AUSTRIAN FGM STUDY

THE APPLICATION OF FGM AMONG MIGRANT WOMEN IN AUSTRIA

AFRICAN WOMEN'S ORGANIZATION

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against female genital mutilation

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STUDY ON FGM IN AUSTRIA

The Use of Female Genital Mutilation (FGM) among migrants in Austria

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Study on FGM in Austria

Content:

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I. Introduction

Female Genital Mutilation (FGM), also known as female circumcision until 1990, is practiced by a significant number of societies in 28 African countries, some countries in the Middle East, and a few local communities in Asia. Recently, the use of FGM has been reported in Australia, Canada, Denmark, France, Italy, the Netherlands, Sweden, and England. In these countries, the victims are predominantly migrants who come from countries in Africa where FGM is practiced (Amnesty International). There is no accurate data on the incidence of use outside of Africa. According to statistical data from Hosken, there are 150 million babies, girls and women throughout Africa in countries where FGM is practiced who suffer this type of mutilation. Of these, 84.77 million live in East Africa, and 64.73 million live in West and Central Africa. 2 million girls and women are mutilated this way every year. Hosken also highlights the fact that these estimates need to be updated in the context of the annual rate of population growth in Africa, which ranges from 2.5% to 3% per year. Topping the list of countries where FGM is practiced are Nigeria (32.54 million), Egypt (29.15 million), Ethiopia (26.42 million), Sudan (11.85 million), and Kenya (10.80 million) (Hosken's FGM Statistics, 1997).

FGM refers to the partial or total removal of the clitoris and/or external female genitalia for cultural, religious, or other nontherapeutic reasons. There are four types of FGM. First, „sunna": in which the clitoral prepuce and/or the tip of the clitoris are circumcised; in clitoral circumcision or clitoridectomy, the clitoris, surrounding parts, and all external genital organs are removed. In infibulation, the clitoris and labia majora are removed. Then the vulva is sutured until only a small opening remains of the vagina through which urine and menstrual blood can escape. This is the most extreme form of FGM. In this case, the vagina must be re-cut and re-sewn for each birth and for sexual intercourse. Infibulation accounts for 15% of all cases of FGM. It is used in Somalia, Sudan, Egypt, Mali, Gambia and some regions of Ethiopia and Eritrea (WHO Fact Sheet 241).

In communities where genital mutilation is practiced, the procedure is usually performed by traditional healers (circumcisers). These are usually old women who use crude instruments such as knives and razor blades. Painkillers are not used, and the hygienic conditions are also extremely poor. The age of girls and women who are subjected to FGM varies from country to country and society to society. It ranges from newborns who are only 7 or 8 days old, as in Ethiopia and parts of Nigeria, to girls in puberty who are between 7 and 12 years old. In societies where the procedure is considered a rite of passage, girls of the same age are operated on in groups and a celebration is held to mark the occasion. Nowadays,

however, this form is on the decline and the girls for whom FGM is used are becoming younger and younger.

The use of FGM does not bring any benefits but only enormous risks. It is known that FGM has long-term effects on the physical and psychological condition of women and girls. The consequences of FGM depend on the type and severity of the procedure, as well as the skill of the performer(s) and the environment. The main sequelae are bleeding, infection, shock and pain, urinary tract infections, menstrual pain, cysts, abscesses, celloid formation, poor scarring, complications during childbirth, and pain during sexual intercourse. Bleeding and infection can lead to death. Long-term complications are irreversible and require medical treatment.

FGM is a widespread harmful practice in Africa. It is generally justified on the basis of tradition and cultural identity, religion, social relations (sociological reasons), such as initiation rites and social integration. All these myths around FGM aim to emphasize women's gender identity and control their sexuality. Chastity, virginity, and marital fidelity are thus supposed to be ensured. In some societies, these myths are deeply rooted. This means that all members of these societies must undergo circumcision wherever they live. This is probably one of the reasons why the use of FGM has been introduced in Europe, America and Australia by migrants from countries where it is practiced. This is also one of the reasons that FGM and other unwholesome traditions can only be fought when values and attitudes change. The use of FGM cannot only be eliminated legally. Rather, it is necessary to understand the problem and bring about a change in attitudes and values. This can be done through grassroots activities, conducting education and information programs in societies where circumcision is common.

The governments of the countries where FGM is used have all signed and ratified the various UN conventions that declare the protection of women's and children's health and protection from all types of use of violence. Much has happened in the last twenty years to abolish the use of unwholesome traditions such as FGM. International organizations, such as UNICEF, WHO, UNFPA and UNIFEM have coordinated their activities and made joint efforts regarding the problem of FGM since 1997.

Some governments of countries where FGM occurs have enacted laws prohibiting it. In America, Canada and parts of Europe, where the occurrence of the practice has been noted, laws have been enacted directly opposing the practice of FGM, or the laws under which FGM falls under child abuse or maltreatment are applied there. This is the case in Austria.

In the countries of origin of FGM, domestic and international NGOs have taken the initiative to fight the practice of FGM and other harmful practices. They are engaged in awareness raising, information, education, advocacy and research. NGO networks and the Inter-Africa Committee on Traditional Practices Affecting Women and Children-IAC-have established committees in 28 African countries to fight FGM and have already seen some success in their efforts. However, they need more support and coordination, as these NGOs are the only organizations working at the grassroots level.

The African Women's Organization in Vienna has given priority to the issue of female genital mutilation (FGM) since 1998. It aims to work with existing NGO networks to ensure that FGM is not practiced among migrants and is abolished in Africa, where it is part of the traditional customs of societies. This will be done through advocacy work, lobbying activities and grassroots support to the project implementing NGOs. The African Women's Organization has done awareness-raising work to raise awareness and understanding of the problem in Austria, and has also lobbied for support for grassroots anti-FGM activities. Furthermore, the extent to which FGM is practiced among migrants from Africa in Austria was recorded.

A study was started because there were strong suspicions and also verbal communications that FGM was being used among migrants in Austria. Similar studies in other European countries have shown that circumcision is common among migrants. As a result, there have been legal actions in some countries. Some NGOs working with migrants have prioritized the issue of FGM in their programs. The study could serve as a basis for the fight against the use of FGM in Europe. It will also raise awareness among immigrants about the consequences of FGM use and its negative impact on women's and children's health. If it is possible to save even one daughter of immigrants from FGM intervention, it will mean salvation for many in the future.

II. Recording the baseline situation of FGM: instruments and methods

A. Overall objective

The overall objective of this study is to record the extent of the use of FGM methods among migrants in Austria, furthermore to reduce and eventually eradicate cases of FGM in Austria. The study recommends the urgent need to take action against FGM among migrants in Austria. It also seeks to deepen the current knowledge and understanding of the problem and to support the activities already started in other European countries in the fight against FGM.

B. Subgoals

- Recording the frequency and all forms of FGM among migrants from Africa in Austria
- Recording the views and justifications for the use of FGM and elaborating strategies for combating FGM from these points of view
- Launching new and sustainable anti-FGM activities in Austria
- Recommending appropriate intervention strategies in the fight against FGM.

C. Study planning

This is a qualitative and descriptive cross-sectional study on FGM among Africans living in Austria. The study is based on a questionnaire with closed and open-ended questions. The questionnaire has three sections:

1) sociodemographic information
2) collection of views on FGM, and
3) intervention strategies.

In order to obtain truthful and complete responses from the respondents, the questionnaires were anonymous.Respondents' names and addresses did not appear on the questionnaires. The interview took place in households, one person per family was interviewed. The interviews were conducted by the interviewers in the homes of the interviewees after they had given their consent.

The African Women's Organization in Vienna prepared an initial questionnaire and held several meetings to make preparations for this project. A preliminary questionnaire was distributed to various experts from different fields, including doctors, health service officials, psychologists, lawyers and NGO staff in Vienna, who made comments, suggestions and additions. The Expert Group (see Appendix) met at the Afro-Asian Institute on December 16, 1999, to finalize the questionnaire. The questions were reviewed individually. Some questions had to be reworded or changed, and new items were added to eliminate confusion about certain terminology. It was decided that both men and women should be studied, as men play a large role in the use of FGM. The interview should be face-to-face, with women interviewing only women and men interviewing only men. It was also suggested that the target population should be 200 to 400 people.

D. Target group and number of respondents

The target population of this study is African migrants, mainly from countries where the use of FGM is widespread. Both genders are involved, and the men and women come from Somalia, Sudan, Ethiopia, Egypt, Kenya, Nigeria, Mali, Burkina Faso, Senegal, Ghana, and Sierra Leone. Not all migrants from Africa were interviewed. Two factors determined the selection of countries of origin for the study. First and foremost, migrants were selected from countries with a high percentage - over 70% - of women where FGM is practiced. With the exception of Ghana and Senegal, these are all countries of origin of those studied. In the case of Somalia, Ethiopia, Egypt and Sierra Leone, this percentage even rises to over 90%. The second factor concerned the total number of migrants from the selected countries living in Austria. The source for recording this population is the magistrates of Vienna, Graz and Linz, where most African migrants live. In these three cities there are 13,380 migrants from all parts of Africa. Of this total, 8,197 are from African countries where FGM is practiced. 4,890 of these are Egyptians and 1,112 are Nigerians living in Vienna. Countries that did not meet these criteria are Djibouti, Eritrea, Uganda, Cote d'Ivoire, Guinea, Liberia, Togo, Benin, Chad and the Central African Republic. The survey covered 3% of these individuals, a total of 250 migrants, 130 of whom were female and 120 male. Participants voluntarily agreed to cooperate and had no cognitive problems.

E. Data acquisition

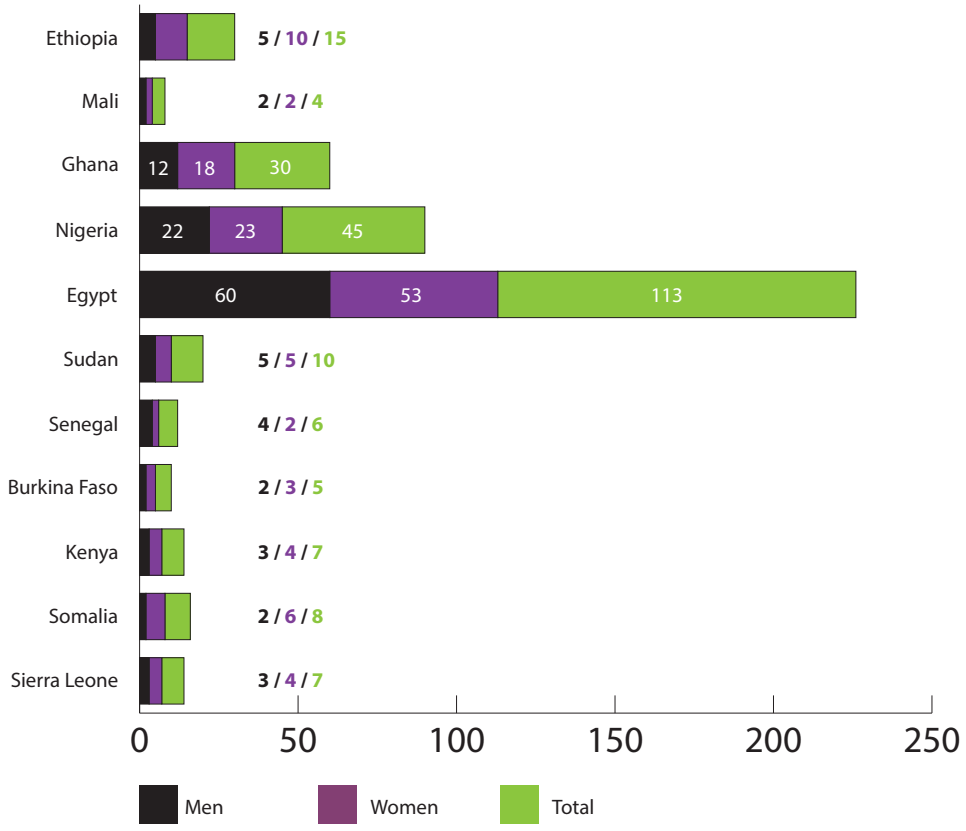
A questionnaire was developed that included socio-demographic information, respondents' views on FGM, and intervention strategies, and was finalized by the expert group. Before finalization, the questionnaire was tested. Interviewers received half-day training on the nature of the questionnaire, approaches and interview methods, and related matters. The target group was selected based on the extent of mutilation in the country of origin of the interviewee(s) and the number of migrants in Austria. The interview method was gender specific, meaning women and men interviewed respectively. The interviewers should be able to speak and write English, German and the mother tongue of the interviewee well. That is, the interviewers were to be from the same country of origin as the respondents. The assumption was that people who share a common culture and tradition can have a more open discussion about things related to their own tradition. Some topics were so sensitive that they could only be broached with the women, such as reproductive issues and child rearing. Other topics involved only the men, such as money and property. Questionnaires were distributed to interviewers and corresponded to the number of respondents from each of the countries studied. The questionnaires were filled out by the interviewees themselves, and in some cases the interviewees were also questioned by the interviewers. Prior to the interview, the respondents were informed of the general objectives of the study and were assured of the confidentiality of the information provided, even before the interviews began. The persons concerned were also assured that there would be no consequences for them or their family members living in Austria if they answered the questions.

III. Result and discussion

A. Sociodemographic data

250 Africans living in Austria took part in the study. The group studied consists of 130 women and 120 men living in Vienna, Graz and Linz. Of the 8,197 migrants who come from African countries where FGM is practiced, 75% live in Vienna. Of these, 59% are Egyptian and 11% are Nigerian. The group studied comes from East Africa - Ethiopia, Egypt, Sudan, Kenya and Somalia, and from West Africa - Mali, Ghana, Nigeria, Senegal, Burkina Faso and Sierra Leone (See Table 1). Countries such as Djibouti, where FGM is widespread, were not included because there were no migrants from that country. The study surveyed 113 individuals from Egypt, or 75.2% of the respondents, 45 individuals from Nigeria, and 30 from Ghana. From these countries of origin, a large proportion of the migrants are from.

Table 1: Group studied by country and gender



A total of 250 people were interviewed (120 men and 130 women)

A1 Age of the examined

The group of those studied is over 20 years old, only 3.6% of them are over 50. Most of the young ones are students who are between 20 and 29 years old, which is 26.4% of the group studied. Almost half of them, or 47.2% (118), are between 30 and 39 years old. The group of older people, who are between 40 and 49 years old, accounts for 20%. Less than 3% did not provide information about their age. Age plays a crucial role in the fight against hurtful practices. Young people are open and can absorb and internalize new values and attitudes if they get the right information, education and communication at the right time. On the other hand, it will be more difficult to persuade older people to change their lifelong held views and beliefs about harmful and traditional practices that are closely related to their religion, culture and tradition.

A2 Religion

The use of FGM does not concern only one religion, but is common in many religions. It is wrongly associated with Islam due to the fact that where FGM is widespread, the Muslim population is larger. This is true in countries in East and West Africa. In truth, in countries where FGM is practiced, the adherents of it belong to both the major religious communities, such as Islam and Christianity, as well as other religions. In our study, the adherents of these traditional practices were followers of Christianity, Islam, as well as other religions. A large proportion of those studied, or 148 individuals (59.2%), are Muslims, while another 87 individuals (34.8%) are Christians. This includes Catholics, Orthodox and Protestants. Looking at religious community affiliation among the three largest groups, it is clear that 85.8% of Egyptians are Muslims, while 71.1% of Nigerians and 53.3% of Ghanaians are Christians. Of the 177 respondents who have children, 121 are Muslim and 56 are Christian. Most of the respondents regularly attend religious celebrations in churches or mosques, depending on which faith they adhere to. From the survey, it appears that both Christians and Muslims practice female genital mutilation. As we will see later, religious leaders play a significant role in justifying and perpetuating the practice of FGM.

A3 The professions of the studied group

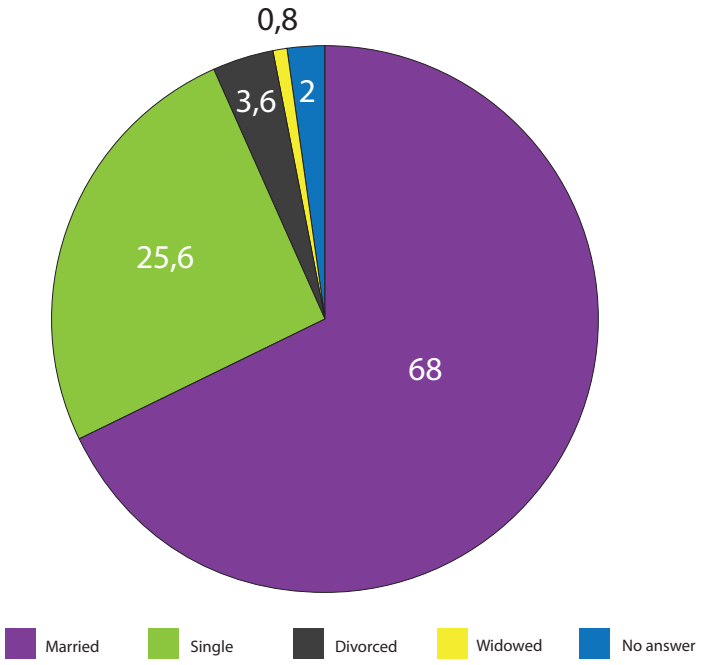
The group studied comes from a wide variety of professions. Most of them had another profession at home or took up a new profession due to training or studies. For example, the number of respondents from the group of teachers or businessmen was lower. From the survey it is clear that currently only 4 people are teachers and 18 are businessmen. From the same group, there had been 26 teachers and 27 businessmen in the country of origin, which means that these occupational groups decreased by 84.6% and 33.3%, respectively. One explanation for this may be that a different level is required here and specific licenses are needed for these professions. The number of housewives was reported as 19 in the African country of origin and has increased to 34 here, or 41%. The number of physicians increased by 75%. Twenty-six reported being refugees and asylum seekers and did not provide information about their profession. Most of them wanted to continue their studies or find a job to support themselves in Austria.

Occupation status is an indicator of educational level. To pursue an occupation, one must complete various levels of formal schooling, which may be a university degree or a technical college. Academically educated people, because of their education and standard of living, are more likely to be able to deal with the problems of traditional and unhealthy practices than a rural population made up of illiterate people. The latter do not have access to education or to information that would provide them with the tools to know their reality, analyze problems and make decisions. Education is the tool necessary to change values and attitudes, especially when it comes to unwholesome practices. It is not clear from the study whether living in another country has led to a change in views and practices. Issues of sexuality are still taboo among female respondents, the elderly, and married couples (except perhaps those who married Europeans). This is compounded by the fact that FGM is not discussed in the mass media or other commonly accessible places frequented by migrants who come from FGM-practicing countries. In the interview, all of those studied stated that they had not heard about this topic on the radio or television, or in newspapers or magazines in Austria. At the same time, a significant number of those examined stated that they had known something about FGM before they had left their country of origin for Europe.

A4 Marriage and family

Of the total number of people surveyed, 170 or 68 % are married. A quarter of those studied are single (see Table 2). Most of the couples married according to the traditional rite of their country of origin. This means, of course, that both partners uphold traditional beliefs and jointly decide to apply the traditional practices practised by their ancestors in the country of origin. In the case of an intercultural marriage between a European and an African, the application of some traditional practices that one of the partners considers to be completely new and possibly harmful may meet with his/her great resistance. It is therefore probably safe to assume that an Austrian woman who marries a man from a country where FGM is practised will not allow her daughter to be brought to that country to have a circumcision performed. As we will see later, this is one reason why children from intercultural marriages are not circumcised.

Table 2: The group of those examined by status in %



Married were 74 men and 96 women (=170), single 39 men and 25 women (=64) . Divorced were 5 men and 4 women (=9), widowed 2 men (=2) and 5 women (=5) gave no answer. A total of 120 men and 130 women were interviewed.

Of those included in the study, 177 (70.8 %) have children. These include children of married, widowed and divorced persons. As far as their age is concerned, 28 are between 20 and 29 years old. The majority, i.e. 95 persons, are between 30 and 39, and 47 persons are 40 to 49 years old. Only 7 persons are older than 50. The total number of children in these families is 456, of which 252 are girls.

B. The views of those studied on the application practice of FGM in Africa

At the beginning of the interview, general questions about FGM were asked, and only later were specific questions formulated. The questions concerned the age of the persons concerned at the time of the FGM procedure in their country of origin, who makes the decision on the application, what ceremonies or other activities accompany the rite of procedures, their personal view on FGM and finally the role and position of their government in relation to the fight against FGM. In fact, the application of FGM procedures in the different African countries shows great similarities. Minor differences concern the age of the girls at the time of circumcision and the festivals celebrated on this occasion.

B1 The age of those affected

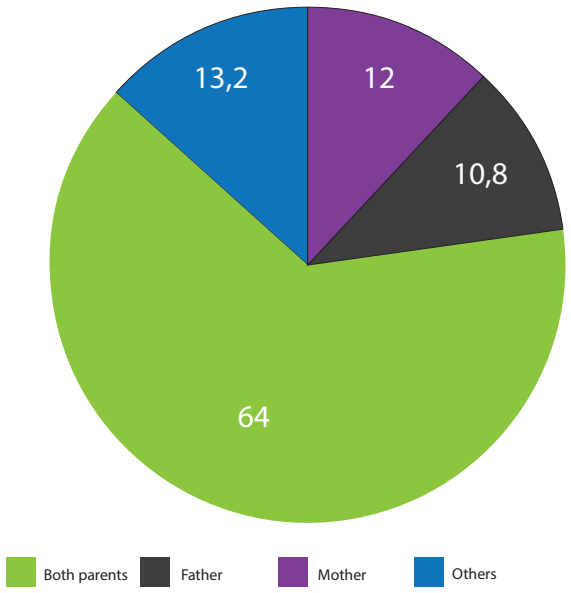
All respondents agreed that the age of the children at the time of the procedure is between 0 to 2 months and over 26 years. In some parts of Africa, especially Ethiopia and parts of Nigeria, children are circumcised 7 to 8 days after birth. 43 of the respondents or 17.2% said that in this case the procedure is performed on babies who are between 0 and 2 months old. 79 of the respondents (31.6%) said that most of the procedures are done before the end of the first year of life. If we look at the three major groups of respondents, i.e. people from Egypt, Ghana and Nigeria, we see that a high percentage of them said that babies under one year of age are usually circumcised. Furthermore, the study shows that the group of 6-13 year olds is considered suitable for this procedure. For 102 people (40.8%), this age group was the right one for practising circumcision. 46.9% of the Egyptian community felt that this age group would be suitable to perform the procedure. One can imagine the reasons for performing the procedure at such a tender age. One reason could be that the procedure can then be done without any resistance from the children and that the pain, shock and trauma of the mutilation cannot be remembered at a later stage. The other reason could be that older children may resist the procedure and may also receive information about the justification and method of the procedure through the school. The age for the FGM procedure depends on local

norms, based on which the use of circumcision has become part of the tradition and culture of the societies. The use of FGM as a rite of passage performed at a later age is becoming less important, circumcision takes place at an earlier age in many societies.

B2 Decision-makers for the FGM interventions

The second issue the group was asked about was the decision-makers in FGM interventions. Is it the decision of an individual (father or mother), is it a joint decision or is it up to outsiders such as relatives or neighbours. The results show that the decision is made by both the father and the mother (see Table 3). 64% (160) of the interviewees said that it was a decision made by both parents. This response came in greater proportion from the Nigerian group, 75.5% of whom said it was a joint decision. This is not surprising, as in Africa most marriages take place within the same clan or ethnic group, which share a common cultural basis.

Table 3: Decision-makers in the event of an FGM intervention in Africa in %



14 men and 16 women (=30) indicated that the mother is the decision maker, 13 men and 14 women (=27) indicated that the father is the decision maker. 78 men and 82 women (=160) indicated that Both are the decision-makers, 15 men and 18 women (=33) indicated that Others are the decision-makers.

The role of other members of the community is indicated by a considerable number of respondents, namely 13.2%. This group consists of in-laws, extended family members, clergy, village elders and others whose role is to preserve traditions. This seems to be particularly the case in Ghana, where 32.2% of respondents said that this group makes the decision about the intervention. The role of others is important when considering African migrants who perform FGM. Migrants do not completely detach themselves from their community of origin. Wherever they live, there will be a link to their community of origin, which is usually cultural. Both beneficial and harmful practices play the important role of building bridges between migrants and their countries of origin.

In addition to this, there is another African cultural element that needs to be put in perspective when asking about decision-makers. This concerns the „blessing" or „good wishes" for a young man or woman from parents and/or village elders. No African wants to disappoint, disobey or disgrace his/her parents, the village elder or members of the extended family. Whatever they say is considered the law and is respected, whether you live in that community or are far from it. Anyone who disobeys is considered an outcast and if he suffers any misfortune, it is attributed to his disobedience to the elders or their lack of blessing. It is therefore natural for Africans not to disobey the decisions and interests of their immediate family, the elders in the extended family as well as the village elders.

B3 Activities around the FGM intervention

Wherever FGM is understood as a rite of passage, genital mutilation is associated with ceremonies. In other cases of circumcision, the ceremonies, which are celebrated with varying degrees of elaboration and grandeur, can also help to reduce the pain and suffering of the young girls affected. However, as we know, FGM is becoming less significant as a rite of passage and the age of the girls is getting lower. In Ethiopia and Nigeria, circumcision is not seen primarily as a rite of passage, and the procedure is performed before the baby is one year old. As we have already seen in the previous section, 31.6% of those surveyed reported that circumcision is performed on babies who are less than one year old.

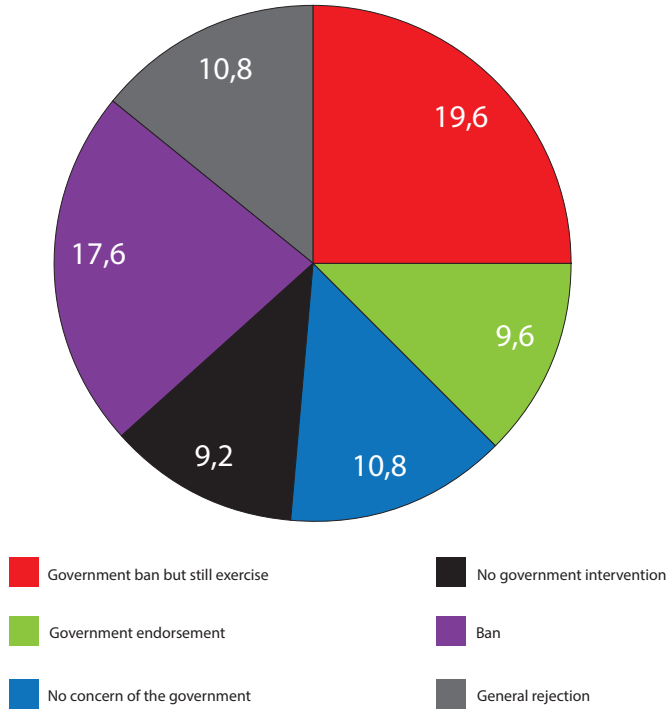
33.2% of the respondents reported that the FGM intervention is celebrated with a feast. The feast may have the following elements: i)family gathering, ii) women-only gathering iii) a large feast iv) a small feast. The size of the feast and the various preparations may depend on the age of the girl and the wealth and reputation of the parents. If girls of the same age group are circumcised at the same time, the feast will be bigger, all parents and neighbours will participate in the preparation and the feast itself. At the

feast, for example, a sheep or a cow may be slaughtered, various traditional foods and drinks prepared, singing and dancing. Among members of the Nigerian community, 61.9% said that the ceremonial preparations depend on the age of the girl. In Egypt and Ghana, small parties are usually prepared for the neighbours and the extended family for this occasion. In Ethiopia, on the other hand, this ceremonial celebration is not significant for most ethnic groups. In the Afar region, however, a large festival is celebrated for the circumcision of boys. For most ethnic groups in Ethiopia, however, a chicken is sacrificed to drive away the evil spirits that threaten the children during circumcision.

B4 The opinion of the group under study and the role of their governments regarding FGM

The impact of FGM on the health of children and women is fully recognised by governments, UN agencies, national as well as international NGOs and activities are being undertaken to combat unwholesome traditions such as FGM. Governments have signed and ratified international conventions and resolutions protecting women and children against abusive practices and all forms of violence. Some governments have enacted laws against FGM, in addition to their criminal laws that punish child abuse. But laws alone are not enough as long as there are no ways and institutions to monitor the application of these laws. The contribution of legislation should not be seen as a stand-alone measure. Legislation in itself, especially as it relates to laws that touch on traditions that are deeply rooted in a society, will only lead to these practices being applied in secret. Legislation should be a supportive tool and accompany other activities in the field of education, information and communication that should lead to a change in values and attitudes. If compliance with the law is not monitored, the government will be indifferent to the problem and will not fight FGM vigorously. All countries considered in this research, with the exception of Somalia, have laws or ministerial decrees or similar regulations enshrined in their constitutions. The responses of the group studied regarding their government's stance therefore do not appear to reflect the efforts of the governments considered in this study.

Table 4: The opinion of the group under study regarding the role of their governments/governmental action in %



The results in Table 4 show the opinion of the respondents (194 people answered this question) about the practical actions of their governments. The fact that most governments have ratified important UN conventions on women and children and that FGM is punishable under the law speaks against the results in the table. According to 9.6% of the surveyed group, governments support the use of FGM. 10.8% of the respondents stated that the government does not care or is indifferent to the issue and that the problem of FGM and that of other harmful traditional practices is not a priority for them. 9.2% of the respondents stated that there are no activities on the part of the government to stop the use of FGM. The latter could be due to the fact that for governments, the use of FGM is not an issue or even meant that any interference could bring unforeseen problems and disrupt the status-quo.

This table also shows that 19.6% of the respondents indicated that the use of FGM is prohibited by law, but FGM is practiced regardless of the penalty imposed. This may be an indication of a lack of institutional means to monitor the application of the law or a lack of grassroots protests to stop FGM within their communities, the serious consequences of which for the health of children and women are well known. 17.6% of the surveyed group stated that the use of FGM is banned in their countries, but do not

provide any information on the effectiveness of this law. This may indicate that some African governments have passed laws criminalising FGM. On the other hand, 10.8% of respondents said that everyone was against it. If everyone does not mean something else, then this answer is very difficult to accept. After all, all respondents come from countries where FGM is widespread. If everyone were against it, the problem would already be solved. A fairly significant number, 16% of those surveyed, have no idea or do not know what their government is doing.

C. The role of those examined in the use of FGM

In the previous sections, we tried to show the background of FGM use in the countries of origin of those studied, in terms of age at intervention, decision-makers for the same, etc. In the present chapter, we will try to bring the issue from the general to the specific level, i.e. by focusing on the group of those studied. In the present chapter, we will try to bring the topic from the general to the specific level, i.e. by focusing on the group of those studied. This group no longer lives in a society where they are pressured to apply traditional practices or follow certain norms and to regard FGM as an intervention that they received from their ancestors as part of their religion, culture and tradition. Questions about personal involvement are very sensitive, they can expose the person or lead to self-accusation, especially where the place where the circumcision was performed is concerned. The questions were therefore asked indirectly, such as *„Do you know anything about this?"* or *„Do you have any information about this or that?"* It can be argued here that these types of indirect questions will elicit personal responses and experiences. Direct questions, however, would not be purposeful. For fear of discovery, challenges and possibly a guilty conscience, people are reluctant to speak openly about the actions they performed on their daughters in the course of the FGM procedure.

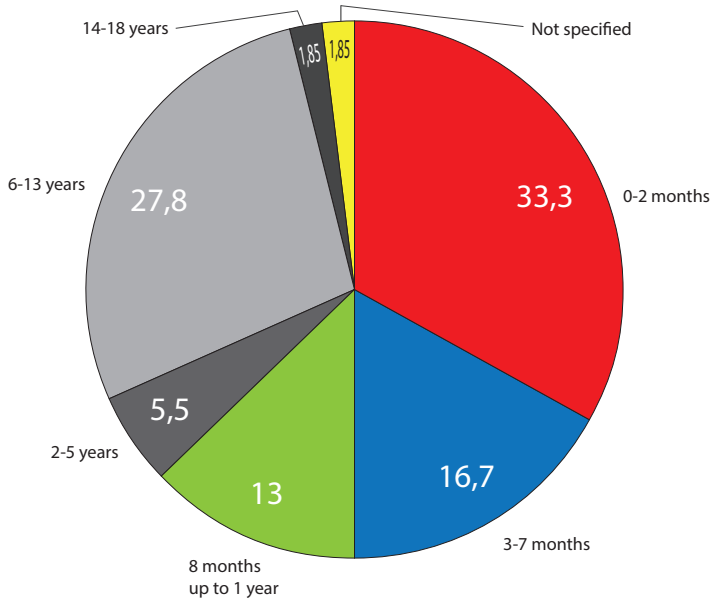
In the section on status and family situation, it was revealed that 177 (70.8%) of the respondents had a total number of 456 children, of which 252 were girls. Of these, it is assumed or expected that they had undergone circumcision. In their responses to the question about an intervention resulting in female genital mutilation, 54 of the 177 respondents (30.5%) said that their daughters had undergone an FGM intervention.

C1 Age during an FGM procedure

According to this study, 88 out of 252 girls (35%) had undergone FGM. The age of the girls at the time of the procedure reflects the situation prevailing in the respondent's country of origin (see the situation in Africa in the previous chapter). One third of the parents whose daughters had undergone FGM reported that they had been operated on before they reached the age of two months (see Table 5). It is important to remember that in countries like Ethiopia and Nigeria, the procedure is done 7 to 8 days after birth. In the present study, 16.7% of families said that their daughters were 3 to 7 months old at the time of circumcision. 63% of parents had FGM performed on their daughters before the age of one. The survey clearly shows that the majority of procedures take place before the end of the first year of life.

In the previous section on the situation in the respondents' countries of origin, it became clear that in addition to the group of children under one year of age, there is another age group for which FGM is widespread. This is the group of 6-13 year olds. Specific information from parents whose own daughters have been circumcised confirms the importance of FGM among this age group. According to this study, 27.8% of parents had their daughters circumcised at this age. Their age at the time of the procedure varies by region. Looking at the larger groups of respondents, 63.6% of Nigerian parents said that their daughters were operated on when they were less than one year old. Among Egyptians, 58.8% of parents said their daughters were circumcised between the ages of 6 and 13. In both cases, the different age groups reflect the traditional practices practised by the respective societies. Rarely, procedures occur after the age of 14, and affect only 1.9 % of the interviewees.

Table 5: Age of the daughters of those examined on whom genital mutilation (FGM) was practised in %



7 men and 11 women (=18) stated that they had circumcised their daughters between 0 and 2 months. 2 men and 7 women (=9) said they circumcised their daughters between 3 and 7 months. 1 man and 6 women (=7) said they circumcised their daughters between 8 months and one year. 2 men and 1 woman (=3) said they circumcised their daughters between 2 and 5 years.
10 men and 5 women (=15) said they circumcised their daughters between 6 and 13 years. 1 woman stated that she circumcised her daughters between 14 and 18 years. 1 woman did not give any information. A total of 54 people were interviewed (22 men and 32 women).

C2 Place of circumcision

Where FGM is widespread and recognised as part of the tradition, circumcision is performed within the community and accompanied by certain ceremonies. These include a celebration before and after the procedure. This can be performed in the village, in the case of an initiation rite in the forest, in the house or under a tree. The choice of different locations, which exist at home, does not exist for procedures performed in countries where FGM is not practised, such as the USA and Europe. The reason for this is that FGM of girls and women is prohibited and therefore not an eligible tradition. Where there is pressure not to perform the procedure, parents are forced to look for another way to

perform the genital mutilation. In order to fulfil their duties in the traditional way and to be able to do so in the presence of the extended family, the clan and others involved, many parents choose to have FGM performed in their home country. Of course, this means that they have to travel there. There are various reasons for this travel, an annual holiday, a funeral or maternity leave, the latter especially if the procedure has to happen in the first weeks of life.

According to this research, the ban on female genital mutilation in many parts of Europe has forced parents to travel to their country of origin for the procedure. Of the 54 families who had their daughters undergo FGM, 88.5% had it performed in their African home country. The remaining 11.5% had the genital mutilation performed in Europe. This percentage is further divided, showing that in Austria 1.9% of parents had their daughters operated on, while 9.6% of parents had the procedure performed in Germany and Holland.

The second important question is the location of the procedure. In Africa, both circumcisers and victims keep the genital mutilation a secret. After all, health services are only available in the urban milieu, FGM is not considered medical treatment, and most FGM procedures are performed by traditional healers at home with various instruments such as razor blades and knives. Where FGM is considered a rite of passage, girls are circumcised together in the village. Only urban dwellers and the elite who can afford an operation have access to medical professionals who can perform the procedure in hospitals or outpatient clinics.

The survey shows that two-thirds (66.7%) of the parents interviewed whose daughters had undergone genital circumcision had the procedure performed in hospitals and/or outpatient clinics. This is a relatively high percentage based on African experience. This indicates that the respondents are academics from the urban milieu who have access to modern health facilities. The remaining 33.3% had their daughters operated on outside health facilities. Of these, 25.9% had FGM performed at home. This group also includes the 7.4% of parents who reported that the procedure was performed by local doctors, with traditional midwives also acting as circumcisers. It is not clear whether the parents had to bring their daughters to the circumciser's home or whether the circumciser performed the procedure as an outpatient in the respective home.

The study tried to find out the situation of migrant children in Austria. In the previous section, it was shown that 54 families or parents reported that they had genital mutilation practiced on their daughters, and this mostly happened in Africa. In order to get additional information on this aspect, the group of respondents were asked *„if they knew*

or had heard that children of migrants born in Austria were circumcised". The results show that 30.4% (76) of the respondents said that they knew and also had information that children born in Austria to migrants were subjected to FGM. On the other hand, the majority of respondents, i.e. 60% (165), clearly stated that they did not know anything about interventions on migrant children and did not have any further information about it. Another 3.6% of respondents did not answer this specific question.

Following this question, respondents who claimed to know about FGM of migrant children were asked to indicate, from their personal experience, where the girls were circumcised. The respondents each indicated more than one place where the procedures were performed. The following ranking of places where circumcisions take place emerged:

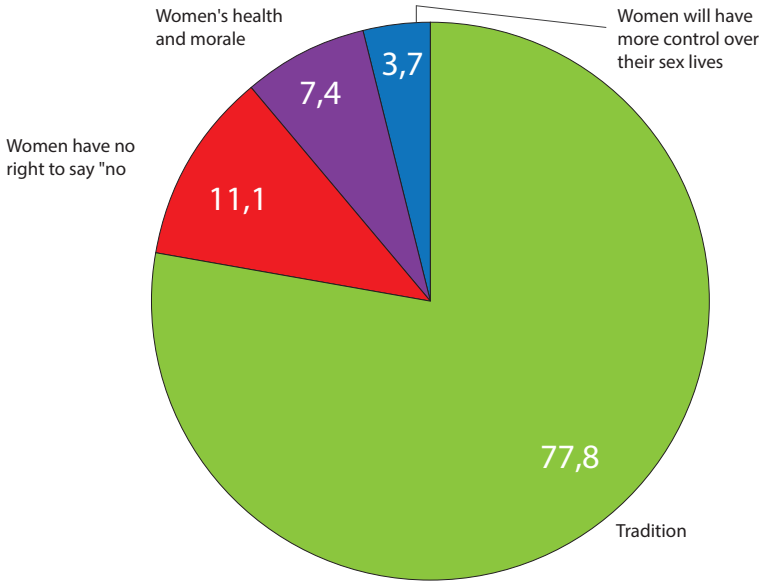
- 63 respondents said the procedure was performed in Africa,
- 29 stated Europe and another
- 21 stated Austria as the place of the operation. In the latter two cases, it was stated that the procedures were done in hospitals. However, there was no additional information about this.

C3 Personal justifications of the persons studied about the genital mutilation of their daughters

Proponents of FGM and those who perform it have countless myths and justifications at their fingertips with which they advocate for the preservation of FGM on women and girls. These include religion, tradition and culture, health (see also the bibliography on female genital mutilation). Respondents who subjected their daughters to this procedure justify this act with similar justifications to those in countries where FGM is practised - going back to the roots. Tradition is again seen as the main reason for justifying FGM practices (see Table 6).

The results of the surveys clearly show that the justifications or explanations given by parents of daughters who have undergone circumcision are based on three arguments: 1. tradition, 2. women's rights and 3. women's sex life. The respondents base their decision and actions on these three main arguments. Of the 54 parents, 77.8% claim that they support FGM for reasons of tradition - because it would preserve traditional norms and practices. They see no reason to deviate from these traditional practices, although they are probably aware that genital mutilation is harmful to health. The second justification, given by 11.1% of parents, is based on the phenomenon that women have no right to say „no". They do this on the assumption that men alone are empowered to make decisions and that it is the duty and responsibility of women to follow these decisions. At the same time, this means that women have no right to make decisions, even if it affects their right to life and their bodies. The further justification gives „benefits" of genital mutilation for women. This is said to be healthy for women and to enable them to keep their sexual desires and needs under control. These reasons were given by 7.4% and 3.7% of parents respectively.

Table 6: Parents' reasons for performing genital mutilation on their daughters in %



A total of 54 people were interviewed. 18 men and 24 women (=42) referred to tradition. 2 men and 4 women (=6) were of the opinion that women have no right to say „no". 2 men and 2 women (=4) invoked health and morality and two women felt that women will have more control over their sex lives.

On the other hand, however, parents who did not subject their daughters to this procedure also gave the reasons why. The respondents gave their tradition, health, human rights, age and other reasons as reasons. Of the majority of those surveyed in this group, 41.6% stated that they did not have the procedure done because it was not part of their tradition. They also describe FGM as an unwholesome tradition that harms women and children. For another 14.2%, FGM is unhealthy. A few of the respondents did not see a moral, psychological or physical need for the operation. Two findings from these responses are particularly interesting: 1) 6.2% of parents do not accept FGM practices because the children are from intercultural marriages, meaning one parent is from Europe; 2) another 6.2% of respondents cited age as a reason for refusal, meaning the child is too young. In other words, this only means postponing the intervention. This decision further means that the procedure will most likely be performed when the daughter is old enough for it, namely between 6 and 13 years.

D. Respondents‘ opinions and views on FGM

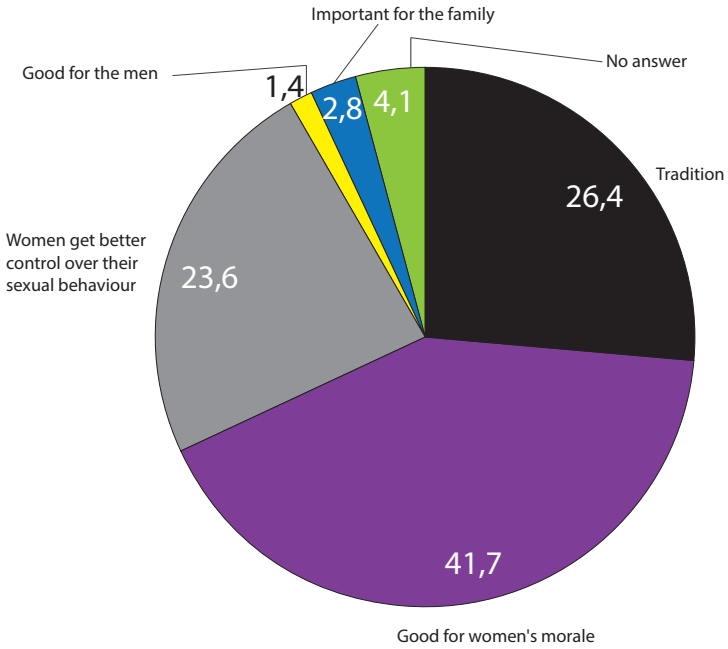
In the following sections, we address how the group under study thinks about FGM and what should be done to prevent and stop these unwholesome practices. The issue of female genital mutilation (FGM) is very sensitive and taboo in the countries where it is practised. The justification of FGM practices is based on culture, tradition and religion. There is no opening for discussion, challenge or change in these areas of life. Unhealthy traditions, and FGM in particular, have only recently been challenged and examined. Regardless of their consequences, certain traditional practices have their proponents and defenders. Calling for change requires that the proponents be identified and the justifications analysed. Once the main justifications are established, appropriate intervention methods can be designed to change views about harmful practices.

The results of the survey indicated that 28.8% of the people studied were in favour of traditional FGM practices. 58.9% of these individuals are men. On the other hand, 68.8% of the respondents do not personally support the use of FGM, of which 55.2% are women. 2.4% of the respondents had no opinion about FGM. The survey shows that men are more likely to support the continued use of FGM.

D1 For and against FGM

Those in favour of FGM cite traditions, morality and sexual behaviour as reasons (see Table 7). These three areas of justification tend to be more prevalent in discussions advocating the continuation of and reasons for the use of FGM practices. Based on the results, 41.7% of respondents believe that the procedure is good for women‘s morale. Another 23.6% of respondents said that it gives women more control over their sexual needs and behaviour. These two justifications are closely related, as it is assumed that a circumcised or mutilated woman will control her sexual needs and behaviour. This will make her a decent woman, a woman who knows and accepts her status and role in the family and society. The importance of tradition for the continuation of FGM practices is given by 26.4% of the supporters. Other justifications, such as that FGM is „good for men“ (probably in relation to sexual intercourse) and the importance of FGM for the family, are only supported by a small number of FGM supporters.

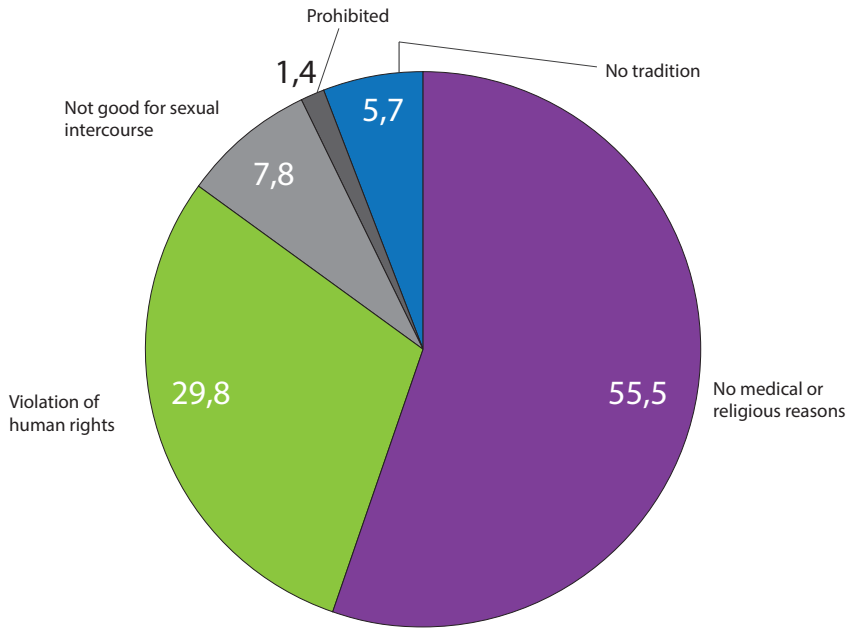
Table 7: Reasons for the use of FGM given by 72 of the FGM supporters in %



A total of 72 people were interviewed. 8 men and 11 women (=19) referred to tradition. 15 men and 15 women (=30) were of the opinion that it is good for women's morale. 13 men and 4 women (=17) thought it gave women better control over their sexual behaviour. 1 woman thought it was good for men, 2 men thought it was important for the family and 3 men gave no answer.

On the other hand, out of 172 people who did not support the use of FGM, 141 gave the reasons why (see Table 8). In some cases, their justifications are the opposite of what those in favour of FGM stated. In their responses, respondents stated that the use of FGM had no justification whatsoever, meaning that 55.3% of opponents strongly believe that FGM offers no medical benefits and that there are no justifications for it in religion either. This refers to the fact that the two largest religions neither advocate nor require female circumcision. Another strong argument against it is the fact that female genital mutilation is fundamentally a violation of human rights, especially a violation of the rights of innocent children who cannot make decisions about this matter themselves. Some of the respondents also see a connection between FGM and sexual behaviour. 7.8% of the respondents state that FGM brings disadvantages during sexual intercourse. The fact that FGM is banned in some countries and is not part of tradition everywhere has an indirect influence on some respondents' attitudes towards FGM.

Table 8: Opinions of 141 people who do not support FGM in %



A total of 141 people were interviewed. 42 men and 36 women (=78) were of the opinion that there are no medical or religious reasons for circumcision. 12 men and 30 women (=42) were of the opinion that it is a violation of human rights. 11 women gave as a reason that it would not be good for sexual intercourse. 2 men gave the prohibition as a reason and 8 women said that it was not a tradition.

D2 Knowledge about the consequences of genital mutilation of women and girls

Another important question asked of the group was about their knowledge of the various effects of FGM on women and little girls. The question was as follows: Do you see anything positive in the use of FGM? The answers depended on the level of awareness and knowledge about the nature and effects of these practices, the level of education and the cultural background. Regarding the positive aspects of FGM, 136 (54.4%) of the respondents clearly stated that they did not see any positive aspects of FGM. Of this group, 57% were women. On the other hand, the respondents for whom FGM has positive aspects stated that circumcision is good for women and, above all, beneficial to their health. They further claim that FGM is 1) healthy for women, 2) preserves the marital fidelity of women and 3) gives women better control over their sexual behaviour. For

14.8% of the respondents, point 2) is most important for the women. Almost a quarter of the group surveyed (23.6%) do not know whether FGM should be seen as negative or positive.

One means of finding out the level of awareness about FGM and its impact on health, as well as other factors, is through perceptions of the side effects of FGM. The people who perform FGM procedures, the circumcisers and the victims, at least those who are old enough to know what is going on, are likely to perceive only the immediate consequences of FGM, such as bleeding and pain. The long-term effects with their severe consequences will probably go unnoticed by them. The health, physical and psychological consequences of FGM are already clearly analysed and supported by medical and other research. In this study, respondents' answers show that 56.8% (142) said they were aware of the negative side effects of FGM. They also attempted to indicate the most important side effects of FGM. The following side effects were mentioned in order of importance: 1) Interference with sexual intercourse 2) Infections 3) Pain 4) Problems during childbirth 5) Bleeding 6) Trauma and 7) Death.
72 of the respondents, i.e. 28.8%, claimed not to know any side effects of FGM interventions, 9.2% did not give any information in this regard.

E. Intervention strategies of the studied group

The use of FGM is an unwholesome tradition that must be stopped and eradicated. Since FGM is deeply rooted in tradition and culture, the eradication of FGM practices must be based on a change in values and attitudes. The question now is how to achieve this. International organisations, NGOs and the government have their own strategies and methods. In this study, an attempt was made to capture the opinions of the group studied on the continued practice of FGM. Should FGM be eradicated, used sporadically or continue to be practiced and who should take responsibility for activities that lead to its eradication?

In the previous chapters, it was shown that 56.8% of the group studied know that FGM causes side effects in women and children. It was also shown that 54.4% are not aware of any positive effects of the FGM intervention. However, this knowledge does not seem to influence their attitude towards eradicating FGM practices. Only 24.4% (60) of the respondents are in favour of the total abolition of FGM. The majority, 76 %, are against the total abolition of FGM. This means that the latter would like to see FGM applied in a different form, probably favouring medical supervision. As has been pointed out several times in this paper, the respondents are in favour of FGM practices for reasons of tradition. As long as FGM continues to be practised in the countries of origin, migrants will continue to practise these traditional practices.

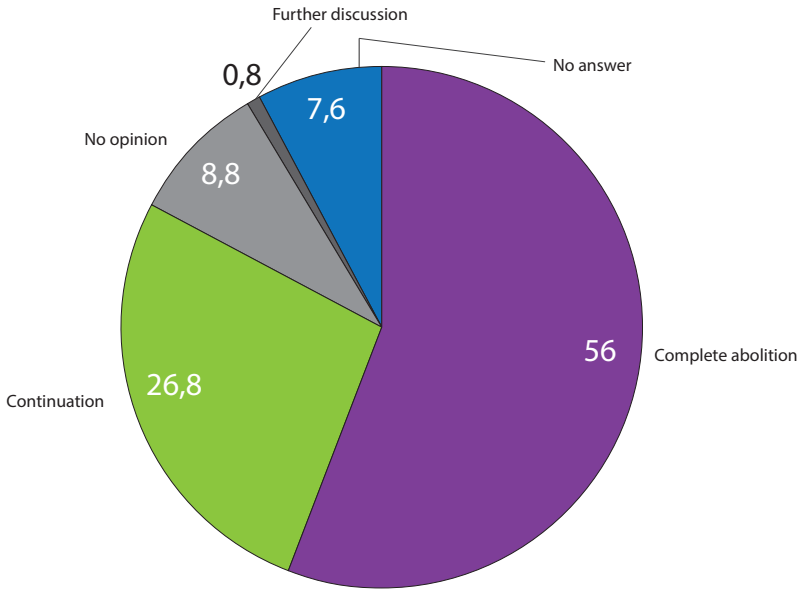
The group studied was asked how changes could be brought about. One response was about medical control. Proponents of medical control claim that the harmful effects on health are reduced if the procedure is performed in a hospital or outpatient clinic under hygienic conditions, with proper instruments and by medical professionals. The results of the study show that 146 of the respondents, 58.9% of whom are women, are in favour of the procedure being performed under medical supervision. However, medical control is not a solution, as FGM should be rejected for various reasons, including the violation of human rights. The World Health Organisation has called on its member states to ban FGM under medical supervision and to discourage medical personnel from performing FGM procedures. The Inter-Africa Committee has also called on its member states to heed the World Health Organisation‘s call.

The group under study sees a legal ban on FGM as a way to prevent and eradicate FGM. But in reality, laws are pieces of paper. If there is no accompanying control over their implementation, they remain worthless. Laws enacted without a change in values and norms are likely to only lead to further problems. In response to the question about laws and consequences for violators, 60.4% of respondents said that laws banning FGM should be enacted. However, 35.6% stated that there was no need for such laws. On the other hand, 1.2% believe that laws are necessary, but that the perpetrators should not be punished.

Regarding the future treatment of FGM, the group studied has different opinions (see Table 9). The answers naturally depend on the level of awareness, the degree of attachment to traditions and culture, the type of marriage, etc.

According to this study, 140 (56%) of those surveyed believe that FGM should no longer be used in the future. The methods and means by which this should be achieved are indicated below. Another 26.8 % believe that FGM practices should continue. The supporters or defenders of FGM are the hawks for religious and traditional reasons. Then there are the undecided who do not know what should happen to FGM in the future. 8.8 % of the group surveyed „do not know" what should be done about FGM in the future.

Table 9: Opinion of the group studied on the future of FGM in %



A total of 250 people were interviewed. 65 men and 75 women (=140) were in favour of a complete abolition of FGM. 37 men and 30 women (=67) were in favour of continuing it. 15 men and 7 women (=22) had no opinion, 2 men wanted to discuss it further and 1 man and 18 women (=19) did not answer the question.

In this last chapter, an attempt was made to find possible solutions regarding the use of FGM based on the experiences and opinions of the group studied. In the discussions on the findings of the study, some possible solutions were presented by the respondents. These include the introduction of laws on FGM, which should be accompanied by the appropriate control mechanisms. Furthermore, a complete ban as well as the rejection of its use under medical supervision came up.

In the survey, people were asked to come up with their own suggestions to solve this sinister practice. Some of the respondents made suggestions, others expressed an opinion, but this in itself does not mean a solution to the problem. For this last group, the problem is local and not global, as if the use of the same was not a violation of human rights or harmful to reproductive health. In other words, it means that FGM is deeply rooted in tradition due to cultural or religious factors and is therefore not open to discussion. One can only be led by the people who practise it. Here, there are two currents that hold this position. 1.2% of the respondents thought that it was an African problem, while another 23.2% said that it was not a European problem. Another 8.4% of the group surveyed see a solution in Europe supporting the fight against FGM and providing resources. A few, namely 8%, believe that FGM is not a problem at all and therefore nothing needs to be done.

As far as practical proposals to fight FGM are concerned, education is mentioned first. Consequently, 34.4% of the respondents suggest that Africans (in Africa) as well as African migrants in Europe, America and Australia should participate in educational programmes on the subject. Another 1.6% see this as the responsibility of parents. Another suggestion, made by 5.2% of respondents, emphasised the need to stop FGM altogether. 15.2% of respondents made no suggestions.

The fight against FGM is being led in a variety of ways by UN agencies, governments, national and international NGOs and civil society. It ranges from introducing legislation to grassroots activities. The surveyed group was asked to name the main actors involved in anti-FGM activities. According to their answers, the main responsibility to solve the problem lies with the government.

Thus, 54.1% said that this was the duty and responsibility of governments. On the other hand, 26.7% attributed this responsibility to local and international NGOs. Finally, 19.2% see religious leaders and community leaders as the right contact persons for the fight against FGM. The actual solution depends on the particular activities that are carried out, which should be done jointly as a team between the government, NGOs and the communities.

The governments of countries where FGM may occur would have to take greater responsibility for the fight against FGM, which they should launch, coordinate and implement. Their tasks consist of introducing laws, educational programmes and interventions at the grassroots level. On the other hand, countries where FGM is not practised must also take part of the responsibility in the fight against it, as FGM is practised by migrants in their respective countries. The goal must be to prevent and eradicate FGM. This requires looking at the problem globally, not just in one's own country. The best and most efficient way to find a solution is to eradicate FGM practices at their source. Europe must therefore support all activities aimed at banning FGM in the countries of origin. In this survey, 135 (54%) people think that the Austrian government should be involved in the fight against FGM. The same number of respondents would like European countries to develop a common position and take joint action in the fight against female genital mutilation.

IV. Recommendations

The study on the use of FGM among migrants included 250 men and women from countries where FGM is practiced. The study shows that FGM is practised among migrants in Austria and that 35 % of girls have undergone this procedure. 63 % of parents whose daughters underwent FGM had this procedure performed when their daughters were less than one year old. 88.5% of the procedures took place in Africa, the rest in Europe including Austria. It turned out that 76 % of the group surveyed is against the complete abolition of FGM. More than half of the respondents, 54 %, believe that the Austrian government and Europe should contribute to finding a permanent solution for the abolition of this sinister tradition.

1. The problem of FGM is no longer taboo, as it is a violation of human rights and has thus become a global issue. It requires joint efforts by UN agencies, governments, national and international NGOs. The latter have already been active at the grassroots level and have formed strong networks. One such non-governmental organisation-NGO is the Inter-Africa Committee on Traditional Practices Affecting Women and Children, which has 28 committees at the national level. The best and surest way to solve the problem is to tackle it at its source, namely in the countries where FGM is practised. As FGM is closely interwoven with culture and tradition, a change in values and norms in the country of origin will lead to its use becoming obsolete among migrants. Therefore, in addition to preventing and eradicating FGM among migrants, it is recommended that grassroots activities be undertaken to combat FGM. These should be supported through educational programmes, aid funds, lobbying, etc.

2. Legislation making FGM a criminal offence is a step in the right direction to show that FGM is not officially accepted and tolerated. In some countries there are specific laws in this regard, in other countries, including Austria, the Criminal Code is used to deal with the problem. Specific laws, such as those contained in the New Zealand Crimes Act of 1966, could play a major role in the fight against FGM.

3. The use of FGM under medical supervision was seen by many (58.4% of the group studied) as a means of avoiding the side effects of the FGM procedure. The basic argument, however, is that FGM is a violation of human rights and therefore not a purely technical issue. Since both the World Health Organisation and the Inter-African Committee prohibit and advise against the use of FGM under medical supervision, FGM as such must be banned. Medical staff and health workers who deal mainly with migrants should be informed and discouraged from practising FGM.

4. The most effective solution to the FGM problem lies in changing values, attitudes and social norms. It is not enough for individuals to change their behaviour. The decision to move away from FGM must be made and supported by the society in which FGM is practised. These changes will take some time, but the result will be more drastic if more people are involved. Changing values and attitudes needs information, education and communication. Field research has highlighted the importance of education programmes.

   a) Since religion is given as a point of justification for FGM, a platform should be created where religious leaders - Catholics, Muslims and Copts - come together to clarify the religious aspects of FGM and set awareness-raising activities. Something similar should be done at the community level, where older people who have lived here for a while and who are respected by their respective communities should do the same.

   b) Intensive awareness-raising activities must be set up in seminars and discussions with experts (lawyers, social workers, doctors, NGO workers overseas etc). The problem should be analysed, the consequences of FGM should be explained and the question of human rights, empowerment of women etc. should be raised. They should particularly address migrants, students and teachers.

   c) Courses on reproductive health and human rights must be held for women who come from countries where genital mutilation is practised.

   d) Furthermore, courses and instructions are to be offered for health workers and social workers who provide antenatal and child care for migrants.

   e) The mass media (radio and television) and newspapers should disseminate more information and educate migrants. Resources should also be mobilised here to support activities in the fight against FGM.

The African Women's Organization is fully committed to implementing these recommendations together with dedicated government departments, NGOs and FGM networks, as well as with all those who have a stake in the abolition of this sinister practice.

V. Attachment

Attachment 1: List of experts

Dr. Eva Rossmann
Dr. Rasheed Akinyemi
Stella Attakpah
Mag. Christine Buder
Dr. Brigitte Bukassa
Mag.Marijana Grandits
Astrid Gruber
Etenesh Hadis
Dr. Afework Kassa
Pamela Olet
Karin Ortner
Mag. Nicole Pinteritsch
Maria Rieder
Mag. Irene Schwarz
Dr. Raaga El Teriefi
Christiane Ugbor

Attachment 2: Questionnaire

(Please tick the appropriate answer and provide any additional explanations)

I. Sociodemographic data

1. Country of origin
2. Gender (F) (M)
3. Age
4. Religion
5. Occupation a) in home country b) in Austria
6. Status (married) (single) (divorced) (widowed)
7. Do you have children? (Yes) (No)
8. If yes, how many boys ... how many girls ...

II. Assessment of respondents' attitudes towards the use of Genital Mutilation

9. Have your daughters been circumcised? (Yes) (No)
10. If yes, at what age were they circumcised? ...
    If no, why were they not circumcised? ...
    If yes, why were they circumcised? ...

11. Were the daughters circumcised in their home country or abroad? ...
12. Were they circumcised at home or in an outpatient clinic/hospital? ...
13. At what age are girls and young women circumcised in your home country? ...
14. Who makes the decision about the circumcision of the children? (Father) (Mother) (Both) (Others)
15. What happens in your home country regarding circumcision of women and girls, what is your government's position regarding the use of FGM? ...
16. Is there a cultural ceremony in your home country on the occasion of a circumcision? (Yes) (No) If yes, describe it briefly ...
17. Do you know or have you heard that children born in Austria to migrants are circumcised? (Yes) (No)
    If yes, where/in which hospital is such an operation performed? ...
    Or were the girls brought to Africa for circumcision? ...
    Or to other European countries? ...

18. Do you personally support female genital mutilation?
    (Yes) (No) (Why? ...)

19. What are the positive aspects or significance of female circumcision ...
    (If it has no significance, go to the next question, if it is significant, go to question 19)

20. Are there any side effects during and/or after the practice of female genital mutilation?
    (Yes) (No)
    If yes, please describe these side effects ...

21. What do you think should happen in the future regarding FGM?

III. Intervention strategy

22. Do you believe that the use of circumcision should be completely abolished or do you see a procedure under medical supervision as an improvement? ...

23. Do you support the view or believe that the use of female genital mutilation should be prohibited by law and that those who perform such procedures should be punished?
    (Yes) (No)

24. If yes, who should enact laws against female circumcision? (Governments) (NGOs) (Others)

25. Should the Austrian government prohibit the use of FGM practices performed by foreign doctors in Austria or indirectly abroad? (Yes) (No)

26. Do you think that European countries should take a common position and actions to fight against FGM? (Yes) (No)

27. What do you think are the solutions to this problem and what should be done in Europe?

The questions were compiled in consultation with experts by the African Women's Organisation in Vienna in January 2000.

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