Screening, stigma and risk: FGM in Norrköping

by HANNAH BRADBY Jun 26, 2014

Who could disagree with the international campaign to end female genital mutilation (FGM) or cutting? Not I. However, the subtleties of how FGM is represented in news media bear some scrutiny. How is the moral high-ground occupied by those who condemn the practice? How might this stigmatise immigrants with whom the practice is associated?

Sweden was the first country in the world to outlaw FGM in 1982. In 1999 the law was strengthened such that the practice is illegal even if committed outside Sweden. However, applying such law has proven difficult with only two convictions over the past three decades.

The oldest continually published newspaper in Sweden (established 1758, aligned with the liberal conservative party 'Moderaterna'), Norrköpings Tidning garnered global attention in June, reporting that all 30 girls in a single school class had been mutilated. They had been identified thanks to a scheme whereby school nurses asked girls whether they had been cut, as part of routine health checks.

School health officials from Norrköping suggest that such screening should be extended across Sweden. This would identify women and girls who have suffered, or who are at risk from genital mutilation. It could also help to identify those that have younger sisters at risk.

However, with further scrutiny, the story unravels a little. The thirty girls were not actually from a single school class, but had been formed a temporary working group as a result of the screening. The Norrköpings Tidning journalist justified the misrepresentation on the grounds to their evident need for help.

In terms of the individual girls’ suffering, their sampling from a single school class or several is irrelevant. But in terms of the representation of FGM as a social and public health problem, it is significant. To have an entire class affected would have had implications for estimates of the prevalence of FGM in Sweden. Especially given that one newspaper reported that the girls in question had been brought up in Sweden, implying that FGM was a Swedish-based practice. In fact where the girls grew up remains unconfirmed, although no prosecutions have been reported as a result of identifying this group’s mutilation.

And there has been dissatisfaction with the reporting of how girls in Norrköping have been affected by FGM, with a Somali woman quoted as saying:
It’s not true that girls can’t pee,” said Nora Dore [... ] “The whole time you are talking about the clitoris being thrown away. Why are you doing it? You are talking about cutting, cutting, cutting, the whole time. It’s a Muslim woman’s problem, it’s not your problem.

Nora Dere goes on to suggest that all Somalis in Sweden understand that FGM is unacceptable and furthermore that the message is widely broadcast in Somalia. Nora Dere is the mother of the man who runs a Somali cultural centre in Norrköping. She got her own daughter (now adult) circumcised before migrating to Sweden. She may wish that Muslim women could be left to look after their own daughters’ wellbeing, but the current political mood is more interventionist. Attention to young immigrant women’s health and wellbeing is to be welcomed, but the nature of that attention is also important.

Two years ago the Swedish Minister of Culture cut into an effigy of a Black woman’s genitals, rendered in cake, apparently to highlight the issue of FGM. Interpreted by one commentator as trivialising the seriousness of FGM and by another as both poor politics and poor art, the discomfort around racism and immigration was evident in subsequent discussion.

FGM is clearly offensive to ideas of women and children’s bodily autonomy. According to a recent survey, more Swedes are worried about the rise in racism than about ongoing high levels of immigration. Talking about racism and cultural difference is fraught with difficulty, as shown by the racist cake (or ‘rasistisk tårta’) incident. FGM represents a moment of certainty, where it is acceptable to condemn a practice aimed at controlling a girl’s sexuality and rendering her an acceptable wife. Perhaps asking school girls questions about their genitals represents a solution. But given that children’s accounts of their lives are routinely treated as unreliable, it also raises the prospect of routine genital examinations – another sort of abuse. Is this a battle between the right of the (immigrant, minority, Muslim) family versus the right of the state to intervene on girls’ bodies?

Nora Dere of Norrköping defines FGM as ‘a Muslim woman’s problem’. She does not specify whether she thinks this is the most important problem facing Muslim women in Norrköping. Nor does she specify what other women’s problems might be, beyond Norrköping, nor who should attend to them. Boys’ circumcision and young women having labiaplasty are possibilities she could have mentioned.

The focus on FGM effectively positions it as the key public health issue facing this group of recent migrants. This carries the risk of losing sight of other health and social needs.

The readiness of health service professionals to identify the deficits of minorities is well researched in the UK. By focussing on what a group of new arrivals is getting wrong, crucial determinants of ill health are often lost to public health policy. These determinants often turn out to be poverty and discrimination, which do not garner many headlines.

Actually FGM is a little girl’s problem. It is the state’s responsibility to protect little girls from child abuse, despite the “rights” of the family of origin. I have never spoken to a survivor of FGM who preferred FGM to a medical check by a doctor or nurse.