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Continuity or Change?

Improved Understanding of Attitudes Towards Female Genital Cutting after Migration from Somalia to Sweden

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Abstract
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Do people's attitudes towards female genital cutting (FGC) change after they migrate from a country where the practice is common, to one where it is not? Alongside increased levels of migration, this question is increasingly being raised. This thesis aimed to expand the understanding about attitudes towards FGC held by Somali men and women in Sweden, and thereby to identify potential factors that impede or facilitate the cessation of FGC. Cross-sectional questionnaire data were collected in four Swedish municipalities to assess attitudes to FGC. To further explore perceptions of FGC, as well as the circumcision of boys, semi-structured interviews and focus group discussions were conducted. Data were collected in 2015.

The findings identified an overall widespread opposition to forms of FGC that cause anatomical change. A majority (78%) expressed an opposition to the continuation of all forms of FGC, with the odds of supporting FGC decreasing with increased years of residency in Sweden. An identified 18% reported a support for the continuation of pricking (FGC type IV). A support of pricking was linked with perceiving it as acceptable according to Islam, not a violation of children's rights, and not causing long-term health complications. Pricking was not defined as a form of FGC by 32%. Most men described a preference to marry an uncircumcised woman (76%) or one who had had pricking (16%). How the individuals perceived the support of FGC in the Swedish Somali community corresponded well with their own approval of the practice. While there seemed to be a continuity regarding the Swedish Somalis' core values of being a good Muslim, not inflicting harm, and upholding respectability, re-evaluation of how these are applied when it comes to circumcision of girls and boys was identified. This resulted in FGC being viewed as a practice that could be abandoned or adapted. Paradoxically, based on the same core values, the circumcision of boys was continuously perceived as an unquestionable required practice. Altogether, these results suggest that a shift in convention towards no FGC is taking place. However, the identified lack of consensus on practices regarded as FGC needs further attention.

Keywords: female genital cutting, circumcision, pricking, migration, gender, sexual and reproductive health and rights, Somalia, Sweden

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Till mamma och pappa

List of Papers

This thesis is based on the following papers, which are referred to in the text by their Roman numerals.

I Wahlberg, A., Johnsdotter, S., Ekholm Selling, K., Källestål, C., Essén, B. (2017) Baseline data from a planned RCT on attitudes to female genital cutting after migration: when are interventions justified? *BMJ Open*, 7(e017506)

II Wahlberg, A., Johnsdotter, S., Ekholm Selling, K., Källestål, C., Essén, B. (2017) Factors associated with the support of pricking (female genital cutting type IV) among Somali immigrants – a cross-sectional study in Sweden. *Reproductive Health,* 14:92

III Wahlberg, A., Johnsdotter, S., Ekholm Selling, K., Essén, B. (2017) Shifting norms and conventions: Female genital cutting and the applicability of social convention theory in a migration context. *Submitted manuscript*

IV Wahlberg, A., Essén, B., Johnsdotter, S. (2017) From sameness to difference: Swedish Somalis' post-migration perceptions of the circumcision of girls and boys. *Submitted manuscript*

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Contents

Abbreviations

CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CI	Confidence Interval
cRCT	Cluster Randomised Controlled Trial
CVI	Content Validity Index
DHS	Demographic and Health Surveys
EIGE	European Institute for Gender Equality
FC	Female Circumcision
FGC	Female Genital Cutting
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
ICC	Intraclass Correlation Coefficient
MC	Male circumcision
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Surveys
NGO	Non-governmental Organisation
OR	Odds Ratio
SD	Standard Deviation
SDG	Sustainable Development Goal
SPSS	Statistical Package for the Social Science
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VAS	Visual Analogue Scale
WHO	World Health Organization

Introduction to female genital cutting

Throughout history, as well as in our contemporary societies, the body has been modified in numerous ways to make it either correspond with or confront social and cultural norms (Cornwall 2012; Fusaschi 2017). This thesis will focus on the global and controversial issue of female genital cutting (FGC). FGC is positioned within the broader concept of sexual and reproductive health and rights, in which the practices of FGC not only affect women's and girls' health, but also violate their human rights (Runeborg and Anderson 2010). Practices defined as FGC have received considerable international attention, with the investment of many human and financial capital resources to gain an understanding about why it is practised and how it can be abolished. However, because prevalence rates show only a very slow decline in practising societies (Shell-Duncan et al. 2016), and as this is accompanied by an increase in migration, FGC has become a global concern.

Definition

The World Health Organization (WHO) defines FGC, or FGM (female genital mutilation) in their terms, as "all procedures that involve partial or total removal of external genitalia or other injury to the female genital organs for non-medical reasons" (WHO 2016b). The practice of FGC has been classified into four types by the WHO:

> Type I involves partial or total removal of the outer structure of the clitoris and/or the prepuce (clitoridectomy);
>
> Type II includes partial or total removal of the outer structure of the clitoris and the labia minora, with or without removal of labia majora (excision);
>
> Type III includes narrowing of the vaginal opening by cutting and appositioning the labia minora and/or labia majora, with or without clitoridectomy (infibulation);
>
> Type IV includes all other harmful procedures to the female genitalia for non-medical reasons, e.g., pricking of the clitoris or surrounding

tissue with a sharp object; blood may be let, but no tissue is removed and no stitching performed (WHO 2008; 2016b).

This definition of the different types of FGC is, in general, not used by practising societies. In Somalia, for example, 'sunna circumcision' and 'pharaonic circumcision' are terms commonly used to refer to different forms of FGC. 'Pharaonic circumcision' refers to infibulation (type III), whereas 'sunna circumcision' usually refers to less extensive forms of FGC but can, however, include all forms of FGC (types I-IV) (Lunde and Sagbakken 2015).

Terminology

There are three commonly used terms to describe genital cutting in girls: 'female circumcision' (FC), 'female genital cutting' (FGC), and 'female genital mutilation' (FGM). Practising societies commonly use the term female circumcision, and this was also the term first used to describe the practice (Johnsdotter 2012; WHO 1998). However, as demonstrated by an inter-agency statement by the WHO, UNICEF and UNFPA, amongst others, this term has been criticised as it is seen to equate the practice with male circumcision, which is perceived to be significantly less harmful than the circumcision of girls (WHO 2008). Further, this term has been criticised for not sufficiently reflecting the severity of the procedure (WHO 2008).

Guided by the work of feminist and activist Fran Hosken, who claimed that the practices of genital cutting of girls should be considered as a form of mutilation, the term 'female genital mutilation' was introduced (Hosken 1979). Activist efforts resulted in an increased acceptance of the term, with the adoption of the term by governments, the WHO, non-governmental organisations (NGOs), researchers, etc. (WHO 1998). However, not all were content with this change in terminology. The term was perceived to be offensive among and towards practising communities, as they do not perceive it this way, nor do they conduct the practice by aiming to mutilate their daughters. Therefore, a local organisation in Uganda suggested a new term: 'female genital cutting' (UNFPA 1996). This term has increasingly come to be used as it is considered to be non-judgmental without indicating that the practice is harmless (which circumcision may do) or performed with malicious intentions (as mutilation may do) (UNICEF 2013).

I have chosen to use the term 'female genital cutting' (FGC) throughout this thesis, as I consider it to be the most neutral term.

The global figures

Worldwide, approximately 200 million girls and women alive today are circumcised, and more than 3 million girls are at risk of FGC annually. FGC is mainly practised in some 30 counties in Africa, concentrated within a swathe of countries from the Atlantic coast to the Horn of Africa. However, the practice also exists in some countries in the Middle East, such as Iraq and Yemen, and in Asia, for example, Indonesia. FGC has also been reported in counties such as India and Malaysia, although no nationally representative surveys have been conducted in those countries. A prevalence of FGC exceeding 80% can be found in Somalia, Guinea, Djibouti, Sierra Leone, Mali, Egypt, Sudan and Eritrea (Shell-Duncan et al. 2016; UNICEF 2016a).

FGC is usually performed on girls sometime between infancy and adolescence; in half of the countries where FGC is practised, the girls will have been circumcised before the age of five. A shift to FGC being performed at younger ages has been noted, possibly as a response to campaigns and the passing of legislation against FGC (Shell-Duncan et al. 2016). The overall prevalence of FGC has declined (UNICEF 2016a). However, due to population growth, the incidence of FGC is expected to increase. Further, in many countries, such as Somalia, there has been no change in the prevalence over the last few decades (Shell-Duncan et al. 2016).

Rationales behind FGC

The origin and type of FGC first practised has not been established, and there are different theories about why FGC was introduced. Various forms of genital cutting of girls have been practised throughout history. Such practices have not been restricted to African countries. For example, forms of genital cutting, such as clitoridectomy, were performed in Europe and North America from the eighteenth to the twentieth century as a way to control sexuality and remedy various illnesses in women (Johnsdotter 2012).

The rationales for the performing of various forms of FGC are manifold, and practising groups may have several reasons or explanations for why it is practised. One rather common idea is that FGC is a way to establish gender identity and to distinguish between the genders. This is done by removing what is perceived as the 'female part' of the man (the foreskin), and the 'male part' of the woman (the external clitoris or labia) (Berkey 1996; Gruenbaum 2001). Other rationales include that the practice promotes the assurance of the girls' – and their families' – social acceptance and respect within their society, for chastity or the suppression of sexuality, to enhance marriageability, to reinforce aesthetic preferences, and as a ritual to mark the transition into womanhood. Further, FGC can also be performed to define

ethnic identity, or religious identity (Gruenbaum 2001; Shell-Duncan et al. 2016).

FGC predates the Abrahamic religions, and, throughout history, FGC has been practised by Christians, Muslims, Jews, and followers of traditional African religions, and they have each considered FGC to be legitimised, or at least not prohibited, by God (Gruenbaum 2001). As this thesis is based on Somalis' views on FGC, who are predominantly Muslims, I will focus on how FGC can be interpreted through a Muslim perspective. The written sources in Islam are the Koran and the hadiths (recorded sayings and practices of the Prophet Mohammed). FGC is not mentioned in the Koran; however, a few hadiths mention the practice. The hadiths were usually passed down through oral tradition at first, then decades later, written down, which may have caused them to become influenced by, for example, political agendas. The authenticity of the hadiths is therefore based on the reputations of the storytellers and whether the hadiths may have been influenced by outside factors. The hadiths that mention FGC are commonly regarded by Muslims as being inauthentic, and, therefore, they are not obliged to follow them. However, those who believe that FGC is sanctioned by Islam can justify it on the basis of these hadiths (Gruenbaum 2001; Johnsdotter 2003b; Rouzi 2013). In one commonly cited hadith, the Prophet Mohammed gives instructions to a woman known to perform FGC: 'if you cut, do not overdo it, because it brings more radiance to the face, and it is more pleasant for the husband' (Rouzi 2013). However, most regard the chain of transmission of this hadith as being weak, and there are also other translations of this particular hadith that render its interpretation ambiguous (Ali 2006; Johnsdotter 2003b; Rouzi 2013).

Consequences for girls and women

FGC is associated with, but does not always have to cause, an increased risk of both acute and long-term health consequences (Berg et al. 2014). In general, the more extensive the form of FGC performed, the higher the risk of complications (Banks et al. 2006; Obermeyer 2005). As FGC is often performed with unsterile instruments and by traditional practitioners, it is reasonable to assume that it may cause acute physical complications. Reports of such consequences include excessive bleeding, genital tissue swelling, and urinary retention (Berg et al. 2014). The long-term physical and psychological consequences of FGC are more difficult to study, and findings are more inconclusive (Berg et al. 2010; Obermeyer 2005). Long-term consequences can include urinary tract infections, bacterial vaginosis, and increased risks of obstetric consequences (Banks et al. 2006; Berg et al. 2014; Berg and Underland 2013).

Regarding the impact of FGC on sexuality: theoretically, scar tissue in the genital area, removal of genital tissue, and psychological trauma related to FGC could affect women's sexuality and body image negatively. However, while some studies can demonstrate that there is a higher risk of reduced sexual function and sexual quality of life among circumcised women as compared to uncircumcised (Andersson et al. 2012; Anis et al. 2012; Berg et al. 2010; Biglu et al. 2016), it has also been shown that circumcised women have sexual erectile tissues for arousal, pleasure, and orgasm – and indeed are able to have orgasms (Abdulcadir et al. 2016; Catania et al. 2007; Obermeyer 2005).

An individual's attitude towards a practice can also be important for how they perceive the effect of the actual practice or behaviour. If one has a positive attitude towards a practice, one is more likely to perceive the effect of the practice as positive: "our attitudes and preferences determine what counts as a harm" (Campbell 2006:227).

Actions for the abolishment of FGC

With the goal to abolish FGC, a vast amount of large-scale campaigns have been implemented at individual, interpersonal, community, and national levels (Johansen et al. 2013; Muteshi and Sass 2005). Common approaches to prevent FGC have been to emphasise the negative health consequences of the practice, introducing alternative rituals, converting excisers, the training of health professionals, issuing public statements against FGC, framing FGC as a violation of human rights and bodily integrity, and through legal measures (Brown et al. 2013; Johansen et al. 2013).

One of the United Nations' earliest initiatives to abolish FGC dates back to the 1950s when FGC was addressed within the United Nations Commission on Human rights. In 1958, the WHO undertook a study on the persistence of customs subjecting girls to ritual operations, bringing international attention to the issue of FGC. In the 1960s and 1970s, NGOs began to lead campaigns to raise awareness of the health risks associated with FGC. The first international conference on the topic was held in Sudan in 1979, where all forms of FGC were condemned (UNICEF 2005). The same year, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) marked an important milestone in the implementation of a gender perspective within human rights mandates (UNHCR 1979). Since then, a large number of regional and international declarations, resolutions, conventions and articles have been passed with the aim to end FGC (Nuño Gómez and Thill 2017), and FGC has been legislated against in many countries (EIGE 2013a; Shell-Duncan et al. 2016).

In 2015, the Sustainable Development Goals (SDGs) replaced the Millennium Development Goals (MDGs), both having a 15-year agenda with tar-

gets to improve health and wellbeing for the world's population (UN 2015a; UN 2015b). The SDGs take on a somewhat broader approach and comprise 17 goals with the aim to achieve a sustainable development for both people and the planet. SDG number five aims to achieve gender equality and to empower all women and girls, by, amongst other targets, abolishing FGC (UN 2015b).

Two key aspects of successful programmes to abolish FGC seem to be to establish collaborations between NGOs and governments to ensure adherence to legislations prohibiting FGC, and community-led initiatives focused on changing social norms and empowering women (Berg and Denison 2012; Brown et al. 2013; McChesney 2015; WHO 2011). However, evaluations of implemented anti-FGC programmes are scarce, making it difficult to determine which programmes work well (Berg and Denison 2012; WHO 2011).

One community-based programme is the Tostan programme. It has been implemented in many African countries and is one of the most lauded anti-FGC programmes today. The aim of the Tostan programme is a public declaration within the community stating that FGC should be eliminated (Diop and Askew 2009). Another community-based intervention programme, which has been implemented in several European counties, is Replace. Replace aims at creating social norm transformation using behaviour change theory (Brown and Beecham 2015) and is one of the few programmes to have been implemented in non-practising countries.

To improve the success of anti-FGC programmes, theories of behaviour change are increasingly incorporated within their planning and implementation. One theory that has been widely used and incorporated in such programmes is social convention theory (Mackie and LeJeune 2009; UNFPA-UNICEF 2014; UNICEF 2005; 2010). According to this theory, the continuation of FGC is upheld by social norms and conventions (Mackie 1996; Mackie and LeJeune 2009). However, studies on the applicability of this theory in an African context show somewhat conflicting results. There is evidence that support the assumption that families' decisions to circumcise their daughters are interdependent of the decision of others within the community (Hayford et al. 2005), and evidence that suggests that FGC is upheld through an intergenerational peer convention (Shell-Duncan et al. 2011). However, that FGC is upheld by social norms has been questioned, and the decision-making process in regard to FGC has been suggested to be more strongly related to individuals and households than to communities (Efferson et al. 2015; Novak 2016).

FGC activism and efforts to abolish FGC have also been criticised for being based on a western, ethnocentric, and discriminatory viewpoint (Ahmadu 2007; Gruenbaum 2001; Longman and Bradley 2015; Njambi 2007; Shweder 2000). Critics have argued that western attempts to abolish FGC reveal a double standard in which similar practices are regarded as being fundamentally different, depending on whether they are practised in the

West or in other cultures (e.g., cosmetic genital surgery, male circumcision, and intersex surgery) (Earp 2016a; Johnsdotter and Essén 2010; Oba 2008; Onsongo 2017). For example, in her description of the British colonial rule in Sudan, and the outside efforts to abolish FGC then and now, anthropologist Janice Boddy raises a critical voice towards Western attempts to abolish FGC: "Yet one wonders whose interests have been at stake in such interventions, as they so regularly denigrate those whose lives they wish to change. The obsolete language of social evolution, of barbarism and savagery that suffused the colonial past, persists in postcolonial diatribes that again claim for the West a monopoly on truth and proper personhood" (Boddy, 2007a:309). However, it is increasingly recognised that FGC, amongst other 'harmful practices', is not strictly bound to certain locations or cultures (Longman and Bradley 2015).

Attitudes and practice after migration

With globalisation, people from FGC-practising countries resettle in countries where FGC is not traditionally practised on girls. An estimated half a million circumcised, first-generation women live in Europe (Van Baelen et al. 2016). The projection of migration flows suggests that, by 2030, this number will almost double (Ortensi and Menonna 2017). Consequently, governments and organisations are increasingly concerned about the risk that immigrant populations will perform FGC on their daughters (EIGE 2015; Socialstyrelsen [Swedish National Board of Health and Welfare] 2015), and FGC is legislated against in all EU member states, through specific or general criminal law provisions (EIGE 2013a). Further, in contrast to the context often found in practising countries, in countries where FGC is not traditionally practised, such as those in Europe, FGC is strongly condemned by the wider society. Migrants therefore have to reconcile two contradictory contexts.

Determining the extent of and attitudes toward FGC in European countries is somewhat difficult, as there are no nationally representative surveys (such as Demographic Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) (MEASURE DHS 2017; UNICEF 2017)) on FGC. There have been about 50 court cases relating to FGC in Europe; the majority of these taking place in France (Johnsdotter and Mestre 2015). Scholars who have studied cultural change have suggested that migration provides an opportunity to distance oneself from the beliefs and cultural traditions of one's country of origin. This in turn could facilitate an attitude change to FGC, or could enable individuals, who were already were against the practice of FGC in their home countries, to openly express themselves as opponents of FGC (Johnsdotter 2002; Villani and Bodenmann 2017). Thus, girls who are born to parents from FGC-practising countries supposedly have a dramatically

lower risk of FGC than they would have if they were born in their parents' home countries (EIGE 2015; Farina and Ortensi 2014; Johnsdotter et al. 2009; Morison et al. 2004). This change in practice could be due to changes in the parents' attitudes towards FGC, inclusion in social networks that do not accept FGC, and the legislation against FGC that makes it difficult to arrange such practices (Berg and Denison 2013; Farina and Ortensi 2014). Further, opposition to FGC among migrants from FGC-practising countries has been described in several studies (Akinsulure-Smith and Chu 2017; Behrendt 2011; Chu and Akinsulure-Smith 2016; Gele et al. 2012), and perceptions of uncircumcised girls are, in general, positive in a migration context (Koukoui et al. 2017; Vogt et al. 2017). However, migrants also express an ambivalence towards FGC, where cultural meanings of virginity and purity remain valued (Isman et al. 2013; Johansen 2016).

Although attitudes and behaviour are related, it is important to point out that individuals' attitudes are not always reflected in their behaviour and vice versa, as described by Shell-Duncan and Hernlund (2006) (Figure 1).

		Attitude		
		Supports FGC	Undecided	Opposes FGC
Behaviour	Adherent of FGC	Willing adherent		Reluctant adherent
	Undecided		Contemplator	
	Abandons FGC	Reluctant abandoner		Willing abandoner

Figure 1. Relationship between attitudes and behaviours. Adapted from Shell-Duncan B., and Hernlund Y., 2006. "Are there 'Stages of Change' in the practice of Female Genital Cutting? Qualitative research findings from Senegal and the Gambia" African Journal of Reproductive Health 10, 57–71.

FGC and male circumcision

Another form of genital cutting is male circumcision (MC) – practised for cultural and religious reasons among about one-third of all men worldwide (Morris et al. 2016; WHO 2007a). As both FGC and MC are performed on children for non-medical reasons, I will here provide an account of some of the views of these two practices in relation to each other.

The circumcision of boys and girls are dissimilar in the sense that, whereas the term FGC comprises a variety of practices, MC is a rather homogenous practice and refers to partial or complete removal of the foreskin of the penis. However, in practically all areas where FGC is practised, so is MC (Caldwell et al. 1997; Shweder 2000; Wells 2012), and the two practices are often regarded as being symbolically complementary (Bell 2005; Johnsdotter 2012; Merli 2010; Wells 2012). Similar reasons for why they are practised can also be found, such as for beautification and cleanliness, as a way to

enhance gender identity, and to prepare the children for a life within a religious community (Berkey 1996; Gruenbaum 2001; The Public Policy Advisory Network on Female Genital Surgeries in Africa 2012).

Despite such similarities, FGC is commonly viewed as a practice that ought to be discontinued, while, on the other hand, there is widespread support for MC (WHO 2008; WHO 2016b). This supportive view of MC was further strengthened when the WHO started to promote it as a tool in HIV prevention (WHO 2007b). However, an opposition towards MC, where arguments that the removal of healthy tissue from non-consenting children constitutes a violation of boys' human rights, are gaining ground (Darby 2015; Earp 2017a; Svoboda 2017). Thus, arguments that are commonly used to condemn FGC are increasingly used to also condemn MC.

Conceptual frameworks

The theoretical basis for this thesis is how social norms and conventions (Mackie and LeJeune 2009; Southwood and Eriksson 2011), and bodily modifications as a way of inscribing gender identity (Cornwall 2012; Richardson and Locks 2014; Schildkrout 2004; Shilling 2003), are related to attitudes towards FGC. These concepts were used to discuss and contextualise the findings, and to grasp how ideals of gendered bodies influence attitudes towards genital modifications. Altogether, this added to the overall understanding of the findings of this thesis.

Social convention theory

Social convention theory is based on the idea that individuals' actions are interdependent (Schelling 1960). Gerry Mackie applied this concept to FGC in Africa and footbinding in China, and suggested that the continuation of these practices may be upheld by a marriageability convention, by a social norm, or by both (Mackie 1996; Mackie et al. 2015; Mackie and LeJeune 2009). What follows below is a description of how the concepts of norms and conventions can explain attitudes and behaviours in relation to FGC.

Individuals will, in general, behave in accordance with social norms and conventions. Further, individuals' behaviours are also influenced by *beliefs* about how other people behave, as well as *believed* conventions (Southwood and Eriksson 2011). Social norms are usually different between groups, and they may change over time. Moral norms, however, are generally intrinsically motivated, commonly found across different groups, and do not easily change (Mackie et al. 2015). For example, being a good parent is a moral norm, however, *how* to be a good parent, the social norm, differs between groups. Accordingly, this can result in the convention to circumcise in one context, while not in another.

The marriageability convention is derived from a hypothesis of the origin of FGC. In highly stratified societies, women of all strata sought to marry a wealthy man. Polygamy was common among high-ranking men, and being able to ensure paternity became important. The practice of FGC, particularly infibulation, may therefore have originated as a way to instil chastity in the girls and thereby ensure paternity. Consequently, to increase the daughters' chances of marriage into higher social strata, families of all social classes

started to circumcise their daughters as a sign of chastity. Over time, FGC became a sign of a respectable girl and thereby a requirement for marriage – a marriageability convention. Further, as families want their daughters to be perceived as respectable by their society, and to have good chances of marriage, there is a social pressure on families to circumcise their daughters. Consequently, FGC persists, as no family alone can refrain from the practice (Mackie and LeJeune 2009). Further, the social norm of FGC maintains the practice in the community, and anyone departing from this social norm risks being ostracised. Therefore, compliance with social norms is important to ensure the acceptance of the girl and her family in the community, and decision-making becomes influenced by the decisions of other families within the community.

In order for a change in attitudes towards FGC to occur, knowledge of an alternative convention of 'no FGC' is needed. Without this knowledge, there is little reason to question, or even recognise, a convention that you live with. If the alternative convention of 'no FGC' becomes more valued than the current convention of FGC, this could give rise to a convention shift – in this case, not to practise FGC. In order for the girls' and families' reputations to be upheld after such a convention shift, it is important that other families also refrain from FGC, thereby creating intramarrying groups for non-circumcised girls. Thus, for a convention shift to happen, enough community members must think that a majority of other community members will coordinate with each other to bring about change in accordance with the new convention (Mackie and LeJeune 2009).

Social constructivism: The creation of gendered bodies

Inscriptions on the body, such as tattoos, scarification and genital cutting, can serve as a marker of identity, as the body is the interface between the individual and society (Schildkrout 2004). Modifications of the body are therefore ways to produce bodies that correspond to (or confront) prevailing social or cultural norms (Cornwall 2012).

Notions of what constitute the 'perfect' male and female bodies vary between cultural groups (Richardson and Locks 2014; Shilling 2003). Genital modifications, such as FGC and MC, are ways of creating ideal gendered bodies, thereby conforming to desired forms of gender expression (Cornwall 2012; Shilling 2003). For example, inscriptions of ideals of sexual containment among women in nineteenth-century Europe and North America were 'ensured' through clitoridectomy. Today, different forms of genital modification as a way to create the ideal female body are commonly associated with women in Africa, but this form of modification is also performed through cosmetic genital surgery in Western countries (Cornwall 2012). The interpretation and importance of bodily inscriptions, such as genital modifi-

cations, are not static. Rather, views of the gendered body are only interpretable within a specific culture and context, and the views are therefore constantly renegotiated (Richardson and Locks 2014).

Rationale for the thesis

As a result of migration, FGC has become a global concern. There is a broad international consensus that FGC should be abolished, and much effort is invested in this goal. Nevertheless, with prevalence rates declining only slowly in practising societies (Shell-Duncan et al. 2016), the goal is far from being reached. Research on attitudes towards FGC after migration to European countries, where an estimated 500,000 circumcised, first-generation women live (Van Baelen et al. 2016), presents diverging results. On one hand, there are indications of a change in attitudes and practice after migration (Johnsdotter and Essén 2016), while, on the other hand, cultural meanings associated with the practices of FGC may also remain after migration (Isman et al. 2013; Johansen 2016).

This disparity emphasises a need to increase the knowledge and understanding of cultural change and cultural continuity within migration contexts, and to identify potential factors that impede or facilitate the cessation of FGC. Further, an increased understanding of the perceptions of FGC is needed to enable the adoption of culturally acceptable strategies for the abandonment of FGC.

Aim

The overall aim of this thesis is to explore attitudes towards female genital cutting (FGC) among Somali men and women in Sweden. As seen in Figure 2, which presents the research questions of the studies, we had planned to conduct an anti-FGC intervention study with the aim of reinforcing change among newly arrived Somalis. However, after collecting baseline data we found a high opposition to FGC among Somali immigrants, and therefore decided not to go through with the planned intervention, as with this baseline, it would not have been possible to detect a change in attitudes. The findings from the baseline study instead raised further research questions that were explored in subsequent studies.

The specific objective of each paper was:

- To present the primary outcomes, from the baseline of a planned intervention study, on attitudes towards FGC after migration (Paper I).
- To investigate important factors for supporting the continuation of pricking among Somalis in Sweden (Paper II).
- To test how well Swedish Somalis' own approval of FGC agree with their perceptions about others, based on hypotheses derived from social convention theory (Paper III).
- To explore Somalis' post-migration perceptions of the circumcision of boys and girls (Paper IV).

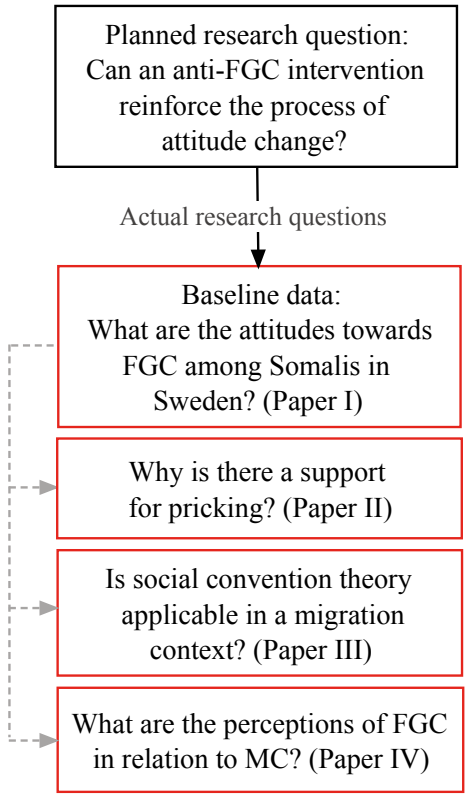

Figure 2. Research questions of the studies, and in which paper they are addressed.

The Somali-Swedish study setting

The studies in this thesis were conducted among Somali men and women living in the four largest Swedish municipalities: Stockholm, Gothenburg, Malmö, and Uppsala. This section will start with a brief introduction to Somalia's history and current socio-political situation, as this gives an understanding of the present-day refugee situation. Thereafter, the focus will be on Sweden with a description of Somali migrants living there, and how FGC is regulated in that context.

The Somali context

Somalia has a history of colonial rule, which divided Somalia into several territories in the late 1800s; The French (now the territory of Djibouti), British (Northern Somalia, today self-declared republic of Somaliland), and Italian (Southern Somalia). The British colony later handed the inland region of Ogaden to Ethiopia, and the Northern Frontier District to Kenya. In 1960, British Somaliland and Italian Somaliland obtained independence and together formed the current borders of Somalia. Subsequent border and clan disputes, and the military coup by General Siyad Barre, led to the outbreak of the civil war in 1988 and caused the state of Somalia to collapse in 1991 (Lewis 2008). Further, the organisation of clans and sub-clans is prominent in Somalia, and these vary in power and numbers. Although clans provide important social networks, the ability of stronger clans to control access to resources is a cause of conflict (UNICEF 2016b).

Today, the Somali population is estimated at 12 million, with the vast majority being Sunni Muslims (Lewis 2008; UNICEF 2016b). Somalia is in the process of recovering from the prolonged period of state collapse (Dalmar et al. 2017; UNICEF 2016b). However, years of instability have adversely affected the health of its population. With a maternal mortality estimated at 737 per 100,000 live births, and an under-five mortality rate of 137 per 1,000 live births, women's and children's health indices are among the worst in the world (UNICEF 2016b). Further, mistrust in clinicians and the care provided, and expensive health care services act as barriers for women to seek reproductive health care (Gure et al. 2015; Kiruja et al. 2017).

The protracted civil war, drought and famine, and non-functioning national institutions have resulted in more than one million refugees and an

equal number of internally displaced people (Cavallera et al. 2016). Consequently, Somalis are one of the largest refugee groups in Europe (Open Society Foundations 2015).

Somalia and FGC

Somalia has the highest prevalence of FGC of any country in the world: it is estimated that 98% of all women (aged 15–49 years) in Somalia are circumcised, among whom approximately 79% have been infibulated, 15% have been cut with flesh removed, and 1% have had pricking with no flesh removed (Shell-Duncan et al. 2016; UNICEF Somalia and the Ministry of Planning and International Cooperation 2014; UNICEF Somalia and Somaliland Ministry of Planning and National Development 2014). In Somali regions, there seems to be a trend towards supporting and performing less extensive forms of FGC (Demissie et al. 2016; Fried et al. 2013; Mitike and Deressa 2009; Newell-Jones 2017; Vestbostad and Blystad 2014). However, the word 'buuryo qab' (uncircumcised), which is a very strong insult, is still used to describe uncircumcised girls (and boys) (Gele et al. 2013a).

The tradition of FGC, and especially infibulation, has been described as a way to ensure women's sexual morality and ensure virginity, which is of importance for marriage and social acceptance within the community (Johansen 2007). Further, there is a belief that FGC is sanctioned by Islam (Gele et al. 2013a). This view is likely enforced by the terminology used in Somalia to describe the practices of FGC (sunna and pharaonic circumcision) as, in Islam, the term 'sunna' means the tradition of the Prophet Mohammed (Abu-Sahlieh 1994).

In 2012, the Provisional Constitution banned 'circumcision of girls' in Somalia, but the ban has not yet been passed by the parliament (Newell-Jones 2016; Shell-Duncan et al. 2013).

Somali immigration to Sweden

Sweden has a population of almost ten million. Compared to other countries, it is a highly secularised and individualistic country (World Value Survey 2017). Approximately 350,000 to 400,000 inhabitants are adherents of Islam, with the fourth largest Muslim group being Somalis (Open Society Foundations 2014). Many Somalis migrated to Sweden around the time of the outbreak of the civil war in 1988, and the number of Somalis in Sweden has since then continuously increased. In 2016, around 64,000 Somali-born men and women lived in Sweden, with an additional 23,000 individuals born in Sweden to Somali parents (Statistiska centralbyrån [Statistics Sweden] 2016a; 2016b). Approximately two thirds of Somali-born living in Sweden

have primary education only, and about one-third are employed (Open Society Foundations 2014).

There are numerous Somali organisations in Sweden. These organisations function as places where Somalis can meet, and they organise different activities, such as lectures and leisure activities. The organisations are generally structured by clan affiliation and comprise members from only one clan, however, many aim to include individuals from several clans, and for some, clan affiliation has lost its relevance in Sweden (Johnsdotter 2010; Open Society Foundations 2014).

The largest Somali population can be found in Gothenburg, followed by Stockholm, Borlänge and Malmö, with Uppsala in 20th place (Statistiska centralbyrån [Statistics Sweden] 2016a) (Table 1). Within the study municipalities, there are certain residential areas where many Somalis live. Therefore, data collection was primarily carried out in these areas.

Table 1. *Number of individuals born in Somalia among those foreign-born living in the four municipalities where data were collected*

Municipality	Population	Foreign-born	Somali-born
Stockholm	940,000	230,000	7,800 (3%)
Gothenburg	560,000	140,000	7,900 (6%)
Malmö	330,000	110,000	2,200 (2%)
Uppsala	210,000	41,000	700 (2%)

Data from Statistics Sweden (Statistiska centralbyrån [Statistics Sweden] 2016a)

The Swedish health care system is largely subsidised and based on the principle of equal access for all residents. However, in Sweden, pregnant women born in low-income countries, such as Somalia, have been found to have an increased risk of perinatal mortality (Essén et al. 2000a) and maternal mortality (Esscher et al. 2012), as well as an increased risk of maternal near-miss morbidity (Wahlberg et al. 2013), when compared with women born in Sweden. The factors contributing to this disparity have been shown to be linked to suboptimal medical care, miscommunication, and having different views on obstetric interventions such as caesarean section (Esscher et al. 2014; Essén et al. 2000b; Essén et al. 2002b). However, factors such as high perinatal and maternal mortality and prolonged labour among circumcised Somali women in Sweden do not seem to be linked to FGC per se (Esscher et al. 2014; Essén et al. 2002a; Essén et al. 2005).

Sweden and FGC

FGC is not traditionally practised in Sweden. However, due to migration, at least 38,000 circumcised women live in Sweden. Somali women constitute the largest group of circumcised women, with approximately 21,000 circum-

cised, followed by women from Eritrea and Ethiopia (Socialstyrelsen [Swedish National Board of Health and Welfare] 2015). Circumcised women can receive help for FGC-related complications at several hospitals. The Amel clinic in Stockholm specialises in care for girls and women who have experienced FGC (Södersjukhuset 2017).

In 1982, Sweden legislated against FGC. In 1999, the law was reformulated to allow for the prosecution of Swedish residents, even if the resident left Sweden to perform FGC in a country where it is not illegal. The Swedish Migration Agency provides group information about Swedish society and children's rights to all individuals who have applied for asylum. As part of this information, the participants are informed that the circumcision of girls is illegal (J Backman, Swedish Migration Agency, personal communication, 3 November 2017). The official position, based on the legislative history of the law, is that all types of FGC, including pricking, are illegal (Johnsdotter 2003a). In a literal reading of the law (translated from Swedish), it states that:

> 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. (SFS 1982:316 1982)

Based on this law, there is a duty to report suspected pending FGC. Based on the Secrecy Act, there is the possibility that the usual regulation for secrecy between authorities can be breached in case of suspected illegally performed or pending FGC (Johnsdotter 2009). The willingness to report suspected cases among professionals and the general public is high in Sweden (Johnsdotter 2003a; 2009). Since the enactment of the law, there have been 86 reports of suspected cases of FGC made to the police (Johnsdotter and Mestre 2017). Two criminal court cases on FGC have resulted in convictions, both in 2006. The two cases involved families of Somali origin, and the act of FGC was said to have been performed in Somalia (Johnsdotter and Mestre 2017). Although the law prohibits all forms of non-medical genital alterations, regardless of age and origin, it is in general enacted only in relation to suspected forms of FGC among immigrants (and not, for example, in cases of cosmetic genital surgery), which has resulted in some Swedish-Somalis, amongst others, perceiving that the law is discriminatory (Johnsdotter 2003a; Johnsdotter and Essén 2010).

Since the 1990s, several preventive actions against FGC have been implemented in Sweden. For example, in 1993, Göteborgsprojektet (The Gothenburg Project) aimed to provide information about FGC to individuals who, in their work, might encounter circumcised women, such as health care professionals and policemen. In 1998, the Swedish National Board of Health and Welfare continued the preventive work against FGC, and their report

formed the basis for the national action plan against FGC that was published in 2003 (Socialdepartementet [The Ministry of Health and Social Affairs] 2003). This action plan was formulated with the aim to work toward the prevention of FGC, and to provide adequate support for circumcised women. Actions taken in relation to this action plan mostly related to knowledge dissemination among professionals (EIGE 2013b). In 2011, the government commissioned the National Centre for Knowledge on Men's Violence Against Women to write an overview of the knowledge and research relating to FGC (NCK 2011). The latest government commission was established in 2013, in which the Swedish National Board of Health and Welfare estimated the prevalence of circumcised girls and women in Sweden, and this group worked towards increasing the competence of health care professionals in responding to FGC (Socialstyrelsen [Swedish National Board of Health and Welfare] 2015; 2016). Another government commission, directed by the Östergötland County Administrative Board, aimed to map how government agencies and NGOs in Sweden work to prevent FGC, and what forms of support circumcised girls and women receive (Länsstyrelsen Östergötland 2015; Nilsson and Blom 2015). The process of developing a new action plan was initiated by the government in 2017 and is currently ongoing (Regeringskansliet [Government Offices] 2017).

Methods

This thesis includes both quantitative and qualitative study designs (Table 2). The study presented in Paper I was designed as a cluster randomised controlled trial (cRCT); however, only baseline data were collected and analysed (the reasons for making this decision are elaborated further under the heading 'Pricking' in the Discussion section). Following this study, questionnaire data from two additional Swedish municipalities were collected. The results from these data are presented in Papers II and III. The qualitative study (Paper IV) was based on semi-structured interviews and focus group discussions (FGDs). All data were collected in Sweden.

Table 2. *Overview of the methods used in this thesis*

Paper	Design	Participants	Measurements	Analysis
I	Baseline data from a planned cRCT	372 Somali men and women living in Gothenburg and Malmö	Approval of FGC, preferred form of FGC on daughter, and continuation of FGC	Simple and multiple logistic regression
II	Cross-sectional	648 Somali men and women living in Gothenburg, Malmö, Stockholm, Uppsala	Factors associated with a support of pricking	Simple and multiple logistic regression
III	Cross-sectional	648 Somali men and women living in Gothenburg, Malmö, Stockholm, Uppsala	Agreement between participants' propensity to support FGC and their perceptions about other Swedish-Somalis. Marriage preferences.	Bangdiwala's B-statistic and Welch's *t*-test
IV	Qualitative semi-structured interviews and FGDs	63 Somali men and women living in Gothenburg, Malmö, Stockholm	N.A. (Qualitative methods)	Thematic analysis

Definition of attitudes towards FGC in this thesis

In this thesis, attitudes towards FGC are the primary focus. An attitude is commonly defined as a learned tendency to evaluate objects, people or issues in a particular way. Attitudes are typically positive or negative, but can also be ambivalent (Hockenbury and Hockenbury 2011). Attitudes are formed through an individual's own experiences and interactions with others, and can also be influenced by, for example, what is said in the media (Delamater and Myers 2011). Attitudes are thus both mutable and dynamic. Further, individuals are more likely to behave in accordance with their attitudes if they anticipate a favourable outcome from others for behaving in a particular way (Hockenbury and Hockenbury 2011). Attitudes can include three components: cognitive (thoughts about the object), emotional (feelings about the object) and behavioural (predisposition to act in a particular way) (Hockenbury and Hockenbury 2011). For example, the participants in this study were asked about whether they thought FGC caused health complications; this can be regarded as a cognitive component. Whether they thought FGC was needed for respectability can be regarded as an emotional component, and what form of FGC they would prefer on a hypothetical daughter can be regarded as a behavioural component.

Development of the questionnaire

The questionnaire used in Papers I, II, and III was developed in several steps (Figure 3). The selection of questions was inspired by questions used in similar studies (Agardh et al. 2010; Babalola et al. 2006; Behrendt 2011; Diop et al. 2004; Gele et al. 2012; HELMI 2012; Jönsson et al. 2013; Kaplan et al. 2013a; Kaplan et al. 2013b; MEASURE DHS 2017; UNICEF 2017).

When the first version of the questionnaire was ready, the wording and understanding of the questionnaire was pilot tested among 13 Somali immigrants. This led to a few questions being removed or rephrased. Further, to gain a better understanding of what type of results could be obtained, a second pilot study with another 35 Somali immigrants was performed with a selection of key questions in the questionnaire. The results from this pilot study implied that the questions were somewhat too blunt to capture variations in attitudes towards the different forms of FGC. As a result of this finding, many of the categorical answer options in the first version of the questionnaire were changed into numerical questions consisting of Visual Analogue Scales (VAS), ranging from 0–100 millimetres, to better capture all different forms of FGC based on anatomy (see heading 'Visual analogue scale' for more information). The calculation of the content validity of the questionnaire followed the steps described by Polit and Beck (2006). The content of the questionnaire was assessed by a group of eight experts. Indi-

viduals in this group were chosen based on their knowledge in the field; they were all researchers on FGC, Somali migrants' health and/or social capital. The experts were assigned to assess the relevance of each item in the questionnaire on a four-point scale: 1 = not relevant, 2 = somewhat relevant, 3 = quite relevant, 4 = highly relevant. The proportion of experts who were in agreement about the relevance of each item, the item content validity index (item-CVI), was calculated based on the number of experts giving a rating of 3 or 4, divided by the number of experts. Thereafter, the average scale-CVI was calculated by adding together the item-CVI scores, and then dividing them by the total number of items. This average scale-CVI should reach a minimum of 0.90 to be considered evidence of good content validity. The average scale-CVI for the first version of this questionnaire was 0.90 (Polit et al. 2007; Polit and Beck 2006).

After the questionnaire had been revised, the content of the second version of the questionnaire was tested. A third pilot study was performed with 12 Somali immigrants, which showed that the revised questions appeared to better capture variations in attitudes, and only a few questions needed to be clarified. The content validity was assessed by three experts, and this gave an average scale-CVI of 0.92, indicating that the questionnaire had satisfactory validity (Polit et al. 2007; Polit and Beck 2006).

The questionnaire was translated to Somali and back-translated to English in order to evaluate the quality of the translation. The Somali term for female circumcision used in the questionnaire was *gudniinka dhedigga/haweenka*, and was specified for girls' circumcision as *gudniinka gabdaha*. The final version of the questionnaire consisted of 49 items, which primarily addressed attitudes towards FGC (see Appendix 1).

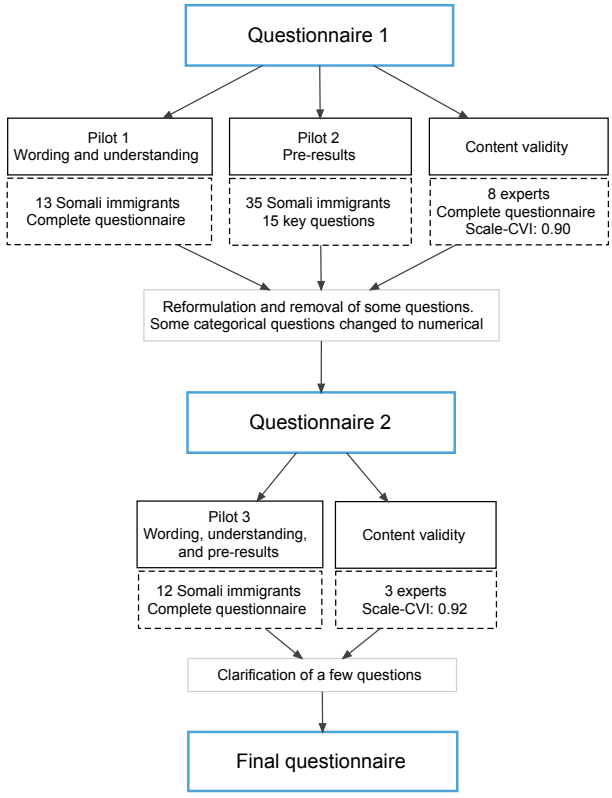

Figure 3. Development of the questionnaire used in Papers I-III.

Visual analogue scale

In the questionnaire, variables assessing attitudes towards FGC were numerical and measured on two different Visual Analogue Scales (VAS) ranging from 0–100 millimetres (mm) to capture all of the different forms of FGC based on anatomy; the higher the number expressed in mm on the VAS, the more extensive the form of FGC. The left end of the VAS (0 mm) was marked with 'Nothing at all', and the right end (100 mm) with 'Flesh removed and closed' (Figure 4). For some questions (e.g., the question relating to which forms of FGC could cause health complications), it was not applicable to have an answer option of 'Nothing at all'. For those questions, the left end of the VAS was marked with 'Pricking, no flesh removed' (and categorised as 0–10 mm on the VAS). To assist the participants in expressing their attitudes on the VAS, a schematic diagram describing roughly the different forms of FGC based on anatomy was provided. Further, research assistants were responsible for collecting data through face-to-face interviews, and they had been trained in how attitudes should be expressed on a VAS.

To ease the interpretation of the VAS when presenting the results, mm were categorised into anatomical forms of FGC (see Figure 4).

Pricking is the least extensive form of FGC that has been described in a Somali context (Johnsdotter 2002). Pricking was therefore placed to the left in the VAS, and was defined as procedures in which the clitoris or surrounding tissue is pricked with a sharp object; blood may be let, but no tissue is removed, and there is no permanent alteration of the external genitalia (UNICEF 2013; WHO 2008). The Somali translation of pricking that we used was *dhiijin aan cad la jarin*.

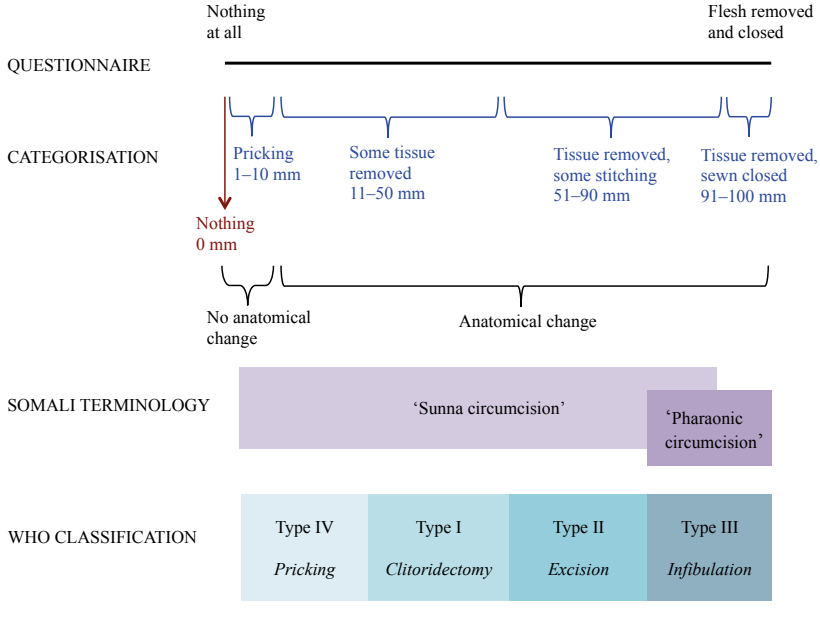

Figure 4. Visual Analogue Scale, ranging from 0 to 100 millimetres, used in the questionnaire to capture all different forms of FGC based on anatomy, how the participants answers were categorised in the thesis, and approximately how this corresponds to the Somali terminology and WHO classification (Wahlberg 2017).

Paper I: Baseline study

This study was designed as a cRCT (registered at ClinicalTrials.gov, identifier NCT02335697). However, after collecting baseline data, we decided not to go through with the planned intervention, and consequently not to collect any endline data.

The *planned* intervention

As many Somalis migrated to Sweden after the outbreak of the civil war, the legislation relating to FGC creates the necessity to examine how Somali attitudes towards FGC might change after migration. While attitudes towards FGC in general seem to change after migration (Johnsdotter 2002), a study from Norway found that 30% of Somali immigrants, mostly newly arrived, supported FGC (Gele et al. 2012), suggesting that this particular group might be a suitable target for programmes aimed at changing attitudes. Further, no anti-FGC interventions with designs containing a comparison group have been performed in any country outside Africa, and the majority of the implemented interventions have been poorly evaluated (Berg and Denison 2012). Thus, knowledge of what types of interventions are effective in changing attitudes towards FGC is lacking. We therefore planned an anti-FGC intervention with a control group to be implemented among newly arrived Somalis in Sweden.

The hypothesis upon which this study was based was that there would be a significantly higher number of individuals who supported FGC among newly arrived Somalis in Sweden than among established Somalis (Gele et al. 2012; Johnsdotter 2002). Subsequently, established Somalis could, as opponents of FGC, be used as facilitators of change among supporters of FGC (Mackie and LeJeune 2009). Somalis who had lived in Sweden for a maximum of four years were defined as being newly arrived (this cut-off was based on a study on attitudes towards FGC among Somalis in Norway (Gele et al. 2012). Accordingly, Somalis who had lived in Sweden for more than four years were defined as being established.

The content of the intervention was based on discussions with Somali colleagues, earlier research experiences with Somali communities, and previous anti-FGC interventions (Berg and Denison 2012; Johnsdotter 2002; McChesney 2015; UNICEF 2005). The intervention was designed to include five meetings between newly arrived and established Somalis over a period of five months – one meeting each month. Discussions during the meetings were to focus on FGC in relation to culture, religion, health, children's rights, and Swedish laws and regulations. However, within the given topic of each meeting, the participants would themselves have been able to decide what aspects they thought were important to know and discuss. At each meeting, an expert who was knowledgeable in the particular topic being discussed would have participated. The meetings would have been facilitated by Somalis familiar with both the Swedish and Somali cultures. The participation of a facilitator and an expert was though to further enable interactive discussions.

Data were planned to be collected on newly arrived and established Somalis at three time points: before the intervention (baseline), one month after completion of the intervention (to allow for reflections and to minimise the risk of courtesy bias (Askew 2005)), and two years after the intervention in order to evaluate whether a potential attitude change persisted over time.

Study design and participants

Baseline data were collected in Gothenburg and Malmö, Sweden. In the two municipalities, eight purposively selected Somali organisations constituted the clusters from which participants were recruited. For a Somali organisation to be eligible for inclusion in the study, it had to welcome both men and women, and not actively work to prevent FGC. After selection of the Somali organisations, they were randomly allocated to either intervention or control, stratified by municipality (Figure 5). Somali-born men and women aged eighteen years or older were eligible to participate in the study.

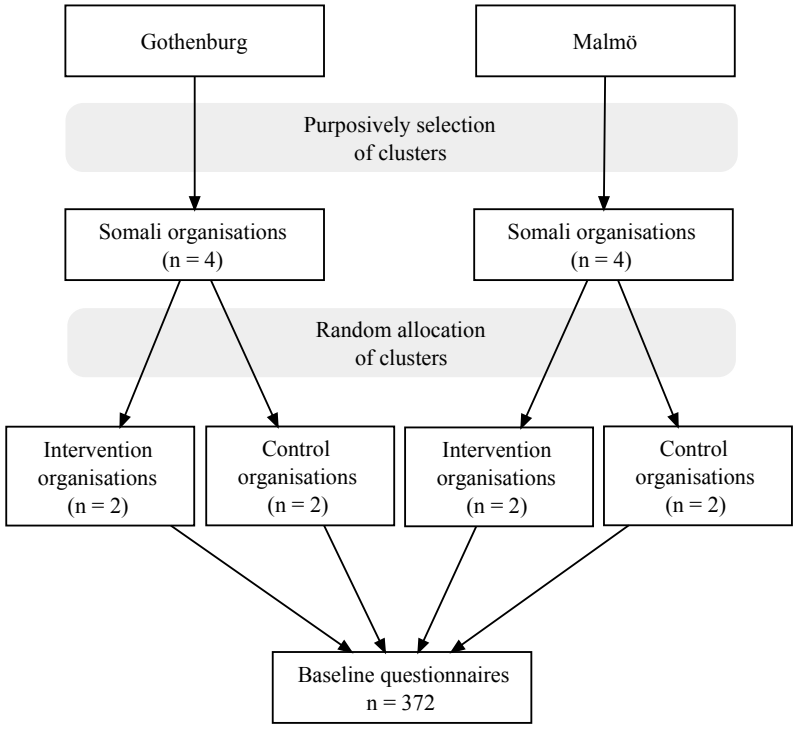

Figure 5. Flowchart of study design of initiated cRCT.

Data collection

From January to December 2015, four Somali research assistants collected data through face-to-face interviews in Somali using the 49-item questionnaire. They were also responsible for recruiting participants, and to ensure that the participants accurately understood the different anatomical forms of FGC. Further, as it may be sensitive to express positive attitudes towards FGC, the research assistants were individuals who are respected within the community and who are not associated with any authority, and they strived towards establishing a trusting

relationship with the participants. Prior to the data collection, I instructed the research assistants on the content of the questionnaire, the procedures for conducting face-to-face interviews, and on strategies for recruiting participants. We also discussed ethical considerations, for example, the importance of adopting a non-judgmental position towards the attitudes expressed by the participants and to inform the participants that the information they provided would be treated with confidentiality. The research assistants were also informed about the importance of conducting interviews in a private setting.

To monitor data collection, I visited and spent a substantial amount of time at the different study areas to assure the quality of the process and to answer any question that arose. For example, some items in the questionnaire were rather complex and could be difficult to understand; therefore, we discussed them together to ensure that they were understood correctly. We also went through the majority of all of the answers in the questionnaires, and, if inconsistencies in the questionnaires were found, we contacted the participant for clarification. This also gave me an improved understanding of the context and the collected data, and an opportunity to discuss the answers and how they might be understood.

Variables

There were three primary outcomes of the study: measuring the participants' approval of FGC, preferred form of FGC on (hypothetical) daughter, and whether FGC should continue. Table 3 defines the outcomes and explanatory variables.

Table 3. *List of variables in Paper I.*

Variable	Description and categories[1]
Outcome	
Approval of FGC	nothing (0 mm); pricking (1–10 mm); removal of tissue (11–100 mm)[1]
Preferred form of FGC on daughter	nothing (0 mm); pricking (1–10 mm); removal of tissue (11–100 mm)[1]
Continuation of FGC	nothing; pricking; removal of tissue
Explanatory	
Gender	man, woman
Age	18–25, 26–35, 36–45, ≥46 years
Marital status	single, married/partner, divorced/widowed
Cohabit	yes, no
Education	no education, Koranic school, primary school, secondary school, university/college
Somali origin	urban, rural
Employment	work full/part time, no work, student
Years of residency in Sweden	≤ 2, 3–4, 5–9, 10–14, ≥15 years

[1] VAS measurement in millimetres in brackets

Sample size calculations

Sample size was estimated for the intended intervention study (Eldridge et al. 2006) using the 'epicalc' package (Chongsuvivatwong 2012) in R (R Core Team 2015). It was calculated to be able to detect a difference of 15 mm as measured on the VAS (ranging from 0 to 100 mm) compared to the data collected before the intervention. Included in the calculations was a current mean cluster size of 20 ± 5, an intraclass correlation coefficient (ICC) of 0.09, power = 0.80, and alfa = 0.05. Twenty percent was added to the optimum number of participants to account for potential loss to follow-up. After adding 20%, the required sample size was calculated at 195 participants, divided into four intervention and four control clusters.

Analysis

Primary outcomes were analysed by descriptive statistics, and stratified by newly arrived versus established. Logistic regression analysis was used to quantify the influence of years of residency in Sweden on attitudes towards FGC. Both crude odds ratios (ORs), and ORs adjusted for the explanatory variables were computed. The level of statistical significance was set to 0.05. The statistical software packages, SPSS (version 23) and R (R Core Team 2015), were used for all analyses.

Papers II and III: Cross-sectional study

The same data were used for Papers II and III.

Study design and participants

This was a cross-sectional survey performed in four municipalities in Sweden: Gothenburg, Malmö, Stockholm, and Uppsala, including questionnaire data collected in Paper I. Eligible to participate in the survey were Somali-born men and women aged 18 years or older. Participants were recruited at Somali organisations, in mosques, in public places (such as African restaurants), and at Swedish for Immigrants courses (SFI). From participants recruited in these places, snowball sampling was used to further reach and include more participants. Table 4 presents the characteristics of the participants. The intraclass correlation coefficient (ICC), calculated using the 'aod' package (Lesnoff and Lancelot 2012) in R, for the municipalities in relation to the three outcomes was below 0.07. Thus, the similarity in attitude towards FGC for participants within the municipalities was low.

Table 4. *Characteristics of study participants*

Characteristics	Gothenburg *n* (%)	Malmö *n* (%)	Stockholm *n* (%)	Uppsala *n* (%)	Total *n* (%)
Gender					
Man	113 (60)	81 (40)	98 (56)	38 (46)	330 (51)
Woman	75 (40)	122 (60)	77 (44)	44 (54)	318 (49)
Age					
18–25	33 (18)	27 (13)	11 (6)	20 (24)	91 (14)
26–35	56 (30)	82 (40)	51 (30)	28 (34)	217 (34)
36–45	43 (23)	52 (26)	52 (31)	19 (23)	166 (26)
≥ 46	55 (29)	42 (21)	56 (33)	15 (18)	168 (26)
Marital status					
Single	92 (49)	69 (34)	49 (28)	36 (44)	246 (38)
Married/partner	76 (41)	112 (55)	111 (65)	44 (54)	343 (53)
Divorced/widowed	19 (10)	22 (11)	12 (7)	2 (2)	55 (9)
Education					
University	14 (7)	23 (11)	16 (9)	9 (11)	62 (10)
Secondary school	79 (42)	56 (28)	56 (32)	16 (20)	207 (32)
Primary school	59 (31)	81 (40)	80 (46)	37 (46)	257 (40)
Koranic school	17 (9)	11 (5)	5 (3)	10 (13)	43 (7)
No education	19 (10)	32 (16)	16 (9)	8 (10)	75 (12)
Somali origin					
Urban	169 (91)	147 (72)	137 (79)	68 (85)	521 (81)
Rural	17 (9)	56 (28)	36 (21)	12 (15)	121 (19)
Years in Sweden					
≤ 2	51 (27)	90 (44)	21 (12)	6 (7)	168 (26)
3–4	42 (23)	28 (14)	29 (17)	12 (15)	111 (17)
5–9	40 (21)	37 (18)	57 (33)	29 (35)	163 (25)
10–14	18 (10)	15 (7)	34 (19)	13 (16)	80 (12)
≥ 15	36 (19)	33 (16)	34 (19)	22 (27)	125 (19)
Employment					
Work	46 (24)	65 (32)	101 (59)	40 (49)	252 (39)
No work	131 (70)	112 (56)	66 (39)	38 (46)	347 (54)
Student	11 (6)	24 (12)	4 (2)	4 (5)	43 (7)

The baseline study included only participants from Gothenburg and Malmö

Data collection

Data collection was conducted in the same way as described for Paper I above, with the only difference being that two additional research assistants (giving a total of six; three women and three men), collected the data. The ICC for the research assistants' collected data in relation to the participants' answers on the three outcomes was below 0.09 (Lesnoff and Lancelot 2012). Thus, the similarity in attitudes towards FGC for participants within the data collected by each research assistant was low.

Variables

The outcome variable for Paper II measured attitudes towards what form of FGC the participant thought should continue to be practised.

As a proxy measure of acculturation, proficiency in the Swedish language was assessed through five questions with response alternatives of 'Poor,' 'Average,' 'Good,' and 'Very good.' Participants who answered 'Poor' on all five questions were categorised as having 'Poor acculturation'; and the remainder as having 'Good acculturation' (Jönsson et al. 2013; Sundquist et al. 2000).

Social capital was measured through five questions. *Social participation* was measured based on the participants' attendance at thirteen social activities during the last year. Based on the median number of activities, the variable was dichotomised into 'high social participation' (> median) or 'low social participation' (≤ median). *Trust in others* was measured through four questions with the response alternatives 'I do not agree at all,' 'I do not agree,' 'I agree,' or 'I agree completely.' The responses were scored from 1 to 4, yielding total scores of 4 to 16. Based on the median score, the variable was dichotomised into 'high trust' (> median) or 'low trust' (≤ median). The balance between bridging and bonding social capital was measured based on three questions measuring trust in others, social participation, and values (Agardh et al. 2010). Individuals who mostly possess bonding social capital have strong ties within a network that strengthen common identities, while individuals that have mostly bridging social capital have stronger links to people from different networks (Eriksson 2011). The three questions measuring the balance between bridging and bonding social capital were highly correlated and therefore combined into *bridging social capital*. Those categorised as having 'non-dominant bridging' in all three questions were defined as having 'non-dominant bridging social capital', while those who had 'dominant bridging' in at least one out of the three questions were defined as having 'dominant bridging social capital'.

Variables measuring attitudes towards and knowledge of FGC (definition of FGC, accepted by religion, needed for respectability, a violation of children's rights, long-term health complications, legal in Sweden) were measured on the VAS and thereafter categorised into different forms of FGC.

Table 5 defines the outcomes and explanatory variables in Paper II.

Paper III measured the agreement between: the participants' approval of FGC and preferred form of FGC on their (hypothetical) daughter; and their perceptions of attitudes among other Swedish Somali men and women. Further, marriage preference among men in regard to women's FGC status was compared with women's perceptions of men's marriage preference. Table 6 defines the variables used in Paper III.

Table 5. *List of variables in Paper II*

Variable	Description and categories[1]
Outcome	
Continuation of FGC	nothing; pricking[2]
Explanatory	
Gender	man, woman
Age	18–25, 26–35, 36–45, ≥46 years
Marital status	single, married/partner, divorced/widowed
Cohabit	yes, no
Education	no education, Koranic school, primary school, secondary school, university/college
Somali origin	urban, rural
Years of residency in Sweden	≤ 2, 3–4, 5–9, 10–14, ≥15 years
Employment	work full/part time, no work, student
Acculturation	poor, good
Social capital: social participation	low, high
Social capital: trust	low, high
Bridging social capital	non-dominant bridging, dominant bridging
Definition of FGC	all forms of FGC (0–10); FGC excl. pricking (11–100)
Accepted by religion	nothing (0); pricking (1–10); FGC excl. pricking (11–100)
Needed for respectability	nothing (0); pricking (1–10); FGC excl. pricking (11–100)
Violation of children's rights	all forms of FGC (0–10); FGC excl. pricking (11–100); never
Long-term health complications	all forms of FGC (0–10); FGC excl. pricking (11–100); never
Legal in Sweden	nothing (0); pricking (1–10); FGC excl. pricking (11–100); don't know

[1] VAS measurement in millimetres in brackets
[2] Those who supported some form of FGC where tissue is removed were not included

Table 6. *List of variables in Paper III*

Variable	Description and categories[1]
Approval of FGC	nothing (0 mm); pricking (1–10 mm); removal of tissue (11–100 mm)
Perceived approval of FGC among Swedish Somali men	nothing (0 mm); pricking (1–10 mm); removal of tissue (11–100 mm)
Perceived approval of FGC among Swedish Somali women	nothing (0 mm); pricking (1–10 mm); removal of tissue (11–100 mm)
Preferred form of FGC on daughter	nothing (0 mm); pricking (1–10 mm); removal of tissue (11–100 mm)
Perceived percentage of Somali girls being circumcised in Sweden	0–100%
Marriage preference (men)	nothing; pricking; removal of tissue; does not matter
Perceived marriage preference (women)	nothing; pricking; removal of tissue; does not matter

[1] VAS measurement in millimetres in brackets.

Sample size calculations

For Paper II, sample size calculations were based on the categorical variable: continuation of FGC. Based on the first 107 collected questionnaires, the proportion expected to support FGC was estimated at 24%. The precision, that is, the desired width of the 95% confidence interval (CI), was chosen to be 0.05. The sample size was multiplied by 2.25 (the average value of the design effect for the DHS indicators (Thanh and Vijay 1997)) to adjust for the design effect, which gave a total sample size of 633.

For Paper III, sample size calculations were based on two numerical variables: approval of FGC and preferred form of FGC on a hypothetical daughter. Based on the first 107 collected questionnaires, SD for these variables was estimated at 10.42 and 17.84, respectively. The precision of the 95% confidence interval was chosen at 2.5. The sample size was then multiplied with a design effect of 2.25 (Thanh and Vijay 1997). The highest estimate of the two calculations gave a required sample size of 441.

Analysis

In Paper II, simple and multiple logistic regression analyses were used to quantify the influence of explanatory variables on attitudes supporting pricking. A forward stepwise logistic regression was used to determine which attitudinal and knowledge variables most strongly affected having supportive attitudes towards pricking.

In Paper III, the level of agreement between the participants' approval of FGC and their perceived approval of FGC among most other Swedish Somali men and women was assessed with Bangdiwala's B-statistic and its corresponding agreement chart (Bangdiwala and Shankar 2013). When measuring agreement, the B-statistic is more stable than kappa, especially when the data are imbalanced, which was why we chose this measurement (Shankar and Bangdiwala 2014). The difference in means in how common the participant thought it was for Swedish Somali girls to be circumcised, depending on the participants' own preferred form of FGC on a hypothetical daughter, was determined by Welch's *t*-test.

For both papers, a p-value of < 0.05 was considered statistically significant. SPSS version 23 and the 'vcd' package (Meyer et al. 2016) in R (R Core Team 2015) were used for all analyses.

Paper IV: Qualitative study

In Paper IV, a qualitative methodology was applied.

Participants

I conducted 18 individual interviews and seven FGDs with 3–11 informants in each. Five participants in the FGDs, purposively selected as information-rich cases, were later interviewed individually. The FGDs were conducted with women only (one FGD), with men only (two FGDs), and with men and women mixed (four FGDs). Individual interviews and FGDs lasted for 25–95 minutes. Individuals of Somali origin, 18 years or older, were eligible to participate.

Data collection

Data collection was inspired by naturalistic inquiry (Lincoln and Guba 1985). The interview process was dynamic; information from one interview helped guide new questions in later interviews. The focus of the interviews and FGDs was to understand the informants' perceptions of the circumcision of girls in relation to the circumcision of boys, and how the two practices could be justified (or not).

I conducted the interviews and FGDs from April to June and from November to December, 2015. The interviews and FGDs were carried out in private settings, and conducted in Swedish, Somali or English, as decided by the informants. Two Somali research assistants helped to find informants through snowball sampling, and they interpreted during the FGDs and interviews conducted in Somali. In Swedish, the term FGC does not exist. Further, as FGM may be understood as infibulation only (Johansen 2006), and be perceived as offensive, I decided to use the Swedish term equivalent to FC [*kvinnlig omskärelse*] for the qualitative interviews with Somalis conducted in Swedish. Sometimes the participants used another terminology, and then I tried to adapt to that terminology. In interviews conducted in Somali, the Somali terms for female circumcision [*gudniinka dhedigga/haweenka*] and for girls' circumcision [*gudniinka gabdaha*] were used. However, as such terms can be understood differently between individuals, I also asked the informants to clarify what they meant by the different terms that they used.

Trends identified in the data were confirmed through member checks performed continuously throughout the interviews and FGDs. When the information received during the interviews and FGDs reflected repeated perceptions and expressions with regard to the topic of interest, we considered that we had reached topical saturation and conducted no further interviews or FGDs (Lincoln and Guba 1985). All interviews and FGDs were audio recorded, and transcribed verbatim.

Analysis

Analysis followed the steps of thematic analysis as described by Braun and Clarke (2006). Transcripts from the interviews and FGDs were read several times and discussed among co-authors. Thereafter, the transcripts were coded, repeated similarities and differences were identified, and themes determined. We went back and forth between the transcripts and the themes until we felt that the themes captured the essence of the data. To sort the data, Nvivo 11 software was used.

Ethical considerations

Ethical approval to conduct the studies was obtained from the Regional Ethical Review Board of Uppsala, Sweden (2014/274). Eligible participants who had received oral and written information about the study and given their informed consent and had had all of his or her questions answered about the project were included in the study. The participants were informed that their data would be treated with confidentiality, and that they, at any time, without providing any reason, could choose to discontinue their participation in the study.

In the quantitative studies, the questionnaires carried no names or other identity markers; instead, a code number was used. Those collecting the data kept a separate code list where the names of the participants were connected to their code, but only if the participant agreed to this. This was done to enable us to contact the participant again if something in the questionnaire needed clarification. This code list was kept separate from the questionnaires. Results from the quantitative studies were presented at group level so that it would not be possible to identify a particular person.

Participants in the qualitative interviews and FGDs were assured that their data would be kept confidential and that any quotes they provided would remain anonymous. Interviews and FGDs were recorded only if the participants agreed to this, which was the case with all interviews and FGDs. The transcripts were anonymised, and I was the only one who had access to the audio recordings. An ethical dilemma when conducting FGDs is to ensure that all participants maintain confidentiality by not telling others what certain participants may have said during the discussions. Therefore, prior to each FGD, the importance of maintaining confidentiality was emphasised.

As female genital cutting is a criminal act according to Swedish legislation, we designed the studies based on an awareness of this legislation. An ethical dilemma concerns a duty to report knowledge or suspicion of planned circumcision of girls to the authorities. This obligation clashes with the principle of confidentiality between the researcher and informant. Because expressing an attitude in support of FGC is not illegal, we decided only to ask

about participants' *attitudes* towards the practice, and we did not ask whether the participants had a daughter. Instead we asked what they would prefer to do if they *hypothetically* had a daughter. Further, as the illegality of FGC is well known among Somalis in Sweden, I believe that the participants were able to make informed choices as to what information to disclose to me and to the data collectors. Throughout the progress of this study I did not receive any information that warranted the activation of this legal duty to report.

Results

The main findings of this thesis are summarised in Figure 6, structured under each research question. The first research question investigated attitudes towards FGC among Somalis in Sweden. The findings from this study gave rise to the second and third research questions, which investigated why there was a support for pricking, and what might influence attitudes towards FGC, respectively. Finally, to better understand the observed attitude change and whether attitudes towards the genital cutting of boys were also influenced by the new cultural context, the fourth research question explored post-migration perceptions of the circumcision of boys and girls.

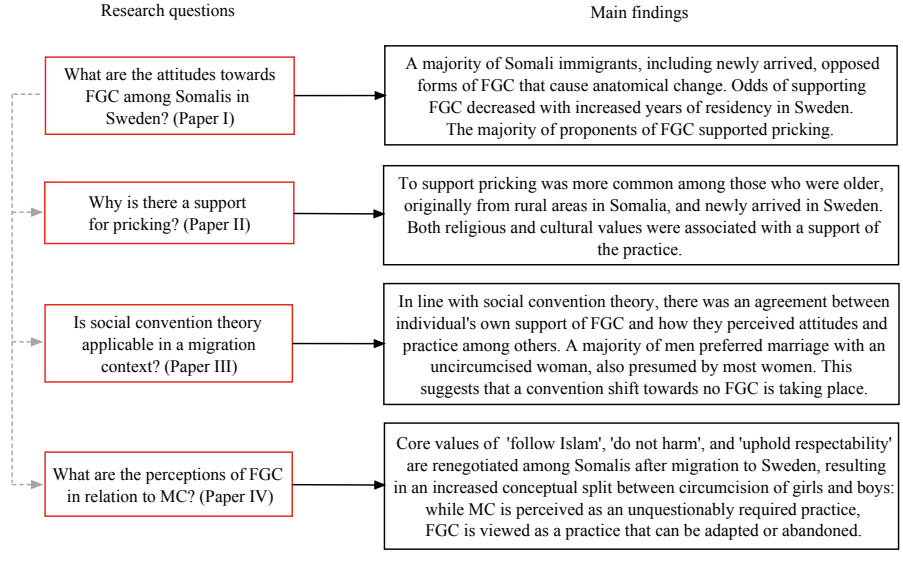

Figure 6. Research questions and main findings.

What are the attitudes towards FGC among Somalis in Sweden? (Paper I)

Paper I examined attitudes towards FGC among 372 Somali men and women living in Sweden (Wahlberg et al. 2017a). As hypothesised, when the three outcomes, measuring approval of FGC, preferred form of FGC on (hypothetical) daughter, and continuation of FGC, were stratified on years of residency in Sweden, a difference in attitudes between newly arrived (0–4 years of residency in Sweden) and established Somalis (> 4 years of residency in Sweden) could be seen. A majority of the established Somalis (99%, 92%, and 99% for the three outcomes, respectively) stated an opposition towards the practices of FGC that cause anatomical change (removal of tissue). However, a high number of newly arrived Somalis (82%, 73%, and 93% for the three outcomes respectively) also stated an opposition towards forms of FGC that cause anatomical change (Table 7).

As seen in Table 7, the reported opposition among established Somalis (n = 166) of all forms of FGC ranged from 75% to 83% in the three outcomes, support for pricking with no removal of tissue ranged from 16% to 17%, and support for anatomical change of girls' and women's genitals ranged from 1% to 8%. Among newly arrived Somalis (n = 206), the reported opposition to all forms of FGC ranged from 53% to 67% in the three outcomes, support for pricking with no removal of tissue ranged from 20% to 26%, and support for anatomical change of girls' and women's genitals ranged from 7% to 27%.

Table 7. *Approval of FGC, preferred form of FGC on (hypothetical) daughter, and what form of FGC should continue to be practised*

Outcome	Form of FGC	Established, *n/N* (%)	Newly arrived, *n/N* (%)
Approval	Nothing	138/166 (83)	121/205 (59)
	Pricking	26/166 (16)	48/205 (23)
	Removal of tissue	2/166 (1)	36/205 (18)
Daughter	Nothing	124/166 (75)	110/206 (53)
	Pricking	28/166 (17)	41/206 (20)
	Removal of tissue	14/166 (8)	55/206 (27)
Continue	Nothing	138/166 (83)	137/206 (67)
	Pricking	26/166 (16)	54/206 (26)
	Removal of tissue	2/166 (1)	15/206 (7)

Of the three outcome variables, the one measuring preferred form of FGC on a (hypothetical) daughter received the highest support for practices that cause anatomical change among newly arrived Somalis (27%, 55/206). However, as seen in Figure 7, presenting the raw data for this variable as measured with VAS millimetres, data were heavily skewed towards zero; the mean value of the VAS was 3.8 mm for established Somalis, and 8.8 mm for newly arrived

Somalis. The support for practices involving the removal of tissue and stitching, such as infibulation (100 mm on the VAS), was close to zero.

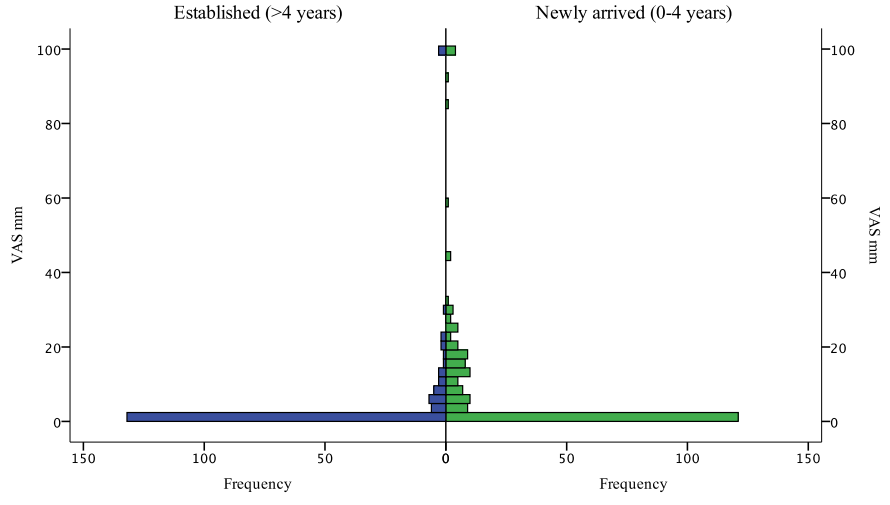

Figure 7. Preferred form of FGC on (hypothetical) daughter, stratified on established and newly arrived Somalis. VAS 0 mm = no form of FGC, VAS 100 mm = tissue removed and sewn closed.

A comparison of those who said they opposed all forms of FGC with those who said they supported some form of FGC (from pricking to sewn closed) showed that the odds of viewing any form of FGC as acceptable, after adjusting for gender, age, marital status, education, Somali origin, cohabitation and employment, was five times higher among Somalis residing in Sweden for two years or less (OR: 5.42, 95% CI: 1.61–18.20) compared to Somalis who had lived in Sweden for fifteen years or more (Table 4, Paper I). Somalis who had lived in Sweden for two years or less also had significantly increased odds of wanting to circumcise their daughter and to support the continuation of FGC. However, the proportion of individuals supporting FGC decreased rapidly over time after migration, suggesting that living in Sweden facilitates a transition in attitudes (Table 4, Paper I).

Why is there a support for pricking? (Paper II)

Paper II examined factors associated with being supportive of pricking (Wahlberg et al. 2017b). Of the 648 Somali men and women living in Sweden who participated in the study, 78% (504/644) reported that they wanted all forms of FGC to be abolished, 18% (113/644) said they wanted pricking with no removal of tissue to continue, and 4% (27/644) said they supported forms of FGC that cause anatomical change. In this study, those who sup-

ported pricking as compared to those who thought all types of FGC should be abolished were included. Thus, the data presented below are based on data from a total of 617 participants.

After adjustment for background factors (gender, age, marital status, education, Somali origin, years of residency in Sweden, employment, and social capital), participants who were older than 45 years, and those who originated from rural areas in Somalia, had higher odds of supporting the continuation of pricking, compared with those participants who were aged 18–25 and were from urban areas, respectively (Table 2, Paper II). In a crude analysis, participants who had reported having attended Koranic school as their only education, and those who were unemployed, had higher odds of supporting pricking. However, when adjusting for other background factors, these associations did not remain statistically significant (Table 2, Paper II).

Further, the odds of supporting pricking were higher among Somalis who had lived in Sweden for two years or less, compared with those who had resided in Sweden for 15 years or longer. However, we found no association between social capital and the support of pricking (Table 2, Paper II).

The participants' attitudes and knowledge regarding FGC are presented in Table 8. Not defining pricking as a form of FGC was associated with higher odds of supporting the continuation of pricking. Higher odds of supporting pricking were also found among those who said they thought pricking was acceptable to do within their religion, as well as those who stated that a young, unmarried woman should have at least pricking to be respectable. A noteworthy 26% expressed that pricking only would not be enough, but that tissue had to be removed for the girl to be perceived as respectable. Further, Somalis who stated that pricking was not a violation of children's rights, or that it did not cause long-term health complications, had higher odds of supporting the continuation of pricking (Table 3, Paper II). Most Somali participants, 91%, knew that all forms of FGC are illegal for Swedish residents. However, those 5% who stated they were uncertain about the law had higher odds of supporting pricking (Table 3, Paper II).

The main motives for supporting pricking differed between Swedish Somali men and women. For men, those who did not regard pricking as a form of FGC or a violation of children's rights had higher odds of supporting pricking. While, for women, those who stated that pricking gave the woman respectability, and reported that pricking did not cause long-term health complications, had higher odds of supporting the continuation of pricking. Religion was strongly associated with the support of pricking for both genders (Table 4, Paper II).

Another explanation for the relatively high number of supporters of pricking could be their exposure to mass media information about FGC. Of the Swedish Somalis, 22% (138/615) reported that they had received information about FGC through mass media in Somalia. According to them, the

information they had received did, to a large extent, support pricking, while opposing the other forms of FGC (Figure 2, Paper II).

Table 8. *Attitudes and knowledge regarding FGC among Swedish Somalis*

Attitude/knowledge	**Form of FGC**	***n/N***	**%**
Definition of FGC	All forms of FGC	414/612	68
	FGC excl. pricking	198/612	32
Accepted by religion	Nothing	430/614	70
	Pricking	108/614	18
	FGC excl. pricking	76/614	12
Needed for respectability	Nothing	386/611	63
	Pricking	64/611	11
	FGC excl. pricking	161/611	26
Violation of children's rights	All forms of FGC	378/616	61
	FGC excl. pricking	206/616	33
	Never	32/616	5
Long-term health complications	All forms of FGC	267/615	43
	FGC excl. pricking	341/615	55
	Never	7/615	1
Legal in Sweden	Nothing	560/615	91
	Pricking	20/615	3
	FGC excl. pricking	3/615	1
	Don't know	33/615	5

Is social convention theory applicable in a migration context? (Paper III)

In Paper III, the applicability of social convention theory in a migration context was tested by examining how perceptions about *other* Swedish Somalis' possibly influenced the participants' own propensity to support FGC (Wahlberg et al., submitted manuscript).

Among the 648 Swedish Somali participants, 73% (469/647) reported that they did not approve of any form of FGC, 16% (103/647) said they approved of pricking, and 12% (75/647) said they approved of the removal of tissue (with or without stitching). There was a strong agreement between the individual's own approval of FGC and how they perceived the approval of FGC among most other Swedish Somali men (B-statistic = 0.85) and women (B-statistic = 0.78) (Table 3, Paper III). However, there was also a tendency that Swedish Somalis to a larger extent said that they perceived that other Swedish Somalis – and especially other women – approved of the removal of tissue, while they themselves did not approve of any form of FGC (Figure 1, Paper III).

Swedish Somali men and women reported that they wanted the following forms of FGC to be performed on their (hypothetical) daughter: 70% (449/645) said they wanted her to remain untouched, 15% (94/645) wanted

her to be pricked, and 16% (102/645) wanted her to have tissue removed (with or without stitching). Those who expressed that they wanted tissue to be removed on a (hypothetical) daughter assessed that, on average, 23% (95% CI: 18.3–27.9) of all Somali parents in Sweden circumcise their daughters. This assessment was significantly higher compared with those who expressed that they would not like genital tissue to be removed on their (hypothetical) daughter, as they assessed that, on average, 8% (95% CI: 6.4–9.1) of all Somali parents in Sweden circumcise their daughters (Figure 2, Paper III).

The majority of Swedish Somali men expressed that they would prefer to marry someone without FGC (76%, 249/327) or with pricking (16%, 52/327), while only 2% (6/327) said they wanted to marry someone who had had a form of FGC that caused anatomical change. This was in agreement with the presumption made by most Swedish Somali women, of whom 68% (210/309) thought men would like to marry someone who had not been circumcised, 22% (67/309) thought men would like to marry someone with pricking, and 5% (16/309) thought men wanted to marry someone with a form of FGC that caused anatomical change. Only 6% (20/327) of the men stated that FGC status did not matter (circumcised or not circumcised), and a corresponding 5% (16/309) of the women thought that FGC status was unimportant to men (Table 9).

Table 9. *Marriage preference among the Swedish Somali men in regard to women's FGC status, and women's presumption about men's preference*

Form of FGC	**Men's preference** ***n/N*** **(%)**	**Women's presumptions** ***n/N*** **(%)**
Nothing	249/327 (76)	210/309 (68)
Pricking	52/327 (16)	67/309 (22)
Tissue removed	6/327 (2)	16/309 (5)
Does not matter	20/327 (6)	16/309 (5)

According to social convention theory, expectations that *other* girls in the community will be circumcised, and that *other* community members support FGC, can affect individuals' own propensity to support FGC. The findings in our study do not contradict such an assumption, as *perceptions* about other Swedish Somalis' views to FGC agreed well with the participants' own views. Further, the majority of Swedish Somali men said they preferred to marry someone without FGC, which indicates that there has been a convention shift with migration to Sweden towards 'no FGC'.

What are the perceptions of FGC in relation to MC? (Paper IV)

Paper IV explored Somalis' post-migration perceptions of the circumcision of boys and girls (Wahlberg et al., submitted manuscript). The data analysis resulted in one main theme: 'MC is unquestionably a required practice while FC is not required and can be adapted or abandoned'. Within this main theme, three sub-themes, reflecting what we found to be constant core values, were defined: 'follow Islam', 'do not harm', and 'uphold respectability'. After migration, renegotiation of how these core values are applied when it comes to genital modification in children resulted in an increased conceptual separation of FGC and MC: the circumcision of boys was commonly perceived as an unquestionably required practice, while the circumcision of girls was viewed by most as a practice that could be adapted or abandoned.

Follow Islam

The importance of being a good Muslim was expressed by most. However, *how* to be a good Muslim was interpreted differently, and some expressed that this view had changed after their migration to Sweden. Many Somalis conveyed that the circumcision of boys was a religious duty, and therefore MC could not be questioned. It was commonly stated that the circumcision of boys could prevent bacteria and urine from accumulating behind the foreskin. Therefore, circumcision was important for cleanliness, as the man otherwise would not be allowed to pray. The view of MC as an Islamic practice was said to be further supported through interactions with other Muslim groups who also practise MC.

> Boys are circumcised in accordance with faith and it is a must. It is not 'sunna', it is obligatory for boys and completely permitted. If you do not do male circumcision, it leads to lots of bacteria which create problems, but if you circumcise the boy then you take away the risk of contracting disease, by removing the foreskin you remove that bacteria. It is mandatory according to Islam. You cannot compare it to sunna [circumcision, in girls], it [circumcision in boys] is mandatory, a must. (Man, FDG 3)

In contrast, many expressed that they had re-evaluated the religious imperative of FGC and, therefore, perceived the practice as unnecessary. Their opposition to FGC was said to be supported by interactions with other Swedish Muslims, as they do not practise FGC. However, some viewed FGC (often pricking) as a religious sunna – a practice they thought was beneficial but not a requirement – enabling individuals themselves to decide what they wanted to do. With pricking being perceived as optional, many thought it could be abandoned as it might cause harm, as expressed by this woman:

> So when you talk about sunna, it means that you can do it or you can refrain from doing it, so if you are told that this is something that can be abandoned, why should you do something that can cause pain or lead to bleeding? (Woman, FGD 4).

Many expressed a support of the law prohibiting all forms of FGC as it offered them a good reason to discontinue the practice. However, some questioned why the circumcision of boys on religious grounds was allowed while it was not for girls:

> Woman: Can I not do what my religion tells me to do? [refers to pricking] […]
>
> Man: So all the children that are born in Sweden, they are not our decision? Is it this country that decides, that says 'No'? She [interviewer] has told you, it [pricking] is illegal in Sweden, there is a law. (FGD 3)

Do not harm

Emphasised by most informants was the importance of not doing something that could harm themselves or others. Many perceived that MC was such a minor procedure that it would not affect the man's health or sexuality. Some thought MC might be harmful if performed in unsterile settings. Therefore, being able to (legally) circumcise boys in Swedish hospitals was valued, and also seen as a sign that MC could not be harmful. Further, there was a perception among some that Swedish men increasingly undergo circumcision for health reasons, and this further supported their view that MC is beneficial:

> There are indeed those who imitate Muslim boys who are circumcised, and some non-believers who opt for circumcision. They say that [an intact foreskin retains] bacteria, and that it is a good thing that the Muslims do when they circumcise their boys, 'We want to do that too,' they want to be similar. (Man, FGD 3).

In contrast, the removal of genital tissue in a girl was commonly described as being harmful and affecting both her health and sexuality. Some described that they had become opponents of FGC after moving to Sweden, as this had increased their awareness of the health risks of FGC. Some also thought that pricking of a girl's genitals could be harmful, while others emphasised that they did not think the practice of pricking would cause any harm, as this involved no removal of tissue:

> That [the pricking] is good, because you do not cause harm as with all other forms [of circumcision of girls]. It does not hurt and it is not sewn closed and it does not cause pain during menstruation or [lead to] any other complication. (Woman, interview 7)

Uphold respectability

With migration to Sweden, some described a need to balance their 'old culture' with the 'new culture'. Many acknowledged that they are now living in a new country, and therefore have to adapt and adhere to the rules of that country. Many emphasised the importance of MC in a man's life, and, as the practice of MC does not conflict with the Swedish legislation, MC can continue to be practised. Further, as MC was perceived as being such an important part of manhood, some thought that others would look down on them and make them feel inferior if they were not circumcised:

> Likely there are those who would say 'Gaaaah!', or talk behind your back [if you are not circumcised]. No one would force you [to be circumcised], but you would feel cheap, you see what I mean? (Man, interview 3)

Many men and women expressed a strong will to move on and leave the practice of FGC behind. For some, moving to another country provided an opportunity to discontinue practices they thought were harmful, such as FGC. However, some also emphasised the importance of not becoming 'too Swedish'. Some suggested that replacing the traditional forms of FGC with a 'milder' practice – pricking – could be a way forward, as this would keep some of the 'old culture' while still adapting to the 'new culture'. When being asked why they think some Somalis support pricking this woman reflects:

> Because they want to follow the custom that their parents used to do. They have to do something [some form of FGC] because their parents used to do something that is not allowed [here in Sweden], but this one [pricking] can be allowed, right? That's why they want to do this one. (Woman, interview 6)

Continuity or change? (Papers I–IV)

To provide an overview of attitudes towards FGC among Somalis in Sweden, I have here merged some of the data presented in the four papers.

A majority of Somali men and women in Sweden reported that they opposed all forms of FGC: 72% (469/647) stated that they did not approve of any form of FGC, 70% (449/645) said they preferred their daughter to remain uncircumcised, and 78% (504/644) said they wanted all forms of FGC to be abolished (Figure 8). The majority of proponents of FGC expressed a support for a form of FGC where no tissue is removed – pricking: 16% (103/647) thought pricking was an acceptable practice, 15% (94/645) preferred their daughter to be pricked, and 18% (113/644) wanted pricking to continue being practised (Figure 8). Overall, the reported support for forms of FGC causing anatomical change was low, however, 14% (89/645) ex-

pressed that they preferred the removal of tissue without stitching on their (hypothetical) daughter (Figure 8) (Papers I-III).

These results were supported by findings from the qualitative study, where many Swedish Somalis expressed that the practice of FGC had been reassessed after migration resulting in a view that FGC could be abandoned or adapted to a 'milder' form of FGC – commonly referred to as pricking. Importantly, pricking, as well as the removal of tissue, was commonly expressed as something *desirable*, while simultaneously acknowledging that it would not be possible to realise this in Sweden due to the legislation (Paper IV).

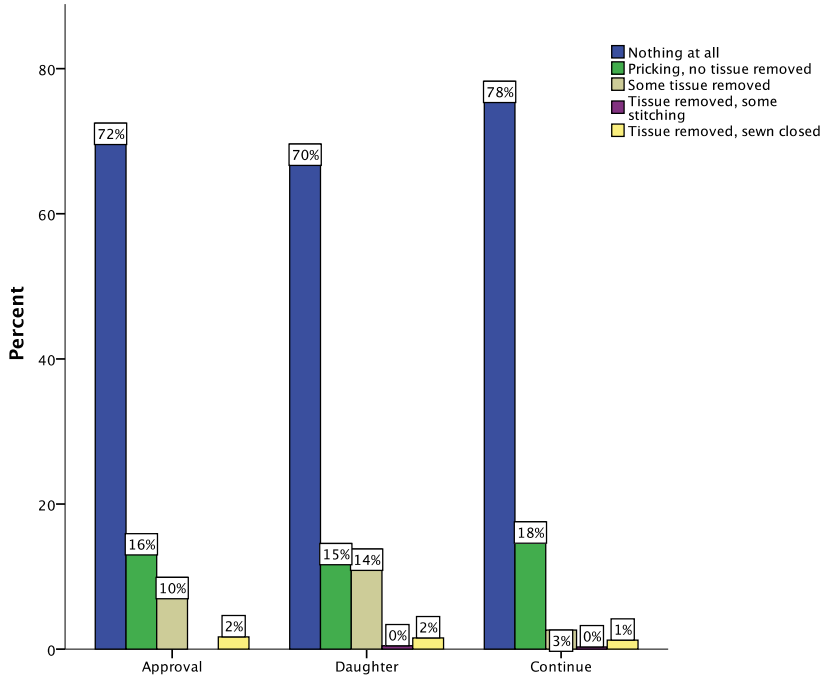

Figure 8. Approval of different forms of FGC ('Approval'), preferred form of FGC on hypothetical daughter ('Daughter'), and what form of FGC should continue to be practised ('Continue') among Swedish Somalis.

Among participants who lived in Gothenburg, there was a higher proportion who expressed an approval of FGC and a preference to have a circumcised daughter, compared to the proportion who expressed a support for the continuation of FGC. In Malmö, the proportion of those who said they would prefer FGC on a daughter and thought the practice should continue was higher compared to the proportion who said they approved of FGC. In Stockholm and Uppsala the proportions were similar across the three outcomes (Table 10).

Table 10. *Approval of FGC, preference on hypothetical daughter, and continuation of FGC, stratified on municipality*

Municipality	***n***	**Approval, *n* (%)**		**Daughter, *n* (%)**		**Continue, *n* (%)**	
		FGC	No FGC	FGC	No FGC	FGC	No FGC
Gothenburg	188	82 (44)	105 (56)	79 (42)	109 (58)	21 (11)	167 (89)
Malmö	203	40 (20)	163 (80)	70 (34)	133 (66)	79 (39)	124 (61)
Stockholm	175	47 (27)	128 (73)	38 (22)	135 (78)	31 (18)	140 (82)
Uppsala	82	9 (11)	73 (89)	9 (11)	72 (89)	9 (11)	73 (89)

Discussion

The aim of this thesis was to investigate attitudes towards female genital cutting (FGC) after migration from a country where the practice is common, to a country where it is not traditionally practised. The analysis and interpretation of the data in this thesis was informed by the concepts of social norms and conventions (Mackie and LeJeune 2009; Southwood and Eriksson 2011), and bodily modifications as a way of inscribing gender identity (Cornwall 2012; Richardson and Locks 2014; Schildkrout 2004; Shilling 2003). Based on the findings of this thesis, which showed a high opposition to FGC among Swedish Somalis as well as decreased odds of supporting FGC with increased years of residency in Sweden, an attitude change to FGC seems to be taking place. The changed social context – as a result of migration from Somalia to Sweden – may be one important aspect of this attitude change, a finding which will be further explored in this section.

FGC – A practice in transition

Migrating to and living in Sweden seems to engender an attitude change regarding FGC. A majority of the Swedish Somali men and women stated that they were opposed to all forms of FGC. In line with these findings, other studies among Somali immigrants in Sweden (Johnsdotter 2002) as well as in other countries (see, e.g., Berns McGown 1999 for England and Canada; Gele et al. 2012 for Norway; Jinnah and Lowe 2015 for South Africa and Kenya; Morison et al. 2004 for England), have also reported changes in attitudes towards FGC. Further, this thesis also demonstrates that Somalis who had lived in Sweden for several years were opposed to FGC to a higher degree than those newly arrived, a finding that was also reported in studies among Somalis in Norway (Gele et al. 2012; Gele et al. 2015).

Understanding change

As FGC is customary in Somalia, why is the opposition to FGC so high among Somalis in Sweden? Because this research has illustrated that social convention theory is applicable in a Swedish migration context, this shift in perception can be understood by adopting this theory as a point of departure (Mackie 1996; Mackie and LeJeune 2009).

Regardless of where they are situated in the world, parents, in general, will want to do what is best for their children. This is a moral norm, which is not easily changed. However, people's perceptions of *how* they can be a good parent, the social norm, may differ between countries and contexts (Mackie and LeJeune 2009). In Somalia, the circumcision of girls is important for their social acceptance in the community and for marriageability. Consequently, if parents do not comply with the convention of FGC, this will bring shame to their daughters as well as to the whole family. Thus, there is a great social pressure on individuals to have their daughters circumcised, and although parents might not support FGC they feel pressured to comply with the convention (Mackie and LeJeune 2009). In Sweden, an alternative convention is in place; that where no FGC is practised at all, and information about how FGC is unnecessary, harmful, and illegal is provided on several levels. Thus, the social pressure is the opposite in the Swedish context, and to be a good parent in this context means that parents do not circumcise their daughters. Therefore, along with this shift to a new social context as a result of migration, the pressure among Swedish Somalis to circumcise their daughters may be reduced, enabling individuals to question and redefine social norms and conventions (Cloward 2015; Johnsdotter 2002; Mackie and LeJeune 2009). Further, Somalis in Sweden also meet and interact with other Muslims who traditionally do not practise FGC. As a result, the religious imperative of FGC may be questioned and reassessed, with FGC no longer being perceived as a religious requirement (Berns McGown 1999; Johnsdotter 2002). Hence, the moral norm of wanting to do what is best for one's child remains, but, in response to the new social context, Swedish Somalis change their attitudes and behaviour so that these, it in the best way possible, will still correspond to their moral norm (Mackie 1996; Mackie and LeJeune 2009). Correspondingly, while relevant in Somalia, FGC has been described among Somali immigrants as not being the norm in Sweden (EIGE 2015:73).

In Somali regions, a consistently strong support for the continuation of FGC has been reported (Gele et al. 2013a; Gele et al. 2013b; Mitike and Deressa 2009; Setegn et al. 2016). However, there are also studies which indicate that attitudes towards FGC are becoming increasingly negative with less support of the continuation of FGC (Abathun et al. 2017; Demissie et al. 2016). Thus, as we do not know what attitudes the participants had before migrating to Sweden, the overall high opposition to FGC could also be due to selective migration. This has been given as a possible explanation for why Sudanese immigrants in Switzerland are more positive to uncircumcised girls than Sudanese in Sudan (Vogt et al. 2017). However, as we found that the odds of Swedish Somalis supporting FGC decreased with increased years of residency in Sweden, this suggests that a change in attitudes towards FGC is occurring after migration to Sweden.

Construction of gendered bodies

Another important factor in the continuation or discontinuation of FGC seems to be how genital modifications, such as FGC, become a way to create the ideal female body (Cornwall 2012; Shilling 2003), a view influenced by culture and context (Richardson and Locks 2014; Vissandjée et al. 2003). While in Somalia, the circumcision of boys and girls has been described as a way to create 'real' men and women (Abdi 2012; EIGE 2015:74); in our results, we could see that, with the changed social context after migration, perceptions of what constituted the ideal male and female genitals had also changed. On one hand, MC seems to continuously be perceived as a bodily sign of the adult Muslim man, while, on the other hand, the importance of FGC as a bodily sign of a respectable Muslim woman seems to have been challenged and re-evaluated.

Public health campaigns, mass media information etc., also contribute to establishing views of how idealised bodies should look (Malmström 2009; Rudrum et al. 2017). Thus, the vast amount of programme efforts to end the practices of FGC, while promoting MC as a health measure (WHO 2008; WHO 2016b), may have influenced the perceptions of the two practices among the Swedish Somalis in this study.

It is also important to note that promoting bodily modifications as a way to create 'perfect' bodies pertains not only to certain practices in African contexts, but, as illustrated by anthropologist Michela Fusaschi: "in all societies, practices that interfere with bodies are aimed at (dis)adapting them to gendered cultural norms and making them more socially '(un)appropriate'" (Fusaschi 2017). Thus, practices such as cosmetic genital surgery, which are increasingly performed in North America and Europe (The Public Policy Advisory Network on Female Genital Surgeries in Africa 2012), are also a way of inscribing gender identity and conforming to a desired gender expression (Cornwall 2012).

Cultivating change

Although a majority of the Swedish Somalis were opponents of FGC, with a suggested increased opposition over time after migration, there were also individuals who expressed a support for the continuation of FGC or who thought there could be positive aspects with FGC, findings also reported in other studies (Ahlberg et al. 2004; Isman et al. 2013). In general, it was somewhat more common to report a support for FGC among participants living in Malmö and Gothenburg, than in Stockholm and Uppsala. Differences in demographics could be one possible explanation for this. Malmö had a slightly higher proportion of participants who did not have any education and who originated from rural Somalia, and Gothenburg had a higher proportion of unemployed participants. Further, both Malmö and Gothen-

burg had a higher proportion of newly arrived Somalis, compared to the other two municipalities. The indication that there are Somalis in Sweden who support pricking, but also practices of FGC that cause anatomical change, should not be overlooked. With the goal of the total abolition of FGC, how can this on-going change in attitudes be encouraged and promoted?

The findings in this thesis suggest that, with migration, attitudes towards the type of FGC that should be performed have changed towards less extensive forms – primarily pricking. Cultural and religious values were found to be associated with the practice of pricking. Accordingly, programme efforts to abolish FGC could, for example, involve religious leaders in the work against FGC, address masculinity and femininity norms, and emphasise FGC as a violation of children's rights and bodily integrity. However, such strategies have been implemented in programmes to change attitudes and behaviour towards FGC before, with varying results (McChesney 2015), and it is therefore difficult to recommend any one specific strategy. However, because individuals commonly base their actions on beliefs about what others do (EIGE 2015:75; Mackie 2015; Southwood and Eriksson 2011), a concept also supported by findings in this thesis, strategies involving discussions and the raising of awareness of attitudes and behaviour among others in the community may be an efficient strategy.

The rights of the child

The importance of safeguarding children's human rights and their right to bodily integrity is often brought forward as an argument against the circumcision of girls and boys (Darby 2016; Earp 2016b). However, interpretations of 'bodily integrity' may differ depending on cultural, social and legal contexts (Ammaturo 2016), and legislating against cultural and religious practices has been challenged by several critical voices (Onsongo 2017; Shweder 2013).

In Sweden, as well as in many other counties, girls are protected from all forms of non-therapeutic circumcision, while boys are not (SFS 1982:316 1982; SFS 2001:499 2001). Darby (2016) argues that such a position represent a double standard where females are favoured over males. As the results of this thesis show, this double standard can easily be identified and used as an argument among supporters of FGC, who can argue that, as long as MC is tolerated, some forms of FGC ought to be as well (also discussed by, e.g., Earp 2017b; Gollaher 2000:200). Consequently, in countries where this double standard exists, it may act as a hindrance to the complete abolition of FGC.

There are two ways in which this double standard could be avoided. Either 'minor' forms of circumcision are allowed on both girls and boys (e.g., as discussed, explicitly or implicitly, by Arora and Jacobs 2016; Gele 2013a; Shweder 2013), or no form of non-therapeutic circumcision of boys or girls

should be tolerated (e.g., an approach supported by Darby 2016; Earp 2017b; McLaughlin 2016). To allow 'minor' forms of genital cutting would allow certain groups to continue with practices that they deem important based on cultural or religious grounds. However, the process of determining what forms of genital cutting are 'minor' in relation to the effects on health and sexuality are very subjective and will differ between individuals (Campbell 2006). Therefore, as argued by Earp (2016b), a better approach may be to base regulations of genital alterations upon considerations of informed consent among adult individuals, rather than on gender, to avoid any violation of the child.

Pricking

Pricking of the clitoris or surrounding tissue, classified as FGC type IV by the WHO, has mainly been documented in a few Asian countries, such as Indonesia, Malaysia, Thailand, and among the Dawoodi Bohra Muslim community in India. In those contexts, pricking has been described as a process of socialisation, commonly perceived as harmless, and, for some, an Islamic practice (Isa et al. 1999; Merli 2012; Newland 2006; Taher 2017). Further, pricking (defined as 'cut, no flesh removed' in DHS and MICS data) has also been reported in an African context (Shell-Duncan et al. 2016). In Kenya, pricking has been described as being performed mostly by health professionals as a symbolic or 'psychological' cut – making the girl feel she has become a woman and been accepted by others, without having to remove tissue (Njue and Askew 2004). However, support for pricking has also been described among immigrant groups in non-FGC-practising countries (Berns McGown 1999; Johnsdotter 2002). In a recent court case in Australia, three members of the Dawoodi Bohra community were convicted for having been involved in performing what appeared to be some form of pricking/nicking on two girls, either by performing the act or by being an accessory to it (Rogers 2016). In another pending FGC case in the US, pricking or nicking may have been performed on several girls, although it remains unclear exactly what forms of FGC had been performed. This case also concerns members of the Dawoodi Bohra community (Earp 2017b).

The majority of proponents of FGC among Swedish Somalis in this thesis supported pricking. This support for pricking inevitably leads to the question of whether pricking is an issue that needs to be targeted with anti-FGC programmes. The following section will describe why we decided not to implement our planned intervention, and highlights two different perspectives of pricking.

The intervention that was not implemented

When I started this PhD project in January 2014, a review of the effectiveness of anti-FGC interventions had been published about a year previously (Berg and Denison 2012). This review identified that such interventions overall had been poorly evaluated, and, more importantly, that no interventions with a control group had been performed in a country outside of Africa. Thus, there was a knowledge gap relating to the effectiveness of interventions in a migration context. Concurrently, a study among Somali immigrants in Norway (a neighbouring country to Sweden) found that 30% supported the continuation of FGC, primarily those newly arrived (Gele et al. 2012). Further, previous anthropological research among Somalis in Sweden had found that many Somalis had reassessed FGC after migration, a process that seemed to correspond well with social convention theory (Johnsdotter 2002). Therefore, our hypothesis was that living in Sweden facilitates an attitude change regarding FGC; and our planned intervention study, based on concepts drawn from social convention theory (Mackie and LeJeune 2009), was aimed at accelerating this process among newly arrived Somalis.

However, after we had collected the baseline data we found that there was already a high opposition to FGC among Somali men and women, including those who were newly arrived, with evidence of an attitude change already happening. The opposition to FGC was higher than we anticipated. Further, among proponents of FGC, most supported pricking, while the level of support for practices that cause anatomical change was low. Thus, the data, as measured on a VAS ranging from 0 to 100 mm, was heavily skewed towards zero. For example, on the question measuring preferred form of FGC on a hypothetical daughter, which was the outcome that received the highest number of supporters of FGC, the mean value for newly arrived was 8.8 mm. With the study being calculated to detect a difference of 15 mm as measured on the VAS after, compared to before, the intervention, it would have been difficult to detect a change in attitudes. Consequently, we would not have been able to evaluate the effectiveness of the intervention, which made it ethically questionable to proceed with and implement an intervention. We therefore decided to not implement the planned intervention.

Zero tolerance or harm reduction

If we, just for the sake of argument, assume that we would have had enough statistical power to detect small changes in attitudes, and that we would not have observed an already strong attitude change, should an intervention directed at changing attitudes towards pricking have been implemented? This question would likely have obtained different answers, depending on whether one views the practice of pricking from a harm-reduction approach or a zero-tolerance approach.

The harm-reduction approach

Within a harm-reduction approach, less extensive forms of FGC are preferred to other more severe forms of FGC, as it, for example, is less harmful for the woman to be pricked than for her to be infibulated (Arora and Jacobs 2016a; 2016b; see e.g., Shell-Duncan 2001 for a discussion of this approach). Thereafter, when practising communities have changed and practise a less severe form of FGC, efforts to completely abolish FGC can be put in place (Latham 2016; Newland 2006). Further, as pricking involves no removal of tissue and does not cause any permanent alterations of the genitalia, it is argued that a medically safe pricking would have a limited impact on health and function (Arora and Jacobs 2016a; Obiora 1997; Rogers 2016; Shweder 2000). This strategy has, amongst others, been proposed by the Somali researcher, Abdi Gele (2013:1), to be applied in Somalia: "Therefore, since the 'zero tolerance policy' has failed to change people's support for the continuation of the practice in Somalia, programmes that promote the pinch of the clitoral skin and verbal alteration of status, with the goal of leading to total abandonment of FC, should be considered for the Somali context." Being able to practise some forms of FGC, such as pricking, also have a religious or cultural value for some, and it is therefore suggested that individuals should have their right to practise their religion or culture (Oba 2008).

How to interpret the (il)legality of pricking is also contested. National and international legislation is sometimes unspecific on whether practices that do not involve the removal of tissue are illegal. For example, the Istanbul Convention, which has been signed and ratified by most European countries, legislates against practices that mutilate or cause permanent changes to the genitalia. Thus, whether pricking, which does not cause any anatomical changes, is illegal could be interpreted differently within different countries (Council of Europe 2011; Johnsdotter and Mestre 2015). It has also been questioned how the removal of healthy genital tissue on boys can be allowed, while a practice on girls that does not involve the removal of tissue is not (Rogers 2016).

Based on one or several of these reasons, propositions that doctors should be allowed to perform pricking on girls have been expressed (see Abdulcadir et al., 2011 for an overview of such suggestions in the Netherlands, the US, and Italy; Arora and Jacobs, 2016a). For example, in 2010, the American Academy of Pediatrics stated that:

> Most forms of FGC are decidedly harmful, and pediatricians should decline to perform them, even in the absence of any legal constraints. However, the ritual nick suggested by some pediatricians is not physically harmful and is much less extensive than routine newborn male genital cutting. There is reason to believe that offering such a compromise may build trust between hospitals and immigrant communities, save some girls from undergoing disfigur-

> ing and life-threatening procedures in their native countries, and play a role in the eventual eradication of FGC. (American Academy of Pediatrics, Committee on Bioethics 2010:1092, cited in Johnsdotter 2012)

However, all suggestions to allow pricking have been met with strong opposition (see e.g., Earp 2016b; Macklin 2016; Shahvisi 2016), and no changes to allow pricking have been made.

The zero-tolerance approach

Zero tolerance to FGC is the approach embraced by most governments, international organisations, and NGOs (Johnsdotter and Essén 2010; Newell-Jones 2016; WHO 2008). All forms of FGC, including pricking, are seen as a violation of girls' human rights and bodily integrity, and they should therefore not be allowed (Earp 2016b; UNICEF 2013). Further, there is a lack of studies on the possible psychological and physical impact of pricking, and it cannot be said conclusively that pricking causes no harm (Leye et al. 2006).

The suggestion that pricking should be allowed to be practised in medical settings as a way to reduce any possible health risk is not supported by advocates of a zero-tolerance approach to FGC. Such medicalisation of the procedure is said to violate established health care ethics as there are no clinical reasons for having to perform it, and as risks such as infections and bleeding cannot completely be avoided (Leye et al. 2006; WHO 2016a). Further, it is argued that allowing pricking to be practised by doctors poses a risk that other practices of FGC will become legitimised, thereby impeding the work to abolish all forms of FGC (WHO 2016a).

Another fear is that allowing pricking would cause only a change in individuals' terminology rather than an actual change in the practice of FGC. For this reason, as well as to document changes over time in the practices performed, the WHO has decided to retain the definition of pricking as a type of FGC (WHO 2008).

Methodological considerations

This thesis consists of both quantitative and qualitative data. What follows below is an account of some of the most important methodological strengths and limitations of the studies in this thesis.

Quantitative data collection

Strengths

The quantitative studies in this thesis were conducted in different regions of Sweden and included a diverse range of Somali men and women in regard to

age, socioeconomic status, and years of residency in Sweden, which contributes to a comprehensive understanding of attitudes towards FGC among Swedish Somalis. With the potential for participants to be illiterate, and to increase our chances of reaching the desired group, we decided to recruit Somali research assistants who could interview the participants using the questionnaire. Both men and women were recruited as research assistants, and they received training in relation to interview techniques and data collection methods, before collecting the data. The research assistants themselves belonged to and had large networks within the Somali group in Sweden, and this, I believe, strongly contributed to and enabled the inclusion of many participants and the collection of a large number of questionnaire responses, particularly when compared with other similar studies (HELMI 2012). Quality checks of the collected data were made continuously, therefore, the number of missing data was very low. In order to get feedback on the findings, we arranged three seminars at Somali organisations, each with around 40 Somali men and women, where findings and interpretations were presented and discussed.

To avoid ambiguous interpretations, we based our survey questions on the anatomical extent of FGC and not the WHO classification (as recommended by Elmusharaf et al. (2006)). Further, 'sunna circumcision' and 'pharaonic circumcision', which are terms commonly used in Somalia to refer to different forms of FGC, are not well suited for research. Pharaonic circumcision refers to infibulation, whereas sunna circumcision commonly refers to less extensive forms of FGC but can, however, include all forms of FGC (Lunde and Sagbakken 2015). Also, the term 'sunna' has an Islamic connotation of a 'good deed', something that is desirable to do but not a requirement (Johnsdotter 2003b), which makes the use of the concept 'sunna circumcision' in research problematic.

Limitations

Random sampling was not possible, as this would have required us to have access to the names and contact information for all Somali-born individuals living in Sweden. Participants were instead recruited through purposive and snowball sampling. This may affect the generalisability of the results and may have caused a selection bias. Further, the use of snowball sampling – that participants who we recruited helped to find more participants – may have resulted in a more uniform sample.

The questionnaire was specifically developed for this study. Variables with potential association with the outcome variables were included in the questionnaire; however, there is a risk that not all important aspects or confounders were accounted for. Confounding occurs when an extraneous variable is associated with both the outcome variable and the exposure, which may lead to incorrectly measured relationships in regression analyses if the extraneous variable is not accounted for through, for example, adjustment.

After such adjustment is made, residual confounding may remain due to unknown extraneous variables not being adjusted for, or that the extraneous variable was not properly measured so that the confounding effect remains, even after adjustment (Kirkwood and Sterne 2003). Further, as this was a cross-sectional study, causality cannot be determined.

Determining ways in which attitudes can be expressed on a VAS may have been understood differently between the participants. However, as the data were collected through face-to-face interviews, the data collectors, who had been trained in how to report attitudes on a VAS, tried to minimise this risk. Nevertheless, not to underestimate the number of participants who did support anatomical change, we chose a strict categorisation of pricking on the VAS (1–10 mm). Consequently, the number of participants reported to support anatomical change (11–100 mm) may be an overestimation.

As Swedish law prohibits all forms of FGC, participants may have been hesitant to express positive attitudes towards the practice. Therefore, when collecting questionnaire data on FGC, there is a risk of social desirability bias. This means that the participants might have been cautious when reporting supportive attitudes towards FGC, and instead provided what they thought was the desired response. Accordingly, it may also have been easier to express a support for pricking, as many perceived that pricking did not cause any health consequences, than to support one of the more extensive forms. We tried to minimise this risk by asking about the participants' attitudes (and not their actual behaviours), and by not asking them whether they had a daughter and, if so, whether they would want to circumcise her. Instead, we asked them what they would prefer if they *hypothetically* had a daughter. Further, we chose data collectors who themselves are Somalis, who know the context well, are known and respected in the Somali group, and who are not connected with any authority. It was also widely known among the participants that all forms of FGC, including pricking, are illegal in Sweden. Therefore, if the participants dared to express a support for pricking, they would presumably dare to express a support for other forms of FGC as well.

It may also be the case that the participants over-reported their support for FGC as a way of asserting their cultural autonomy, just as backlashes have been described in contexts where FGC is traditionally practised and anti-FGC interventions or legislation have been implemented (Boddy 2007b; Camilotti 2015). Another limitation is that, because we studied attitudes towards FGC, it is not possible to draw far-reaching conclusions about the participants' actual behaviours.

Qualitative data collection

Strengths

Conducting both semi-structured individual interviews and FGDs enabled us to capture individual perceptions through the interviews, and to capture social norms within the group through FGDs. Individual interviews provided an opportunity for informants to share matters that they might not have been comfortable with sharing during group discussions. FGDs, on the other hand, provided an opportunity for the informants to gain a better understanding of others' views and to react to these. Interacting with Somalis through spending time at Somali organisations and in their homes helped me to broaden my understanding of the context and of the statements made during the interviews and FGDs. I also continuously discussed the findings and their possible interpretations with the Somali research assistants, as a way to validate the analysis. The findings from the qualitative study were presented and discussed during one seminar at a Somali organisation.

Limitations

I tried to include a variety of informants with respect to age, years of residency in Sweden, educational level, clan affiliation, etc. However, there were slightly more young informants, than what would have been the case if the study had aimed for a representative recruitment of informants, which may have resulted in certain tendencies in the perspectives presented. As I do not speak Somali, two of the research assistants, Zahra and Asha, interpreted during the interviews and FGDs when the informants preferred to speak Somali. There is a possibility that the informants knew or had heard of Zahra or Asha, which may have affected the interviews and FGDs. Individual interviews conducted in Somali were simultaneously translated into Swedish. In the FGDs conducted in Somali, summaries of the discussions were translated, and later, an external translator translated the audio recordings into Swedish. As Zahra and Asha had been involved throughout the whole research process, from providing input on the study design, to the collection of quantitative data and beyond, they were able to guide me in the cultural setting and I could discuss translations and interpretations of the interviews and FGDs with them. Therefore, being dependent on translators can also be seen as a strength.

Reflexivity

Given that FGC is criminalised in Sweden, a common response I get from others when I present this research is that informants would not dare to express their 'true' standpoints on FGC. It may be that what was said during the interviews reflects normative responses of social desirability, especially because I can be regarded as an 'outsider'. However, this may also have

encouraged the informants to explain their 'insider's' perceptions to me (Kusow 2003). Further, my social position as a white, non-circumcised, university-educated woman could also have affected the interaction with the informants (Liamputtong 2010). However, from my perspective, many of the informants were open and confident with expressing their attitudes, not only about issues of FGC, but also about other issues such as khat use and radicalisation in the Swedish Somali group, none of which portrayed a positive picture. Qualitative research also offers an opportunity for informants to elaborate on the motives underpinning their views. Thus, to express trustworthy arguments during an entire interview for a position that one in reality does not hold can be difficult. Besides that, many informants openly expressed support for pricking, despite the fact that most of them knew that this practice is illegal in Sweden. Further, there were also those who expressed support for the forms of FGC that cause anatomical change, and they were not hesitant when explaining their motives for this.

During many of the interviews and FGDs, there was a rather relaxed atmosphere, despite the seriousness of the topics being discussed. This was one of my intentions from the beginning, as I did not want the interviews or FGDs to feel like some sort of 'authoritative investigation', but rather, that the purpose of my being there was to understand their point of view. Some topics were easier to talk about than others. The Somali group in Sweden is very used to being associated with FGC, not least through media reports. However, the practice of male circumcision (MC) has not, by far, been discussed to the same extent in Sweden as FGC has. This may be why the questions about FGC in general did not seem to surprise any of the informants, while those relating to MC did. As neither FGC nor MC is traditionally practised in Sweden, some of my questions regarding those practices may have been perceived as 'naïve'. However, it is my impression that this made the informants keen to really explain, and make me understand, how they viewed these practices.

Conclusion

The results presented in this thesis illustrate a widespread opposition to FGC, particularly to practices that cause anatomical change, and demonstrate that, with increased years of residency in Sweden, the odds of supporting FGC decreases. This opposition was also indicated through a described preference among men to marry an uncircumcised woman, a presumption which was also perceived by most women. Altogether, these findings suggest that a shift in convention towards no FGC is taking place. At the same time, this thesis reveals that some Swedish Somalis support pricking, which is classified by the WHO as FGC type IV, but which many did not consider to be a form of FGC. Cultural and religious meanings were described as factors that support the rationale for performing this practice. Further, this thesis recognises that an individual's own approval of FGC corresponds well with their perceptions about the attitudes and practices of others in their community. Thus, how the debate surrounding FGC is framed may influence an individual's propensity to support FGC.

Somalis' dissociation from all or most forms of FGC after migration to Sweden could be understood as changed perceptions of what constitutes the ideal body. While there seemed to be a continuity regarding the Swedish Somalis' core values of being a good Muslim, not inflicting harm, and upholding respectability, renegotiation of how these are applied when it comes to genital modification in children resulted in, on the one hand, continuously perceiving the circumcision of boys as an unquestionable required practice, while, on the other hand, perceiving the circumcision of girls as a practice that can be abandoned or adapted. At the same time, some proponents of FGC perceived it as a double standard to allow the circumcision of boys, but not milder forms of FGC for girls, such as pricking. With the identified support for pricking, more empirical evidence of the various aspects of pricking is recommended.

Recommendations

The findings in this thesis identify a number of opportunities for improvement in the work towards the abolishment of FGC. The following recommendations can be suggested:

- As discrepancies in the regulation of genital modifications on children are easily recognised by individuals who support such practices, it is recommended that a gender analysis of current legislation and its implementation is conducted.
- There is lack of consensus on practices regarded as 'female circumcision'/'female genital mutilation/cutting'. This issue must be addressed because pricking is not always understood as FGC by practising communities, and may thus be an aspect missed when, for example, conducting research studies, implementing programmes, and defining guidelines.
- A suggested strategy to increase the opposition to FGC is to raise awareness of prevailing attitudes towards FGC among others in society. Knowledge that others do not support FGC can help facilitate a change in attitudes among supporters of FGC. Well-established migrants could play a key role in developing such a strategy, thereby encouraging the abolishment of FGC among those newly arrived.
- The following areas are suggested for future research:
  - Increased knowledge of the actual practice of pricking, and its possible physical and psychological impact.
  - Improved understanding of why some proponents of FGC opt for the removal of tissue while others deem this unnecessary.

Summary in English

Female genital cutting (FGC) includes a number of practices that intentionally alter or cause injury to the female genitalia for non-medical reasons. The World Health Organization classifies FGC into four types. Type I includes partial or total removal of the external clitoris, type II includes removal of the external clitoris and labia minora (and sometimes majora), and type III includes the removal of the labia minora and/or majora followed by a suture to narrow the vaginal opening, with or without removal of the external clitoris. Type IV includes all other harmful procedures to the female genetalia for non-medical reasons, e.g., pricking of the clitoris or surrounding tissue. FGC is mainly practised in 30 counties located in Africa, the Middle East, and Asia. Approximately 200 million girls and women alive today are circumcised, usually before the age of 15 years. FGC may cause both acute and long-term health consequences, with more extensive forms of FGC having higher risks of complications. During the last few decades, much effort has been invested in abolishing FGC. In 2015, the United Nations adopted a new global sustainable agenda – the Sustainable Development Goals – that were to replace the previous Millennium Development Goals. Goal number five aims to achieve gender equality and empower all women and girls, by, amongst other targets, the abolishment of FGC. However, with global prevalence rates of FGC either remaining static or only slowly declining, this goal is far from being reached.

As a result of migration, FGC has become a global concern. Estimates suggest that approximately half a million women who have been circumcised live in Europe. In Sweden, an estimated 38,000 girls and women are circumcised, with the majority originating from Somalia (21,000), and others from Eritrea (6,000), and Ethiopia (5,000). Such migration from traditionally FGC-practising countries to non-practising countries raises questions about whether attitudes towards FGC in the new cultural context remain constant or change. This thesis builds on quantitative and qualitative research with Somali men and women living in different areas of Sweden, with the aim of exploring their attitudes towards FGC.

In Paper I, attitudes towards FGC among Swedish Somalis were investigated. The vast majority opposed FGC practices that cause anatomical change. However, there were those who expressed support for, primarily, pricking, a practice classified as FGC but – as it involves no removal of tissue – which does not cause permanent change. Those who had lived in Swe-

den for a shorter time period were more likely to support some form of FGC, compared to those who had lived in Sweden for many years. This suggests that living in Sweden facilitates a change in attitudes. This support for pricking, and what appeared to be a change in attitudes with increased years of residency in Sweden, merited further exploration, which was pursued in subsequent papers.

In Paper II, factors associated with wanting pricking to continue being practised were examined. To support pricking was more common among those who were older, from a rural area in Somalia, and newly arrived in Sweden. Further, to support pricking was more common among those Swedish Somalis who regarded pricking as acceptable by religion, or necessary for ensuring respectability. Not perceiving pricking as a form of FGC, nor as a violation of children's rights or causing long-term health complications was also associated with wanting pricking to continue being practised. Knowledge that all forms of FGC are illegal in Sweden was high. Yet, those who were not certain about what forms of FGC are legislated against had higher odds of supporting pricking.

In Paper III, Swedish Somalis' *own* approval of FGC, and their perceptions about the approval of FGC among *other* Swedish Somalis were examined. The Swedish Somalis' own attitudes towards FGC and their perceptions of other Swedish Somalis' attitudes were similar, suggesting that expectations about what others prefer tend to affect an individual's own propensity to support FGC. Most Swedish Somali men expressed that they would prefer to marry a woman who had not been circumcised, which was also presumed by most women.

In Paper IV, Swedish Somalis' perceptions of FGC in relation to the circumcision of boys were explored. After migration, the perceived desirability of the circumcision of girls and boys was re-evaluated, resulting in a distinct separation between the two practices. On one hand, the circumcision of girls was, by most, no longer perceived as a religious requirement nor a bodily sign of a respectable woman, and could therefore be abandoned or adapted. On the other hand, the circumcision of boys was continuously viewed as a bodily sign of a respectable, Muslim man, and thus viewed as an unquestionable required practice.

In conclusion, there seems to be a change of attitudes towards FGC among Somali men and women in Sweden. This thesis points at certain areas worthy of attention in the work towards the abolishment of FGC. Pricking of the clitoris or surrounding tissue was not understood as a form of FGC by several Swedish Somalis. Thus, the use of terminology when conducting studies and implementing programmes may affect the results obtained and the subsequent conclusions. Further, knowledge that most others do not support FGC may facilitate a change in attitudes among supporters of FGC, a strategy suggested to be included in programmes working towards ending FGC.

Qoraalka oo kooban (Summary in Somali)

Goynta xubinta taranka dumarka (FGC) waxaa ka mid ah dhowr dhaqamo oo si ula kac ah u bedelaya ama sababi kara dhaawaca xubinta taranka dumarka iyaado aan sababo aan caafimaad ahayn la darsa. Haayadda qaramada midowbe oo caafimadka (World Health Organization, WHO) waxay gudniinta uqaybiisay afar nooc. Nooca I, waxaay ka koobantahay kintirka oo inyaar ama kuligeed la jaro/gooyo. Nooca II, waxaa la jaraa kintiirka oo dhan iyo faruuryaha gudahaa iyo mar mar xitaa faruuryaha korey. Nooca III, waxaa ay ka koobantahay, bisihimahaa korey iyo kuwi gudahaa la jaro, kadib na la tola sidii loo yareeyo siilka afkiisa horey, iyaadoo kintirka laga jarey ama loo daaye. Nooca IV, waxaay ka koobantahay ayuu nooc ah oo nidaamyada halista ah oo gabadha la mariyaa, matalaan; kintiirka iyo/ama nudaha ku xeeran, dhiig laga keeno iyado loo adeegsanaayo qodax ama cirbad.

Gudniinta waxaa laga yaqaan 30 wadan oo ku yaal Afrika, Bariga Dhexee (Middle-East) iyo Asia. Qiyaas ahaan waxaa jooga 200 miljaan gabdhood iyo dumar oo gudaan aduunka, badana waxaa la gudaa intii ay 15 sano ay san gaarin. Gudniinta dumarka (FGC) waxaay keeni kartaa ama sababi kartaa caafimad daro mid mudo gaaban ama mudo dheer ba leh, side ay u kala koreeyan ay saameynta caafimadka na u kala daranyihiin. Qarniyada dhow la soo dhaafay, xoog badan baa la galiyaay sidii looga mamnuuci lahaa gudniinta dumarka. Sanadkii 2015, Qaramada Midoobay waxay ku heshiiyeen qorshe cusub oo lagu wadi karo oo caalami ah - Hadafyada Horumarinta joogtada ah - kuwaas oo ahaa inay beddelaan Himilooyinka Horumarka ee Kun-sannadka hore. Goolki shanaad, am tirada bartilmaameedka shanaad, waxaay ujeeddadeedu tahay in lagu gaaro sinnaanta jinsiga oo awood loo siiyo dhammaan dumarka iyo gabdhaha, iyado oo ay ka mid tahay bartilmaameedyada kale, taas ay ku jirto joojinta gudniinka gabdhaha. Si kastaba ha noqotee, marka la eego heerka baahsanaanta gudniinta dumarka (FGC) oo soo jiraynta waxaay tusaaysaa in si tartiib tartiib ah hoos u dhacaya, ama meeshiisa taagan, taas na waxaa la dhihi karaa, yoolkani waa mid aad u fog.

Soogalootida iyo guriintaka dadka waxaay keentay in gudniinta ay noqoto dhibaato khuseeyso aduunka oo dhan. Waxaa la qiyaasaaya in ay nus miljaan dumar oo gudan ay manta ku noolyihiin Yurubka. Waxaa la qiyaasaaya in 38,000 gabdhood iyo dumar ku nool Sweden in ay gudanyihiin, kuwwaso oo ka kala yimid wadamada Somalia 21,000, Eritrea

6,000 iyo Itoobiya 5,000. Hadaba waxaa la is weydinayaa, in soogalootida dumarkaas oo ka yimid wadamo dhaqaanka gudniinta looga yaqaan, oo usoo guuray wadan aan laga aqoon daqankaas, in wax iska badeleen aragtida daqankaas ama waxaay ka aamin sanaayeen. Cilmi baaristaan ama thesis-kaan, waxay ku dhisantahay baritaan la ga dhex sameeye rag iyo dumar Soomali ah degaan magalooyiin kala duuwan oo Iswidhan ku yaal.

Qeeybta kowaad (Paper 1) waxaa la baarey, aragtiida ay Somaalida Iswidhan ay ka qabaan gudniinta. Waxaa soo baxday in qayb ballaaran bulshadaas ay ka soo horjeedan gudniinta bedelaayo muuqalka xubinta taranka, laakin waxaa ku jiray qaar ogol in la mudo (cirbad ama qodax lagu mudo) oo dhiig laga keeno ee aan waxba laga gooyniin gabadha. Kuwii mudo yar deganaa wadanka Iswidhan, ayaa u badnaa in ay ogolaadan gudniinta ama ay aaminsanyihiin in gabdhaha la gudo, marka loo bar bar dhigo kuwii wadanka wax badan degnaa. Natiijadaas waxaay tusaaysay in dagitaanka Iswidhan ay u fududaaysay isbedelkaasi. Sidaa looga sal gaaro isbedelkaasi iyo saameynta ay ku leedahay mudada qofka uu jooga Iswidhan, ayaa lagu sii baaray qaybahaa ku xigaa cilmi baaristaan ama thesis-kan.

Qaybta labaad (Paper II), sababahaa la xiriiro gudniinta dhiig ka keenida ayaa dib loo baaray. Dadka taageraaye gudniinta noocan, waxaay u baadnaayeen dad miyiiga Somalia ka imaaday iyo kuwo wadanka Sweden ku cusub. Waxaa kale taagerayee qaar aaminsan in ay gudniintaas ay diinta ka hor imaanin diinta Islaamka ama ay muhiim u tahay sharafta gabadha, ayago aay san u arkiin in ay gudniin ba ay tahay ama xadgudub xaquuqda gabadha. Ayago ku andacoonayaa in ay wax dhibaato weeyn aysan u geeysanaayniin gabadha. Intooda badan way ogaayen in gudniinka uu mamnuuc ka yahay Iswidhan, laakin kuwii aan hubin noocyada gudniinta laga mamnuucay wadanka, ayaa u badnaa kuwa taagero gudniintaas.

Qaybtaa saddexaad (Paper III) waxaan baarnay ogalaashaha gudniinta iyo fikradahaa ay ka qaban ogolashaahaas balaaran ee Somalida kaleedahay. Natijada ka soo baxday waxa ay muujisay in labadaas la is bar bar dhigay ay isu dhowyihiin. Taaso na ay sameeynayso aaminka shaqsiga waxay soo jeedinaysaa in filashooyinka ku saabsan dadka kale ay doorbidaan inay saameyn ku yeeshaan shakhsiyaadka u gaarka ah taas na keenaysa in ay u taageeraan gudniinta dumarka. Nimanka badankoodi waxaay cadeeyen in ay jaceylyihiin in ay gursadaan dumar aan gudnaayn, dumarka na markii la weydiiyaay iyaga na fikradaas way la qabeen ragga. Fikradaan oo ah, in la jecelyahay dumarka aan gudnaayn, waxaay mujinaysaa in isbedelkaas dacay inta ay Iswidhan joogen oo ay ka sii tageyaan gudniinta.

Qaybta afraad (Paper IV), fikradahaa Somalida Iswidhan dagan ay ka qabaan gudniinta wiilasha ayaa la sahmiyaay. Guritaanka ka dib, isbedel baa laga dareemay rabitaanka ama hamiga ay u laahaayeen gudniinta gabdhaha iyo wiilasha, taaso oo keentay in labada la kala saaro. Hal dhinac waxaa jiray, fikradda laga qabay gudniinta gabdhahaa oo ahayd in diiniyaan ama

wax ku xiran gabadha xishmadeeda. Saas awgeeda ay u arkeen in dhaqan aan waajib ahaayn oo laga tagi karo ama la qaadan karo. Dhinaca kale na, gudniinta wiilaasha waxaa loo arkaaye in ay weli tahay dhaqan diiniyaan iyo xishmadda jirka qofka ragga ku xirantahaay, oo aan sua'aal kujirin.

Gabagabada, waxaa muuqdo in isbedel ka dhacay aragtida ay ka qabeen gudniinta ragga iyo dumarka Somalida Iswidhan ku nool. Cilmi baaristaan ama thesis-kaan wuxuu tilmaamayaa meelo gaar ah oo ku habboon in la tixgeliyo marka laga hawl galaayo barnaamijyo ku saabsan sidi loo baa bi'in karo gudniinta dumarka. Thesis kaan wuxuu tilmaamayaa meelo gaar ah oo tix gelin u baahan, oo ku taxaluqa shaqada ee ku saabsan joojinta gudniinta. dhiig ka keenidda kintirka ama nudaha ku xeeran, taaso oo ah wax dhowr qof oo iswiidhish-Soomalida ka mid ahaa aan u fahmaayniin in ay gudniin ay tahay ba. Markaa, isticmaalka eraybixin markaad sameynayso daraasadaha iyo hirgelinta barnaamijyada, waxay saameyn karaan gebagebaynta iyo natiijooyinka laga heli karo baritaankaas ama darsadaha. Waxaa kale oo dheeraad ah, in aqoonta dadka la kordhiyo oo la tusa in dadka intooda badani ma taageersano gudniinta dumarka. Taas waxaay fududeyn kartaa isbedelka habdhaqanka taageerayaasha guniinta, waa istaraatijiyad ku haboon in lagu daro barnaamijyada ka shaqeeya joojinta gudniinta dumarka.

Sammanfattning på svenska (Summary in Swedish)

Kvinnlig könsstympning/omskärelse innefattar ett flertal ingrepp som avsiktligt förändrar eller skadar kvinnans könsorgan utan att det finns någon medicinsk anledning. Världshälsoorganisationen klassificerar kvinnlig könsstympning/omskärelse i fyra typer. Typ I innefattar ingrepp där klitoris yttre del delvis eller helt tas bort, och typ II innefattar ingrepp där klitoris och de inre blygdläpparna (och ibland de yttre) tas bort. I typ III tas delar av de inre och/eller yttre blygdläpparna bort för att sedan sys ihop för att på så vis minska den vaginala öppningen, detta med eller utan borttagande av klitoris. Typ IV inkluderar alla andra skadliga ingrepp på kvinnans könsorgan som utförs utan att det finns någon medicinsk anledning, t.ex. prickning av klitoris eller omkringliggande vävnad. Kvinnlig könsstympning/omskärelse praktiseras huvudsakligen i cirka 30 länder i Afrika, Mellanöstern och Asien. Cirka 200 miljoner tjejer och kvinnor är idag omskurna, vanligtvis innan 15 års ålder. Kvinnlig könsstympning/omskärelse kan orsaka både akuta och långsiktiga hälsoeffekter, med högre risk för komplikationer vid mer omfattande ingrepp. Under de senaste årtiondena har många insatser gjorts för att få sedvänjan att upphöra. År 2015 enades Förenta Nationerna om en ny global agenda – de globala målen för hållbar utveckling – som ersatte de tidigare millennieutvecklingsmålen. Mål nummer fem syftar till att uppnå jämställdhet och stärka kvinnors och flickors egenmakt, detta bland annat genom att avskaffa kvinnlig könsstympning/omskärelse. Men med en oförändrad eller endast sakta nedåtgående global förekomst av kvinnlig könsstympning/omskärelse så är målet långt ifrån att uppnås.

Genom migration har kvinnlig könsstympning/omskärelse blivit en global angelägenhet. Uppskattningar tyder på att cirka en halv miljon kvinnor som har blivit omskurna bor i Europa. I Sverige är uppskattningsvis 38,000 tjejer och kvinnor omskurna, med majoriteten härrörande från Somalia (21,000), Eritrea (6,000) och Etiopien (5,000). Migration från länder där sedvänjan traditionellt utförs till länder där den inte gör det, så som Sverige, väcker frågor om huruvida attityder till kvinnlig könsstympning/omskärelse förblir konstanta eller förändras. Den här avhandlingen bygger på kvantitativ och kvalitativ forskning med somaliska män och kvinnor bosatta i olika delar av Sverige, med målet att utforska deras attityder till kvinnlig könsstympning/omskärelse.

I artikel I undersöktes attityder till kvinnlig könsstympning/omskärelse bland somaliska män och kvinnor i Sverige. En majoritet motsatte sig ingrepp som orsakar en permanent förändring av kvinnas könsorgan. Det fanns emellertid de som uttryckte ett stöd för fram för allt prickning, ett ingrepp som klassificeras som kvinnlig könsstympning/omskärelse men – eftersom ingen vävnad tas bort – inte orsakar en permanent förändring. De som hade bott i Sverige under en kortare tidsperiod var mer benägna att stödja någon form av kvinnlig könsstympning/omskärelse jämfört med dem som hade bott i Sverige i många år, vilket tyder på att migration till Sverige leder till förändrade attityder i frågan.

I artikel II undersöktes vilka förklaringar det kan finnas till att somalier i Sverige vill att prickning ska fortsätta att utföras. Det var vanligare att stödja prickning bland de som var äldre, från landsbygden i Somalia, och nyanländ i Sverige. Att stödja prickning var också vanligare bland de som ansåg att prickning var ett accepterat ingrepp inom deras religion eller att det gjorde kvinnan respektabel. Personer som *inte* definierar prickning som en form av kvinnlig könsstympning/omskärelse, som ett brott mot barns rättigheter, eller anser att det kan orsaka långsiktiga hälsokomplikationer var också mer benägna att stödja prickning. Kunskap om att alla former av kvinnlig könsstympning/omskärelse är olagliga i Sverige var hög. Men de personer som inte var säkra på vilka former av kvinnlig könsstympning/omskärelse som är olagliga hade högre sannolikhet att stödja prickning.

I artikel III undersöktes hur uppfattningar hos andra potentiellt påverkar ens egna attityder till kvinnlig könsstympning/omskärelse. Svensksomaliernas egna attityder till kvinnlig könsstympning/omskärelse och deras uppfattningar om andras attityder stämde väl överens, vilket tyder på att förväntningar om vad andra tycker påverkar individernas egen benägenhet att stödja kvinnlig könsstympning/omskärelse. De flesta svensksomaliska män uttryckte att de skulle föredra att gifta sig med en kvinna som inte var omskuren, vilket också antogs av de flesta kvinnorna.

I artikel IV undersöktes svensksomaliernas uppfattningar om kvinnlig könsstympning/omskärelse i relation till omskärelse av pojkar. Efter migration omvärderades synen på omskärelse av tjejer och pojkar, vilket resulterade i en tydlig separation mellan de två ingreppen. Å ena sidan uppfattade många att omskärelse av tjejer inte längre var ett religiöst krav eller ett kroppsligt tecken på en respektabel kvinna och därför ansåg man att sedvänjan kunde överges eller anpassas. Å andra sidan betraktades omskärelse av pojkar fortsatt som ett kroppsligt tecken på en respektabel muslimsk man och därmed var det ett obestridligt nödvändigt ingrepp.

Sammanfattningsvis verkar det ske en förändring av attityder till kvinnlig könsstympning/omskärelse bland somaliska män och kvinnor i Sverige. Den här avhandlingen har identifierat ett antal aspekter som är viktiga att vara medveten om i arbetet mot kvinnlig könsstympning/omskärelse. Flera svensksomalier ansåg inte att prickning av klitoris eller omkringliggande

vävnad var en form av kvinnlig könsstympning/omskärelse. Därmed kan den terminologi som används vid genomförande av studier i ämnet påverka resultatet och slutsatserna. Kunskap om att en majoritet inte stödjer kvinnlig könsstympning/omskärelse kan underlätta i arbetet med att förändra attityder bland de som stödjer sedvänjan, en strategi som med fördel kan inkluderas i insatser som syftar till att få kvinnlig könsstympning/omskärelse att upphöra.

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Appendix

Somali SciLive

Baseline questionnaire

Chose one alternative for each question if not otherwise stated

IDENTIFICATION	
1.	**Somali organisation code** _____
2.	**Participants code** _____
3.	**Interviewers name** _____
4.	**Date (YYYY/MM/DD):** _____/____/____
5.	**Interview duration in minutes** _____

RESPONDENT'S BACKGROUND	
6.	**Sex** ☐ Man ☐ Woman
7.	**What year were you born?** *As written in your passport* Year (YYYY): _____
8.	**How long have you lived in Sweden?** ☐ Less than 2 years ☐ 3-4 years ☐ 5-9 years ☐ 10-14 years ☐ More than 15 years
9.	**What is your level of education?** ☐ Not been to school/ not completed any grade ☐ Koranic school only ☐ Primary school (1-9 years) ☐ Secondary school (10-12 years) ☐ College/ university
10.	**Before you came to Sweden, where did you grow up?** ☐ City

☐ Village/ countryside

☐ Nomadic life

11. What is your marital status now?

☐ Single

☐ Married/ in a relationship

☐ Divorced/ widowed

12. Who lives in your home?

Several options can be selected

☐ I live alone

☐ Husband/ wife/ partner

☐ Children

☐ Father, mother, father in law, mother in law

☐ Other relatives

☐ Other, specify: _____

13. Do you have social welfare benefits (försörjningsstöd) from your municipality?

☐ Yes

☐ No

14. What is your main employment status?

☐ Work full time/ part time

☐ In a program organized by the placement service for work (Arbetsförmedlingen)

☐ Studying Swedish (SFI, basic Swedish etc.)

☐ Student (those who are studying something else than Swedish)

☐ Retired/ On sick leave/ On parental leave (with parental benefits (föräldrapenning))

☐ Unemployed

15. What is your religion?

☐ Muslim

☐ Christian

☐ Atheist

☐ Other

16. Rate your comprehension and use of the Swedish language in the following situations

	Poor	Average	Good	Very good
(a) Ability to understand news reports on the radio and television	☐	☐	☐	☐
(b) Speaking Swedish at meetings	☐	☐	☐	☐
(c) Communicating with authorities over the telephone, (*i.e.,* calling the Health Department,	☐	☐	☐	☐

Social Security Office, or Unemployment Center)				
(d) Reading books in Swedish	☐	☐	☐	☐
(e) Completing a written application for employment	☐	☐	☐	☐

FEMALE CIRCUMCISION, BACKGROUND

Before asking the questions below, show the picture (Picture 1) of the different types of female circumcision to the respondent. Explain the different types, and that not everyone regard all these types as female circumcision. Show the other picture (Picture 2) and explain that this one also has the option Nothing at all. Have these pictures infront of the participant during the entire interview. Refer to them when there is a question starting with Picture 1 or Picture 2.

For the questions with the VAS-scale, the respondent should themselves draw the line in the questionnaire.

Make sure to explain to the respondent that the attitudes and opinions he/she express will be confidential, and that there is no right or wrong.

17. See picture 1: What do you regard as female circumcision?

Notera: Med denna fråga menas vilka ingrepp de tycker hör till begreppet "kvinnlig omskärelse".

Note: Indicate direction

Pricking, no flesh removed ——————————— Flesh removed and closed

Explain that when we use the word female circumcision in the questions below it includes all types.

18. Have any of your family members undergone female circumcision?

☐ Yes

☐ No

☐ Don't know

19. Ask only women: Have you yourself been circumcised, and if so, what was done at that time?

Note: See Picture 2.

☐ Yes: Pricking but no flesh removed

☐ Yes: Some flesh removed

☐ Yes: Flesh removed and some stitching

☐ Yes: Flesh removed and closed

☐ No

☐ Don't know

☐ N/A

20. In Somalia, have you ever received information through mass media about female circumcision (video, TV, newspaper, internet)?

Note: See Picture 2.

☐ Yes

If yes, was the information mainly:

Supporting:

☐ Pricking but no flesh removed

☐ Some flesh removed

☐ Flesh removed and some stitching

☐ Flesh removed and closed

Opposing:

☐ Pricking but no flesh removed

☐ Some flesh removed

☐ Flesh removed and some stitching

☐ Flesh removed and closed

☐ No

21. In Sweden, have you ever received information through mass media about female circumcision (video, TV, newspaper, internet)?

Note: See Picture 2.

☐ Yes

If yes, was the information mainly:

Supporting:

☐ Pricking but no flesh removed

☐ Some flesh removed

☐ Flesh removed and some stitching

☐ Flesh removed and closed

Opposing:

☐ Pricking but no flesh removed

☐ Some flesh removed

☐ Flesh removed and some stitching

☐ Flesh removed and closed

☐ No

22. Have you yourself ever actively taken part in any group, organisation, or campaign working against female circumcision?

Note: participation in the Somali SciLive intervention should not be registered as "Yes, in Sweden".

☐ Yes, in Somalia

☐ Yes, in Sweden

☐ Yes, in both Somalia and Sweden

☐ No

FEMALE CIRCUMCISION, DAUGHTER

23. **See picture 2: We don't know if you have a daughter. But let's hypothetically say that you do have a daughter, what would you then do?**

Nothing at all ——— Flesh removed and closed

24. **How many within the Somali community in Sweden do you think circumcise their daughters?**

No one ——— Everybody

FEMALE CIRCUMCISION, ATTITUDES

25. **See picture 2: What do you think is acceptable to do?**

Notera: Här ska den intervjuade svara på vilka typer av ingrepp han/hon tycker är acceptabla att utföra.

Note: Indicate direction

Nothing at all ——— Flesh removed and closed

26. **See picture 2: What do you think most Somali men in Sweden think is acceptable to do?**

Note: Indicate direction

Nothing at all ——— Flesh removed and closed

27. **See picture 2: What do you think most Somali women in Sweden think is acceptable to do?**

Note: Indicate direction

Nothing at all ——— Flesh removed and closed

28. **See picture 2: What do you think is accepted to do according to your religion?**

Note: Indicate direction

Nothing at all ——— Flesh removed and closed

29. See picture 1: When, if ever, will the circumcision cause long-term health complications for girls/women?

Note: Indicate direction

Pricking, no flesh removed ——— Flesh removed and closed

☐ Never

30. See picture 1: When, if ever, will the circumcision become a violation of children's rights?

Note: Indicate direction

Pricking, no flesh removed ——— Flesh removed and closed

☐ Never

31. See picture 2: To be a seen as a respectful not yet married young woman, what is needed according to you?

Note: Indicate direction

Nothing at all ——— Flesh removed and closed

32. What benefits do girls themselves get if they undergo circumcision?

Several options can be selected

☐ Cleanliness/hygiene
☐ Social acceptance
☐ Better marriage prospects
☐ Preserve virginity/prevent premarital sex
☐ More sexual pleasure for man
☐ Religious approval

Other, specify:_____

☐ No benefits

33. What benefits do girls themselves get if they do NOT undergo circumcision?

Several options can be selected

- ☐ Fewer medical problems
- ☐ Avoiding pain
- ☐ More sexual pleasure for her
- ☐ More sexual pleasure for the man
- ☐ Follows religion

Other, specify:_____

- ☐ No benefits

34. There are people who want female circumcision to be abolished and other people who want it to be continued. What of the following do you want to continue?

Note: Several options can be selected. See Picture 1.

- ☐ Pricking but no flesh removed
- ☐ Some flesh removed
- ☐ Flesh removed and some stitching
- ☐ Flesh removed and closed
- ☐ All of them should be abolished

35. Do you think it is a good idea for men to be involved in the debate on female circumcision?

- ☐ Yes
- ☐ No

36. Ask only men: For your marriage, do you prefer a woman who is circumcised or one who is not circumcised?

Note: See Picture 2.

- ☐ Not circumcised
- ☐ Circumcised: Pricking but no flesh removed
- ☐ Circumcised: Some flesh removed
- ☐ Circumcised: Flesh removed and some stitching
- ☐ Circumcised: Flesh removed and closed
- ☐ It doesn't matter
- ☐ N/A

37. Ask only women: Do you think Somali men prefer to marry a woman who is circumcised or one who is not circumcised?

Note: See Picture 2.

- ☐ Not circumcised
- ☐ Circumcised: Pricking but no flesh removed
- ☐ Circumcised: Some flesh removed

☐ Circumcised: Flesh removed and some stitching

☐ Circumcised: Flesh removed and closed

☐ It doesn't matter for them

☐ N/A

FEMALE CIRCUMCISION, KNOWLEDGE

38. **See picture 2: What is legal to do in Sweden?**

Note: Indicate direction

Nothing at all ——————————— Flesh removed and closed

☐ Don't know

39. **Living in Sweden, is it legal to take a girl abroad for circumcision?**

☐ Yes

☐ No

☐ Don't know

MALE CIRCUMCISION

40. **Ask only men: Have you yourself been circumcised?**

☐ Yes

☐ No

☐ Don't know

☐ N/A

41. **Do you see any reason for questioning circumcision of boys?**

Notera: Här ska den intervjuade svara på om han/hon ser några skäl till att inte utföra manlig omskärelse, om han/hon ser något skäl till att ifrågasätta utförandet av manlig omskärelse.

☐ Yes

☐ No

42. **Some people say that male circumcision is a violation of children's rights, do you agree?**

☐ Yes

☐ No

43. **In regard to physical health, where would you place the effects of male circumcision?**

Notera: Om sträcket dras precis i mitten innebär det att den intervjuade varken ser några fördelaktiga eller skadliga effekter av manlig omskärelse. Om strecket dras mer till vänster innebär det att den intervjuade tycker att det finns fler fördelaktiga effekter, och om strecket dras mer till höger så tycker den intervjuade att det finns fler skadliga effekter.

Only beneficial ——————————— Only harmful

44. In your opinion, are circumcision of girls and boys comparable practices?

Note: Several options can be selected. See Picture 2.

- ☐ Yes, pricking but no flesh removed is comparable with male circumcision
- ☐ Yes, some flesh removed is comparable with male circumcision
- ☐ Yes, flesh removed and some stitching is comparable with male circumcision
- ☐ Yes, flesh removed and closed is comparable with male circumcision
- ☐ No, none of them are comparable with male circumcision

SOCIAL CAPITAL

Before asking the questions below, explain for the respondent that you now will ask some questions about his/her daily life in Sweden.

45. Make a decision about the following statements

	I do not agree at all	I do not agree	I agree	I agree completely
(a) Most people would take advantage of you if they had an opportunity	☐	☐	☐	☐
(b) Most people try to be fair	☐	☐	☐	☐
(c) You can trust most people	☐	☐	☐	☐
(d) You cannot be careful enough when dealing with other people	☐	☐	☐	☐

46. Have you during the last 12 months…

Note: The following applies only during the time spent in Sweden. Several options can be selected.

- ☐ Participated in a study circle/course
- ☐ Participated in a union meeting
- ☐ Participated in a meeting of Somali organizations
- ☐ Participated in a meeting of other organizations
- ☐ Been to the theatre/cinema
- ☐ Been at a cultural event/activity
- ☐ Participated in a religious event
- ☐ Been at a sports event
- ☐ Participated in a celebration of the Somali independence day
- ☐ Participated in a demonstration of any kind
- ☐ Visited a public event, e.g. music concert, entertainment or similar
- ☐ Participated in a big gathering of relatives

☐ Been at a private party or wedding/engagement party

☐ None of the above

47. **During your social activities, how many of the other participants in those activities are of the same background (e.g. sex, education or country of origin) as your own?**

Note: Chose one alternative

☐ All the other participants in those activities have the same background as my own

☐ Most of the other participants in those activities have the same background as my own

☐ About half of the participants in those activities have the same background as my own

☐ Most of the other participants in those activities have a different background than my own

☐ All the other participants in those activities have a different background than my own

48. **Does a person's background (e.g. sex, education, or country of origin) affect your level of trust for them, for example the credibility for what they say about different things?**

Note: Chose one alternative

☐ I only trust persons with the same background as my own

☐ I trust persons with the same background as my own rather more than others

☐ I trust persons with the same background as my own a bit more than others

☐ I trust persons with the same background as myself equally as much as others

☐ I trust persons with the same background as myself less than others

49. **How well do your common opinions and values match other persons of the same background (e.g. sex, education or country of origin) as your self?**

Note: Chose one alternative

☐ All my opinions and values are the same as other persons' with the same background as my own

☐ Most of my opinions and values are the same as other persons' with the same background as my own

☐ About half of my opinions and values are about the same as other persons' with the same background as my own

☐ Most of my opinions and values differ compared with other persons' with the same background as my own

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