to be that FGM is a hideous crime (conclusions after reading letters to the editor in daily papers in connection with the documentary in 2001). It would be political suicide for anyone to defend the practice of FGM in public, and it has, to the best of my knowledge, never happened. To give a taste of the tone of the public discussion, the former Minister of Family and Children's Affairs has defined FGM in public with the words: "This is not about culture [in the positive sense of the word], but it is a hideous, cruel and dreadful custom" (TT, 22 May 2002).

The "religious leaders" exposed in the documentary were collectively reported to the police by many persons (Case C). In Helsingborg, an ordinary citizen reported suspicion of FGM to the police (Case O, involving male circumcision), already in 1999. In the year 2000, an anonymous list of girls said to have been circumcised in Somalia was handed over to BO (the ombudsman for the children) involving the Cases E, F, G, and N.

Besides these examples, no reports to the police or the social authorities from the public sector (excluding the sectors discussed below) have been found. One explanation of this result might be that few citizens from the majority population have contact with African immigrant groups, since many immigrants live in segregated areas. Another explanation might be that despite contact, ordinary citizens find nothing to report (that is, there is no reason to suspect instances of FGM in these groups).

The school sector and pre-school sector

Many reports originate from the pre-school and the school sectors. It seems as if many people working in these sectors take their duty to report suspected cases of FGM, or fear of future FGM, very seriously.

In many cases, their first measure is to report to the social authorities (e.g., Cases A, D, H, 8) who, in turn, in many cases involve the police.

In a study by Malmström (1999), interviews among staff in two multiethnic schools showed that knowledge about FGM was limited, and that many teachers were not aware of their duty to report suspected cases (see Cases 14 and 15). The whole issue was surrounded by feelings of uncertainty. On the other hand, the informants of this study took the issue seriously, in that nobody brushed off the discussion as being an irrelevant question for Swedish society.

This situation of uncertainty may have changed during the past years, due to the mass medial attention and measures from the Swedish Board of Health and Welfare. Malmström's report gave the board reason to direct efforts toward professionals within the pre-school and school sectors. Staff in these sectors can find information about FGM and guidelines in a publication from the Swedish Board of Health and Welfare (2002), also accessible as a pdf-document on the Internet. Schools are encouraged to have clear guidelines to confront cases of suspicion.

The school nurse interviewed in this study delivers the following description of the situation in her school:

> *- Do you ever discuss the fact that some girls go away on trips during summer holidays?*
> "Yes, in periods. But not all the time. The teachers know more about which of the girls go away during vacations, I don't have that kind of knowledge."
> *- If they had suspicions of some girls at risk of FGM, would they discuss it with you?*
> "Yes, I think so."
> *- And how would you act?*
> "I would ask the girl to come to my room, and then we would have a conversation. I would not attack her with questions; more like small talk, 'So you are going away on a trip this summer?' and so on. Ask her about the trip, how long it would last, and then I would ask the parents to come to my reception. I would have a discussion with them,

pointing out that I know that this tradition exists in their home country, and I would make sure that they know about the Swedish FGM law, and the negative health consequences. 'I will see you again after the summer, and now you know we have this in mind'."
- And let's say that you are still suspicious when the girl comes back after holidays ...
"I would talk to the parents again, and if I still felt suspicious about it, I would contact the social authorities. Parents know that, this duty we have to report cases of child abuse to the social authorities; that's not only concerning suspected FGM. Well, I would tell them that these suspicions are there, and that I have to report them to the social authorities."
[School nurse]

In contrast to the teachers interviewed in Malmström (1999), this school nurse describes a relationship to the social authorities as very good and characterised by confidence. In general, the school and pre-school sectors are the largest groups reporting to the social authorities:

"Schools report a lot, it's the largest group. The health care sector and ordinary citizens are smaller groups. The police are another group, and also the social authorities themselves: sometimes new situations are discovered during investigations. We also have the reports among the social authorities, e.g., from one district to an other district. When it comes to physical abuse of children, during 2001, about two hundred cases of suspicions of abuse were reported. About forty cases of suspected sexual abuse of children."
[Social worker]

During one year, about two hundred reports on abuse of children reach the social authorities in Malmö, a city with about 250,000 residents. Most of these reports are turned in by staff in the school sector. This figure indicates a general willingness to implement the law when it comes to reporting cases of child abuse or maltreatment.

The health care sector

Some reports to the authorities are received from staff within the health care sector (e.g. Cases I, L, 6).

The Secrecy Act states the health care staff's *option* (not duty) of reporting FGM to the police under certain circumstances. However, health care staff have a duty to report any case of child abuse to the social authorities.

In this study, the health care professionals seem to see it as their duty to report all cases of child abuse to the social authorities:

- And if it concerned a girl who was born in Sweden and you know for sure that FGM has been performed?
"If I can establish that examining the girl? Then it's my duty to report it, and I would. But I don't report it directly to the social authorities or the police, I report it to our welfare officer at the hospital, that's the routine; she contacts the social authorities. And I don't have to know for sure to report it, it suffices with suspicions. Then it's my duty to report."
[Gynaecologist]

Professionals within the health care sector do not seem to think that the phenomenon of FGM is the internal business of the immigrant communities:

- It seems to be a problem in some European countries, that there are professionals backing off when they face FGM; they kind of ignore it because they see it as a problem of the immigrant communities. Is this familiar to you?
"Oh no, not at all. There are routines for handling these cases. No, that is not a general attitude, not at all. That kind of fear does not exist in Sweden."
[...]
- If you were faced with a young woman who seems to have had a recent circumcision performed, what would you do?
"Report it immediately to the social authorities. It's my duty to report it to them, for them to investigate it further. But I've never been in that situation."
[Midwife]

If there were a large number of FGM cases in the health care sector, this ought to be known by the social authorities. This does not seem to be the case, according to the social workers in this study.

Further, hospital legal experts in Stockholm, Göteborg, and Malmö have been contacted for the purpose of this study. They all described the situation in similar words: They have not been contacted over the years and asked about issues concerning suspected FGM. It is likely that they would have known about cases discussed at their hospitals, if it was common that health care personnel faced the problem frequently. The only exception was Malmö, with one case discussed with the legal expert (Case 6). Their comments were quite similar:

> "I have discussed it with my colleagues now, and at least one of them has worked here for more than ten years. None of us have ever heard about cases involving FGM. If it had been an issue among the employees in this hospital area, we would have heard about it."
> [Hospital legal expert, Göteborg]

> "I've never heard of one single FGM case from the health personnel."
> *- If this had been a recurrent problem to the health professionals in your area, would you have heard about it?*
> "Absolutely."
> [Hospital legal expert at all the Stockholm hospitals during the whole decade of the 1990s]

A conclusion is that even if there may have been unreported cases of suspected FGM in the health care sector, they are probably not numerous. If so had been the case, the legal experts at the hospitals would have been notified. Another hospital legal expert, who worked 1997-2002 at the hospitals in Göteborg which are attended by many immigrants, has not heard of even one case concerning FGM. He concludes that the instances, if there are any, must be few:

> "Even if every ward has its own guidelines, it's common to contact the hospital legal expert when there is a case of a sensitive character. In my experience, people want to make sure that everything is handled according to the book."
> [Hospital legal expert in Göteborg]

The police and the social authorities

The police have an absolute duty to report any case involving children to the social authorities. The social authorities have an *option* of reporting FGM cases to the police under certain circumstances (see the box on page 14). There is obscurity surrounding the exact relationship between the laws, which a state commission on secrecy is reviewing at the present time.

This situation makes it possible for some policemen to suspect that there are FGM cases known to the social authorities, but which are never reported to the police:

> "Yes, they [the social authorities] have an *option* of reporting any crime committed against a child. Then they don't have to observe secrecy. Neither do the personnel from the health care sector. The obligation to observe secrecy is only there when it comes to adults: then the crime must be punishable with a minimum of prison for two years, before they may break secrecy. The law says that they *ought to* report crimes involving children to the police, but there is no absolute duty."
> *- How does this work in reality?*
> "What do I know? We have no cases! But I know from other situations where crimes involving children have been committed, that there have been cases when they did not report it to us."
> [Police officer]

At the same time, there seems to exist a general willingness to report to the police among the social workers, and in some places even guidelines which establish the duty to report when a child is victim of a crime (such as in Malmö where a municipality social committee has to give formal approval in cases when a social worker argues that there are strong reasons *not* to report a crime to the police, according to a key

informant). It may also be possible that social workers interpret their relationship to the law in a way that allows for an absolute duty to report to the police:

> *- Let's go back to the relationship between the Act on FGM and the Secrecy Act…*
> "The way I see the laws, we have no general obligation to report crime to the police. But the Act on FGM is a kind of special law, a specific kind of violence against children, which has special rules; there we have the duty to report, as the Act on FGM does not make any exceptions for social workers when it comes to an obligation to report it to the police."
> "According to the Secrecy Act, if a woman is physically abused by her husband, I can't report this to the police against her will. If I obtain knowledge of a rape, which is a crime that can lead to a minimum of two years in prison, then I have the *option of reporting* it. When it comes to FGM, we have a special law for that crime. The law says that *anyone* who knows anything about a FGM crime has a *duty* to report it to the police, and that is not the case when it comes to, e.g., the crime of rape. I know that when the FGM law was introduced, we had the same kind of discussion: does 'anyone' refer to general citizens or are officials at authorities also included? We concluded that the law lacks any restrictions, i.e. it is applicable to any person regardless of their position."
> [Social worker]

We have several cases which have been reported to the police by the social authorities (for instance, Cases B, D, H, I, J, M). According the social worker/key informant in this study, this attitude ought to be prevalent among social workers in Sweden:

> *- If there were strong suspicions about a performance of mild FGM, e.g., a so called pricking, do you think an individual social worker would go ahead and report it to the police?*
> "You don't report to the police if your knowledge is based on rumours only. But if it is clear that there has been some kind of abuse, then it is a crime, and it is up to the police to investigate it, it's not up to us. In a case like that, we would report it to the police, even if we see a well-functioning family in all other respects. I think that's the way social workers would act. But it's difficult to be dead sure, since we don't have any cases of this kind."
> [Social worker]

In the hearsay cases described by social workers but which have not reached the police, the cases have not involved serious enough suspicions of crime to report them to the police, or else the social authorities have checked up on the families themselves, organising medical examinations and so forth (e.g. Cases 2, 3, 9, 10).

"The Göteborg case" (Case H) has become well-known for the breakdown of the relations between the police and the social authorities. The police have publicly accused the social authorities of unwillingness to cooperate in this case, and have stated that the inability to bring the case to trial was a result of passivity on the part of the social authorities. The police officer in charge of the Göteborg case states in an interview that usually relations are really good between the police and the social authorities in her area ("there was something really unusual and strange about that specific case"). She adds that she knows for certain that there do not exist numerous cases in the social sector which never reach the police: "As a member in our cooperative network, I would know about them". The memo written by Palmgren (2002) also gives a picture of good relations between the police and the social authorities in this district.

Some of the informants have mentioned a general duty to co-operate among authorities. (The Act on State Administration [1986:223], section 6: "Every authority shall be of assistance in their relations to other authorities, within the limit of its own activities".) Having this specific section in mind, some have argued that in cases of suspected FGM, there are good reasons to provide information to the police, even though there is no requirement to do so.

The municipality legal experts in Stockholm, Göteborg, and Malmö all agree that they would have known about it, had FGM been a widespread phenomenon with which the professionals employed by the municipalities (for instance the social workers) had been faced. The legal expert in Stockholm directed me to the person responsible for formulating guidelines when it comes to dealing with cases involving children and youth. She meets all the social unit heads on a regular basis:

> "I can't recall any specific cases. When it comes to FGM, there is a strong emphasis on prevention and searching activities. I would probably have heard of it, if there were cases circulating in the system."

[Responsible for harmonising the guidelines in the Stockholm social districts]

The criminal prosecution and the court procedures

No cases in Sweden have reached court. However, some cases have reached the prosecution authorities. Any police investigation concerning FGM is headed by a prosecutor. The failure to take any case to court has various explanations:

1) it turned out that no crime had been committed (e.g. Cases A, C, I);
2) it was impossible to prove that FGM was performed (e.g. Cases E, G, H);
2) it was impossible to prove if the performance of FGM was illegal (Cases D, F, J, K).

There is no reason to presume neglect on the part of the prosecution offices. They seem to have taken all these cases seriously. In this study, the topicality of the FGM issue was highlighted by the prosecutor:

> "FGM cases would be classified within public prosecution. As soon as you get a report of FGM on your table, you have an absolute duty to investigate it. We *have to* prosecute in every case where we have information about a suspected crime and we foresee a conviction. However, if the submission of evidence is insufficient, we don't take it to court."
> [...]
> *- Are there any financial aspects to this, when it comes to prosecution of FGM?*
> "No, not at all; the resources exist. And it is an issue with topicality. So, if there was a real case, we would put a lot of resources into it."
> [Prosecutor]

The prosecutor of the Göteborg case says that the professionals in this field look forward to handling cases in the future, when the passage of time will make it impossible for parents to claim that their daughters were circumcised abroad before 1999. In fact, already in the first government bill on FGM (Prop 1981/82:172), it was claimed that the suggested Act on Female Circumcision was in accordance with the values of the prosecutors. In other words, it was assumed that a law prohibiting female circumcision would be respected and complied with by the prosecution authorities.

Discussion

Regarding some of the hearsay cases it remains unclear who reported the case to the authorities. Nevertheless, we see examples of reports to the authorities from all sectors: the general public, the school and pre-school sectors, the health care sector, and so on. None of the informants in this study present a picture of an abundance of unreported cases in their respective sectors.

Cases of FGM may remain unreported either

1) because no professionals or other citizens in Sweden have discovered them; or
2) because professionals or other citizens fail to report them to the police or the social authorities.

It is impossible to establish how many these unreported cases are. The fact that many of the cases described above are about unfounded suspicions gives us a hint that the system basically works rather well, even if there may be exceptions and cases missed. A conclusion to be drawn is that the sectors mentioned above implement the law quite well.

7. Obstructing and encouraging factors

Obstructing factors

• How to find cases

When asked about the scarcity of cases in Sweden, and the fact that no case has been taken to court, many of the informants pointed out the difficulty of identifying cases as the most important obstructing factor:

> "The difficulties in discovering instances of FGM. How can we find cases? Discovery must take place in the health care sector, in school, in child day care, in child health centres. What if a child does not come back after summer leave? The police know nothing, not until we get a report. And if this really happens, I don't see any problem with the law. Such a case would be possible to take to court."
> [Police officer]

> *- What are the problems when it comes to applying the law, in your opinion?*
> "Getting information about these families. Naturally, if you intend to have your daughter circumcised, you do not discuss the matter with the authorities. They know it's a crime, that it's not okay to have it performed … of course it's surrounded by silence. The difficulty of discovering when it has happened."
> [Social worker]

Solution?

The possibility of a general screening of school girls was suggested by Palmgren (2002) and some of the key informants:

> "Why don't we screen all girls, letting all of them go through genital examinations? We have had that as a general procedure on small boys for many years, why not also on girls? Aren't we supposed to have a society of gender equality?"
> [Police officer]

> "We've done it for years when it comes to boys. Why not girls? That would defuse the whole issue. Such a procedure could be part of a more general health check-up where you check sight and hearing abilities. It's about how it's done."
> "That control of the genitals, when taking place on Somali girls, could be performed by someone of Somali origin, someone the family feels safe with and who speaks the same language. We have to find good ways of examining these girls when it's needed."
> [Midwife]

However, one of the key informants was critical of the idea of a general screening of girls:

> "I'd say that such an examination of a girl of this age would be too intrusive. It's a very sensitive age. And there are girls who have certain experiences ... no, I really don't recommend that."
> [School nurse]

A general screening of girls has been discussed in public in Norway, Denmark, and Sweden, but has not so far been applied as routine in any of these countries. In Sweden a general screening of all boys in the first grade has been routine for many years (to make sure that the testicles are located in the scrotum), but today this former routine is optional. The suggestion by some of the key informants concerns a similar examination of the female genitals. This screening of girls would be general, to avoid stigmatisation of certain ethnic groups.

• How to assess if FGM has been performed (types I, II and IV)

> "The problem of establishing that FGM has been performed. Extremely few physicians know what a young girl looks like in her genital area, and what divergence there may also be in normally shaped genitals. This requires specialist qualifications."
> [Prosecutor]

This seems to have been the key problem in the Göteborg case. The girl was obviously not infibulated: she had suspiciously small labia minora. Was it within the range of what could be considered normal, or was it a result of FGM? Before sufficient medical examination had resulted in a conclusion, relations between the police and the social authorities had broken down. (The police asked the social authorities for assistance in taking the girl to further examination, the social authorities claimed they had summoned the girl's family without results, and that they were prevented from taking the case any further.)

Case I also shows the difficulty when it comes to determining whether FGM has been performed or not. A nurse found the changes of the a girl's genitals "striking", while two physicians could not find any signs of FGM at all.

Solution?

The only possible solution to this problem is specialisation of professionals, in the same way as there exist experts in the field of assessing signs of incest and sexual abuse of children through genital examinations.

The optimal choice of an expert to examine suspected FGM cases, as long as there are no specialists concerned specifically with FGM cases available, would be a child surgeon. Paediatricians do not usually perform genital examinations. Neonatologists mostly see genitals of newborns. Specialists in forensic medicine more often see dead people than living ones. Gynaecologists are used to examining the genitals of adult and adolescent women, not those of children. There is also a potential expert competence among physicians dealing with female genital malformations.
[Source: gynaecologists]

• How to date when FGM was performed

In Sweden, the FGM law was reformulated in 1999, removing the principle of double incrimination. This means that all forms of FGM performed on girls domiciled in Sweden (citizens, residents, refugees, etc.) before 1999 can not be classified as illegal, as long as they have been performed in a country where such acts are not considered criminal.

A crucial problem in police investigations in some cases has been the inability to prove that certain FGM performances actually took place after 1999.

> *- What do you think is the most important obstructing factor for an application of the law?*
> "I don't know really. Can it be that it is quite difficult to prove it? But on the other hand, if you have a girl circumcised, a genital examination will prove it. It can probably be tricky to prove when and where the circumcision took place."
> [School nurse]

How can a scar be dated?

- There is an "emergency" phase after a trauma such as circumcision: 1-2 days;
- The week following the cutting can be dated with relative ease;
- There is usually a bright reddish scar for 6-12 months in regular skin (like the skin of the vulva) – it is usually more difficult to determine the age of scars in the genital tissue of the mucousa (like the labia minora and the vagina), which heals quicker.

These circumstances make it difficult to establish **when** a circumcision has been performed. [Source: gynaecologists]

If no evidence can be gathered from medical investigation, circumstantial evidence could be of help in a criminal investigation. But here also the police and prosecutor face problems:

> "Either you get the information – or you don't. If we are to establish when a girl went to Somalia, it is not always possible to prove it. For how long do the airlines keep records? The passports are not stamped in Sweden, and only in some other countries."
> [Police officer]

The prosecutor of some of the Göteborg cases also mentions this difficulty. If the performance of FGM has taken place in another country which is a part of the Schengen agreement, there is no way to trace travel on the basis of passports.

Palmgren (2002) states that there is a certain connection between groups in Göteborg and London, and that possible FGM activities may take place in relation to this connection. In addition, some people who have become objects of police interest in cases of suspected FGM have moved to London.

Solution?

> "Time is on our side. Soon there will be no way to explain away FGM. All girls born after 1999 must, by necessity, be genitally unharmed. Or we will know for certain that a crime has been committed."
> [Prosecutor in Göteborg]

Better networks regarding FGM at an international level have been suggested by some of the informants:

> *- Recommendations for the future?*
> "That more resources are provided for stronger cooperative networks in Europe."
> [Prosecutor]

- **The general difficulty associated with crimes committed within the family**

> *- What are the difficulties of applying the FGM law?*
> "The same difficulties as with any law concerning crimes within families. It's always harder to deal with crimes like incest, infanticide, and so on. This doesn't mean that the law is wrong; it's about this being a complicated issue, and it always will be. You can't make it easier through a reformulation of the law. What matters here is more education and sensitivity training in the professional groups facing this."
> [Gynaecologist]

Palmgren (2002), a police officer with good knowledge about suspected FGM cases in Göteborg, also mentions this difficulty:

> Investigation of this crime is associated with great difficulties, since victim and perpetrator(s) belong to the same family, and their relation is characterised by a position of dependence. There is a weakness in our ability to protect the victim, in that it is seldom possible to use compulsion toward the person injured with the purpose of finding evidence or bringing about an interrogation. This means that the perpetrator is always one step ahead of the judicial system, and, in addition, in a position where he or she can strongly influence the person injured.
> [Palmgren 2002:5]

Encouraging factors

• Good knowledge of FGM and the Act on FGM

As the key informants were selected due to their key positions in the field of FGM and/or domestic violence, it was not surprising that all of them had good knowledge about the general phenomenon of FGM. I usually framed the questioned along the lines of "How would you explain FGM to an ignorant person?" All of the key informants could talk about the subject at length, with good knowledge about different kinds of FGM, and all were well aware of the variety in the various groups performing FGM with respect to motives, age, etc. All informants stressed the cultural aspect of the tradition, and did not ascribe any prominent role to religion.

Many professionals had been informed about FGM during their education or during further training in their fields (e.g., the prosecutor, the police officer, the gynaecologist, the social worker). There was a general impression in the interviews that this knowledge was not confined to these key informants, but was part of a more general educational training accessible also to their colleagues. The unstudied area here is the school sector. According to Malmström's study (1999), knowledge in this sector was scarce. It is difficult to establish whether things have changed, due to efforts on the part of the board of health and welfare after her study, or due to the public attention after the television documentary in 2001, or if the situation remains as before.

All the key informants had good knowledge about the law, and most of them expressed the view that this knowledge is relatively well known among their colleagues.

• Consensus on the nature of the crime (a child victim perspective)

Most informants talked about the issue of FGM in a way that revealed an understanding of the act of FGM as a violation of a child's rights. When discussing the duty to report suspected cases, informants stressed the importance of a child victim perspective:

> "In Sweden, the FGM law and its implementation is about focusing on the child as a victim."
> [Gynaecologist]
>
> *- Do you see it as a problem that this is about cultural clashes?*
> "No" [with emphasis].
> *- You don't have the feeling that it would be unpleasant to be accused of being racist?*
> "No [with emphasis]. I see it like this: I haven't baptized my children, I think they should have the possibility of deciding for themselves when they grow up. If you choose FGM as an adult, that's one thing. But being a *child*, you are denied that chance to choose for yourself. This is not a decision for the parent to make."
> [Police officer]
>
> *- If it was possible to prove that an illegal FGM had been performed, what's your personal opinion on the possibility of convicting and sentencing the parents?*
> "A crime is a crime… and a crime should be punished. Or else it would make no sense to have legislation. But the punishment is not the most interesting thing in this. If FGM has been performed already, there is nothing to do to reverse it. And, of course, it doesn't make the situation better for the child to lose her parents above everything else. I see the symbolic significance of punishment as important: we can't have a law if we don't punish people who violate it. But I see the real importance of the law in how it works in prevention, not in an urge to give back, 'now look, you bastard…' It's not a good thing for a child to lose his or her parent, but at the same time FGM should be considered to be violence against a child."
> [Social worker]

This general attitude is in line with a widespread depiction of a child's inviolability in the public rhetoric of Swedish society. Sweden was the first country in the Western world to legislate against spanking of children. In 1958, corporal punishment of children in school was outlawed. In 1979, all forms of discipline involving physical violence toward children became prohibited in Sweden:

> Chapter 6, Section 1: Children have a right to care, security and a good upbringing. Children shall be treated as individuals worthy of respect and shall not be subjected to corporal punishment or other abusive treatment.
> [Law (1983:47) in the Parent's Code]

The law is interpreted in this way by the organisation Save the Children in Sweden: "Parents can never use violence when disciplining their children. Both physical violence – slaps, hair pulling, pinches, etc. – and psychological punishment – locking up a child in a closet, threatening, scaring, excluding or ridiculing – is prohibited by law" [Save the Children, Sweden].

Practically all children in Sweden know that their parents cannot use any form of violence toward them, even if relatively few actually report their parents to the police (but it does occur with some frequency). The police officer comments:

> "We have to take violence against children very seriously. Not turn our back on a child who turns to an adult, 'but hey, it was just a box on the ear'. Slapping a child in that manner is actually petty physical abuse, it is punishable. We don't accept that adults are physically violent to each other. There should be absolute zero tolerance when it comes to violence against children. Now that we have a law prohibiting any form of violence against children, then we shall apply that law. Therefore everyone working in the health sector, the school sector, or day care sector should act accordingly and report this kind of crime."
> [Police officer]

A social worker in a suburb of Stockholm with many immigrants bases his conclusion that FGM does not occur to a high extent upon the existence of reports to the social authorities concerning violence within the family:

> "We have many young girls, mainly Arab girls, who shout to high heaven if anyone at home is violent or threatening. If FGM had been common among the Somalis here, we would have known it from the young girls here. We don't have one single report involving FGM."
> [Social worker in the Stockholm area]

In summary, there is a strong consensus in Swedish society on the reprehensible nature of FGM. These values may be strongly associated with the values associated with the anti-spanking law from 1979.

• High level of alertness

Among the informants in this study, the level of alertness was very high, as well as a strong motivation to deal with a real case:

> "We haven't had any reports! I would really like to get a report, to see if it would be possible to take the case all the way to court."
> *- Is a report on FGM to the police always taken seriously?*
> "Yes, absolutely. We have worked with educational efforts here for many years now, and FGM is part of that. There is no risk that an individual policeman would ignore such a report."
> "I see no obstacles, as long as we have a report, a medical investigation proving FGM, etc. The system is here to handle this kind of case. The difficulty lies in finding the girls. So many girls from these countries are walking around out there [makes a gesture toward the window], there must be girls who are younger than 18 and who are genitally mutilated. And who went through this FGM after 1999. But how can we find them?"
> [Police officer]

> *- Is it possible that an individual social worker makes the decision on her own: 'Well, this circumcision has already taken place, and there is nothing we can do to reverse it. It will be better protection for the child not to report it to the police'?*
> "Then she behaves in an incorrect manner. I don't say that the situation is impossible, but it would be against our guidelines. If we take a look at the Act on FGM, this law decrees that everyone who receives information about this crime has a duty to report it

to the police. The way I read the law, I commit official misconduct if I don't report it to the police. If social workers were supposed to be exceptions from this duty to report, it ought to have been mentioned in the law."
[Social worker]

- Do you think that the law is known in these groups?
"Yes. During all these years with patients, I've only met one couple that did not know the law well. I discharged them from the hospital and said, 'Now you have a baby girl. Do you have any plans to have her circumcised?' They said, 'Yes, but only the little one; that's not prohibited, is it?' They talked about the risk of having her clitoris grow, and I used myself as an example, 'I'm not circumcised and I didn't have a willie grow out'. I had them visit a few times more, and then I let them go."
- What was their standpoint then?
"By then we had talked it over several times and they knew exactly what the law says about it. I was reassured that they were convinced of the advantages of no circumcision, or else I would not have let them go."
[Gynaecologist]

When asked about the level of alertness, one of the informants replied:

- What would you say about the level of alertness among professionals in Sweden?
"Thanks to all the public debate, the level of alertness is very high. If you compare it to the number of girls who really risk circumcision, it is really high. And if you compare it to the relative alertness when it comes to the life situation of children living with drug addicts for instance. The mass media has created a scenario of exaggeration."
[Gynaecologist]

The school nurse interviewed as a key informant always brings up the subject of FGM when she meets these families, and the same goes for the midwife and the gynaecologist. Again, the "dark spot" are the pre-school and school sectors: it is difficult to decide whether the level of alertness is high there. On the other hand, the first known suspicion of FGM in Sweden (Case A) emerged in a day care centre, and several other of the cases discussed above concern suspicions from personnel in these sectors.

After the television documentary in 2001, and the highlighting of so-called "summer holiday mutilations" (a phrase coined by the reporter), this expression has become fashionable in the mass media, but also among teachers and health care staff (personal experience). The existence of such a phrase, referring to vacations from school, may have helped in raising the level of alertness also in the pre-school and school sectors.

In a note on cooperation between the Swedish police (District of Angered) and the British police (New Scotland Yard) involving exchange of information on FGM, it is stated that:

"The complex of problems was the same [in both countries], but the Swedish legislation was harsher and here [in Sweden] the level of alertness was considerably higher among authorities and the general public."
[Palmgren 2002:4]

• The existence of guidelines, cooperation among the authorities and cooperative networks

A facilitating factor in dealing with suspected cases of FGM is knowledge of how to act practically, that is, having access to guidelines. Other encouraging factors are existing cooperation among authorities, and existing cooperative networks whose aim is facilitating the handling of this kind of case.

The only key informant who lacked specific guidelines regarding FGM was the prosecutor:

- Are there any guidelines for prosecutors concerning FGM?
"Issued by the Prosecutor General? No, because we haven't had a case in Sweden yet. Usually it is actively debated cases which give rise to such guidelines. But such guidelines will probably be issued if it turns out that there are problems applying the law."
[Prosecutor]

All the others had access to guidelines concerning FGM, or had already established routines for dealing with cases of suspected FGM.

The cooperation among the authorities seems to work well when it comes to exchange of information in suspected FGM cases, and in joint efforts in both preventive work and investigative work.

The extension of this kind of cooperation has in many places resulted in cooperative networks [*samverkansgrupper*], which, in addition to the police and social authorities, often also include health staff, school staff, NGOs, and so on.

8. A note on prevalence

The public discussion on the prevalence of FGM in Sweden

There exists a general belief in Swedish society that FGM is being practiced behind closed doors among African (Somali) immigrants. The official number of girls said to be at risk of being subjected to FGM is 5,000. The former Minister of Family and Children's Affairs claimed a year ago, in an interview with the Swedish News Agency TT, that "we" know for sure that parents take their children out of Sweden to other countries to have their daughters mutilated. When asked about the prevalence of FGM acts performed in Sweden, she answered: "To a lesser extent" (TT, 22 May 2002).

Thus, the official position in Sweden is that FGM occurs in immigrant communities, and that the scarcity of reported cases is exclusively a result of an inability to discover them. A similar argument has been put forward by other actors in Swedish society:

In the 2001 documentary it was argued that "Swedish authorities have difficulties in handling genital mutilation of girls" and that "Swedish authorities have not succeeded in investigating even one single case". It was also argued that "a couple of thousand girls" out of the five thousand at risk in Sweden "have been genitally mutilated or are at risk of this".

BO (the ombudsman for children) claimed, after having arranged one round-table conference, that "We have not taken the life situation of these girls seriously. Authorities, the health care sector, the pre-school and school sectors, the police, and the prosecution authorities all have reason to take some of the blame for this on themselves." She stated that these groups lack knowledge of FGM and the Swedish FGM law, that guidelines are non-existent, and that the duty to report cases is ignored by professionals (Nyberg in GP, 18 January 2002).

It is important to note that no study has been undertaken to investigate such claims. These allegations can rather be understood as the result of a widespread "truth" about why reported cases are so few. Since the basic assumption is that there is a high prevalence of FGM in our African communities, the scarcity of reported cases must be explained by incompetence on the part of the authorities.

An alternative description

The public discussion in Denmark has taken a somewhat different turn. When there have been public allegations about kitchen-table circumcisions in Denmark, and others have followed by talking about tougher legal measures, some journalists have tried to discover the empirical basis of the allegations. This attitude is exemplified here by the following newspaper article:

> One of the few places where it has been possible to estimate the number of Somali girls being circumcised is in Odense [with about 185,000 residents]. Since 1995, there has been a systematic investigation into the prevalence of circumcision among the Somali girls. No girl has been found who has been circumcised during her time in Denmark, says senior physician Susanne Buhl, head of the paediatricians in this district. "We perform a health check-up including all children when they start attending school, that is, at the age of seven. Doing that properly means taking a look when the children have taken their clothes off. When it comes to boys, we make sure that their testicles are situated in the scrotum, and when it comes to Somali girls, we check, among other things, if they have been circumcised. It's not a dramatic event, and the parents can be present – if they prefer to", says Susanne Buhl and adds that the Somali parents are just as interested as anyone else in having a health check-up for their children.
>
> "We know that it is important to talk with these parents about circumcision. And when we start already at this point [when the children begin attending school], it will not be an issue when we bring it up later", she says. Her experience is that parents are relieved when they are informed about the legal ban on circumcision in Denmark. Relieved that others have taken over the decision.
>
> "Among the older girls, the ones I began examining back in 1995, most of them were circumcised. But not their younger sisters, who have grown up in Denmark. In grade 9 we ask the girls about circumcision again, but we don't examine them, because that would be too intrusive. On the other hand, this is not a taboo issue to them, so I am quite confident about the trustworthiness of their answers."
>
> [*Berlingske Tidene*, 5 February 2003]

Note that this is the situation as described among a group of Somalis in Denmark, who could have chosen to have their daughters circumcised abroad if that had been their wish – since Denmark only very recently removed the principle of double incrimination (in June 2003). In other words, these parents could have carried out circumcision – for instance in Somalia – without running a risk of being prosecuted in Denmark.

In Sweden, no such systematic screening of girls has taken place. The taken-for-granted assumption that FGM is going on at a large scale has not been challenged in public. The findings from Odense reported in the article above are consistent with the findings of our qualitative study among Somalis in Malmö (Johnsdotter et al. 2000, Johnsdotter 2002). There is a fundamental relief among Swedish Somalis at the possibility of *not* having to let their daughters go through circumcision. The exile context gives rise to a situation where what was formerly seen as the "normal" and "natural" state of the female genitals is reflected upon and revaluated. The interaction with other exiled Muslims who do not circumcise girls, such as the Arabs, gives rise to an internal debate on Islam and female circumcision, ending in a general conviction that God forbids any harm of his creation.

This course of events was confirmed by most of the informants in this study. Some of the experiences of professionals working with African immigrant families are quoted below:

Personal experience among the key informants

Police officer:

- What do you know about FGM in Sweden?

"Only what I know from the mass media, we haven't had any cases of our own."

[...]

- Are there any rumours about cases of FGM within the police force?

"No, actually not, not here in X. Not a single one that I have heard of."

Social worker:

- Why, do you think, we have this scarcity of cases in Sweden?

"Well, I don't know really. I suppose that there are some cases where it has happened and we do not know anything about it, since it's surrounded by silence. It is considered to be an issue that only concerns the family. But I also believe that there are many families who have changed their attitudes on FGM."

Midwife:

"I have a strong sense that African women have the experience that the Swedish law protects them, that the existence of the law gives them security, that they feel satisfied with its existence. [...] They live with a sense of security here in Sweden – their daughters have an opportunity to escape the tradition of FGM. My worries are about those girls going back to Somalia during vacations. There is the real risk group. We must be better at informing about the consequences of the law, that the parents may be prosecuted if the girls are mutilated when they return to Sweden."

"As I said before, I don't think these women from Africa's Horn or any of the other countries want to uphold this practice any longer. If they got anything positive from living in Sweden, this may be it: this change of attitudes to FGM. Then I think that there are families who still would like to have it done, but then there is the FGM law. The law protects these girls. If they stay in Sweden, they will never be mutilated. But yes, I'm sure that if you add people from all these countries, there are still those who would prefer to have FGM performed. But this is not obviously the same thing as actually having it done. It is something completely different, the move from thought to action. The lack of cases in Sweden may very well be about the fact that FGM doesn't exist in Sweden. That's how we must interpret the situation, I can't see how we can understand it in any other way."

Gynaecologist:

- Do you discuss it with your patients?

"I guess I'm the only doctor here who *always* discusses it. I bring it up also with pregnant women from the groups concerned. The general tendency during recent years is that many patients express indignation, 'You should know that I already know about that'. I never met with that kind of attitude five or six years ago."

> "It's a group which is very easy to work with when it comes to moulding opinion. If you compare it to trying to make pregnant women quit smoking, the discussion on FGM lands much better. When you see an African couple that have a newborn baby girl and you talk about circumcision, it's so much easier to reach them. They laugh and say, 'Of course we wouldn't, you are talking to modern people here!'. Someone may suspect that I am being duped, that they deceive me, but in the end, my experience is extensive. My conclusions are based upon many years working with these families."

Another factor to reckon with is the risks associated with actually having FGM performed on a girl domiciled in Sweden. Among the Somalis, 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. 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.) Somalis are well aware of how the mass media describe the FGM issue and how they are depicted as cruel parents (Johnsdotter 2002). Choosing to perform FGM in such a context would not be a wise decision, and it is unlikely that FGM would be performed in Sweden by anyone of sound judgement.

The real risk group: African girls not returning to Sweden

There is also a risk associated with having FGM performed abroad and then bringing the girls back to Sweden. Aside from the danger of having someone from the pre-school or school sectors, or the health care sector, finding out, there is also a risk that the girl may expose her parents when talking to the authorities. As in many other ethnic groups, it occurs that Somali adolescents report their parents to the social authorities, a source of frustration to many Somali parents. A prevalent fear is that one mistake (in the eyes of the authorities) is enough to lose all your children, if the authorities judge a person to be unfit as parent.

Hence, the real risk group consists of girls taken abroad, who do not return to Sweden. A few of the cases discussed above may involve such instances (Cases E/2, G, K, 12). It is difficult to assess how many of these girls there are. Still, there is only anecdotal evidence of such cases. A systematic survey would be valuable.

Solution?

A solution to this situation could be the prevention, as far as possible, of young African girls from leaving Sweden. This seems to have been a valuable strategy in Cases 3, 7, 9, and 10. There are basically two ways. One is to cut back financial social assistance (as in Case 9), if the case concerns a family supported by social welfare. Another way is to take the girl who risks circumcision into temporary custody, using compulsion. The family can be reunited when the rest of its members have returned to Sweden.

Another aspect to consider in preventive work is the power of group pressure. In today's Sweden, the public message to the concerned immigrant groups is that the tradition of FGM is secretly upheld. For the sake of prevention, it would be better to present a public message focusing on cultural change in the field of FGM. In the political scientist Gerry Mackie's analysis (1996, 2000) of the structural similarities of infibulation and foot binding, he claims that one of the key factors behind the abrupt abandonment of the thousand-year-old tradition of foot binding in China was the belief that "everybody else" had abandoned that tradition. Once the number of people openly stating resistance reach a critical mass, the rest will follow. Both foot binding and female circumcision provide advantages only as long as they are considered the conventional and obvious things to do. A better way to deal with the FGM issue in Sweden than to insist on an unfounded allegation that the practice is being upheld, would be to present the growing evidence of a general abandonment of the practice to the concerned immigrant groups. This would most likely encourage the relatively few Swedish Africans still in favour of FGM to alter their views and dissociate themselves from the practice.

9. Summary

There are a number of factors to be reckoned with in an overall analysis of the existing laws regarding FGM and their judicial consequences. In summary:

Immigrant communities in focus

• The largest group of immigrants in Sweden coming from a country where FGM is performed consists of Somalis. They number well over 20,000 people in Sweden.

• The second largest groups are from Ethiopia and Eritrea, in total about 15,000 persons. There is no known case where a person from any of these countries has been suspected of the illegal practice of FGM.

Legislation and its implementation

• Sweden has had a law banning FGM since 1982.

• No case of FGM has ever been taken to Swedish court.

• Most cases of suspected FGM in Sweden can be classified in one of the following categories:

I. Cases reported to the police (A-O)
   i. No FGM had been performed
   ii. No way to establish if FGM had been performed
   iii. No way to establish if FGM had been illegally performed
   iv. Rumours, no specific suspect

II. Hearsay cases reported in interviews (1-15)
   i. No FGM had been performed
   i. Fear of future performance of FGM
   ii. Girls leaving Sweden, not coming back

The majority of the cases are unlikely to have involved illegal FGM.

• Implementation of the law seems to work well in all sectors.

Efforts at FGM prevention

• Sweden has had several state prevention programmes against FGM since 1993, including the construction of cooperative networks involving authorities and other actors.

• NGOs, supported by the authorities, have arranged training courses on FGM in the concerned immigrant groups, resulting in health advisors working with moulding of opinion.

• The issue of FGM has been discussed repeatedly in the mass media, including in a television documentary from 2001, which attracted a lot of attention.

Factors which obstruct and encourage the implementation of existing legislation

• Obstructing factors

I. How to find cases
II. How to determine whether FGM has been performed (types I, II and IV)
III. How to date when FGM was performed
IV. The general difficulty associated with crimes committed within the family

• Encouraging factors

I. Good knowledge of FGM and the Act on FGM
II. Consensus on the nature of the crime (a child victim perspective)
III. High level of alertness
IV. Existence of guidelines, cooperation among the authorities and cooperative networks

Estimated prevalence

It is often assumed that there is a high prevalence of FGM among Africans in Sweden. There are good reasons to doubt this assumption.

The material gathered concerning the cases of suspected FGM in Sweden supports the view that the occurrence of FGM in Sweden is low or non-existent. It is unlikely that there would be a high number of unreported cases of FGM in Sweden at the same time that most suspected cases reported to the authorities are unfounded.

The scarcity of confirmed cases leads us to the conclusion that the level of alertness is quite high and, possibly, the number of unreported cases might be low.

The following factors will be suggested to explain the scarcity of confirmed cases in Sweden, leading to a situation where no case has been taken to court:

• *The FGM law works in a preventive way.*

• *State preventive programmes have had effects, both in African exile communities (moulding of opinion) and among professionals working with these groups (good knowledge of FGM and the law, high level of alertness).*

• *Internal debate in the African exile communities has led to a general abandonment of the tradition of FGM. In Sweden, African immigrants get an opportunity to escape a group pressure to continue a harmful practice.*

Suggestions for the future

• Specialization of medical experts assessing suspected cases of FGM

• Discussion of the pros and cons of a general screening of all girls in school

• Better FGM networks among European authorities

• Special attention to African girls who risk leaving the country without returning

• Focus on growing evidence of resistance to FGM in the concerned immigrant groups in order to make use of positive group pressure in preventive work

Warbixin kooban

Tarjume: Asha Omar Geesdiir

Waxaa haboon in la fiiriyo asbaabo dhawra inta aan la lafa gurin guud ahaan jiritaanka sharciga gudniika.

Dhugashada jaaliyaddaha shisheeye

• Tirada ugu badan jaaliyadaha shisheeye ee ka soo galay dalalka uu ka jiro gudniika haweenku ee ku nool dalkan Sweden waxaa ugu badan Somalida kuwaas oo tiro 20 000 ka bada ku jooga.

• Jaaliyadaha shisheeye ee iyana ku tiradda xiga, kana yimid sidoo kale dalal gudniinka haweenku ay ka jiraani waa Ethiopiya iyo Eriteriya oo iyana marka la isku daro ay ka joogaan tiro ilaa iyo 15 000 oo qof dhan. Majiro ilaa iyo hada qof lagu soo eedeeyay kiis la xidhiidha xaldaha gudniinka dumarka een kor ku soo xusney dadka dhamaan kayimid dalalkaas iyaga ah.

Xeer u dajinta iyo dhaqan galinta sharciga

• Sweden waxay lahayd sharciga mamnuucya gudniinka dumarka ilaa iyo 1982.

• Majiro wali kiis la xidhiidha gudniinka dumarka oo maxkamad Sweden ku taal la horgeeyay.

• Tuhunka ugubadan ee gudniinka dumarka ee dalkan Sweden waxa uu u dhacaa mid ka mida xaaladahan hos ku xusan.

I. Dhacdooyin lagu wargeliyay boliska (A-O)
- i. ma dhicin guninka haweenka oo la fuliyay.
- ii. ma jiro dariiq lagu qeexi karo in la fuliyay gudniinka.
- iii. ma jiro dariiq lagu qeexi karo in gudninka haweenka ee sharcidarrada ah la fuliyay.
- iv.ma jiro tuhun khaasa, aan aheyn kutirikuteen.

II. Warbixino laga qoray wareysiyo la yiri lana maqlay (1-5)
- i. ma dhicin gudninka haweenka oo lafuliyay.
- ii. waxaa jira cabsi laga qabo mustaqbalka in la fuliyo gudniinka haweenka.
- iii. gabdha ka taga sweden ee aan soo laaban.

• Xaaladaha badankooda waxaa loo qiimeynkaraa kuwa aan u ekeyn falka sharci darada ee gudniinka haweenaka.

• Dhaqangalinta sharcigu waxuu u muuqdaa in uu si wanaagsan uga fulay dhamaan qeybaha uu saameeyo.

Dadaalka ka hortagga gudniinka haweenka

• Sweden waxaa ka jiray qorshayaal heer qaran ah oo la xiriira ka hortagga GH tan iyo 1993 dii, waxaa taa sii dheer abaabulidda iskaashiga iyo wadda shaqeynta quseysa heyádaha kala gedisan.

• Urururadda samafamalka oo ay caawiyeen hey addaha, ayaa abaabulay tababarro waxbarasho oo ku saabsan GH ee quseeya kooxaha sogalootiga ah taas oo dhalisay raiga iyo shaqadda warbixiyayaasha caafimaad ee la xiriira gudniinka haweenka.

• Qadiyadda gudniinka si isdaba joog ah ayay uga hadashay warbaahintu si maqal iyo muuqaalba leh sanadkii 2001, taas oo abuurtay dareen weyn oo la xiriira GH. Ku dhaqanka sharciyadda jira ee mumnuucaya falka GH.

Qaabka xakameynta iyo ka horgga

I. Sidii lagu heli lahaa falalka.
II. Sidii loo qiimeynlahaa darajadda uu yahay (nooca I; II iyo IV) haddii uu dhaco fal danbi ee laxiriira GH.
III. Sidii loo keydinlahaa marka ay dhacaan falalka GH.
IV. Guud ahaan dhibaatooyinka la xiriira danbiyaddaas ka dhaca qoysaska dhaxdooda.

Tilmaantaha mudan

I. Aqoon wanaagsan oo loo yeesho GH iyo falaka GH.
II. Isbarbar dhigga denbiyadda assalkooda (marka laga eego danbiyadda caruurta laga galo)
III. Foojignaan heer sareysa.
IV. Jiritaanka wada shaqeynta xog ogaaladda iyo heyaddaha dowladda.

Qiyaasta baaxadda

Inta badan waxaa lagu qiyaasaa in uu aad ugu badan yahay gudniinka haweenku Afrikanka ku nool dalkan Sweden.Waxaa jira sababo wanaagsan ee u sal noqonkara shakigaas.

Xogta laga ururiyay kiisaska la tuhmey oo la xiriira GH gaar ahaan dalkan Sweden ayaa muujineysa aragti ah in GH uu aad ugu yar yahay dalkan ama uusan jirinba.

Waxaa nasiibdaro ah in kiisas badan oo la xidhiidha GH aan loo soo gubin hayadaha ay-quseyso islamarkaana kiisaska aad loo tuhmay ay noqdeen kuwo la cadeyn kariwaayey.

Xaqiijinta kiisaska oo aad u liidata ayaa waxay inoo horseedeysa in darajadda foojig-naaneenu aad u sareyso, taas oo suuro galin karta in tiradda kiisaska aan la soo gudbin laga yaabo in ay aad u yaryihiin.

Dhacdooyinkan hoos ku xusan ayaa qeexeya faahfaahinta kiisaska tiradda yar ee ka dhacay sweden, kuwaas oo dhamaan noqday wax maxkamad lagu soo oogi kari waayay xaqiijindarro owgeed.

• *Sharciga GH waxa uu ku saleysan yahay ka hortagga falka.*

• *Qorshaha qaranka ee ka hortagga GH waxa uu saameeyay, labaddaba hadeytahay afrikanka dibadda ku nool iyo hadey tahay Xirfadlayaasha la shaqeeya kooxahaas iyaga ah, kuwaas oo adeegsanaya aqoon sare,sharci, iyo foojignaan aad u sareysa.*

• *Doodaha ka dhaxdhacay bulshada afrikanka ah ee dibadda ku nool ayaa u horseeday in good ahaan ciribtiraan dhaqanka la xiriira gudniinka haweenka. Afrikanka soogalootiga ah ee ku nool dalkan Sweden waxay heleen fursad ay kaga fakadaan cadaadiska kooxaha ku dhaqma dhaqankan xun ee GH.*

Ra´yiga mustaqbalka

• In aqoonyahanada caafimaadka ay baaraan kiisaska la tuhunsan yahay ee la xiriira GH.

• In laga hadlo khasaaraha iyo faaiidada uu leeyahay baaritaanka xubnaha taranka ee gabdhaha ardeyda ah oo dhan iyaga oo aan loo eegin assalkooda amma halka ay ka soo jeedaan in lagu wada sameeyo guud ahaan baritaan caafimaad.

• Waddashaqeyn ka wanaagsan tan hadda jirtaa inay dhaxmarto heyádda yurubiyan ka ah ee ka shaqeeya GH.

• In foojignaan gaara loo yeeshaa hablaha afrikaanka ah ee ka tagayo waddanka oo aan soo laabanin.

• In fiira gaara loo yeesho wanaagga iyo xoogga ka hortagidda GH ee ka dhax kobcaya kooxaha soo galootiga ah loona is ticmaalo ka hortagga iyo ciribtirka falka xun ee isaga ah.

Sammanfattning

Ett antal faktorer bör ingå i en analys av den svenska lagstiftningen och dess tillämpning. Sammanfattningsvis:

Invandrargrupper i fokus

• Den största invandrargruppen i Sverige som kommer från ett land där kvinnlig omskärelse praktiseras är den somaliska. De är långt mer än 20 000 i Sverige.

• De näst största grupperna kommer från Etiopien och Eritrea, de är sammanlagt omkring 15 000 personer. Det finns inget känt fall där någon med bakgrund i dessa länder misstänkts för olaglig kvinnlig omskärelse.

Lagstiftning och dess implementering

• Sverige har haft en lag mot kvinnlig omskärelse sedan 1982.

• Inget fall av kvinnlig omskärelse/könsstympning har lett till åtal i Sverige.

• De flesta fallen av misstänkt könsstympning i Sverige kan grupperas i följande kategorier:

I. Fall som anmälts till polisen (A-O)
   i. Ingen könsstympning hade utförts
   ii. Ingen möjlighet att avgöra om könsstympning hade utförts
   iii. Ingen möjlighet att avgöra om könsstympning utförts i strid mot gällande lag
   iv. Rykten, ingen särskild person misstänkt

II. Hörsägenfall som omtalades i intervjuerna (1-15)
   i. Ingen könsstympning hade utförts
   i. Farhågor om att könsstympning skulle komma att utföras
   ii. Flickor som lämnat Sverige utan att återvända

I en majoritet av dessa fall är det osannolikt att illegal kvinnlig könsstympning förekommit.

• Implementering av lagen tycks fungera väl i alla sektorer.

Insatser för att förebygga kvinnlig omskärelse/könsstympning

• Sverige har haft åtskilliga statliga förebyggande program mot kvinnlig omskärelse/könsstympning sedan 1993, med bl a skapandet av samverkansgrupper med myndighetspersoner och andra aktörer.

• Frivilligorganisationer har arrangerat informatörskurser för personer i de berörda grupperna, vilket fått som resultat att hälsoinformatörer arbetar med opinionsbildning.

• Frågan om kvinnlig omskärelse/könsstympning har med jämna mellanrum diskuterats i massmedia; bl a i en TV-dokumentär från 2001, som väckte stor uppmärksamhet.

Faktorer som försvårar och underlättar en implementering av lagen

• Försvårande faktorer

I. Svårigheten att finna fall
II. Svårigheten att fastställa att ingrepp skett (gäller typ I, II och IV)
III. Svårigheten att datera när ett ingrepp skett
IV. Allmänna svårigheter med brott som sker inom familjen

• Underlättande faktorer

I. Bra kunskap om kvinnlig omskärelse/könsstympning och om lagen mot könsstympning
II. Konsensus om brottets natur (ett barnofferperspektiv)
III. Hög grad av vakenhet och beredskap
IV. Förekomsten av riktlinjer, samarbete mellan myndigheter och samverkansgrupper

Uppskattad förekomst

Det antas ofta att kvinnlig omskärelse/könsstympning förekommer i stor skala bland afrikaner i Sverige. Det finns goda skäl att ifrågasätta det antagandet.

Materialet som här samlats av misstänkta fall i Sverige stödjer antagandet att det handlar om en låg eller icke-existerande förekomst. Det är osannolikt att det skulle finnas ett stort antal oanmälda fall av kvinnlig omskärelse/könsstympning i Sverige samtidigt som de flesta fall som rapporteras till myndigheterna är ogrundade.

Bristen på bekräftade fall leder till slutsatsen att beredskapen är mycket hög, samtidigt som förekomsten av oanmälda fall bör vara begränsad.

Följande faktorer föreslås för att förklara bristen på bekräftade fall i Sverige och det faktum att inget fall lett till åtal:

• *Lagen mot kvinnlig könsstympning fungerar preventivt.*

• *Statliga program mot kvinnlig omskärelse/könsstympning har gett resultat, både i afrikanska exilgrupper (opinionsbildande) och bland yrkesverksamma som kommer i kontakt med dessa grupper (bra kännedom om sedvänjan och om lagen mot den, hög grad av beredskap).*

• *Intern debatt inom de afrikanska exilgrupperna har lett till att man generellt har övergett traditionen. I Sverige får afrikanska invandrare möjlighet att slippa det grupptryck som verkar för upprätthållandet av en smärtsam tradition.*

Förslag inför framtiden

• Specialisering av medicinska experter som kan göra undersökningarna i misstänkta fall av kvinnlig omskärelse/könsstympning.

• Diskussion om fördelar och nackdelar med en allmän screening av flickor i skolan.

• Bättre samarbete och nätverk mellan europeiska myndigheter.

• Speciell uppmärksamhet vad gäller flickor som riskerar att lämna landet utan att återvända.

• Fokusering på de växande beläggen för motståndet mot kvinnlig omskärelse/könsstympning i de berörda invandrargrupperna, i syfte att utnyttja ett positivt grupptryck i det preventiva arbetet.

List of informants interviewed

Personal meetings, interviews tape-recorded and transcribed

- NN, district prosecutor
- NN, detective superintendent at the police
- NN, social worker, coordinator of the Domestic Violence Unit
- NN, school nurse
- NN, specialist in obstetrics and gynaecology
- NN, midwife, one of the initiators of the "Network against FGM"

Telephone interviews
– some tape-recorded and partly transcribed, some recorded with notes

Legal experts at hospitals
- NN, hospital legal expert, Stockholm
- NN, hospital legal expert, Göteborg
- NN, hospital legal expert, Göteborg
- NN, hospital legal expert, Malmö

Legal experts at the municipality level
- NN, municipality legal expert, Stockholm
- NN, municipality legal expert, Göteborg
- NN, municipality legal expert, Malmö

Social workers
- NN, unit investigating cases involving children, Spånga-Tensta, Stockholm
- NN, unit for youth, Rinkeby, Stockholm
- NN, Skärholmen's social welfare office, Stockholm
- NN, administrator of guidelines concerning children and youth to social authorities, Stockholm
- NN, Gunnared's social welfare office, Göteborg
- NN, Biskopsgården's social welfare office, Göteborg
- NN, Rosengård's social welfare office, Malmö

Police officers
- Relevant officers at all 21 police districts in Sweden
- NN, police officer involved in cases of suspected FGM in Göteborg
- NN, police officer in charge of the "Göteborg case"

Prosecution
- NN, prosecutor in the "Göteborg case"

Health care staff
- NN, head school nurse, Stockholm
- NN, school nurse, Malmö
- NN, gynaecologist, on possibilities of establishing point of time of FGM from genital examination
- NN, school doctor, Malmö

Others
- NN, appellate judge, secretary of the state committee revising the Secrecy Act
- NN, journalist with access to all documents concerning the "Göteborg case"
- DO (the ombudsman against ethnic discrimination), on a case reported to the DO office
- Statistics Sweden (SCB)
- National Council for Crime Prevention (BRÅ)

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Göteborg
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K 166256-02
K 147408-01
K 162278-01

Jönköping
K 18752-01

Helsingborg
K 46657 (verbatim rendering on phone)

The documents handed out by the police authorities included, in many cases, medical certificates, reports of the social authorities, etc.

DO case Dnr. 454-98.