DISCRIMINATION OF CERTAIN ETHNIC GROUPS? ETHICAL ASPECTS OF IMPLEMENTING FGM LEGISLATION IN SWEDEN

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Ethical aspects of implementing FGM legislation in Sweden

Malmö University, 2009
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FOREWORD

This report is a result of a multi-country project, which was financed by the EC Daphne Programme and monitored by Dr. Els Leye at the International Centre for Reproductive Health, Ghent University in Belgium. Countries represented by researchers in the project are Belgium, the UK, France, Spain, and Sweden. The current project is called *Towards an improved enforcement of FGM legislation in Europe: Dissemination of lessons learned and capacity building of actors in legal and (para)legal fields* and builds on a previous project conducted in 2003-2004 by the same research group: Evaluating the impact of existing legislation in Europe with regard to female genital mutilation. The former project included a survey of FGM-related legislation in all EU member countries, as well as a deeper analysis of these issues in the five countries.

In the current project the researchers are:

- Els Leye — ICRH, Ghent University, Belgium
- Naana Otoo-Oyortey — FORWARD, United Kingdom
- Linda Weil-Curiel — CAMS, France
- Sara Johnsdotter — Faculty of Health and Society Malmö University, Sweden
- José Garcia Añon, Ruth Mestre i Mestre — Centre of Studies on Citizenship, Migration and Minorities; Universidad de Valencia, Spain

The general objective of the current project is to formulate and propose practical recommendations for the implementation of FGM legislation in Europe. More specific objectives concern addressing

the existing review of criminal and child protection laws on FGM in the EU, now with an update of earlier research and an expansion to include recent EU member states. Furthermore, in the five countries, workshops were held to discuss specific issues relevant to each country in regard to existing implementation of FGM legislation.

The workshops held in Sweden are presented in this report. Guidelines in Sweden for all concerned professional groups do exist and they are easily accessible on the website of the Swedish Board of Health and Welfare. Exposure to the topic of FGM also includes the fact that two cases of FGM have recently been taken to court and ended up in custodial sentences. The issue of 'female genital mutilation' is regularly discussed in the mass media, and the Swedish public is generally quite familiar with the existence of this phenomenon. Therefore, for the Swedish context, I will take the discussion of legislative implementation one step further and include a discussion of ethical aspects and the issue of discrimination. To this end, the workshops in Sweden revolved around the question: "Is there discrimination of certain ethnic groups in the current implementation of FGM legislation in Sweden?"

In working with this report, I received substantial input from a legal expert, John Stauffer, of the governmental authority known in English as The Ombudsman against Discrimination. I warmly thank him for his input.

Finally, I am deeply grateful to Pauline Binder for her patient proofreading of the manuscript.

Malmö, 3 April 2009

Sara Johnsdotter

1. BACKGROUND: "FEMALE GENITAL MUTILATION" IN SWEDEN

In 1982 Sweden legislated against FGM and was the first Western country to do so. With the influx of many Somalis in the beginning of the 1990s, there was a revival of attention paid to FGM. At this time a national project was launched (*the Göteborg Project*) to deal with disseminating information to professionals and to work with the moulding of opinion within the concerned immigrant groups.

Compared to many other countries in Europe, Sweden shows a high level of alertness when it comes to suspected cases of FGM; knowledge about legislation banning FGM is generally high and there is additionally a long history of guidelines for various professional groups (Johnsdotter 2004, Leye et al. 2007). The emphasis on identifying illegal cases of FGM is supported by the mass media, which repeatedly gives this issue attention. For instance, the high-profile daily newspaper, *City*, recently had a placard reading: "Midwife alerts: The health care system in south Sweden ignores that women are being genitally mutilated" (29 November 2008).

Since the law came into effect in 1982, about twenty reports on suspected FGM have reached the police. Some of these were groundless (one case concerned a boy being circumcised; others were based merely on rumours without a specific suspect, etc.). In some cases, the suspected family had moved to another country, while in others the genital examination showed that no FGM had taken place.[1]

1 For a detailed description of these cases and the so called 'hearsay cases' (cases reported by professionals in the field who were interviewed during the former project), see Johnsdotter (2004).

Two cases have been taken to court and ended up in custodial sentences. Both will be briefly described in this report.

In some of the cases representing suspicion of FGM in Sweden, compulsory genital examinations of minors have taken place. None of these cases has shown that FGM was performed. These cases will be in focus in this report. Particularly noteworthy is the present dichotomy within Swedish society: there is a strong political will to have effective enforcement of the FGM legislation, while at the same time contiguous anti-discrimination legislation exists, as well as a social movement working against the stigmatization of immigrants. An important question to be addressed here is to ask, 'What happens when such aims clash?'

1.1 Ethnic groups in focus

1.1.1 Somalis

According to Statistics Sweden, there were about 21,600 persons born in Somalia in 2007. This figure does not include Somali births that took place while Somali parents were living in Sweden. Estimates on the number of Somali-speaking people living in Sweden vary from 40,000 to 60,000 (the variation is partly due to the fact that some Somalis arrived in Sweden with passports from neighbouring countries).

Most Somalis arrived in Sweden in the first half of the 1990s, when the Somali state had collapsed and the country was torn apart by civil war. There has also been an influx of new immigrants from Somalia during recent years: more than one thousand every year (Johnsdotter et al. 2009). Statistics further indicate that the Swedish Somali group is one of the most segregated immigrant groups in Swedish society (Lövkvist 2007).

It seems that an overwhelming majority of Swedish Somalis abandon the practice of female circumcision living in Sweden. The internal debate revolves around Islamic arguments, where it is concluded that FGM – especially more extensive forms – violate Koranic teachings. However, positive values attached to FGM are still discussed among many Swedish Somalis, even though there is animated discussion of

negative aspects such as medical complications. The Koranic ban[2] of FGM and the relief at *not* having to subject a daughter to FGM seem to be aspects that dominate (Johnsdotter 2002, 2003). The collective self-image is complex; some Somalis state that FGM is a practice almost completely abandoned by Somalis in Sweden, while others say that they believe there are many hidden cases (although not in their own circle of kin and friends).

Nearly all cases of suspected FGM in Sweden have concerned families with origin in Somalia.

1.1.2 Ethiopians and Eritreans

In Sweden, there are more than 18,000 persons who were born in Ethiopia or Eritrea. The majority of Ethiopian and Eritrean residents in Sweden immigrated during the 1970s or 80s as political refugees, following a slow but steady inflow from the 1950s to mid-1980s. In the late 1980s, more than 1,000 arrived each year. Thereafter the figures decreased; since then there has been an influx of about 200 persons a year from each country.

Most Ethiopians and Eritreans in Sweden live in the three largest cities and in the university cities. There are no statistics regarding these groups' general position in the labour market; however, the lack of alarming reports can possibly be interpreted as a positive sign. By comparison, Somalis, whose immigration to Sweden peaked in the 1990s and coincided with economic recession, have had serious problems as a group in the labour market. While Somalis have come to be regarded as 'hard to integrate', the Ethiopians and Eritreans seem to have escaped this fate. Further, newly arrived immigrants from Ethiopia and Eritrea have had the opportunity to merge with networks of countrymen who were already well integrated into Swedish society (Johnsdotter et al. 2009).

Thus far, there has been no case of suspected FGM among families with their origin in Ethiopia or Eritrea. A qualitative study with the aim to investigate the internal debates on FGM among Swedish Ethiopians and Eritreans showed that that the practice is redundant, i.e. it is completely socially acceptable to let a girl grow up uncircumcised. For Ethiopians and Eritreans, no crucial value was associated with the practice – in contrast to the Somali

2 Considered most important is the Koranic verse 30:30: "Let there be no alteration in Allah's creation."

group. The predominant collective self-image among Ethiopian and Eritrean residents in Sweden was that of a group having abandoned this tradition (Johnsdotter et al. 2009).

1.1.3 Gambians

Gambians in Sweden number a little more than 3,000 persons. Very little is known about the group in Swedish society, besides the fact that immigration to Sweden seems to be associated with a long history of Swedish tourism in the Gambia. After Somalis, Eritreans and Ethiopians in Sweden, the Gambians make the biggest group from a country where FGM is practised. No study has thus far been conducted to investigate into internal debate about FGM among Swedish Gambians. However, the first FGM case in Norway concerns a Gambian couple, whose children (born in Norway) were taken back to Gambia to live and who were subjected to FGM.[3]

1.2 Asylum

A legal base for asylum-seeking on the grounds of FGM is stated in the *Aliens Act* in a formulation stating that a person who "feels a well-founded fear of suffering the death penalty or being subjected to corporal punishment, torture or other inhuman or degrading treatment or punishment" has a right to ask for asylum in Sweden (chapter 4, section 2).

It remains unclear how many women have obtained asylum in Sweden by referring to the risk of FGM. This is due to the fact that risk of being subjected to FGM is part of a bigger picture (The Swedish Migration Board 2005).

In October 2008, Sweden had the first known case of a person receiving asylum due to FGM as the sole basis. A one-year-old girl from Eritrea got permission to stay in Sweden, and also her mother and brother, due to the risk of FGM in their home country. This decision changed the former praxis, where the risk of FGM could work as a means for asylum in combination with other grounds, being an example of gender-based violence. At issuing the decision about the girl from Eritrea, an official from the Swedish Board

3 See e.g. an article published by Daily Observer, http://observer.gm/ Africa/article/2008/6/9/ gambians-fgm-charge-in-norway

declared on national news that from that point all girls who risk being subjected to FGM have the right to protection by being granted asylum in Sweden (Henrik Winman, The Swedish Migration Board, in *Rapport*, 2008-10-24).

1.3 The question of screening

During the last ten years, the option of introducing general or selective genital screening to detect FGM has been discussed. The issue was especially debated by many people in 2006, when a liberal politician (who had subsequently become a minister of the government the following year and who is currently Sweden's Minister of Integration and Equality) gave the following proposal in a newspaper article:

> Adopt compulsory gynaecological examinations of girls. The society needs to find ways to prevent, disclose, and prove FGM. In schools we should introduce compulsory check-ups performed by physicians, in line with those already existing for boys [check-ups to see whether the testicles are located in the scrotum]. For girls, this check-up should take place some time during their time in high school. Such an examination would not only function as a controlling device, but it would also offer an opportunity to discuss sexuality, the woman's genitals and women's diseases. [Nyamko Sabuni, "Check the genitals of all high school girls", Expressen, 2006-07-17.]

Screening is a method in medicine to find instances of a certain condition by examining a large number of people, and include those who show no signs or symptoms. In discussions about implementing screening, one must weigh the benefits of finding cases against the adverse effects of the screening itself (for instance, stress and anxiety caused by the screening procedure). According to a report published by the WHO in the 1960s, there are some principles that should be considered at implementing a screening procedure. Among them are that the condition should be an important health problem, that there should be a treatment for the condition, that the procedure

is acceptable to the population concerned, and that case-finding should be a continuous process and not a 'once and for all' project (WHO 1968).

Benefits from *general screening* procedures in European countries (all girls of a certain age being screened) or *selective screening* (all girls of certain risk group being screened) would include the possibility of detecting and finding evidence of FGM, as well as possibly preventing cases of pending FGM. Adverse effects might include the risk of violation of bodily integrity, as well as any effects resulting from the repressive nature of the screening itself (i.e. the ultimate purpose would be to detect criminal cases and not to treat for a medical condition). When it comes to selective screening, such a procedure would raise the question of discrimination. Further, it would be a tricky task to decide who to include in the category 'at risk for FGM' and who to consider being out of risk.

Aside from ethical issues raised in connection to screening of girls' genitals, financial aspects are also highlighted. A screening of this magnitude would be costly to introduce and maintain. Further, it would jeopardize the relationship between school health care staff and pupils – a relationship ideally built on trust. Finally, it can be argued that other forms of screening in Sweden (for instance, check-ups of boys' testicles and mammography) builds on voluntariness; the suggested screening of girls for FGM would, however, be mandatory and would ultimately take the issue of screening to another level, where ethics are concerned.

2. CASES

2.1 Two FGM court cases

Since 1982, two cases have ended up in court. An additional case involved the detention of a Swedish Somali man during a one month period. These three cases are described below.

I. Mölndal, 2006

A 16-year-old girl (here called Amina), tells her school welfare officer that she has been physically abused by her mother for several years, with her mother using various objects during the beating of her daughter. She also says her mother had her subjected to FGM when she was age eleven, during a trip to her mother's home country, Somalia, in 2001. Now Amina fears for her life, since her mother has tried to hit her with a frying pan while she was asleep. Amina's sister had stopped their mother. Amina also says that her mother has repeatedly checked her genitals, trying to find out if she has had sexual intercourse. Certificates from experts in forensic medicine supported that Amina has been circumcised (type II) and physically abused. Additionally, records show that over the years, Amina's mother reported six times to the police that her children had been raped.

During the police investigation and court proceedings, Amina claims that her two sisters (in 2001 aged 12 and 7) were also circumcised on the same occasion. Both of these young girls were genitally examined by physicians when they were younger, in connection with the rape reports filed by their mother. These prior investigations showed that the two sisters had not been subjected to

(any extensive form of) FGM and, thus, if circumcised now it must have been done in an unlawful way. Hence, if the sisters had been genitally examined by forensic experts at a point in time subsequent to their trip to Somalia, circumcision could possibly have been proven in court. Had the authorities done this, the police and prosecutor could have had the possibility to use the *Act regarding Special Representative for a Child* to take the girls to compulsory genital examinations, even against their mother's will, in efforts to find evidence of circumcision. However, they refrained. A possible explanation could be that the girls denied their sister's allegations during interrogations and defended their mother with fervour (this despite the fact that one of the sisters admitted she was, in fact, circumcised). In any case, the court did not seem to doubt that all the girls were circumcised in Somalia in 2001. The formal charge, however, concerned only Amina.

The mother, aged 43, was charged with FGM and serious violation of bodily integrity in regard to Amina, and she was sentenced to three years in prison.
[Source: Police investigation and court verdict.]

II. Göteborg, 2006

A 14-year-old girl (here called Muna) born in Sweden but her parents being from Somalia, turns to the Swedish embassy in Addis Ababa. She has been living with her father and brother in Mogadishu since she was ten years old, but now she has run away with a man. She says that her father has beaten her and has for years abused her psychologically, and that he has threatened her with a gun, has sent her to jail for some period of time, has plans to marry her away by force, and that he has had her circumcised.[4] Medical examination shows that Muna has been subjected to FGM, type II.

Her father, Ali, 41 years old, is detained when he returns to Sweden to partake in legal negotiations regarding custody (there is a dispute over custody between Ali and his ex-wife).

Ali is subsequently sentenced to prison in district court. Since Muna said during interrogation that both her father and aunt were present in the room when she was circumcised, Ali's sister

4 Further, she was not allowed to socialize with friends or to watch TV. Later police interrogations with her younger brother Adam, twelve years old, contradicted this description of their life in Somalia. For instance, he could easily name several of Muna's friends that she used to spend time with.

is also taken into custody when she arrives in Sweden. In a later interrogation, Muna admits that her aunt was not in the room, and her aunt is then released after six months in detention. Another circumstance is that in the first interrogation, Muna is positive about the point of time: she says she knows for sure that FGM took place in Mogadishu in January 2005. In later interrogations, however, she changes her mind: it may have been in August 2004, or perhaps as late as in the summer of 2005 (shortly before she arrived at the embassy). There is no other evidence pointing toward Ali as the perpetrator besides his daughter's account. There are reasons to question whether this man got a fair trial, and reasons to believe that he was sentenced for political reasons without sufficient evidence. Available facts and circumstances show that Ali is probably innocent (Johnsdotter 2008a,b). He was sentenced to 2 years in prison for FGM.
[Source: Police investigation and recordings from court proceedings.]

2.2 One case of temporary detention

In November 2008, a Swedish Somali man is detained in Malmö after being suspected of conspiracy to FGM. About a year before that, he had taken four of his children (all of them Swedish citizens) to Somalia and had left them with his parents. After some six months of living in a village in the Somali countryside, his oldest daughter, aged 15, runs away and turns up in Addis Ababa. She asks the personnel at the Swedish embassy for help to get back to Sweden. After a while it turns out that she has been circumcised during her stay at her grandparents' home (type II, according to the medical certificate). She tells the Swedish officials that her two sisters have also been circumcised. Her father is in Sweden at the time the circumcision took place. However, his daughter states that he had not opposed the procedure when it was suggested by relatives at an earlier point. The police tried to find enough evidence to support a charge of conspiracy to FGM, but failed. The man is released following four weeks of detention.
[Source: Police investigation.]

2.3 Compulsory genital examinations without consent

The cases presented in summary:

A. Stockholm, 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 on 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. aThe mother said that she was herself willing to take her daughter to a doctor for genital examination. The social worker involved in the case insisted on an examination the very same day, in the presence of one person from the social welfare office and one person from the day care centre.

Problems arose when the girl was taken for genital examination. According to the mother's reports to the police (for calumny) and the Ombudsman against Discrimination, the mother was not offered an interpreter and was not properly informed about the suspicions. The examination was also performed despite 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 infection.
[Source: Police investigation.]

B. Göteborg, 1999

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 had been discovered during an earlier examination – as the changes of the genitals were so "striking" – so she restricts her actions to writing a note in the medical case record.

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.

About two months later a detective inspector makes the decision to act in this case. A few weeks later, representatives of the police, the social authorities, and a physician make a house call. The parents are informed that they are under suspicion of conspiracy 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 accusations insistently and indignantly, and cannot understand why anyone could think they would harm their own child in this way. Later the same day, one expert in forensic medicine and two child urologists declare the girl's genitals to be completely normal. None of them, examining the girl under narcosis, could find signs of any kind of violence or of an operation.
[Source: Police investigation.]

C. Uppsala, 2004-2005

On May 13, 2004, a father takes his daughters to a child care clinic for a routine check-up. He mentions that the older girl is going to East Africa with an aunt to visit relatives. The nurse asks the father if after this trip she could see the girl again and have her examined. The father replies that there was no reason for that.

The nurse summons the parents to a meeting that same month. The mother shows up. The mother tells the nurse that both she and her husband are opponents of FGM and that there is no risk whatsoever that their daughter will be circumcised during the trip. The nurse reports to the child protection unit (the social authorities) that she has a suspicion that the girl will be circumcised.

In August, after the trip, the social authorities summon the parents to a meeting and a meeting takes place in September. Present are the parents, a social worker, the nurse and her superior. The district physician tells the parents that "in Sweden, it is illegal to abuse your children through genital mutilation." The parents declare that they

are opponents. A conflict arises and the father leaves the building, with the mother also leaving soon afterward.

The social authorities try to persuade the parents to agree to a genital examination in order to clear themselves of suspicion. They refuse.

In March 2005, the social authorities report suspected FGM to the police. They open an investigation. In late summer 2005, the parents were interrogated. In autumn 2005 a 'special representative of a child' (according to Law 1997:997) was appointed. This representative decided to have a genital examination performed. The girl in question is collected from school by the police. She does not want to go to hospital. At Uppsala Academic Hospital she is subjected to a thorough genital examination, which shows that she has not undergone FGM. The police investigation is closed in February 2006.
[Source: Plaint filed by lawyer representing the Ombudsman against Discrimination]

The Ombudsman against Discrimination sued Uppsala City, stating that the authorities had acted against the Discrimination Act, and also Article 8 of the European Convention, stating a right to respect one's private and family life. The case is not yet closed (as of October 2008).

The lawyer who was the child's special representative has received a formal warning from the Swedish Bar Association for not accompanying the girl during the genital examination that was enforced upon her.

D. Stockholm, 2006

A girl tells her friends at school that she has been circumcised during holidays in Somalia. This information reaches the Swedish authorities who want to have the girl examined. Her parents refuse. The girl is taken to compulsory examination without consent. The genital examination reveals no signs of FGM.
[Source: personal communication with legal expert at the office of the Ombudsman against Discrimination, who in turn had the case described by an Anti-Discrimination Office in Stockholm.]

E. Malmö, 2008

A girl aged 11, from a family having their origin in Somalia, visits her school physician for a routine check-up. Her mother accompanies her, which is the routine in Sweden. The school personnel knew that the girl has recently been to Somalia. After a while the school physician takes the girl to another room without notifying the girl's mother. The girl is asked to pull down her trousers and to show her genitals. When she asks why, the school doctor says that it is a routine control and that she needs to cooperate, or someone else will check her genitals. The doctor tears off her trousers and underwear in a hurry. The girl tries to cover her genitals with her hands, but the school physician forces her hands away. The girl leaves the room shocked and crying. Her mother becomes very upset and reports the school physician to the police. The police conclude that no formal crime has been committed and close the case. The incidence is now reported to the Ombudsman against Discrimination office.
[Source: A news feature from the radio and personal communication with the family.]

2.4 Two additional cases of examinations in Scandinavia

F. Aalborg (Denmark), 2003

A case from Denmark is included in this list. It is of special interest, since it gave rise to a collective response among the Danish Somalis.

On January 30, 2003, a Danish Somali family gets a visit. The family has lived in Denmark for nine years, both parents working. There are five children. One of the children, a girl aged six, spent some time in Somalia with her mother during the summer in 2002. The authorities developed suspicions that the girl was circumcised in Somalia during their stay. The parents deny the charges. The father calls the local newspaper, but they say they are not interested. When confronted at the home, the visitors are asked to show a court decision giving them the legal right to examine the girl, but they say they do not need one. They are from child protection and have a report about suspected female circumcision. They ask the mother to undress the child and put her on a table, so that the school physician, who is accompanying the child protection officers,

can examine her. The parents try to persuade the visitors that no examination is needed, since the girl is not circumcised. Then they are told that if they refuse examination they risk that the girl will be taken into custody by force, with police assistance if necessary. After about two hours the parents give in and the child, now crying, is laid down on a table. The examination does not show any signs of female circumcision. A few days later, the family moves to England. [Source: Dr. Ola M. Vedel in a report to Amnesty.]

As a result of this incident, some ten Danish Somali community-based organisations went public declaring that if more genital examinations were executed by force, Danish Somali parents would keep their daughters from Danish institutions (schools, day care centres), since the security of the girls was called into question. [Source: www.indvandrertv.dk, April 12, 2003.]

G. Gentofte (Denmark), 2008

Pre-school staff suspected that a little girl with parents from Ethiopia had been subjected to FGM. Early one morning there was a house call from the police and social authorities. Parents were taken into interrogation and the girl was taken for genital examination, performed by forensic experts. The girl's older brother was left at home and told that he probably would not see his parents for a while.

The forensic experts concluded rather soon that the girl had not been circumcised, but instead had a vaginal inflammation. Probably the infection was a result of the girl's hygienic circumstances around using the toilet at the day care. The policy at the day care centre was that small children should wipe themselves clean at visiting the toilet; however, since this child was overweight, the routine was problematic to her.

The parents asked for financial compensation for the humiliation they were subjected to. In court they were denied compensation, since the police argued that they were never formally arrested. [Source: Newspaper article, TT-Ritzau, *Expressen*, 2008-11-21.]

3. WORKSHOP I: ETHICAL ASPECTS OF THE ENFORCEMENT OF FGM LEGISLATION

The first workshop took place on September 26, 2008, at the Faculty of Health and Society, Malmö University. Key actors from the health care sector, the social authorities, and the police were present, as well as researchers in the fields of law, social work, and anthropology, and also key officials from government organizations, such as the Ombudman against Discrimination, the Swedish Board of Health and Welfare and the County Council. The workshop lasted for six hours.

3.1 Participants

Afrah Hussein
Social worker, municipality of Eslöv
Anna Gustafsson
Chief inspector, head of the Malmö police department dealing with violence within the family
Annika Staaf
LLB, PhD in Sociology of Law, specialized in law enforcement involving children
Astrid Schlytter
Associate Professor, Social work, Stockholm University, specialized in honour crimes

Birgitta Essén
Associate Professor, obstetrician and gynaecologist, senior lecturer at Uppsala University and chief physician at Uppsala University Hospital
Janneke Johansson
Special advisor at the Finnish League for Human Rights. Project Manager for the national Finnish program to fight FGM, the KokoNainen Project
John Stauffer
Legal expert at the Ombudsman against Discrimination office, a government authority
Margot Olsson
Child protection officer, head of Malmö municipal cooperative organization against violence within the family
Maruja Arévalo
Responsible for issues of integration at the section of public health at the county council
Nasra Ali Hussein
Close to a degree in Social work at Göteborg University
Owolabi Bjälkander
Investigator specialised in FGM, the Swedish Board of Health and Welfare
Stefan Kling
School physician, Malmö
Sara Johnsdotter
Associate Professor, anthropologist, researcher in the field of female circumcision.
Workshop organizer, minutes secretary
Per Brinkemo
Journalist specialized in Swedish Somalis, workshop moderator

3.2 Key questions

In the field of FGM legislation enforcement, what types of situations involve ethical dilemmas? How can these dilemmas be overcome?

3.3 Aim of workshop

The aim of the workshop was to identify scenarios in FGM legislation enforcement that may lead to ethical dilemmas, and to suggest possible actions or procedures that minimize stigmatizing effects as concerns a group as a whole or that minimize violations to the integrity of the individuals involved in specific cases.

3.4. Workshop themes

As a starting point, four cases of genital examinations executed by force were presented; the first three very briefly by Sara Johnsdotter and Per Brinkemo (cases A-C), the fourth and at the point most recent (case D) in detail by the Ombudsman against Discrimination legal expert, John Stauffer.

The moderator Per Brinkemo presented a fictitious case: *A teacher tells the school physician that she has suspicions that 9-year-old Waris was circumcised during holidays in Somalia. Her personality seems to have changed, she seems to walk differently and she often goes to the toilet.* The discussion started from this situation: how wide or narrow is the room to maneuver for the various actors given the prevalent legislation?

3.4.1 Level of suspicion

According to legislation, any suspicion that a child does not fare well should be reported to the social authorities. A school physician has an absolute obligation to act and report when faced with information that can imply a need for the social welfare committee to intervene on behalf of protection of the child. But where is the limit making it possible to conclude with some certainty that there is reason to report? Where to draw the line between a passing thought of suspicion and information enough to feel the urge to report?

In this case, we discussed various scenarios in an attempt to identify where to draw that line. For instance, what if the school physician sees both the young girl and one of her parents and brings up the issue of personality change and walking difficulties, and both parent and girl deny that such changes have taken place? What if he

or she openly brings up the subject of female circumcision, to see how the child or the parents react to that?

Here we could see clearly how the various public sectors have different objectives and operational ends. The primary goal of professionals in the health care sector is to ensure and work for the patient's health and wellbeing, which is also close to the goal of the social authorities. The police, on the other hand, focus primarily on the investigation of possible crimes. This implies that different kinds of light are shed over this situation.

- The school physician has a primary interest in finding out whether the child has problems with her health or wellbeing, but he or she must also take the duty to report to the social authorities into account.
- The social authorities would like to know if there is reason to investigate the life situation of that specific child. Their action will depend on what is expressed in the report from the school physician: *Is he or she worried that the child is not faring well?* Then they will consider opening a social investigation. *Does he or she state that the child may have been subjected to FGM?* Then they will notify the police, since they (almost without exception) have a duty to notify the police when a crime may have been committed against a child. They may also see reason to follow up with a social investigation.
- The police have no interest in having professionals (in this fictitious case, the school physician) who suspect FGM discussing the matter with the presumptive offenders. The lesser said about it, the better for a prospective police investigation.

How much suspicion is required (i.e. substantiated enough) to make a case to report? Persons reporting to the social authorities are not supposed to investigate the case themselves. In guidelines to school staff, the Swedish Board of Health and Welfare points out:

> If the school staff has suspicions that a [FGM] procedure has been performed, the school direction should consider a report to the social authorities. Note that a professional in the preschool and school sectors should not be the one to investigate 'to be

> sure' before reporting. This [investigating] is the responsibility of the social authorities and, possibly, the police.
> [The Swedish Board of Health and Welfare 2005:39]

The police should be notified when there is a *possibility* that the crime has been committed. However, these are always subjective considerations. Facts that evoke suspicions in one person do not seem alarming to another.

3.4.2 Clash of goals

A physician's primary goal is to focus on health. In the fictitious Waris case, the school physician may worry about the health of Waris: is she really walking differently and using the toilet often? Is there a medical situation here? A more thorough examination may be needed, but if it concerns the genitals a school clinic may not be the optimal place for an examination to take place. Further, in order to refer the girl to a specialist (a gynaecologist; a child surgeon) a stronger indication is needed than comments from a teacher – if the girl and the parent deny the symptoms. However, it would be possible to have the girls examined genitally if the girl and her parents permit it. (At least one such case is known from the previous EC Daphne project.[5])

If we change the perspective, such an examination and advancement in a possible illegal FGM case is not in the interest of the police. In their view, the fewer people who have talked to the presumptive offenders about FGM, the better. When and if they open a criminal investigation, they prefer having the possibility to investigate the case without too much influence from other actors.

The social authorities may act in several ways, and their course of action depends on the nature of the case. Is this a case of child neglect? They may talk to the girl and raise the issue of FGM as a part of a wider picture.[6] Focus in a case like this requires providing

5 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 (Johnsdotter 2004:35).

6 However, the social authorities have limited rights to talk to a child without the knowledge or permission from the parents (legal guardians). The law states that the social authorities must give legal guardians a speedy notification when an investigation regarding their child has been opened. It has been argued, though, that the law does not say anything in detail about how speedy that notification must be – a fact that opens up for a period of time when authorities may act without the knowledge of legal guardians (Schlytter 2004).

adequate help and support. However, as soon as the case seems to involve abuse or another crime, they have to cease asking questions about the possible crime and leave the investigation to the police.

'The rights of the child' may also vary with perspective. On one hand, one can argue that it is the right of the child to be talked to and listened to, before any investigation involving her family starts. On the other hand, one may argue that the right of the child is best considered by opening an investigation that takes the pressure off the child: a child is often loyal to her or his parents, even when they have committed a crime involving this child.

By the same token, what is considered 'the best interest of the child' may vary with context. Imagine a case where a young girl is part of a well functioning family, her parents loving and caring, and it turns out that she has been unlawfully circumcised. Is an emotionally and socially demanding police investigation really in the best interest of this child? The legislation and prevalent guidelines give professionals at the social authority room to manoeuvre: The incidence of unlawful FGM is in itself not a basis for taking a child into care (and thereby suspending parental authority). However, such a case should be reported to the police.[7] Parallel to the police investigation, the situation ought to be monitored, since the strain of the whole process may lead to a need to safeguard the child and perhaps other children in the family (in case, say, the parents are being taken into detention).

3.4.3 The risk for discrimination

Wherein lies the risk of discrimination at the implementation of the FGM legislation? If we return to the Uppsala case of compulsory genital examination (case D), it is evident that the suspicions and the actions taken were based in part on the *ethnic background* of the family and not on factual circumstances. These Somali parents attempted to declare their opposition to the practice of FGM, but were denied a receptive audience among the social authorities and the medical representatives. The police further investigated (i.e. interrogated) the parents based on a predilection of assumptions

7 There is formally no absolute duty; however there are guidelines stating that a crime against a child must be reported to the police unless there are good reasons not to report, focusing on the best interest of the child. In addition, as shown in the former EC Daphne project, it was obvious that key actors in the social authorities in Sweden were each convinced that they had an absolute duty to the report FGM crimes to the police (Johnsdotter 2004, Leye et al. 2007).

made by the social and medical authorities that the parents must be lying.

According to legal praxis, no suspect is expected to prove his innocence: the onus of proof is placed on the party suspecting crime. However, in this case, the burden of proof moved from the authorities to the Somali family, who was strongly urged to accept a genital examination in order to prove that their daughter remained uncircumcised. When they rightfully refused to prove their innocence – by refusing to agree that their daughter should go through a genital examination – the suspicions toward them increased and the police were brought in.

The normal procedures for trying to establish the situation of a maltreated child were not followed in this case by the social authorities: more succinctly, a proper investigation was not conducted. It is quite clear that the actors involved – the child care clinic, the social authorities, the police, the prosecution, and the girl's special representative – all considered compulsory genital examination to be the only option. Ordinary routines and the rule of the law were abandoned or failed.

Of further interest, some time had passed between the original suspicion on the part of the nurse and the moment when she decided to act. The nurse's delayed actions strongly conclude that her disposition did not grow out of specific concern for the wellbeing of the girl or from additional information that should have been collected about the case, but instead her actions resulted from an inner process where her own personal worries increased.

A too-strong focus on implementation of the FGM legislation may also be discriminatory in other ways. The rightful care and support these girls are owed according to legislation (social support according to the *Social Services Act* and the right to have access to care on equal terms according to the *Health and Medical Services Act*), may be jeopardized if professionals meeting these girls focus too strongly and too singularly on the issue of FGM. Complementary social evils that the girl suffers from, or other personal problems she has, may be overlooked by social workers trying the find out if she has been subjected to FGM. The critique can be made for medical professionals focusing inappropriately on FGM. To represent the latter, the following case is known from Sweden:

> A gynaecologist reports that a Somali girl, 16 years old, came to the clinic to undergo an abortion. Health care staff at the clinic (who had recently watched the documentary "The Forgotten Girls" about FGM) 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 for abortion, e.g., giving the woman sufficient pain-relief drugs during her abortion. [Johnsdotter 2004:32.]

3.4.4 The risk for arbitrariness

If any professional meets a Somali parent and starts thinking about the risk of FGM, we have a hypothetical situation where practically all Somali parents risk being reported to the social authorities (or to the police). This is not the current situation: few cases of suspicion are actually reported. However, we can draw the conclusion that there is a big risk for arbitrariness within this topic. Indeed, parents are not reported because of substantial information to support suspicion; parents are reported because they have happened to meet professionals who, for some reason or another, have come to think about the possibility of FGM. There is a clear and great hazard here, regarding *which* families become objects for investigation.

If professionals are sensitised toward FGM while not simultaneously being offered relevant guidelines or protocols on the best way to handle suspected cases, the threat for arbitrariness is further heightened. Therefore, FGM sensitizing campaigns directed toward professionals must always be accompanied by relevant knowledge and proper guidelines.

3.4.5 Minimizing the risk for violation of bodily integrity

In the Uppsala case, no official talked to the girl before she was subjected to compulsory genital examination (with the exception of the officials attempting to persuade the girl to go with the police to the hospital when they collected her in school.) What the police are expected to do when a report reaches their hands is to build an investigation where the level of suspicion is either strengthened

or weakened. In the ideal case, the police talk at length to people during their investigation (including the girl and her parents), aiming to build a strong case before such a step as compulsory genital examination is executed. A suspicion must have been substantiated during the course of the investigation for a measure like forensic examination to be taken. In the Uppsala case, this substantiation was missing.

3.4.6 Minimizing discrimination in the implementation of FGM legislation[8]

The current situation is characterized by a shortage of relevant knowledge on FGM, such as reasonable estimates on the prevalence of FGM in Sweden. Professionals in the field need more specific knowledge, but also knowledge about the importance of following guidelines or protocols when the case concerns suspected FGM. If cases of suspected FGM are handled as any other suspected case of child abuse (according to existing protocols), the risk of discrimination would decrease.

The cases of compulsory genital examinations described here illustrate that the protocols have not been followed, or at least not in a satisfactory way. This opens up for a situation where prejudice and racist attitudes (in certain persons or at a structural level) are given space – which, in turn, leads to increased risk of arbitrariness and discrimination.

One possible solution is that the Swedish Board of Health and Welfare formulates a clear protocol on how to deal with suspected cases and in different kinds of situations, including a more profound discussion on the level of suspicion before a case is reported to the police.

In addition, it needs to be clarified from the governmental bodies that the suspected cases of FGM should be handled in the same way as other suspected cases of abuse or maltreatment of children. Singling out FGM as a particularly reckless form of child abuse may have the effect that ordinary protocols are abandoned and the cases are handled in imperfect and questionable ways.

8 This section relies heavily on input from the Ombudsman against Discrimination office legal expert, John Stauffer.

Of particular note, if FGM is treated as a special form of child abuse, as very distinct from other ways of maltreating children, this may create a breeding ground for stigmatization of specific ethnic groups. It needs to be discussed whether a perspective condemning all types of violence toward a child is preferable to a special emphasis on FGM.

3.4.7 Minimizing the risk for stigmatization of entire ethnic groups

The Ombudsman against Discrimination office has been contacted by many Swedish Somalis who claim that they are discriminated against for being Somalis, especially in relation to the social authorities and in the health care sector. FGM is a part of a bigger picture.

It has been discussed whether having a specific criminal law on FGM enhances the possibilities to have cases taken to court; the overall conclusion is that this is not the case (Leye et al. 2007).[9] Yet another aspect is whether introducing a specific criminal law becomes stigmatizing. If it works well to prosecute and sentence offenders using general criminal law banning bodily harm and mutilation, then the existence of a specific legislation (in reality concerning only certain ethnic groups) may be redundant and, in effect, unnecessarily stigmatizing.

3.4.8 Respectful treatment

The attitude of representatives from the public sector seems to be of crucial importance in the Uppsala case. When the parents showed up at a meeting with representatives from the social authorities and the health care sector, they were met with statements such as "here in Sweden it is unlawful to abuse children by genital mutilation" and "even if you did not do this – you are still Somalis."[10] Many people of Somali origin in Sweden report to the Ombudsman against Discrimination office that their fellow countrymen often

9 There are specific criminal laws banning FGM in e.g. the Scandinavian countries, Spain and the UK. In other countries, among them France, the act is punishable under general criminal law. France is the country where most FGM cases have ended up in prosecutions and sentences (Leye et al. 2007). In Finland, there is ongoing debate on whether or not a specific criminal law on FGM should be introduced (personal communication, Janneke Johansen, special advisor at the Finnish League for Human Rights, 26 September 2008).

10 Cited from the plaint issued by the Ombudsman against Discrimination office.

feel unnecessarily questioned and offended during their dealings with Swedish authorities, especially the social authorities and the health care sector. They are often asked questions about their family situation and about FGM in situations where such questions are completely unmotivated.

It is important that professionals representing authorities treat people as individuals – and not as representatives of specific ethnic groups. An individual is not necessarily a carrier of the characteristics and attitudes seen as 'typical' of a certain group. Disrespectful treatment in such a way is therefore a form of discrimination from the part of the authorities.

3.4.9 Optimal organization

The nurse in the Uppsala case, when faced with a suspected case of FGM, seems to have been left rather alone with her concerns: access to counselling and support is vital in a situation such as this. For professionals to be expected and able to act in professional ways, they need to have adequate support, which is a matter of organisation.

In Malmö, a new model has been introduced, *Crisis Centre for Children and Youth*, where the activities of several public sectors gather under the same roof. Social authorities, police and prosecutors, and health care staff work in close cooperation. The respective activities taking place at the crisis centre (forensic examination, social support measures, police interrogations, etc) are carried out smoothly for those people seeking help/potential victims, all in the same place.[11] If it is necessary to have 'a special representative of a child', such a person can be appointed via court order within a few hours. Such a measure makes it possible for a child making a claim of abuse to be physically examined without requring permission from the legal caretakers. The overall aim of the centre is to work with the entire family in cases where children are being physically or sexually abused; to simultaneously give help and support to victims, and to successfully take legal action against the offenders. This organization, where various professionals' competencies converge, needs to have clear and relevant knowledge

11 Kriscentrum för barn och ungdomar i Malmö [Crisis centre for children and youth in Malmö]. Summary presented at a conference arranged by the Ombudman for Children, spring 2005.

about FGM in order to deal with suspected cases in an appropriate way. Otherwise, the short and speedy decision paths may increase the risk of mistakes and unjust treatment.

The crisis centre model is being evaluated and will possibly prove valuable as a best practice model at the national level in the future. Nevertheless, there are still organisational structures all over the country (for instance, school nurses and staff at child health centres) where such close cooperation and access to immediate consultation from experts in other fields are lacking.

3.4.10 Knowledge

Lack of knowledge about the practices of female circumcision, but also about changing attitudes in regard to female circumcision among immigrants, may give rise to prejudice and faulty decisions and actions. This goes both ways: lack of knowledge may lead to reporting when there is no actual reason to report, but also to non-reporting when there are good reasons to do so.

Further, knowledge about discrimination is needed in the public sectors. Professionals ought to become aware of when their actions are discriminatory and therefore unlawful, as well as about how their own prejudice and ignorance may influence actions and decisions.

3.4.11 Professionalism vs. emotionality

The emotionally charged atmosphere surrounding FGM may give rise to rushed decisions and abandonment of usual routines. In the Göteborg case (case B), the nurse noting in the medical record that the baby had gone through FGM overstepped her authority. Following hospital routine, she ought to have turned to a physician for an inspection of the baby's genitals.

In the Uppsala case (case D), both the social authorities and the police seem to have acted and opted for compulsory genital examination before more close investigations had been carried through. Possibly, the examination by force would not have been seen as an optimal measure if a more thorough investigation, including communication with the girl, had taken place.

Consequently, it becomes crucial that cases of suspected FGM are not handled as exceptional cases or in 'sidetracks' running beside usual routines. If such cases are treated as if they were routine and comparable to other cases where children may have been subjected to crime, violence or other abuse, faulty decisions due to emotionality can be avoided.

3.4.12 Compulsory genital examinations: a price that has to be paid?

A final question in the discussion during the workshop was this: *Is the fact that some Swedish African girls are subjected to compulsory genital examinations a price that has to be paid if we want to take legal action against FGM and have cases brought to court?* (A question that can be rephrased more critically into: *"Is this the price Somalis in Sweden have to pay for originating from Somalia?"*)

Different views were presented and summarised into "yes" and "no".

Yes, since this crime is exclusively committed within certain ethnic groups and not at all in others. Consequently, investigations, including genital examinations showing no traces of crime, will always only affect people with certain ethnic backgrounds. As long as this practice can not be proven to have been completely abandoned by immigrant groups, this is a reality we have to accept.

No, since the way some of these complusory genital examinations have been carried through is a violation of the Discrimination Act. The *handling* of these cases within the public sectors must not be discriminatory. That is, measures must not be taken against a person if his or her ethnical background is the *only* base for action. According to the Discrimination Act, it suffices that the ethnic background has been a contributory cause for a specific treatment for the law to say that discrimination has taken place. Criminal acts are taken by individuals and not by groups. Thus, stigmatizing an entire group can not be seen as a legitimate means in combating a crime.

4. WORKSHOP II: VOICES FROM THE SWEDISH SOMALI COMMUNITY

The second workshop took place on November 2, 2008, at a conference centre in Kista, Stockholm.

4.1 Participants

Twenty persons were present. Ibrahim Bouraleh, former chairperson of the national umbrella organisation for Somali associations in Sweden, chaired the workshop. He also translated all statements from Somali to Swedish and the other way around. Eleven women were present and nine men; some were young, the majority middle-aged and a few were older. A few were from the mosque. A few were students at the university. There were some home-language teachers and others who were working members in associations. The workshop had been announced in a mosque some week before it took place, and a flyer had been distributed by some key actors in the community.[12] Beside the Swedish Somali participants, Sara Johnsdotter and Dr. Birgitta Essén were present. The workshop lasted for four hours.

12 My special thanks to Bashir Ali and Ibrahim Bouraleh.

4.2 Key questions

How is Swedish FGM legislation discussed among Somali residents in Sweden? What is the general view of the compulsory genital examinations without consent that have been performed? Why is it that nobody from the Swedish Somali community reports suspicion of FGM to the authorities?[13]

4.3 Aim of workshop

To map the internal views on the implementation of FGM legislation among Swedish Somalis, that is, the group that is primarily concerned; and to highlight the ethical aspects of this implementation through conveying some of their voices.

4.4 Workshop themes

4.4.1 The practice generally abandoned

The workshop participants seemed to agree that female circumcision is a practice that is generally abandoned among Somalis in Sweden. A middle-aged man said, "When it comes to pharaonic circumcision, I can't even imagine that a Somali in Sweden, being in full possession of all senses, would have had it done for the last fifteen years. Everyone is opposed to it." A woman of the same age agreed, but called for a discussion about so called "sunna" (a milder procedure): Is everyone convinced that *sunna* procedures should also be completely abandoned?

One theme that was recurrent was the fact that 'female circumcision' is today openly discussed by Swedish Somalis, in contrast to the strong cultural taboo that had traditionally prevented Somalis from discussing this issue. This was obvious during the workshop, where women and men were sitting together and quite a few women spoke openly about their own childhood experiences of

13 There is, however, one known case where the report of suspicion was made by a Swedish Somali. In 1995, a Swedish Somali pre-school teacher in Göteborg reported to the social authorities that one of his pupils had been away on a trip and avoided any discussion about what had happened during that trip. The case is discussed in detail in Johnsdotter (2004), case H.

female circumcision. People also agreed that most Swedish Somalis are aware of the FGM legislation. However, most participants did not state their willingness to report suspected cases themselves. On the other hand, nobody said that they would *not* do it. One woman touched upon her willingness to report by saying, "We are here to discuss our children and their future. I hope we can be honest. I hope we can unite, for today we are sadly disunited. I want to confess that as a child I was one of the bullies. I was one of the girls harassing other girls who were not circumcised. I even ran after and dragged girls back, those who tried to escape circumcision. I was proud then, that I helped forcing others to go through it. Today I have to admit to myself that I am partly responsible that those women live circumcised. I testify here that I haven't circumcised my own daughters, and I swear that I will report if I ever hear about girls living in Sweden being cut."

4.4.2 Girls at risk

Several participants stated that preventive work in the field of female circumcision must be continued into the future, especially in relation to newly arrived families from Somalia. A young woman said, "New groups of Somalis keep arriving in Sweden, and they need their time to go through the process of adjusting, to reach the point where we are today." Hence, efforts to mould opinion are crucial also in the future.

4.4.3 Views of the court cases in Sweden

It seems that court case I has not been discussed very much among Swedish Somalis. The woman being sentenced to prison for FGM, Somalis have told me, was obviously not mentally healthy and the whole case is just tragic.

When it comes to the second case concerning Ali Elmi, this case has given rise to more of a debate. Several men at the workshop wanted to clarify men's role in this, and one of them concluded, "So you can see how girls in Somalia are circumcised not because of their fathers, but *in spite of* what their fathers want." Everyone present at the workshop agreed that Ali Elmi must be innocent of what he was sentenced for.

So why is it that no Swedish Somali has gone public, stating that a huge mistake has been committed by the Swedish legal system? Several answers to that were offered. One is that the Swedish Somali group is disunited, and many people expected Ali's own clan to act. Another aspect is that Somalis are unaccustomed to acting within a democratic society, where issues are debated within a public sphere. A woman said, "I may have many opinions, but it does not cross my mind that I should go and knock on the door of the Swedish broadcasting company to tell them."

A man, a student at the university, said that even if he had wanted to state in public that Ali was sentenced for a crime he did not commit, he would refrain from doing it out of fear. The FGM activists, he said, are a resourceful and strong group in Sweden. They support the verdict out of political reasons. "They own this question, they are the prime stakeholders. And if they contradict me in public, who would people believe?"

The men especially expressed during this workshop their feelings of vulnerability in relation to the Swedish society – in not being able to trust that they will receive fair treatment in the legal system. One of the men compared the situation to what happens sometimes in the US, when black people in America can 'play the race card' if they do not get employment they have applied for: in Sweden today, Somali mothers have the possibility to 'play the FGM card' if they would like to threaten their husbands during conflict and pending divorce. Quite a few men in this workshop expressed that being Somali men in Sweden they feel utterly vulnerable.

4.4.4 The compulsory genital examinations

Nobody at the workshop supported compulsory genital examinations. Many spoke of it as a violation, which in the long run – if such enforced examinations without consent continue to take place – will make the Somali group turn away from the Swedish society, either in a symbolic way or literally by leaving the country. A young woman said, "I would like to marry and start a family. However, these incidences make me doubt if I am willing to raise children in this country. I can't imagine having a daughter who is forced to go through that."

Someone suggested that these compulsory examinations ought to be reported to the European Court of Human Rights, and somebody else suggested that Swedish Somalis should turn to the United Nations and complain about this.

A middle-aged woman argued that if an examination is really necessary and there is no way to escape it, choice of doctor should be discussed with the parents to create a feeling of security for the girl and to also diminish the dramatic element.

Several workshop participants highlighted that enforced examinations without consent from the child's parents implied a **loss of parental authority**. In addition, it was stated that these incidents paint Somali parents as being irresponsible, as if they do not care about the wellbeing of their children.

4.4.5 Discrimination and stigmatization

In the same vein, several participants argued that this situation is discriminatory and stigmatizing of the entire Somali group in Sweden.

A young man said, "I can't see why the Swedish society worries so much about this. Why can't they give us some credit for how fast change has taken place? Instead they make us feel discriminated against, for the way they discuss this issue and the way they treat us as less than acceptable parents."

A middle-aged woman added that she feels stigmatized by the way the mass media always depicts practices of FGM presenting the worst case scenario with pictures of horrifying tools, for example. "It is always the dark side of this that they expose, never the positive things like how our attitudes have changed," she said.

A young university woman argued that much of the research produced is tinted by political considerations and confused with activism: "Researchers who have become activists have their own agenda, an agenda that politicians and journalists love, but this situation entails a deceit to the Somali group in Sweden." She expressed her doubts about whether the Swedes in general would ever be willing to truly listen to the Somalis living in this country. She went on comparing the compulsory genital examinations of young African girls with earlier dark moments in the Swedish history, such as the enforced sterilizations in the 1940s or enforced displacement

of certain minority groups earlier in history. She concluded, "Don't the Swedes learn anything from their own history? Have they *really* considered how an experience like this may affect a child and her confidence in others?"

An older man said, "Being a Somali man in Sweden, you know when you meet someone from the authorities, that this person wonders who you are – are you perhaps a terrorist, a cheater, a quat-dealer or a mutilator?"[14] He continued, "Somalis are afraid of the authorities and the mass media. The issue of FGM is only a tiny part of a more complete situation of constant vulnerability on many levels."

4.4.6 Instead of suspicions: patience and support

"I am grateful to the Swedish society for how they have supported the work against FGM. But we still need support in several ways. The whole issue must be discussed on a long term basis," a middle-aged woman said, "New Somalis arrive constantly, and they need time to go through the process and to arrive at the point where we are at now." She and others called for patience and support, rather than the sole focus on repression and punishment.

Someone highlighted previous and ongoing campaigns and preventive work in the FGM field in Somalia, and said that this work must be done in systematic and methodical ways. Several people mentioned the word 'patience' and argued that newcomers need their time to adjust to a new society and to rethink this practice. Support from society, from the mosque and from country fellowmen was said to be crucial in this process.

4.4.7 Future challenges for the Swedish Somali community

Many participants mentioned the fact that the Swedish Somali community is socially disunited. There are obvious obstacles to

14 In 2001, two Swedish Somali men were accused of terrorism by the US. The Swedish government was forced to freeze all their financial assets. Both men were later freed of suspicion. In 2008, several Somali families' homes were searched by the Swedish security police and three men were detained for terrorism (the charge being that they had dealings with terrorist groups in Somalia). They were released after some time.

In a series of articles in Göteborgs-Posten in 2007, it was argued that the Somalis in Sweden were a group that had completely failed to integrate. Among other things it was stated that cheating with social benefits is a common strategy in the group.

Quat is the traditional Somali drug, a plant that is chewed and works as an amphetamine-like stimulant.

creating a national organisation representing each and all groups in Sweden; given the fractioned clan system and current conflicts in Somalia. One problem that some mentioned was the fact that Somalis in Sweden are more focused on what is going on in Somalia than what happens in Sweden. A man said, "If it's raining in Mogadishu, we take out the umbrellas here in Stockholm." And, someone added, as long as Somalis in Sweden are disunited and have their focus elsewhere, the Swedish society gets space for treating them in whatever way they want.

A key question that was mentioned over and over again, is what the Swedish Somali community can do avoid future compulsory genital examinations without consent from parents. How can they work to counter existing suspicions toward Somalis as a group? One man already had experience of an increased cooperation between Swedish schools and a group of home-language teachers. This cooperation had been initiated after the incident of the Stockholm case (case E). Key persons from the community have better opportunities to assess risk and likelihood that a family would practice female circumcision, and he suggested a more systematic cooperation. Everyone seemed to agree that new strategies are needed, and that measures aimed to prevent failure in the communication between the authorities and the families are essential, especially to the degree that enforced examinations must take place in order to establish whether a crime has been committed or not.

A final issue discussed was how the Swedish Somalis can speak out. A middle-aged man suggested a conference on March 8, the International Women's Day, and the others seemed to agree that this was a good idea. The following themes for the conference were suggested: the case of Ali Elmi (case I); Somali parenthood and the view of Somali parents as being irresponsible; compulsory genital examinations – a dictatorial element in a democratic society; how to best to support the family when enforced genital examination has been performed.

5. DISCUSSION AND RECOMMENDATIONS

There is an obvious difference between the Nordic countries if we compare where enforced genital examinations of young African girls have taken place. Denmark has two cases of compulsory examinations; Finland and Norway have no such cases at all. Sweden has at least five documented cases. Such variation may exist all over Europe. The suggestions discussed below primarily concern countries such as Sweden, where there is a strong political will to identify illegal cases of FGM and to sentence the culpable. In other countries, where there is less emphasis on repressive measures against FGM, these suggestions may not be relevant.

Thus far, compulsory genital examinations in Sweden have not revealed any FGM. Thus, there is reason to discuss the level of suspicion at filing a report which may lead to such a drastic step. On the one hand, professionals have a duty to report any kind of suspicion that illegal FGM has been performed. On the other hand, if they take measures that are based *solely* on the fact that relevant persons are of a certain ethnic origin, they violate the legislation aimed at preventing discrimination. This is a tricky balance that is not easily sorted out.

Recommendation: **Clear instructions from supervisory authorities[15] are needed regarding the definition of what makes a suspicion substantiated enough to file a report.**

15 In Sweden, that would be the Swedish Board of Health and Welfare.

If professionals are sensitised toward FGM, but do not also receive relevant guidelines or protocols, there is a considerable risk that they handle suspected cases in an imperfect way. Measures taken by professionals who are agitated often lead to rushed decisions. In continuation, they may act in discriminatory ways.
Recommendation: **FGM sensitizing campaigns directed toward professionals must always be accompanied by relevant knowledge (including legislation regarding discrimination) and proper guidelines.**

Singling out FGM as a particularly reckless form of child abuse may have the effect that ordinary protocols are abandoned and that the cases are handled in imperfect ways. To avoid confusion, agitation and rushed decision-making when it comes to suspected cases of FGM, policies on FGM need to stress that existing protocols aimed at dealing with child abuse also work well when it comes to FGM.
Recommendation: **FGM policies should stress that FGM is a form of child abuse that should be dealt with within existing structures handling child abuse and crimes committed against a child.**

There is considerable risk that FGM campaigns in Western countries, focusing only on risk estimates and repressive measures, will work in stigmatizing and discriminatory ways. In the second workshop of this project, Swedish Somalis expressed feelings of being vulnerable in relation to authorities and being misrepresented in public discourse. In public discourse, little attention is paid to the fact that an overwhelming majority in the group has abandoned the practice. This may be a poor strategy, which carries the risk that immigrants from these African countries turn away from the host society, since they are not being treated as equal citizens. Further, positive effects of a reverse strategy are lost. According to the theory of social convention (e.g. Mackie 1996, 2000), key aspects of rapid abandonment of harmful practices include "an explicit, public affirmation on the part of communities of their collective commitment to abandon FGM/C" and also "an environment that enables and supports change" (UNICEF 2005:14). The crucial step here is to focus on change and to use it as a positive force in preventive work. In sum, if certain families are ambivalent toward FGM, and are given the impression that this tradition is upheld and

therefore expected within the group, this situation will increase the risk of FGM for their daughters. Conversely, if we focus on social change, and emphasize how rapidly this tradition has been abandoned among many immigrant groups, this may have an effect that ambivalent parents tip over and ultimately disassociate themselves from the practice. This is the model adopted by parts of UNICEF and is used in designing their projects at a global level (UNICEF 2005).

Recommendation: **European policies on FGM should be framed not only in repressive terms, but also with a focus on positive social change, thereby enhancing the climate for preventive measures to be fruitful.**

Sweden is a good example of a state where the political will to deal with FGM may have lead to too drastic measures to deal with the issue. One needs to find a balance here. There are young girls in our societies who are at risk of having to go through FGM; we therefore need to construct and maintain societal structures prepared to deal with suspected cases of FGM – and we ought to keep the level of alertness high. Yet, we must not let this alertness and willingness to protect young girls from FGM turn into spectacles where exaggerations flourish, where ethnic groups are unjustly stigmatized, and where the legal rights of citizens are sidestepped (as in case II). Further, we need to find ways to safeguard young European African girls, and to protect them from FGM, without increasing the risk that their bodily integrity is violated without sufficient cause by state representatives.

In the field of preventive work against FGM, ethical aspects and the question of discrimination have thus far been downplayed. It is a paramount consideration that must be regarded in future preventive work and in implementation of FGM-legislation.

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RELEVANT LEGISLATION[16]

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.

16 This is an updated version of a section from the earlier report "FGM in Sweden" (Johnsdotter 2004).

> If the crime has resulted in danger to life or serious illness or has in some other way involved particularly reckless behaviour, 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. If the crime has been committed abroad by or upon someone who is or has been a resident of Sweden, prosecution can take place. Swedish citizenship is not necessary for liability to the law. If the crime has been committed in Sweden, any person (asylum-seeker, illegal, etc.) may be prosecuted in a Swedish court.

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; 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 (information gleaned during an interview with a prosecutor).

Further, it is unclear what the official stand is toward cosmetic genital surgery, so called "designer vaginas." As 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. Thus 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 Swedish Board of Health and Welfare has declared that cosmetic genital surgery is to be compared to cosmetic surgeries in noses and breasts and therefore legal (Johnsdotter et al. 2005:92).

In 2007, a woman stated that too much tissue had been removed from her labia and clitoris during a cosmetic operation of her genitals and that she felt mutilated. The case was not reported to the police. However, she filed a report to the Medical Responsibility Board and the surgeon received a formal warning (*Sydsvenskan*, 26 September, 2007).

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 (2001:453)]

> **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 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 people 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 2005:49f).

Chapter 14. Reporting of abuses

Section 1: Any person receiving information about 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 3 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 2 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.

Professionals at schools and in children day care centres, as well as ordinary citizens, have a duty to report any suspicion of FGM to the social authorities. An official who fails to report 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 2005:32). 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 has not only the authority to intervene in order 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 (known as environment cases) or the young person's own behaviour (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 can not 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 2005:32.]

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 (2005:49).

When there is 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 (2005:49-50). If the parents do not allow a medical examination, a prosecutor may apply for a special representative for a child, in accordance with Law 1999:997 described below (Swedish Board of Health and Welfare 2005:50).

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 about 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). Earlier, there was a more general option of reporting crimes to the police when such acts could lead to a minimum of two years in prison (ibid.). In 2006 the law was reformulated with special regard to FGM: when suspicions concern that a minor has been subjected to FGM, the case can be reported regardless of the type of procedure (i.e., also very 'mild' types that may give short or perhaps no time in prison can be reported).

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).

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.

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.

Discrimination Act

[Diskrimineringslag (2008:567)]

> **Section 1.** The purpose of this Act is to combat discrimination and in other ways promote equal rights and opportunities regardless of sex, transgender identity or expression, ethnicity, religion or other belief, disability, sexual orientation or age.
> […]

Section 4.

In this Act discrimination has the meaning set out in this Section.

1. Direct discrimination: that someone is disadvantaged by being treated less favourably than someone else is treated, has been treated or would have been treated in a comparable situation, if this disadvantaging is associated with sex, transgender identity or expression, ethnicity, religion or other belief, disability, sexual orientation or age.

2. Indirect discrimination: that someone is disadvantaged by the application of a provision, a criterion or a procedure that appears neutral but that may put people of a certain sex, a certain transgender identity or expression, a certain ethnicity, a certain religion or other belief, a certain disability, a certain sexual orientation or a certain age at a particular disadvantage, unless the provision, criterion or procedure has a legitimate purpose and the means that are used are appropriate and necessary to achieve that purpose.

3. Harassment: conduct that violates a person's dignity and that is associated with one of the grounds of discrimination sex, transgender identity or expression, ethnicity, religion or other belief, disability, sexual orientation or age.

[…]

In summary: The legislation prohibits any kind of discrimination of people of a certain ethnic background. Technically, discrimination under the law has taken place when ethnic background becomes a contributory cause for the receipt of specific treatment.