End the Cut

The situation of Female Genital Mutilation in the European Union and Sweden.

actionaid

After
empowering women

Co-funded by the Rights, Equality and Citizenship (REC) Programme of the European Union

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ActionAid Sweden is part of The AFTER project implemented in collaboration with six partners in five European countries, including: ActionAid Italy, ActionAid Ireland, Respect for Change in Belgium, Simetrias foundation and The University of Castilla-La Mancha (UCLM) in Spain.

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1. The AFTER project and the fight against FGM/C

1.1. Female genital mutilation/cutting

Female genital mutilation/cutting (FGM/C) includes procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons. There are four major types[1], and for this reason we could use the plural, female genital mutilations:

- Type I or clitoridectomy: It is the partial or total removal of the clitoris.
- Type II or excision: It is the partial or total removal of the clitoris and the labia minora.
- Type III or infibulation: Labia majora are cut causing a narrowing of the vaginal opening through the creation of a covering seal. Only a small opening is preserved for urine and menstrual flow. Vagina is preserved so virginity of the woman is guaranteed. Later, this type of mutilation sometimes requires the practice of de-infibulation, in which the area is again cut open to allow for sexual intercourse and childbirth.
- Type IV: This includes all other harmful procedures such as pricking, piercing, incising, scraping and cauterizing the genital area of the woman.

With any of these four types, FGM/C involves cutting a healthy and functional part of the woman´s body which causes physical, psychological and emotional harm to girls and women[2]. Thus, it is a type of extreme violence against women, considered by the United Nations to be a severe violation of the human rights of women and girls.

This practise has roots particularly in power dynamics that aim - among others - to tame women's sexual desires. There are a variety of reasons argued in favour of mutilation: it is considered as part of the rituals of initiation to adult life by which girls become women and start to be part of the adult community; a sign of femininity and beauty, it prevents the clitoris from growing too long and looking like a penis. It is also practiced for hygienic reasons; both spiritual and physical, meaning purity and health (it would increase fertility, improve birth delivery, and the wellbeing of the baby); and lastly for religious reasons, to protect virginity and avoid promiscuity, etc.

There is not a specific age for its practice; it can be done in the first weeks of the girl's life or after the delivery of the woman's first child. Most commonly, however, it is practiced between 5 and 14 years old, concurrent with rituals of initiation to adult life. To avoid resistance among girls and legal problems derived from its prohibition, it is currently being practiced earlier – on girls under the age of 5[3].

The consequences of FGM/C are different depending on the type of mutilation, hygienic conditions and instruments used, and the skills of the person who performs it. They include: death of the girl/woman, harm to her sexual organs, haemorrhage, chronic infections in the urinary tract and genitals, stones in the bladder and urethra, renal disorders, fistulas, fibrosis, persistent anaemia, strong and constant pain, higher risk of contracting HIV or hepatitis, as well as trauma and fears, among others. Psychological and social consequences are less researched, however, from a biopsychosocial perspective FGM/C implies a deep change in different areas of the person's functioning, a cut in the life trajectory of the girls and women who suffer the practice[4].

FGM/C is a severe violation of girls and women's rights and integrity. It threatens their physical, sexual, reproductive, psychological and social integrity. The Universal Declaration of Human Rights (UDHR) (1948)[5], in its Articles 1, 3 and 5, states unequivocally the need to treat all people as equal, emphasizing the right to life, liberty

and security of person, not subjecting anyone to torture and other cruel and inhumane treatment and/or punishment. These Articles capture explicitly the rights which the practice of FGM/C violates because women have a right to physical and mental integrity. The practice of FGM/C not only denies women their right to physical and mental integrity, but also their freedom from violence and the highest attainable standard of health.

According to the last report by UNICEF (2016)[6], 200 million girls and women have undergone FGM/C. And of that number, it is estimated that 44 million are girls under the age of 14. Mutilation is a practice deeply rooted in some ethnic groups, mainly in Africa and Asia, but because of migration it has become widespread in other continents, making it a global concern. For this reason, it is necessary to design measures from an international perspective which can be applied at the national and local levels, according to the characteristics of the specific contexts.

In 1990, the United Nations Convention on the Elimination of All forms of Discrimination against Women (CEDAW) in its recommendation number 14 on *Feminine circumcision*[7], urged Member States to adopt appropriate and effective measures for its eradication.

In December 2012, the United Nations condemned FGM/C. For the first time, through a resolution aimed to intensify global efforts for the elimination of female genital mutilation[8], it urged Member States to promote programmes and plans to raise awareness, educate and qualify which can complement punitive measures. During the United Nations World Summit on sustainable development, celebrated in New York in September 2015, the eradication of FGM/C was included in goal number 5 (of 17 Sustainable Development Goals (SDGs)) agreed as part of the Agenda 2030[9].

In Africa, great efforts are being made to eradicate FGM/C. In the Protocol of the African Charter on Human and People's Rights on the Rights of Women in Africa, approved in Maputo in 2003, commitments and obligations were set to eradicate mutilation; in 2011, in Malabo, the African Union decided to prohibit FGM/C[10]; and in 2016 the Pan African Parliament and the United Nations Population Fund signed an agreement on the prohibition of the practice in over 50 of their Member States.

Together with this, there have been numerous initiatives at national and local level. However, if we want these efforts to be effective, it is necessary to ensure all the commitments already made are acted upon.

1.2. Presentation of the report

This report is part of the AFTER (Against FGM/C Through Empowerment and Rejection) Project, co-funded by the European Commission[11]. This project is made up of a consortium of 6 partners in 5 European countries: ActionAid Italy, ActionAid Sweden, ActionAid Ireland, the International Foundation Simetrías and the University of Castilla-La Mancha (UCLM), both in Spain, and Respect for Change in Belgium. The main objectives of the project are: to decrease the risk of women and girls from FGM/C practising countries living in the EU from being subjected to FGM/C, and to raise awareness among local authorities and professionals in order to guarantee prevention measures and support services at national and local level.

To achieve these goals, one activity of the project was to conduct research on the issue of FGM/C in Sweden. UCLM coordinated this part of the project and is the partner responsible for this report. The research covers the analysis of the immigrant population originating from FGM/C practising countries living in Sweden, so as to study the policies and legislation related to this topic and the local services dealing with FGM/C.

Interviews with relevant stakeholders were conducted with the purpose of analysing their discourses, their knowledge on the issue as well as their opinion about FGM/C, laws, policies and services. In order to progress in the fight for the eradication of FGM/C, AFTER includes educational work with groups of men and women using Reflection-Action methodology to start and/or motivate participants in the conceptual change needed to abandon this practice. This work is carried out at other stages of the project.

2. Population originating from countries where FGM/C is practiced in the EU and Sweden

2.1. Introduction

In this section, we carried out a descriptive analysis of the population living in EU and born in FGM/C risk countries. To work for the prevention or the support of FGM/C victims it is necessary to understand the dimensions of its prevalence. Due to migration, today there are people residing in Europe who originate from countries where FGM/C more commonly occurs. Thus, to design appropriate lines of intervention it is important to estimate the affected population and its geographical localization. For this purpose, Eurostat database was analysed to study the distribution in the 28 EU countries of the population originating from 30 countries, most of them African, where FGM/C are practiced: Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Ivory Coast, Djibouti, Egypt, Eritrea, Ethiopia, The Gambia, Ghana, Guinea, Guinea-Bissau, Indonesia, Iraq, Kenya, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Somalia, Sudan, Tanzania, Togo, Uganda and Yemen.

The terms used to locate the information in the Eurostat database were: population registered in Europe in 2015 born in the 30 countries in general and broken up by sex; demographic change in this population for 2010-2015; country of residence in the EU; and girls 0-15 years old with nationality from any of the aforementioned countries. In the case of girls, *nationality* was used instead of *country of birth* because the risk of FGM/C is determined by the parents' culture and because many of the girls who could be under this cultural influence may have been born in Europe.

UNICEF's (2016)[12] prevalence index was used to estimate the impact of the practice in each of these populations. This prevalence index let us estimate how many people are exposed to the influence of this practice. When people migrate, they carry with them culture and traditions

baggages for the sake of keeping the links with family and community residing in the country of origin or in the host country. This index has been applied to both men and women for different reasons: firstly, although it is a practice suffered by women and girls, its consequences also affect men, for example in their relationships; secondly, FGM/C is a tradition sustained by patriarchal social system, so the role of men is essential; and finally, among the objectives of the AFTER project is to create space for groups of men and groups of women to meet. These groups use the Reflection-Action methodology in order to stimulate conceptual change on the basis that sustains FGM/C.

Many women might have undergone FGM/C before their arrival to their current countries of residence in Europe and others might have suffered it during a visit to their home country. The ideas and traditions are difficult to change, they travel with people and, in this case, they can be fed through links with extended family and the community of origin.

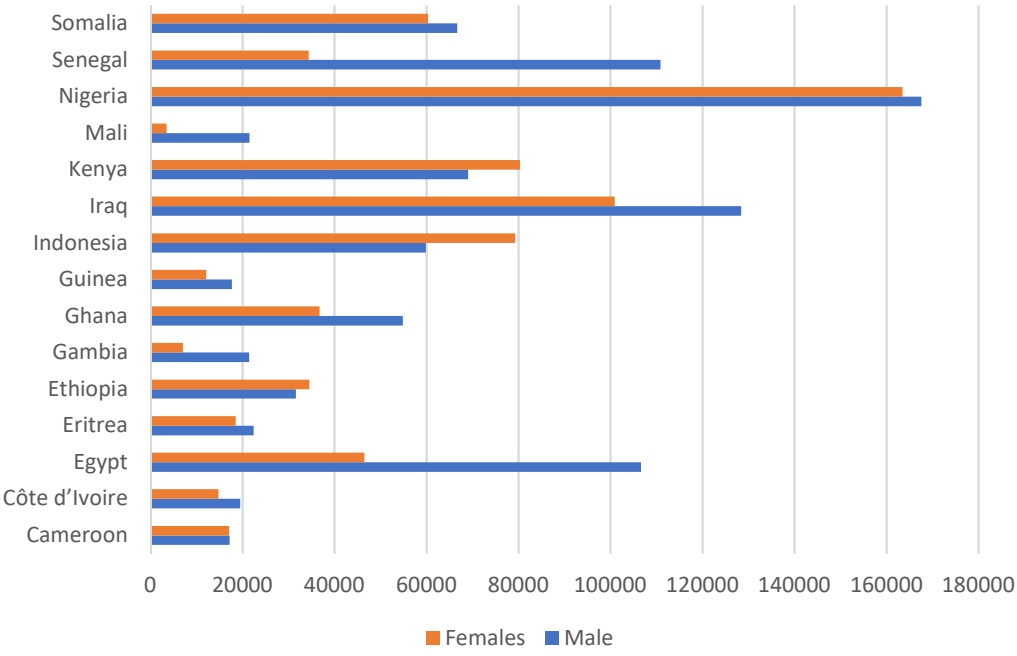
2.2. European data analysis

European data analysis

According to Eurostat (2016), in 2015 the population born in FGM/C risk countries living in the EU territory had risen to 1,731,571 (Figure 1) 750,558 of which (43%) are women. These numbers further increase if Germany and France were included (for these two countries 2015 data were not available when the research was closed). The most updated numbers in these cases are found in the 2011 census, showing 311,752 (47% women) for France and 100,670 (48% women) for Germany.

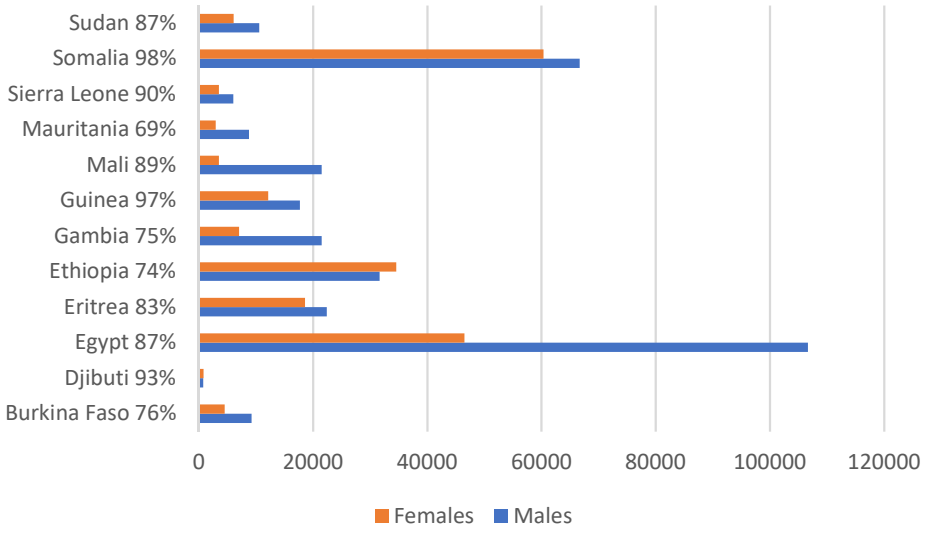
In terms of distribution, the European countries with a higher concentration of population originating from FGM/C risk countries are: Italy (448,996), United Kingdom (313,046), Netherlands (269,879), Sweden (266.392) and Spain (182,439). On the other hand, the largest communities originating from FGM/C risk countries who live in the EU are: Nigeria (331,116; 49% women), Iraq (229,407; 44% women), Egypt (153,179; 30% women), Kenya (149,417; 54% women), Senegal (145,294; 24% women) Indonesia (139,188; 57% women) and Somalia (127,071; 47% women). In general, the number of men exceeds the number of women, except for the case of Ethiopia (52% women), Indonesia (57% women), Kenya (54% women) and Tanzania (53% women).

Figure 1.
Population originating from the 30 countries where FGM/C is practiced with higher presence in the 28 EU Member States.



Source: Compiled by authors based on Eurostat (2016).

Figure 2.
Population in European Union originating from countries with higher FGM/C prevalence (percentages indicate the prevalence in each country according to UNICEF)[13].

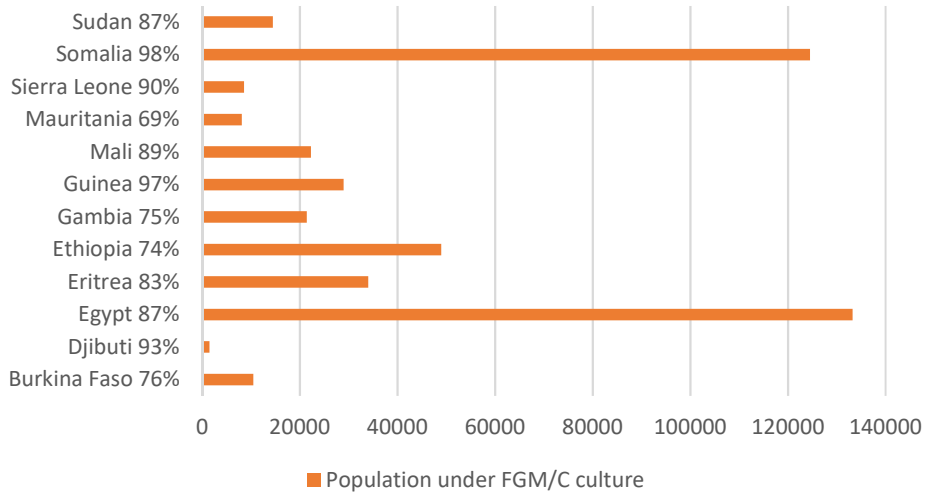


Source: Eurostat (2016) and UNICEF (2016)[14].

In terms of the level of risk, according to data from UNICEF (2016) on FGM/C prevalence among girls and woman aged 15 to 49 years around the world, twelve countries show a prevalence higher than 68%, which we consider here as FGM/C-higher risk countries. The total number of people living in the 28-EU who originate from these countries is 524,548 (Figure 2). Of which, 200,797 (38%) are women. Moreover, in some countries such as Somalia, Sudan, Eritrea, Egypt (southern border) or Djibouti, the most extreme types of mutilation (type III) are practiced which, therefore, makes the situation even more serious for these communities.

If we take the population originating from countries with the highest prevalence of FGM/C, according to UNICEF definition (Figure 3), it can be observed that the 98% of the 127,071 Somali residents in any EU country and the 87% of the 153,179 Egyptians might have been exposed to the influence of this practice. This implies that small communities from some countries of origin are represented might be exposed to FGM/C due to pressure of their families and ethnic groups. This is the case for Guinea, with 29,909 residents, who show a prevalence of 97%, seeing that affected population rising to 29,012, almost the whole community; or Sudan, with a prevalence of 87%, where the citizens affected might rise to 14,502.

Figure 3.
Population living in EU originating from FGM/C risk countries by prevalence index.



Source: Compiled by authors based on Eurostat (2016) and UNICEF (2016)

The distribution of population by sex is displayed in Table 1. While in most of the cases the number of men living in the EU exceeds the number of women, Mali is remarkable, as the number of men is six times higher than the number of women, as are The Gambia and Mauritania, where the number of men is three times higher. These three communities originate from countries with a high prevalence of FGM/C, 89%, 75% and 69%, respectively. Therefore, it is essential to take men into account in terms of the fight against FGM/C[15], and focus on them when implementing educational actions. This is because they usually are the most powerful in their communities and, therefore, the ones who can stimulate change and exert pressure to eradicate mutilation. Furthermore, from a comprehensive perspective we must not forget that all negative consequences of mutilation (physical and psychological) also affect men.

From a comparison of data from 2010 to 2015, the communities from FMG/C risk countries in the EU which have increased the most are: Nigeria with an increment of 44,000 people; Iraq with more than 30,500; Egypt with over 23,000 people; and Eritrea with almost 17,000. In the case of Somalia, an abrupt decrease is shown in data from 2012 to 2013 (in about 100,000 people) which is followed by a strong increase and then a constant rising pattern. The same pattern was confirmed by Eurostat data using nationality (people living in the EU who maintain the nationality of some of the countries considered) as an indicator instead of country of birth. These unexpected changes were not satisfactorily explained during the process of data analysis. No migratory movements to other territories in the EU were detected for the Somali population during those dates and no alternative explanation was found for this atypical variation.

Table 1.
Population from FGM/C risk countries living in the EU by sex

Source: Compiled by authors based on Eurostat (2016)

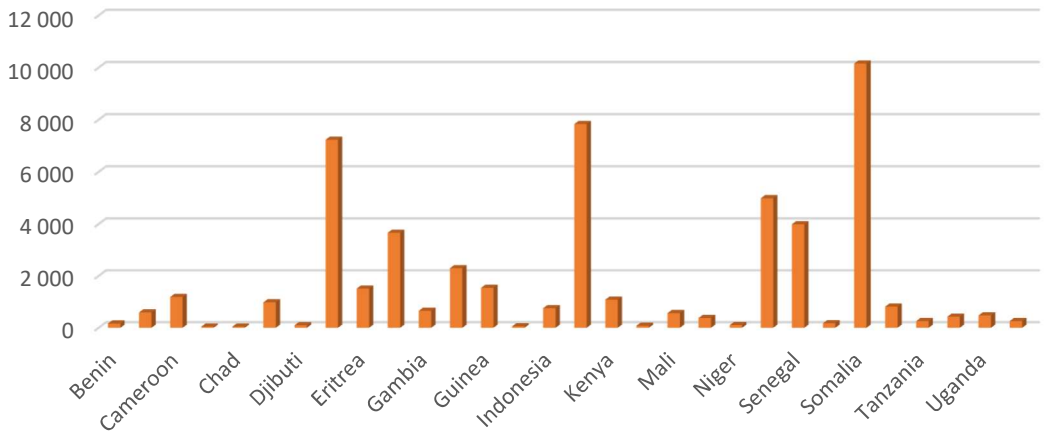
	Män						Kvinnor					
	2010	2011	2012	2013	2014	2015	2010	2011	2012	2013	2014	2015
Benin	2 381	2 540	2 680	2 782	2 760	2 839	1 533	1 615	1 698	1 739	1 800	1 854
Burkina Faso	8 505	8 651	8 714	8 746	9 110	9 366	3 963	4 049	4 141	4 192	4 335	4 549
Kamerun	13 452	14 871	16 075	16 795	16 858	17 698	12 665	13 871	14 904	15 716	16 216	17 329
Centralafrikanska republiken	374	408	449	457	441	500	329	357	367	375	377	415
Tchad	739	786	873	895	918	913	361	386	488	502	494	511
Elfenbenskusten	17 957	18 435	18 863	19 068	19 524	19 774	13 178	13 483	13 865	14 084	14 592	14 882
Djibouti	483	589	668	730	789	848	534	620	699	794	842	920
Egypten	93 236	93 702	102 534	103 425	96 612	106 791	36 443	36 820	41 961	42 426	39 342	46 541
Eritrea	12 497	13 191	14 141	15 049	16 942	22 468	11 559	12 387	13 450	14 503	15 970	18 606
Etiopien	27 724	28 585	29 599	30 108	29 891	31 831	31 159	31 908	33 170	33 826	33 345	34 617
Gambia	19 852	20 192	20 515	20 142	19 285	21 585	5 730	6 085	6 410	6 600	6 722	7 077
Ghana	103 721	52 918	53 972	53 501	53 219	54 990	77 981	32 739	34 273	34 954	35 196	36 872
Guinea	16 152	18 525	19 370	19 361	18 603	18 812	8 004	9 343	10 537	11 420	11 986	12 618
Guinea-Bissau	816	856	950	958	995	1 157	470	506	534	533	562	596
Indonesien	66 217	64 861	63 982	62 553	60 816	59 899	84 756	83 468	83 085	81 686	79 610	79 289
Irak	112 315	117 620	123 835	125 010	122 798	128 447	86 477	90 173	95,439	97 635	96 794	100 960
Kenya	79 859	74,746	73 458	81 450	80 926	69 096	79 344	71 295	80 190	82 675	84 473	80 388
Liberia	4 256	4 378	4 565	4 579	4 248	4 310	2 042	2 118	2 212	2 252	2 199	2 216
Mali	24 997	24 386	22 845	21 132	20 433	21 626	2 510	2 708	2 929	3 153	3 337	3 567
Mauretanien	11 059	11 210	10 763	9 995	9 375	9 094	2 513	2 652	2 712	2 826	2 890	3 008
Niger	1 714	1 990	2 070	2 102	2 280	2 305	798	896	997	1 047	1 097	1 142
Nigeria	143 698	144 038	174 916	169 915	164 718	167 748	143 571	141 567	160 352	157 111	160 199	163 630
Senegal	113 302	112 979	111 903	109 643	108 874	111 151	28 631	29 279	29 924	30 428	32 412	34 504
Sierra Leone	5 709	5 867	6 029	6 069	5 916	6 117	2 999	3 139	3 281	3 415	3 398	3 537
Somalia	87 447	98 651	94 131	56 770	61 558	66 923	108 367	113 611	117 556	50 467	56 348	60 503
Sudan	8 496	8 841	9 573	9 799	9 586	10 647	4 248	4 500	5 027	5 315	5 439	6 122
Tanzania	3 132	3 346	3 524	3 608	3 476	3 582	3 497	3 614	3 779	3 864	3 851	4 003
Togo	6 613	7 368	7656	7839	7955	7849	3981	4340	4605	4749	4899	5061
Uganda	3 481	3 641	3842	4019	4134	4593	3989	4226	4521	4766	4893	5412
Jemen	997	1159	1562	1714	1801	2014	694	815	1006	1148	1207	1320
Totalt	991 181	959 330	1 004 057	968 214	954 841	984 973	762 326	722 570	774 112	714 201	724 825	752 049

Regarding the number of girls at risk, it is difficult to determine the precise number of them who are actually at risk. In this report, we have taken the number of girls under 15 years of age who were born in an FGM/C-risk country as an indicator. It is likely that some of these girls might have undergone FGM/C in their home countries before arriving to Europe. However, these numbers would increase if we consider those girls who are part of families originating from FGM/C-risk countries but were born in Europe or any other country of transit previous to their current country of residence. This is because their nationality will depend on the legal and administrative requirements of each country. Thus, in order to achieve more accurate information, it would be necessary to use more specific search criteria, such as *country of birth* and *nationality of parents*. Since these were not the criteria used in this research to select at-risk population (we used country of birth as the only indicator), we must assume that the number of girls who may be exposed to this risk is probably higher than the numbers provided in this analysis.

As shown in Figure 4, the largest group is Somali girls (10,153, 19% of the total of girls), a country with a high-risk, which makes it likely that a proportion of these girls have undergone FGM/C before traveling to Europe. It is followed by Iraq with 7,833 girls (15% of the total) Egypt (7,323, 14%), also a high-risk country, Nigeria (4,990, 9%), Senegal (3,992, 8%) and Ethiopia (3,665, 7%). According to these numbers, the total amount of girls living in the EU from FGM/C risk countries is 52,413. However, this number might be increased, as previously mentioned, if we include those who were not born in the country of origin but who are culturally exposed to FGM/C through their families. Also, special attention must be paid to girls whose nationalities correspond with countries showing the highest prevalence levels, in total 27,383, who might have an exposition level equal or higher than 69%.

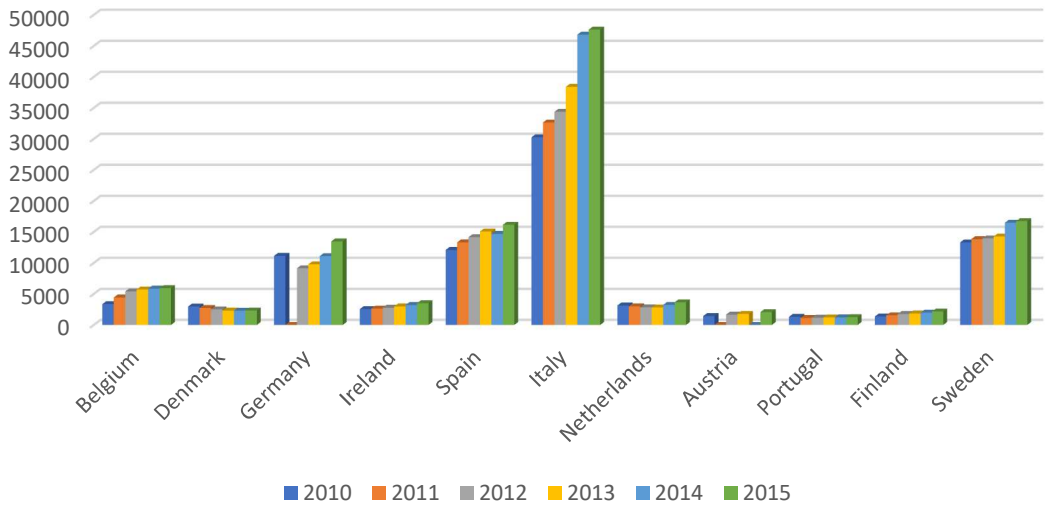
Figure 4.
Number of girls under 15 years born in FGM/C risk countries living in the EU by country of birth.

Source: Compiled by authors based on Eurostat (2016)



If we look at the distribution of girls among EU countries where there is a significant amount (Figure 5), we find that some of the largest numbers are shown by countries involved in the current report, such as Italy, Spain or Sweden and that the numbers have considerably increased in the last five years.

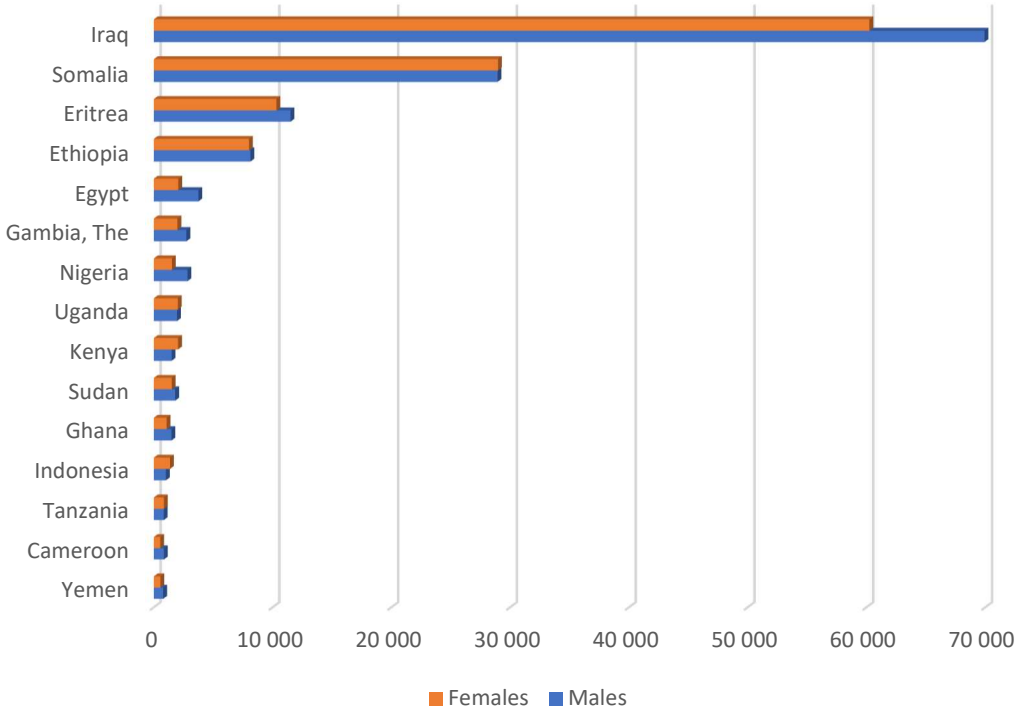
Figure 5.
Girls (nationals) under 15 years old from FGM/C risk countries by country or citizenship.



Source: Eurostat (2016)

2.3. Sweden: National analysis Data

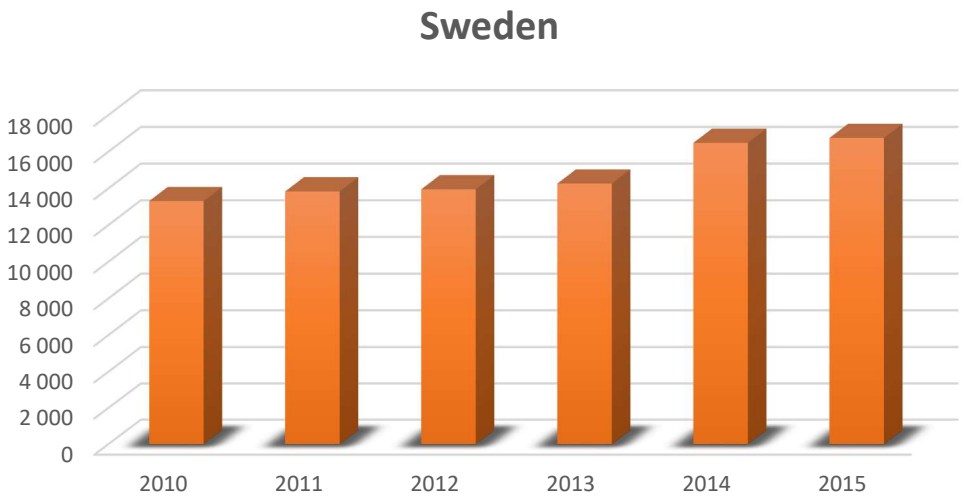
Figure 6.
Population originating from FGM/C risk countries



Source: Eurostat (2016)

Sweden is one of the European countries with the largest population originating from FGM/C-risk areas. According to data available from Eurostat16, the number of people originating from the 30 countries where the practice is most common, rose to 266,392 in 2015 of which 47% (125,343) are women. Furthermore, the number of girls under the age of 15 originating from FGM/C- practicing countries was 16,749.

Figure 7.
Girls under 15 years old with one of the 30 nationalities FGM/C countries



Source: Eurostat (2016)

Figures reveal that the population from FGM/C-practicing countries in Sweden has increased by 25% in 2015 compared to (213,181) in 2011.

The nationalities with the highest representation in Sweden are Iraqis with 130,178 people of which 46% are women, followed by Somalis with 57,906 of which 50% are women, followed by Eritreans with 21,827 of which 47% are women, followed by Ethiopians with 16,145 of which 50% are women. These four nationalities represent 85% (226,056) of the total migrant population originating from the 30 countries[17] where FGM/C occurs most frequently.

There are 111,605 people in Sweden from countries where the prevalence of FGM/C is equal to or higher than 68%, according to UNICEF definition. Out of which include 48% women. Therefore, there is a high probability among this migrant population of having suffered mutilation or being at risk. Additionally, the last figure includes 44% of women who originate from areas where the most serious type of mutilation, type III, is practiced.

3. European level analysis.

3.1. Characteristics of the EU policy on FGM/C

We start from the following premise already stated: the practice of FGM/C is a severe form of violence against women which affects their physical, psychological, sexual, reproductive and emotional integrity. There are many different types of violence against women: domestic violence, sexual violence including rape, human trafficking, physical violence including forced abortion and forced sterilization, physiological violence, female genital mutilation, forced marriages, honour crimes, and many more. When the EU refers to FGM/C, sometimes it is mentioned as general violence against women, one more type similar to the ones just mentioned; in other moments it is considered as a specific type of violence.

The Universal Declaration of Human Rights (UDHR) (1948), Articles 1, 3 and 5 state unequivocally the need to treat all people as equal, emphasizing the right to life, liberty and security of person, not subjecting anyone to torture and other cruel and inhumane treatment and/or punishment. These Articles capture explicitly the rights which the practice of FGM/C violates because women have a right to physical and mental integrity. The practice of FGM/C not only denies women their right to physical and mental integrity, but also make them vulnerable to violence and deny them highest attainable standard of health. A very important step has recently been made with the ratification in May 2017 by all the Member States of the EU and the Council of Europe of the Convention on preventing and combating

violence against women and domestic violence (Istanbul Convention)[18]. This convention recognizes explicitly FGM/C as a type of violence against women and its ratification obliges the EU to protect and support victims by providing services such as permanent telephone help lines, specific medical support, etc. It is also important to mention that the EU Charter of Fundamental Rights[19] is binding in all Member States and that it recognizes in Article 3 the right of physical integrity and in Article 4 the prohibition of torture and inhumane or degrading treatment, considering that FGM/C is understood as a form of torture.

There is no European mandatory legislation dealing specifically with FGM/C, however, this issue is incidentally mentioned in various European Directives. In particular, they refer to this practice (FGM/C) as a risky situation that could be invoked to request ”international asylum” in a country of the European Union (Directive 2013/32 / EU[20]); or as an act that will be prosecuted as a crime by the person who practices it (Directive 2011/99 / EU[21]); or as a situation that makes the person who suffers it a ”victim of violence”, having the right to assistance, support and protection by the State (Directive 2012/29 / EU[22]).

Preventive policy is the most efficient way of combating this social torment, but as it has already been pointed out, the existing European Directives do not align with this. We only find some Resolutions of the European Parliament or Communications of the European Commission, but their legal effectiveness is scarce, while leaving to the discretion of the Member States their effective fulfilment. These resolutions, communications, conclusions, etc. in short, are what European law calls ”soft law”, meaning they can just advise or drive policies to States Member.

The European Parliament has adopted four resolutions on FGM/C in 2001, 2009, 2012 and 2014, calling on the Commission and Member States to provide legal, and other means required to raise awareness, protect and support victims and ensure that offenders are prosecuted. The European Parliament, based on the work done by its Committee on Women’s Rights and Gender Equality, has actively contributed to the prevention of violence against women. It has adopted a number of resolutions, such as that on 14 June of 2012, entitled “ending female genital mutilation”, that considers the importance of adopting a strategy to combat violence against women. In this resolution, the European Parliament urges the Commission to make it a priority to end violence against women and girls and, through the allocation of appropriate financial resources, to support targeted and innovative programmes within countries both in and outside of the EU.

The European Commission has been quite active in the field of violence against women and has adopted a number of instruments. The Communication from the Commission *Towards the elimination of female genital mutilation* (2013)[23] has a strong focus on prevention through sustainable social change. This Communication only contains commitments to combat violence against women and the elimination of FGM/C, both within and outside the EU, recognizing that the link between affected communities in the EU and its countries of origin must be taken into account.

The EU is committed to supporting those entities who have been actively engaged in this area for many years, in particular international organizations, Member States and NGOs. EU Member States will continue developing policies and implementing measures, bearing in mind that FGM/C is included in several aspects requiring multidisciplinary measures and close cooperation with the communities in which it is practiced.

In fact, actions to prevent and combat violence against women have only been covered by EU programmes since the end of the 1990s with the launch of the Daphne Initiative, followed by the Daphne Programmes, as well as an answer to a resolution of the Parliament on

the need to establish an EU-wide campaign for zero tolerance of violence against women. It must also be mentioned that the European Institute for Gender Equality was created under the Regulation 1922/2006 of the European Parliament and the Council of 20 December 2006. Its main objectives include to provide European institutions with research and data and to manage existing knowledge to support decision-making by policymakers and meet the needs of target population.

Besides this, FGM/C is mentioned both by the Program of Stockholm (2009) of the European Council and by the Strategy of the European Commission for the Equality among women and men (2010-2015). In the first one the vulnerability of women who have been victims of the practice is recognized and, therefore, the need to provide legal protection and economic support through the existing programmes. In the second, the adoption of a European strategy to combat violence against women and prosecute FGM/C is foreseen.

Policies for the prosecution of FGM/C have received more attention. FGM/C is a crime in all EU Member States, either through specific legislation or general dispositions. A principle of extra-territoriality is often included, making it possible to prosecute FGM/C when it is committed abroad, as families often take their daughters to their country of origin to have them mutilated.

The cross-border protection of victims of gender-based violence has been achieved through the promulgation of *Directive 2011/1999*[24], which proclaims that ”in a common area of justice without internal borders it is necessary to ensure that the protection offered to a natural person in a Member State is maintained and continues in any other Member State to which the person is to be transferred or has moved. It should also be ensured that the legitimate exercise by citizens of the Union of their right to move and reside freely within the territory of the Member States under Article 3 (2) of the Treaty on European Union (TEU) and the Article 21 TFEU does not undermine its protection”. This Directive establishes the ”European Protection Order”, the purpose of which is to ensure that protection resulting from certain measures adopted under the domestic law of a Member State may be extended to another Member State in which the person to be protected resides or remains.

Directive 2012/29[25] applies to criminal offenses committed against people residing in the Union, provided that criminal proceedings have taken place in the past or are currently taking place in the Union. If FGM/C occurs outside EU borders, victims of such infringements will benefit from the guarantees established by the Directive, provided that criminal proceedings are continued in the Union. This directive provides that victims of crime must be recognized and treated in a respectful, sensitive and professional manner, without discrimination of any kind on the grounds of race, colour, ethnicity or social origin, genetic features, language, religion or belief, political or other opinion, Membership of a national minority, property, birth, disability, age, sex, gender expression, gender identity, sexual orientation, or place of residence.

It is also important to highlight, although FGM/C is not explicitly mentioned, the Directive 2011/36/EU on preventing and combating trafficking in human beings and protecting victims from a gender perspective[26]. This legislation extends the concept of ”trafficking in human beings” used in previous legislation to include other forms of exploitation, paying special attention to children who may be victims of trafficking.

Another interesting way of protecting the victim is provided by Directive 2013/32 on ”common procedures for granting or withdrawing international protection”[27], which lays down common procedures and deadlines for the examination of applications for asylum by risk of suffering FGM/C. General time-limit for deciding whether or not to grant international protection is six months, which can be considered as an improvement. European legislation did not oblige Member States to meet a specific deadline.

3.2. EU campaigns on FGM/C

FGM/C is included in human rights and political dialogues with partner countries and in annual dialogue with civil society organizations. The EU participated and made a financial contribution at the 2014 Girl Summit in London to support actions to achieve gender equality and wellbeing of children, and continued support of advocacy for improved national legislation on FGM/C where it is needed.

In September 2015, the EU launched a diplomatic outreach with a global focus on all forms of violence against children and women and a focus on ending child, early and forced marriage and FGM/C. All EU Delegations received instructions to carry out actions in priority areas of their choice and include the reporting in their human rights country strategy in December 2015.

The EU has supported and contributed to the resolutions of the World Health Assembly, and the work of the World Health Organization in this area, and also in the broader context of violence against women.

The EU is currently supporting 12 projects in non-EU countries, for a total amount of approximately EUR 5 million, with the objective of putting an end to FGM/C[28]. The EU is also about to support UNICEF-UNFPA Joint Programmes on the Abandonment of FGM/C: accelerating change.

3.3. Cases of FGM/C prosecution at European level

Cases found in the EU on FGM/C are mostly related to asylum. There is an important report about analysis of Court Cases[29]. Around 20,000 women and girls seek asylum from FGM/C risk countries of origin in the EU every year. This number has remained relatively constant between 2008 (18,110) and 2011 (19,565), despite the total number of female applicants having increased from 65,125 in 2008 to 93,350 in 2011. This is due mostly to the general reduction in asylum claims from Somalia; Somali women and girls represented about 20% of all female applicants in 2011, down from 27.8% in 2008[30].

We find a paradox in European Union politics. On the one hand, FGM/C is widely recognized as a Human Rights violation in the EU and its Member States but, on the other hand, cases to grant asylum are denied by various national courts.

The increasing migration leads to an increasing number of women and girls from African and Middle-Eastern countries where FGM/C is practiced. The last decades have brought more and more asylum seekers to the European Union, many of who are considered by EU citizens as economic migrants and not people in need of protection. This includes cases where women are seeking asylum for themselves, but also cases where children are the applicants.

Considering the number of women and girls from FGM/C risk countries seeking from asylum and the possibility of a progressive increase in the amount of requests based on this reason in the EU, there exists a need of specific guidelines to harmonize and support the decision making process among the member States and to improve the information provided to applicants. The high number of applicants, together with the complexity, the embarrassment and the stigma caused by FGM/C, require specific training to improve the decision making when gender issues are raised and in particular in cases of FGM/C. And also to qualify those who interview and decide about eligibility to improve their skills to create an adequate climate where applicants feel comfortable to talk about their cases[31].

4. Sweden: National level analysis

4.1. Introduction and methodology

In this section we will analyze the existing normative and policy framework on FGM/C in Sweden. The methodology used in this analysis consisted of the creation of different categories in order to understand the situation in Sweden as well as to compare it to the four countries/cases (Spain, Italy, Ireland and Sweden), based on the regulations and policies found.

Firstly, the report will analyze the existence (or absence) of instruments specifically designed to fight against FGM/C in Sweden according to the different regulation or policy areas (penal, minor protection, gender-based violence, foreigners and asylum, health and social services). At the same time, we find it useful to detect those instruments in which FGM/C was not explicitly mentioned, but which could be used to protect and/or regulate de facto issues derived from this practice. Additionally, the report presents an analysis of the main measures contained in each of the instruments considered. For this purpose, we used three categories of analysis: measures for prevention, protection and prosecution of FGM/C.

Secondly, FGM/C penal cases existing in Sweden will be summarized, indicating the resolutions adopted by the juries and the consequences of applying penal action as the only form of intervention to face this problem.

In third place, the report will study the campaigns against FGM/C elaborated in Sweden, not only those driven by governments but also other relevant ones produced by private entities. Finally, the report will look into the specific budgets allocated to FGM/C by the national government.

4.2. Legal and policy framework

4.2.1. Specific instruments for fighting against FGM/C / mentioning FGM/C

In this report we have categorized as frameworks dealing with FGM/C those where this practice is explicitly mentioned and regulated (Table 2). By instruments we understand both legal or strategic dispositions (plans, protocols or guidelines for practice) adopted by public institutions.

Sweden has four instruments in which FGM/C is explicitly mentioned. These instruments are developed in the penal, health/social service and gender-based violence contexts. From a penal perspective, Sweden was the first country where FGM/C was prohibited in 1982 (Act.1982:316, prohibition of circumcision of women). In 1998 this law was revised and terminology was subsequently changed from “female circumcision” to “female genital mutilation”, and more severe penalties for violations were imposed (Act.1998:407). The law was further reformulated in 1999, to allow for extraterritorial prosecution (removal of the principle of double incrimination[32]) (Act: 1999:267).

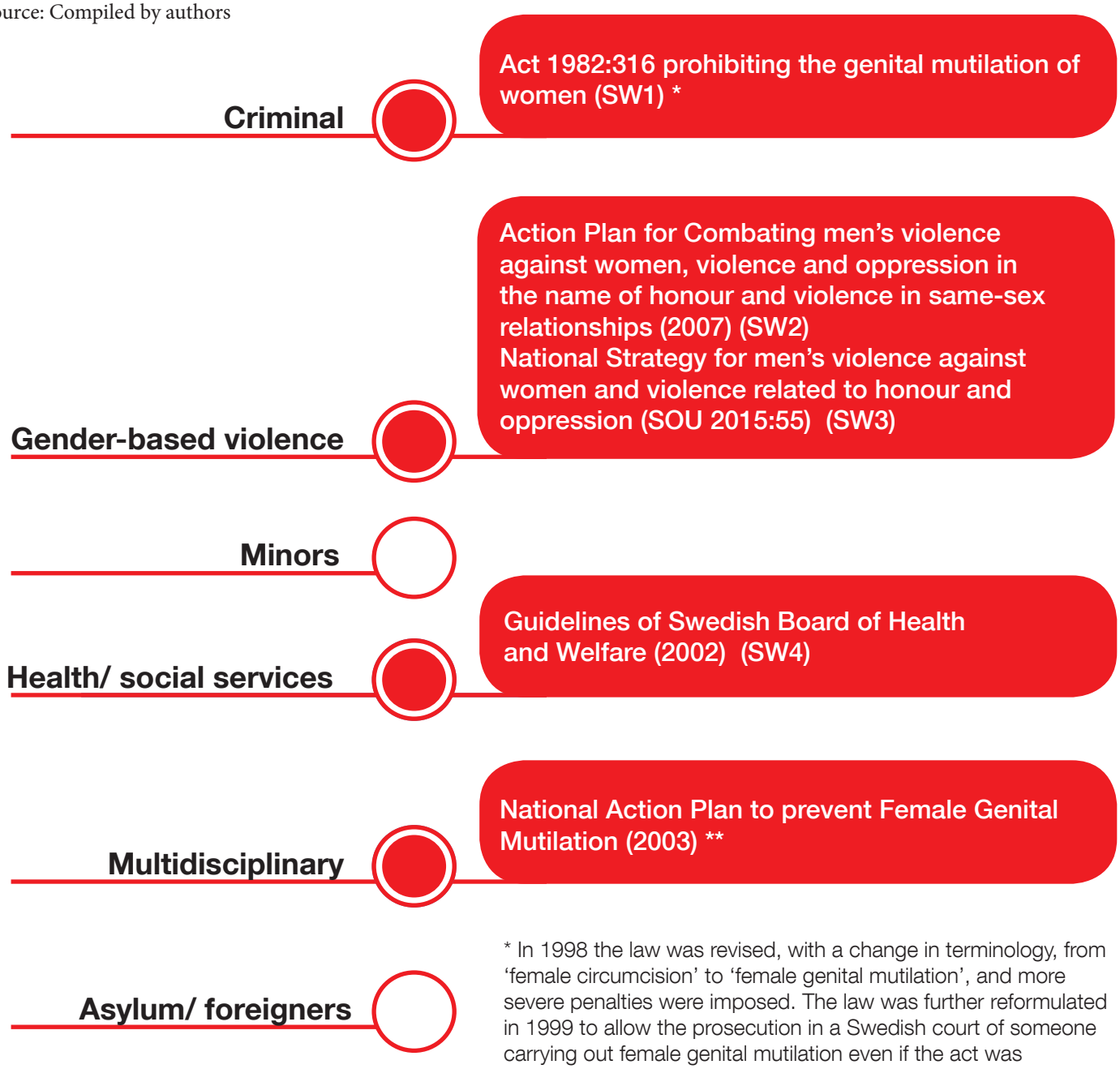
With regards to the health/social service context, the Swedish Board of Health and Welfare elaborated on some guidelines demanding the necessity of reporting cases of FGM/C, in 2002 (SW4). These demands have put an end to the silence set by the Law of Social Services (2001:453) (SW12) concerning FGM/C, as social services professionals are obligated to intervene if there is a risk. Furthermore, in 2003 a *National Plan for the Prevention of FGM/C* was developed. Despite its importance, the national plan has not since been renewed.

In the context of the fight against gender-based violence, an *Action Plan for Combating men’s violence against women, violence and oppression in the name of honour and violence in same-sex relationships* (SW2), was drawn up

in 2007. FGM/C was included and considered a form of violence and oppression in the name of honour. The National Strategy for men´s violence towards women and violence related with honour and oppression (SOU 2015:55) (SW3) in 2015 was a continuation of this strategy. This strategy highlights forced marriage and female genital mutilation as forms of violence against women and considers specific measures for the protection of victims and the prosecution of this practice.

Table 2.
Specific frameworks for FGM/C / mentioning FGM/C

Source: Compiled by authors



* In 1998 the law was revised, with a change in terminology, from 'female circumcision' to 'female genital mutilation', and more severe penalties were imposed. The law was further reformulated in 1999 to allow the prosecution in a Swedish court of someone carrying out female genital mutilation even if the act was performed in a country where it is not a criminal act.

** Expired and not renewed.

4.2.2. Measures for prevention, protection and prosecution of FGM/C

In the detailed analysis of each of the measures that covers FGM/C, it can be seen that Sweden incorporate measures for the prevention, protection and prosecution of FGM/C (Table 3). The code in brackets refers to the instrument (Table 3) containing the specific measure.

In this report, we use the term *measures for prevention* to refer to those community actions directed to avoid FGM/C from being done and to eliminate the risk of FGM/C being practiced (primary prevention) and to reduce its effects after the practice (secondary prevention). For this reason, the target population is the general community or specific groups from the community.

Measures for protection/assistance emphasize the support to the victim and consequently, women and girls who are victims of FGM/C are the primary targets of these actions.

Finally, *measures for prosecution* are directed at people who are responsible for the practice of FGM/C. These measures apply to those who directly commit the crime and, if that is the case, those who are the legal guardians of the girl.

Sweden has various measures in place for the prevention of, protection/assistance from and prosecution of FGM/C. Concrete measures have been developed on the issue of violence against women; (*National Strategy for men´s violence towards women and violence related with honor and oppression, SOU 2015:55*) and health (*Guidelines of Swedish Board of Health and Welfare, 2002*). Moreover, the National Strategy establishes that every county in Sweden should receive concrete instructions on how to support victims in cases of violence against girls and women (FGM/C is explicitly included) and also indicates a specific annual budget for this overall purpose. Furthermore, *in the Guidelines of Swedish Board of Health and Welfare, 2002* (SW4), training on FGM/C for professionals in the health sector is suggested as a preventive measure.

Table 3.
Classification of measures

Prevention	Protection/Assistance	Prosecution
On-line training and documents to inform health professionals about FGM/C (SW4).	Responsibility of the social services to provide support and assistance to the victims of honour-related violence and oppression, including FGM/C victims (SW4).	MGF is a crime punished with jail penalty of 2 to 10 years. (SW1).
Every county in Sweden will receive guidelines on how to provide support to victims of gender-based violence, including specifically FGM/C (SW3).	All citizens have a duty to report knowledge or suspicion of FGM/C to the social authorities. Staff at schools and in children day care and ordinary citizens have a duty to report any suspicion of FGM/C to the social authorities (SW4).	An official who fails reporting commits breach of duty (to report knowledge or suspicion of FGM/C to the social authorities) and may be prosecuted (SW4).
Specific annual budget (€35 million) allocated to fight against gender-based violence, including specifically FGM/C (SW3).	Authorities and professionals in schools, preschools, health institutions and police are obliged to report to the social service if they suspect about signs or potential risk of subjecting a child to mutilation (SW4).	Ministerial proposal (Ds 2001:1) to extend the period of legal prescription of FGM/C so the period would start when the victim is 18 years old (SW2).
	Social services are allowed 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 (SW4).	
	To guarantee the observance of the Istanbul Convention about FGM/C (art. 38) (SW3).	

Source: Compiled by authors

OTHER MEASURES

Prevention	Protection/Assistance	Prosecution
	If it is suspected that a minor have been victim of a crime, the legal representative can demand a medical examination, even without parental consent (SW7). Girls and women who were subjected are the right to obtain the support and the health care (SW10). Social services and healthcare professionals who are under professional secret are obliged to report in case they have knowledge of child abuse (SW11). In case of risk the authorities are allowed to keep the minor under custody (SW5).	Prosecution of Swedish residents who commit a crime out of Sweden prosecution of Swedish residents who commit a crime out of Sweden (SW5).

Among the measures for protection/ assistance of victims, in accordance with the responsibility of the social services for providing support and assistance to FGM/C victims, social services are allowed to take a young person into care in cases where there is no other alternative to protect a minor from the risk of being mutilated.

Generally, citizens are obliged to report to social authorities if they know of, or suspect a case of FGM/C. This duty is a legal obligation for all authorities, professionals in schools, preschools, healthcare centers and police institutions. In connection with the legal aspect, an official who fails to report such an instance commits breach of duty and may be prosecuted.

Moreover, as mentioned above, FGM/C is considered a crime in Sweden and offenders are subject to prison sentences of 2 to 10 years. Lastly, it is worth mentioning that there is a ministerial proposal (Ds 2001:1) included in the *Action Plan for Combating men's violence against women violence and oppression in the name of honor and violence in same-sex relationships, 2007* (SW2). According to this plan, the statute of limitations period during which an offender can be prosecuted would be extended as FGM/C is usually performed when the victim is 5-year-old or older, so the period of legal prescription would start when the victim is 18 years old.

4.3. Cases of FGM/C prosecution at national level

The practice of FGM/C is punished with a jail penalty, following the indications of the *Resolution of the European Parliament 2001/2035*[33].

Sweden was the first European country to adopt specific legislation on FGM/C in 1982. However, it was not until 1998 that severe punishments are applied: two to four years in prison and up to 10 years if the crime endangered the life of the girl/ woman.

Only two cases have been carried to tribunals in Sweden: Case no. B 3153-06 at Mölndal District Court (3 years), and Case no. B 5015-06 at The Court of Appeal for Västra Götaland (2 years).

4.4. Campaigns against FGM/C at national level

Government campaigns

2015
National Board of Health and Welfare: online materials on FGM/C for training healthcare professions

2013–2015
Östergötland, County Administrative Board led a campaign called Dare to see - A guide for the support, care and protection of girls and women who are, at risk of being genitally mutilated. The campaign offers educational videos, guideline information, hotline for professionals, templates for local action plans, informative meetings with municipalities and parents and girls/women affected by FGM/C.

CSO campaigns

2014–2017
"It's about love and Love is free".
Save the Children

4.5. Budget and funding for fighting against FGM/C in the national context

There is no specific budget that is solely designed to combat FGM/C.

5. Services

1. Judicial and police services
No services found.

2. Health
- AMEL-clinic (Söder Hospital, which is the only clinic specialized in addressing FGM/C issues all across Sweden).
- Karolinska Hospital (public): Reconstruction surgery after FGM/C.

3. Social services
No services found.

4. Education
No services found.

5. NGOs
- RISK - National Association for Ending Female Genital Mutilation (private): It is a nongovernmental organization works with grassroots and partner organizations to end FGM/C in Sweden and beyond. A partner organization called Female Integrity was set up in 1995 and both organizations work together to map out future strategy to end the practice in Sweden. They also work closely with the Ethiopian Women's Association in Uppsala.
- Unga Kvinnors Värn (private): an NGO that offers Social service and shelter for young people and women.
- Elektra (private): Is a project part of the youth organization Fryshuset. It offer support for girls and boys who live under the honour-related violence and oppression, including FGM/C.

6. Women/Gender-based violence

- Origo (public entity): offers hotline support to the victims of honour-related oppression. Origo consist of social workers, police and midwives.

7. Other services

- GAPF Riksföreningen Glöm aldrig Pela och Fadime–(private): a Swedish acronym for "Never Forget Pela and Fadime" is a secular, non-profit association working against honor related violence, it focusses on both men and women who are exposed to honor violence and their goal is to help and support those affected as well as being a source of information about honor-related violence in Swedish society.
- Hotlines for girls/women who may be subject or subjected to violence, including FGM/C:
  - Kvinnofridslinjen
  - Linnamottagningen
  - Systerjouren Somaya
  - Terrafem

6. Stakeholders: evaluation of the fight against FGM/C

6.1. Methodology and stakeholders' profile

In this analysis, we consider it essential to analyse the perspective and opinion of those professionals and political representatives who are somehow involved in the fight against FGM/C so we can obtain significant conclusions about current policies and services available in Sweden.

In this section we will present the qualitative analysis of the discourses collected from the stakeholders interviewed in Sweden. Four of the six interviewees worked for NGOs and the other two came from the health context. The full profile of the stakeholders interviewed in the four countries (Spain, Italy, Ireland and Sweden) can be consulted in the Annex.

Three categories emerged from the analysis of the discourses representing three different perspectives from which to understand the fight against FGM/C:

- **Structural/social level**: knowledge and personal opinion about policies, resources, services existing in the country and region where the stakeholder works;
- **Professional level**: stakeholders' views on the intervention actions against FGM/C;
- **Personal attitude level**: sensitivity and personal involvement in this topic.

6.2. Structural/social level

The analysis of the interviews conducted shows that some of the stakeholders have a more in depth knowledge of the legislation and this enables them to have a more critical perspective. This point of view is shared by those who are in direct contact with this problem, even if they have not read the legal regulations. For example, they consider Swedish law to be ineffective, that it does not properly protect girls because detection is difficult, and that FGM/C is usually practiced when the girl is abroad so when it is detected it is already too late. They think the law is more persuasive than punitive; an impression that would explain why even with a law that clearly criminalizes this practice, the number of sentences is very limited. They add that the norm is weak and minimally effective because of the lack of funding, resources and specific policies for sensitization. Moreover, they underline the concentration of resources in the big cities which makes the vulnerability of women and girls higher in the small towns.

6.3. Professional level

Discourses clearly reveal a lack of information on FGM/C. The interviewees acknowledge the absence of training and information in the different levels of the process and among the agents involved. They claim that training should

start with health agents such as gynaecologists, doctors, nurses, etc. and in the universities and nursery schools. This way the problem could be stopped from the beginning.

Stakeholders think that training is essential, not only in the health context but also in the other contexts involved such as the school and social services where there is specific training on gender equality but there are not any courses on FGM/C. In fact, sensitization campaigns usually talk about sexual violence and not about FGM/C. This training should be extended to families, as main agents, both fathers and mothers must be informed of the consequences that mutilation involves. The interviewees claim that some mothers do not want their children to be mutilated and consider this as a sign of change in their cultures. They claim that more work should be done with these mothers who are changing their minds.

Another discursive line is the lack of resources derived from insufficient funding, meaning FGM/C specialized clinics, with sexual health counselling, professionals and interpreters so they can provide high-quality assistance. It is remarkable that, in their view, existing hospital services are not reached by the affected and at risk population because of a lack of basic information about such services and other counselling services. The low efficacy of the organization and management is evident. Moreover, sectors involved are not coordinated, there is a lack of personnel in the prevention area and also a lack of awareness to work with professionals and communities.

6.4. Personal attitude level

The concern about FGM/C is clear among professionals who are in contact with this reality. They have a very critical perspective about the situation and also express a very good disposition to working on this area and developing a training plan for raising awareness and eradicating FGM/C.

7. Recommendations

7.1. Recommendations at EU level

- Correctly identifying the communities where FGM/C is practiced is essential to carrying out an effective prevention and working towards its eradication. Furthermore, together with nationality or country of birth, which are the most frequent data collected, it is essential to incorporate data on the ethnic group to which women and girls belong to.
- To implement measures for the improvement of research.
- To keep track of FGM/C cases in health records.
- To create, implement and evaluate policies to welcome and integrate migrant populations coming from FGM/C risk countries, which should be respectful with the fundamental rights and basic needs of the people (food, housing, health, work, safety, etc.).
- To develop policies to prevent FGM/C and guarantee protection to the victims and asylum.
- To incorporate gender, intercultural and human rights perspectives to policies.
- To design and implement comprehensive plans/policies. To create mechanisms for the coordination of different services and units which offer assistance to FGM/C victims, as well as coordination of CSOs with experience in this type of work and those who support population who might be at risk.
- To put into practice effective procedures and evaluate the level of implementation of the policies, laws and services and the quality of their functioning, and to allow public access of the results of these evaluations.

7.2. Recommendations for Sweden

There have been two plans against GBV where FGM/C has been explicitly mentioned since 2007. This is something to be positively highlighted, as the protection from FGM/C can be improved by implementing the measures, resources and services offered to women who suffer other types of GBV. Nevertheless, it would be important to mention FGM/C more explicitly and to develop specific regulations and plans in the context of minor protection. An alternative to these specialized regulations would be to incorporate FGM/C in the basic articles of the existing instruments in the minor context, similar to the regulation of GBV. This would be helpful to reduce the limitations in the application of the existing regulations in the minor context.

- To develop a new action plan to ensure continuity of the previous one from 2003 and to improve those measures which have been inefficient.
- Specialized services and resources are needed across the country to guarantee the access by those who are in need for them.
- To set up coordination protocols to promote the collaboration among existing services, both public and those offered by different NGOs.
- Greater efforts in the dissemination of the existing resources among the population to facilitate the access for the affected population.
- To allocate clear, sufficient and sustainable funding to implement legislative changes, to develop policies on FGM/C in all its dimensions and to set up pertinent services and resources.

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