Alice Behrendt

Listening to African Voices

Female Genital Mutilation/Cutting among Immigrants in Hamburg: Knowledge, Attitudes and Practice

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Forword

Dear readers,

According to the World Health Organization, every year an estimated number of three million girls and women are at risk for the harmful tradition of Female Genital Mutilation/ Cutting (FGM/C). Nearly 140 million girls and women suffer from its severe and long-lasting health consequences. FGM/C mainly is practiced in sub-Saharan Africa and Egypt, but also in some Arabian and Asian states as well as in some ethnic groups in Middle- and South America. The practice is one of the cruelest forms of violence and violates the basic human right of physical and mental integrity.

It therefore is a strong matter in our victim protection to initiate and improve measures concerning the prevention and prosecution of FGM/C and to supply appropriate support. We know for sure that through migration and globalization, FGM/C also is a problem in Europe, but yet we do not know a lot about the occurrence, background and attitudes of African immigrants in Hamburg.

Being the patron of this study, I am therefore particularly pleased that Plan Germany presents profound information about attitudes, motives and practices on FGM/C in Hamburg. It is the first study in Germany interviewing a large number of key Informants, African immigrants and concerned women and men.

We will use these insights to refine victim protection measures and to provide affected women and girls with the support they need.

I would like to thank everyone who contributed to the realisation of this study.

Yours sincerely

Dietrich Wersich

Head of the Ministry for Social and Family Affairs,
Health and Consumer Protection of the
Free and Hanseatic City of Hamburg

Acknowledgments

Those who helped in conducting this research project were numerous. I would like to thank in particular:

- The participants, the families and the institutions who received members of the research team.

- The interviewers who showed outstanding commitment and patience in obtaining access to the different immigrant communities and encouraging them to talk about female genital mutilation/cutting: Traore Hawa Aissata, Andrea-Vicky Amankwaa-Birago, Armand Awo, Helena Bosompim, Coulibaly Brahima, Liethian Youssouph Coulibaly, Marie Lydie Dossou, Perpetual Ekeh, Noreen Khanali Ellrott, Nancy Falke, Lulit Mekonnen Gebeyehu, Mersha Alehegne Mengistie, Irena Mischke, Aboubacar N'Diaye, Zita B. Tsafack Ndongmo, Harouna Nebie, Manneh Nouhou, Maria Adam Nyangasa and Mohamed Toure.

- The project coordinator of Plan Germany, Dr Anja Stuckert.

- The communication team of Plan Germany, in particular Barbara Baden, May Evers, Christina Frickemeyer, Samia Kassid and the intern Jennifer Werner.

As the author of this report, I am responsible for potential errors in the interpretations of answers given during the interviews and group activities.

Alice Behrendt

Dakar, 31st December 2010

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1 Executive Summary

Background and objectives

Female Genital Mutilation/Cutting (FGM/C) is a harmful traditional practice. It is estimated that between 100 and 140 million girls and women have been subjected to the practice worldwide. Most of them live in Africa, but there is also a considerable number of women concerned among immigrant populations in Europe.

Little attention has been given so far to the perceptions of African immigrants in relation to FGM/C. Campaigns and activities are mostly based on anecdotal evidence and are often carried out without the implication of main stakeholders of the African immigrant communities. The purpose of the current project was to listen to the opinions, perceptions and propositions of immigrants from Sub-Saharan Africa regarding the practice of FGM/C. It was implemented in collaboration with the Hamburger Behörde für Soziales, Familie, Gesundheit und Verbraucherschutz (BSG) (Department of Social and Family Affairs, Health and Consumer Protection) and under the patronage of Senator Dietrich Wersich.

Method

The evaluation activities included a literature review and a three-month field study targeting immigrants from Sub-Saharan Africa residing in Hamburg. The principle research activities took place from July to November 2010. The research was led by a consultant who worked jointly with a team of 20 students and researchers with African migration background. After a one-week preparatory workshop, the research team started with a qualitative research component: they carried out key informant interviews with African community members as well as with activists, researchers, health personnel and social workers from institutions that provide services to immigrants. The objective of the key informant interviews was to gather first-hand information from particularly knowledgeable and compliant persons on how the immigrant populations feel about and deal with the practice of FGM/C in the context of migration. The total number of key informants interviewed was 91. After the qualitative component, a quantitative component was launched. It consisted of interviewing, with the help of a structured questionnaire, a total of 685 women and 1082 men originating from 26 Sub-Saharan countries. The aim of the questionnaire was to investigate the knowledge of, attitudes toward and practices relative to FGM/C among immigrant communities of different origins. All quantitative and qualitative data collected in the individual interviews was analysed disaggregated by sex and by country of origin. Parents of daughters who were assessed to be at risk of being subjected to FGM/C in the future ($n = 13$) were identified so that they could participate in a follow-up project implemented by two of the women researchers.

Results

According to official records, about 11,200 immigrants from Sub-Saharan Africa reside in Hamburg. The findings of the current study indicate that about 40% of these immigrants have roots in families where FGM/C is practiced. There are more men from practicing families than women due to the considerably higher proportion of men immigrants from certain countries in West Africa (Guinea, Burkina Faso, Gambia, Cote d'Ivoire) in which there is a moderate to high prevalence of FGM/C. The majority of immigrants from practicing groups (≈ 70%) associates FGM/C with one or more advantages, notably the social acceptance of their community, better marriage prospects as well as the reduction of the sexual desire in women. Furthermore, about 18% of the participants from practicing groups perceive FGM/C as a religious requirement. There are both Christians and Muslims in this group, although the Muslims represent the greater proportion.

About two-thirds of the participants reported some awareness of the risks and harm arising from the practice of FGM/C. The proportion was significantly smaller among immigrants from practicing families. The lowest degree of awareness was found among members of the Guinean and Gambian communities.

It can be estimated that at least 30% of women immigrants from Sub-Saharan Africa underwent FGM/C before migrating to Europe. The most common types are: Type 1 (Partial or total removal of the clitoris and/or the prepuce) and Type II (Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora). Infibulations seem to be a rare exception.

The majority (80%) of the interviewed immigrants pronounced themselves in support of the abolition of FGM/C. The remaining 20% advocated either for the continuation of the practice or reported uncertainty. The proportion of supporters and uncertain participants was considerably higher among immigrants from practicing families (32%) than among immigrants from non-practicing families (7%). Men were more likely than women to be in favour of FGM/C or to be unsure about the future status of the practice.

Within the cohort of daughters of the interviewed immigrants, about 7% of the girls had been subjected to FGM/C. Only a small minority of these girls was living in Europe. Furthermore, about 10% of the parent participants had either the intention to subject their daughters to FGM/C or declared uncertainty regarding the fate of their daughters. This result points to the fact that there is a number of girls in Hamburg who are in danger of undergoing FGM/C in the future. There was little concrete evidence, however, that FGM/C was practiced on German territory. The most common scenario is that one or both parents or a member of the extended family takes the girl to the country of origin. There were also several indications of FGM/C being carried out by members of immigrant communities from West Africa in France.

There is a relatively strong awareness among immigrant populations that FGM/C is a punishable act in Germany. The experiences with the rigorous application of the German legal system and the fear of sanctions have a strong dissuasive effect on parents who are in favour of FGM/C.

Conclusion and recommendations

Overall, most immigrants from Sub-Saharan Africa speak out for the abandonment of FGM/C. Still, there is a solid portion of immigrants from practicing families in Hamburg that maintains positive or indifferent attitudes towards FGM/C. The findings enabled us to cluster the immigrant communities from Sub-Saharan Africa into three categories according to the need for intervention:

- immigrant communities with a strong need for intervention: Nigeria, Guinea, Gambia, Northern and Central Togo, Northern Benin, Mali and Burkina Faso;
- immigrant communities with a moderate need for intervention: Kenya, Ethiopia, Cote d'Ivoire, Northern Ghana;
- immigrant communities with little or no need for intervention: Southern Ghana, Southern Togo, Southern Benin, Cameroon, Niger.[1]

Based on these findings, we recommend the development and implementation of an action plan against FGM/C, targeting primarily immigrants from practicing groups in the city of Hamburg. Activities should focus mainly on preventive measures, but should include a certain number of interventions that aim at improving the quality of assistance for women who have undergone the practice. Further recommendations for the preparation and implementation of the action plan can be summarised as follows:

- The preparation and implementation of the action plan should take place under African leadership and ownership. German and International NGOs can take the role of facilitators by providing technical and financial support for the implementing structures, but should not be frontline actors during community-based interventions.
- There is a large number of African immigrant associations in Hamburg. We propose to consult and invite them to contribute or to take the lead on the implementation of activities in their communities.
- Immigrants from communities with a strong need for intervention should be the priority target group;
- Activities can also be directed through information exchange hubs such as Afro Shops, African restaurants, as well as hair dresser and barber shops.
- The integration of networking and advocacy activities at city, national and international levels can increase the impact;
- Further research initiatives should explore the attitudes and practices of communities that were not reached during the current project (e.g. Egypt).

1 The research did not provide enough information on immigrant communities of the following countries: Eritrea, Sudan, Senegal, Tanzania, Liberia, Guinea Bissau and Sierra Leone.

2 Introduction

2.1 Background

Female genital mutilation/cutting (FGM/C) is a harmful traditional practice consisting of the removal of part or all of a girl or woman's external genitalia. FGM/C is common in many societies in Africa and to some extent in Asia. Within practicing communities, FGM/C is a deeply rooted and accepted tradition. Adherents consider it an important custom for the socialisation of girls and young women, preparing them for a life as faithful and honourable daughters, wives and mothers. Non-practitioners, human rights and gender-equity activists condemn FGM/C as a violation of fundamental human rights such as the right to bodily integrity and protection against violence.

While FGM/C used to be considered an "African phenomenon", it has become a global issue in the context of migration. Thousands of African migrants arrive in Europe every year. In total, there are about five million African immigrants registered in EU member states and it is believed that there are millions of irregular African immigrants living in the EU. Most of them migrate for labour, hoping to make a better living than in their country of origin. Among the immigrants from Sub-Saharan Africa and from Egypt, many have roots in communities and families that practice FGM/C. In the past decades, several incidents of girls from Sub-Saharan Africa being subjected to FGM/C in Europe have made the headlines. In France, over 30 cases of FGM/C were brought to court and the culprits – parents and practitioners – were given prison sentences. Anecdotal evidence of FGM/C being practiced among immigrants has appeared in other EU-countries as well.

Nonetheless, the data on perceptions, attitudes and practices relating to FGM/C of immigrants with roots in practicing countries is limited and focuses mainly on populations from Eritrea and Somalia. In the specific case of Germany, the government, non-governmental organisations (NGOs) and civil society lack effective approaches for tackling the issue. Therefore, Plan Germany in partnership with the Hamburger Behörde für Soziales, Familie, Gesundheit und Verbraucherschutz (BSG) (Department of Social and Family Affairs, Health and Consumer Protection) developed a pilot project for one of Germany's major cities, Hamburg. The aim was to establish an action plan against FGM/C in collaboration with members of immigrant populations from practicing countries.

2.1.1 Plan

Plan International, one of the oldest child-focused organisations in the world, supports development programs in 48 countries. Plan is an organisation without religious or political affiliation. It finances sustainable and child-focused self-help projects mainly by means of sponsorship, but also through grants and public funds. Plan Germany supports more than 300,000 of the 1.2 million sponsored children world-wide, thus reaching more than two million people in the program areas of Asia, Africa and Latin America. The projects are being planned and carried out in close cooperation with the children, their families and their communities. The aim is to improve the living conditions of the people in a sustainable way. Plan's child protection work in Africa includes support to community based and national initiatives to stop FGM/C and any other form of abuse or violence against children.

Plan is recognised as a private and independent organisation by the Economic and Social Council (ECOSOC). The German Central Institute for Social Affairs (DZI) has conferred Plan Germany its donation seal, which confirms transparency and efficiency in the field of donations.

2.2 Project objectives

The main purpose of the project was to develop an effective and locally adapted approach to promote the abandonment of FGM/C among immigrant groups in Hamburg.

The specific objectives were as follows:

- To assess the proportion of immigrants with roots in practicing families in Hamburg;
- To explore the attitudes, perceptions and opinions among immigrants from Sub-Saharan Africa toward FGM/C, notably the advantages perceived, the position of their religion on FGM/C and the proportion of supporters and opponents of the practice;
- To provide an estimation of the proportion of girls and women concerned from different countries of origin;
- To assess the ratio and profile of girls at risk;
- To investigate whether families subject their daughter(s) living in Hamburg to the practice and if yes, how they proceed;
- To establish profiles of low- and high-risk communities (by country and region);

- To explore the level of awareness about the medical risks and other disadvantages resulting from FGM/C among immigrants from Sub-Saharan Africa in Hamburg;
- To collect ideas from men and women immigrants on how FGM/C can be addressed and effectively prevented among practicing communities in Hamburg.
- To identify opponents of FGM/C within communities of practicing origin who are interested and motivated to lead and participate in activities against FGM/C.

2.3 Research questions to be investigated

One priority of the research was to explore the socio-cultural and demographic risk factors for FGM/C among immigrants. This included the investigation of the following research questions:

- What is the proportion of practicing ethnic groups and families in Hamburg?
- What is the profile of the regions of origin of the immigrants? Are they from regions with low, moderate or high prevalence rates?
- What is the proportion of women who have undergone FGM/C?

Another focus of the study concerned the knowledge of, and attitudes and perceptions toward FGM/C among immigrants. We were interested in exploring the following questions:

- What does FGM/C represent for immigrant families from practicing countries in Sub-Saharan Africa?
- What advantages and disadvantages are associated with the practice for the individual, the family and the community? What factors contribute to the decision of an individual or a family to maintain the practice? Are there differences in the perceptions of men and women?
- To what extent are immigrants from practicing countries aware of the risks and the harm posed by FGM/C? What do they know about the short and long-term medical, psychological and sexual consequences? Are there differences in the perceptions of men and women when it comes to the harm caused by FGM/C?
- How do immigrants from practicing countries see the position of their religion towards FGM/C? What is the position of religious leaders in Germany (imams, priests, pastors)? Are all immigrants informed that neither Islam nor Christianity considers FGM/C a religious requirement?
- Are immigrants informed that FGM/C is punishable in Germany? If yes, how have they been informed?

A comment on the terminology used in this report

There has been an ongoing controversy regarding the appropriate terminology to be applied when dealing with the topic of FGM/C. The roots of the debate are in strongly diverging perceptions of FGM/C among those who adhere to it and those who condemn it. The World Health Organization (WHO) and other United Nations agencies as well as many human rights organisations have opted for the term “female genital mutilation” to highlight the gravity of the act and to avoid drawing parallels to male circumcision. The term female genital mutilation, however, differs from and can even be opposite to the expressions used in communities adhering to the practice. In one local ethnic group in Guinea, for instance, the term used for FGM/C translates to “mutual help”. Other local languages name the practice “initiation” or “cutting” or “girl circumcision”. In the main African official languages (English and French), the terms “female circumcision” or “excision” remain up to present the most commonly used expressions.

Experiences from community based interventions show that the term “mutilation” is often contra-indicated when it comes to the abolition of FGM/C. Many of the girls and women who have undergone FGM/C feel offended, stigmatised or victimised by the term. Even if willing to break with the tradition, they tend to reject their collaboration or commitment to the abandonment of FGM/C when approached with this terminology. In search of a more neutral term, “female genital cutting” (FGC) emerged. It is mostly found in research documents, for example in the Demographic and Health Surveys implemented by African governmental institutions.

In recent years, UNICEF and other international institutions have started using the term female genital mutilation/cutting (FGM/C) in their documents. The intention of using this term is to highlight the gravity of the act, but also to acknowledge the need to choose an appropriate term where the context requires it.

As an international organisation committed to child rights and protection, we opted for the same compromise throughout this report. For linguistic convenience, we occasionally employ the term “circumcised” to refer to women and girls who have undergone FGM/C. This is not meant to trivialise the experience they went through; it is simply the expression that most women prefer when talking about their status. This document is of a descriptive nature; it can be used as a resource for advocacy campaigns, but should not be considered an advocacy tool in itself.

- How do immigrant families in Hamburg proceed in the practice of FGM/C? Who executes the practice and where is it carried out?
- Where and under what circumstances do women who have undergone FGM/C seek medical care? What precautions do they take during pregnancy? Do they participate in preventive care programs?
- What suggestions are given by immigrant women, men and youth for the elimination of the practice of FGM/C within practicing groups in Hamburg? How and in what context can the topic be addressed and by whom?

The choice of adequate information channels, platforms and media is crucial for the implementation of effective prevention and awareness-raising projects. In order to identify the most relevant media and other information sources of African immigrant communities, we explored the following questions:

- Where and through what information channels do African immigrants inform themselves? What types of media (journals, web pages, newspapers, radio and television channels) do they use?
- What types of media and locations could be appropriate dissemination channels for activities directed against FGM/C?

3 Methods

3.1. Stages of study implementation

The research project was implemented in the following three phases/stages:

I. Preparation of the field study:
- Development of the methodological concept of the study and literature review (Feb 2010 - Jun 2010);
- Meetings with the Hamburger Behörde für Soziales, Familie, Gesundheit und Verbraucherschutz (BSG) (Department of Social and Family Affairs, Health and Consumer Protection) (March 2010 - June 2010);
- Recruitment of interviewers (May to August 2010);
- Participatory training and preparation of the data collection (August 2010);
- Development of a toolkit (August 2010);

II. Implementation of the field study:
- Collection of qualitative data (Aug - Sept 2010);
- Collection of quantitative data (Sept - Oct 2010)

III. Data entry, analysis and report writing
(October - December 2010)

The three stages are explained consecutively in the following paragraphs. Furthermore, ethical considerations (section 3.5) and difficulties and limits of the research (section 3.6) are outlined.

3.2. Preparation of the field study

3.2.1. Development of the methodological concept of the study

Plan Germany has funded several projects promoting the abandonment of FGM/C on the African continent. Over the past decade, Plan has become more and more active in advocating for effective prevention of FGM/C in Germany and for improving national, regional and global approaches for the abolition of the practice. An obstacle to scaling up programs against FGM/C in Germany (and in Europe) has been the absence of baseline data. Most activities in Germany have been implemented on the basis of anecdotal evidence or on data from Africa which are not necessarily valid for communities of the diaspora. To fill this gap, Plan started designing a project to establish baseline data on FGM/C for one pilot city in Germany. The idea was to explore how immigrants of different practicing countries perceive the practice of FGM/C and whether there is evidence that the practice continues in Germany. The location chosen was the city of Hamburg. Being one of Germany's largest city and a vibrant centre of the country's economy, Hamburg has become home to many migrants from Africa and from the West African region in particular. It is also the site of Plan Germany's office, which ensures the presence of the necessary logistics and contacts to facilitate the implementation of such a project. The study concept was revised and fine-tuned with support of other experts regarding FGM/C in Germany (Terre des Femmes, GTZ, Integra) and an extensive literature review was carried out.

The research questions to be investigated are complex and include a wide range of variables. In order to create valid data, the methodological approach incorporated the following components:

- It is participatory, cooperative and engages community members in a joint research process;
- It uses a triangulated research design by working with different tools to collect qualitative and quantitative data from different target groups;
- It foregrounds gender and other axes of social difference in the research design, data collection and analysis;
- It is innovative and committed to co-learning;
- It is culture-fair and trans-disciplinary, drawing on resources from ethnic, developmental, sociological, psychological, critical media literacy and women's studies.

3.2.2. Recruitment of interviewers

Discussing the topic of FGM/C in an interview setting is a delicate matter: the practice is taboo and not easily discussed with strangers. The ethnic group, age and sex of the interviewer also play a significant role. People tend to give more details when talking to someone of the same sex, who is about the same age and who is familiar with traditional practices of the ethnic group. Furthermore, some women might still suffer from post-traumatic reactions related to their experience of FGM/C. They feel sad or disturbed when the topic is raised or make efforts to avoid it.

Apart from the topic, conducting interviews with African immigrants is challenging in itself:

- Numerous African immigrants are more comfortable expressing themselves in languages other than German, in particular when it comes to sensitive topics. Some immigrants only speak local dialects.

- Many of them are struggling to legalise their papers and refuse to provide information, fearing that this might endanger their residence status and influence the outcome of their asylum process.
- Some cultures demand that the husband gives his permission before the wife can be interviewed.
- Many immigrants have accumulated negative experiences since their arrival in Germany: the daily encounters with authorities, the police and their work colleagues are marked by discrimination or racism. This reduces their willingness to show high compliance during interviews;

Hence, we needed interviewers who have access to, are known by the communities and are considered by most African community members as acceptable persons to pose questions on this sensitive topic. In order to obtain access to different communities and to both men and women, we made efforts to recruit a team uniting diverse nationalities and ethnic backgrounds[2] as well as the same number of men and women of different ages. Further requirements for the interviewers were:

- Integration in one of the African communities and to have a wide range of contacts with other African migrants;
- Fluency in either French or English (as spoken in Sub-Saharan Africa);
- Fluency in at least one local language;
- Motivation and commitment to participate in research on FGM/C;
- Emotional stability and maturity to cope with the psychological hardship of conducting interviews on FGM/C;
- Intellectual capacity and moral integrity sufficient to collect high quality data and to deal with the research topic appropriately;
- A German work permit.

Plan Germany launched the recruitment process in May 2010 by posting an advertisement on the student vacancy page of the University of Hamburg. In the following weeks, efforts to spread the advertisement were multiplied. Flyers were posted in Afro Shops and student halls. The call for applications was communicated to friends and former colleagues of African origin who could further disseminate the call for applications. Once recruitment interviews had started, candidates were invited to forward the advertisement to other African immigrants. We made special efforts to identify potential candidates from high prevalence countries (e. g. Guinea, Ethiopia) or countries with a high number of migrants in Hamburg (Ghana, Togo, Nigeria and Egypt). By August, 12 interviewers had been selected, six women and six men from the following countries of origin: Ghana (2), Togo (1), Cameroon (1), Guinea (1), Gambia (1), Kenya (1), Ethiopia (2), Tanzania (1), Burkina Faso/Senegal (1) and Cote d'Ivoire (1). Once the second phase of the data collection, the quantitative survey, had started, another nine interviewers joined the team. These were six women and three men (from Guinea (1), Nigeria (2), Cote d'Ivoire (1), Ghana (1), Burkina Faso (2), Benin (1) and Togo (1)). Plan Germany did not receive any applications from candidates of Egyptian origin. Despite several attempts to get access to the Egyptian community and identify potential candidates, we were not able to recruit any interviewers from this country.

3.2.3. Training of interviewers and preparation of the data collection

The 12 recruited interviewers were invited to participate in a 5-day training and preparation week from 16 to 20 August 2010. The sessions were prepared and facilitated by the report author. The agenda of the first half of the week aimed to encourage the interviewers to explore their feelings and perceptions towards the practice and to build up their knowledge of FGM/C. The sessions included contents such as:

- the prevalence, geographical spread and different types of FGM/C,
- socio-cultural and religious motives for practicing FGM/C,
- medical, sexual and psychological risks and effects associated with the practice,
- the legislation in African and European countries regarding FGM/C as well as
- programming strategies to eliminate FGM/C in Africa.

The sessions of the second half of the week had the objective to present, discuss and adapt the research methodology, to train and practice interview and question techniques and to develop and finalise question lists for the key informant interviews. The interviewers learnt about and conducted role plays on how to introduce the topic of FGM/C in a sensitive manner. The importance of keeping a neutral attitude during the interview and of using non-suggestive methods of posing questions was particularly emphasised in order to avoid influencing the response pattern of the participants and to avoid the creation of socially desired answers. At the end of the week, a work plan for the first weeks of data collection was jointly drawn up.

3.2.4. Description of the research tools

The methodological approach of the project included two data collection methods: (1) key informant interviews and (2) semi-structured individual interviews with African community members.

2 Of Sub-Saharan countries practicing FGM/C.

3.2.4.1. Key informant interviews

Key informant interviews are indicated if a research topic is complex, sensitive, emotionally loaded or if it explores practices of an illegal nature. As FGM/C corresponds to all these characteristics, we opted for key informant interviews in the first phase of the data collection. The purpose was to collect information from people of diverse backgrounds and socio-demographic status to get first-hand orientations on the topic in Hamburg, to establish a wide range of contacts for the quantitative phase and to gather recommendations and solutions from those with access to the people concerned.

Key informant interviews are qualitative in-depth interviews with people who know what is going on in the communities targeted by the project. Key informant interviews resemble a conversation among acquaintances, allowing a free flow of ideas and information. The interviewers frame questions spontaneously, ask for information and take notes, which are elaborated on later. If the key informant accepted, the interview was taped and later transcribed. The interviews were loosely structured, relying on a list of questions to be discussed. There were three different types of question lists available in English and in French according to the target group interviewed:

- One for members of the African community[3] (see annex 8.2)
- One for health personnel (gynaecologists, paediatricians, midwives) (see annex 8.3)
- One for activists, researchers and persons working for the authorities or in counselling or intercultural centres (see annex 8.4).

The question lists for the key informant interviews were developed during the preparation week by the interviewers and the research coordination.

A key informant was anyone with relevant information to share. These included authorities, leaders or simply particularly open and credible community members. While selecting key informants, the interviewers targeted a diversity of persons (representatives of all practicing countries) and approached informants from different sectors: health personnel, teachers, lawyers, religious leaders, government officials, young mothers and fathers, activists, youth and students. They also tried to identify participants of different age groups and of both sexes.

3.2.4.2. Interviews during the quantitative phase of the project

The interviews during the second phase of the research consisted of individual in-depth consultations with women and men who originate from countries where FGM/C is practiced. The objective was to interview a representative number of individuals in order to be able to illustrate in figures and numbers the perceptions and practices on FGM/C within different African immigrant communities from practicing countries.

The questionnaire was structured in three sections: (1) socio-demographic information, (2) knowledge of, attitudes towards and experiences with FGM/C and (3) the acculturation level of the interviewee. The questionnaire also offered space on an additional page to note comments and observations on the interview process, the reactions and non-verbal messages of the participant. The questionnaires were available in French and English.

The first section is a sequence of structured question to assess the socio-demographic profile of the interviewee (country of origin, time spent in Germany, residence and marital status, profession etc.). In the second section, all but one item were closed questions. The questions were adopted with a couple of minor modifications from the standardised sections on FGM/C of the Demographic and Health Surveys (DHS)[4] used in African countries to investigate relevant variables. We added the option "does not want to answer" to most questions to give interviewees the option not to answer a question in order to avoid the reporting of false data. To some questions we also added the alternative answer "question was not asked". The interviewers could choose this option if they felt that the interview setting and the relationship with the participant did not allow for certain types of information. For the items regarding FGM/C, we designed two questionnaire templates, one for women and one for men. In the questionnaire for men, one question was whether they preferred to marry a circumcised or non-circumcised woman. Married men were asked whether or not their wife had undergone FGM/C. The questionnaire for women contained a question on their status (circumcised/non-circumcised) and, if they had undergone FGM/C, a series of questions on the circumstances of the practice followed.

The third section contained 16 items measuring the level of acculturation on a 4-point-Likert scale (strongly disagree – disagree – agree – strongly agree). The items were extracted from the Lowlands Acculturation Scale (Mooren, Knipscheer et al. 2001): five items from the domain "Social Integration",

3 Of FGM/C practicing countries only.

4 The DHS are available on www.measuredhs.com

three items from the domain "Traditions", two items from the domain "Loss" and three items from "Values". The scores obtained in each domains were counted together to determine the total score determining acculturation.

The questionnaire templates for men and women are displayed in annex 8.5 and 8.6.

3.3. Implementation of the field study

After the five days of intense study preparation, the interviewers started conducting key informant interviews for a period of 16 days. Weekly meetings to discuss progress as well as difficulties and challenges were held throughout the period of data collection. During these meetings, the interviewers had the opportunity to share their experiences and to mitigate the strong emotional burden of their work that accumulated from listening to testimonies of despair and suffering or through the repeated encounter with harsh and negative reactions from the participants. They were also invited to come for individual meetings with the research consultant for emotional support at any time.

On September 7, 2010 another training and preparation meeting took place with all interviewers to train them on the conducting of structured interviews and to discuss and adjust the questionnaire templates. The phase of collecting quantitative data started after the session and continued until October 31st.

In order to put the study participants at ease during the interview and to obtain high quality data, the interviewers were able to spend up to several hours with potential participants to prepare the interview and to establish an atmosphere of mutual trust. The interviews were conducted in a language chosen by the interviewee (including diverse local languages).

3.3.1. Collection of the qualitative data

We explored different sources for the identification of key informants: the network of the interviewer team, African clubs and associations, counselling and intercultural centres as well as contacts of the BSG. For the interviews with health personnel, we contacted gynaecologists working in neighbourhoods with a high proportion of immigrants. The interviewers also tried to approach health personnel of African origin assuming that people prefer to be treated by someone of the same cultural background. When selecting key informants, the interviewers targeted a diversity of persons (representatives of all practicing countries) and approached informants from different sectors: health personnel, teachers, lawyers, religious leaders, government officials, young mothers and fathers, activists, youth and students. They also aimed to identify participants of different age groups and of both sexes.

For each conducted interview the interviewers submitted a cover page which included socio-demographic information and either an audio file of the interview or a written report.

3.3.2. Collection of the quantitative data

Due to limited time and resources, Plan Germany had to restrict the number of countries to be included in the phase of quantitative data collection. As it had not been possible to recruit interviewers from Egypt or to establish valuable contacts in the Egyptian communities during the first phase of the data collection, the sample was narrowed to immigrants from countries located in Sub-Saharan Africa. If the immigrant community of a country in Sub-Saharan Africa was very small and impossible to reach, again it was not taken into consideration. This was the case for immigrants from the following countries: Mauritania, Democratic Republic of Congo, Central African Republic and Chad. Countries outside Africa where FGM/C is known to be practices were also not part of the research (Indonesia or Yemen, for example).

For the quantitative survey, we aimed to identify statistically representative sample sizes from the three countries with the largest immigrant population (Ghana, Togo and Nigeria). We used a confidence level of 95% and a confidence interval of 5% to calculate the sample sizes.[5]

The immigrant communities of the remaining Sub-Saharan countries are much smaller, ranging from 12 persons (Somalia) to 483 persons (Cameroon). Reaching representative samples within these small populations was not considered feasible as it would have demanded reaching the majority of the population. For the Guinean female immigrant population (56 women), it would have meant, for instance, to approach 49 of the 56 women. Hence, the decision was made to interview as many persons as possible and to aim at reaching about 25% of the women and 25% of the men of the immigrant population of each country. Special efforts were employed to reach high-prevalence countries (e.g. Guinea, Gambia and Ethiopia) and to approach communities where the qualitative interviews had shown the need for further investigation (Nigeria, Togo).

3.3.2.1. Sampling

As we had no means of locating the study population, we could not carry out a random household sampling. We therefore opted for a non-probability survey incorporating three strategies:

5 Of Sub-Saharan countries practicing FGM/C.

1 The interviewers approached diverse localities where African immigrants of different profiles gather, such as:
   - churches and mosques in different areas of the city;
   - language classes for women at intercultural centres;
   - cultural events and meetings of immigrant populations from different countries;
   - the Africa Café organised by Hamburger Aids-Hilfe;[6]
   - Afro-Shops in different areas of the city;
   - the Hauptbahnhof (central train station) and shops and restaurants in the surrounding area, known to be a main meeting point of African immigrants in Hamburg;
   - asylum seeker compounds;
   - the university campus;
   - amusement arcades and betting agencies;
   - assemblies of African associations.

Before starting the interviews in these locations, the research team approached traditional and religious leaders, heads of associations or shop owners to explain the study objectives and to obtain an authorisation prior to conducting the interviews.

2 The interviewers started consulting their private networks and conducted interviews following a so-called snowball system (one participant would introduce them to the following participant);

3 The interviewers obtained further contacts from key informants of the previous phase.

The number of persons who refused to participate in an interview about FGM/C were registered by the researchers. It was sometimes difficult to understand what motivated a person to reject the request to give an interview. Some men and women reported frankly that they did not want to discuss the topic of FGM/C while others refused out of discomfort with the socio-demographic questions or because of non-availability.

3.4. Data entry, analysis and report writing

The qualitative and quantitative data was translated from local languages into English or French before the analysis. In order to improve the validity of the responses, we took into account the atmosphere, the compliance of participants and our observations during the interviews. When the researchers noted doubts on the validity of the responses, the subject was excluded from the data analysis.

The qualitative data was analysed and classified into groups according to the item discussed and the interviewee's country of origin. This stage allowed us to quantify the frequency and similarity of responses, experiences and reactions, and to generate hypotheses on how immigrants in favour of the practice proceed when they want to carry out FGM/C.

The quantitative data was analysed with the support of SPSS (Statistical Program for Social Sciences, version 12.0). For the comparison of groups, independent t-tests and chi-tests were used. The data analysis included comparisons using the following variables:

- Age and gender
- Education level
- Countries, area of origin and ethnic groups,
- Place of residence in country of origin (urban or rural),
- Religion
- Social and residence status and
- Family relationship to FGM/C (practicing or non-practicing origin)

3.5. Ethical considerations

To ensure good ethical practices in all phases of the research, we took the following measures:

- We realised a participatory preparation of the data collection and the research toolkit as to ensure that the interview tools were be culturally sensitive and appropriate.
- The interviewers were trained on how to create a trust-inspiring and safe interview setting.
- The purpose of the study was explained in detail to the participants and they had the liberty of ending the interview at any time without giving an explanation.
- If participants requested more information about Plan or the project, the interviewers handed out the project coordinator's visiting card and an information leaflet about the organisation.
- The interviewers ensured privacy and confidentiality to all participants.
- The participants could choose the option "do not want to answer" if they felt uncomfortable with a question.
- A weekly monitoring meeting was organised to provide the necessary emotional and technical support to the field team.
- We put in place a response mechanism for girls being at risk of being subjected to the practice.

The last point demanded the mobilisation of additional resources and forged the way to a follow-up project that was initiated during the second phase of the data collection. It is described in the section below.

6 An institution implementing preventive programs for HIV/Aids and providing support to people living with HIV/Aids. The Africa Café is organised once a month to gather and inform members of the African community.

3.5.1. Follow-up project for girls at risk of being subjected to the practice

In the second and third week of the quantitative survey, several researchers reported cases that demanded a closer investigation. These were:

- Participants whose daughters had been subjected to the practice in Africa;
- Participants who made their intentions known to subject their daughters to the practice.
- Women participants who affirmed that their daughters might be subjected to the practice by the husband's family during a holiday in their country of origin and that they were not in a position to protect their daughters;
- Women participants who were indifferent about the status of their daughters and who announced that it did not matter to them if the daughters were subjected to the practice during a home visit to Africa.

We organised an additional meeting to discuss each of the cases. The conclusions of the meeting were as follows:

- No action could be taken for the daughters who had already been subjected to the practice. The girls concerned had undergone FGM/C in Africa and most of them still lived there. There was no means of tracing them in order to assess the need of support. A small minority of the girls was living in Hamburg, but had been subjected to the practice before migrating to Europe.
- The other cases required a follow-up and monitoring, but there was no girl in immediate danger. The case analysis indicated that there was sufficient time to develop a response strategy.
- We consulted an advisor of the intercultural centre in Eimsbüttel[7] and our focal point at the BSG and developed a response strategy adapted to the needs of each individual case. At the time of report writing, the need for follow-up responses had been identified for 13 girls living in nine different families of West African origin.[8]

3.6. Difficulties and challenges during the project

The difficulties were mainly linked to the mobilisation and availability of participants, their reactions to the research topic and the accessibility of communities from certain countries.

3.6.1. Availability of participants and of women in particular

The interviewers reported repeatedly that it was challenging to fix appointments with potential participants. The beginning of the data collection coincided with the second week of Ramadan and many families gathered outside working hours to break the fast and were not available for interviews. Moreover, numerous African immigrants are shift-workers and difficult to reach as they start working very early or get home very late. Identifying women for interviews was a particular challenge. They are less represented in places of public gathering and less likely to accept an interview on FGM/C with a stranger. Organising an interview with a Muslim women could be particularly time consuming. The researcher was expected to obtain an authorisation from the husband before conducting the interview. This sometimes implied that a researcher had to visit the same family several times before being able to meet the husband and to make an appointment with the woman to conduct the interview.

3.6.2. Lack of interest in the topic

The topic of FGM/C proved to be of little or no interest to many immigrants approached during this research. They communicated that it was not a priority issue for them and often insisted on discussing their current problems linked to topics like the status of their residence permit, the work permission, job seeking or their accommodation. Moreover, some stated that this type of study should take place in Africa and not in Europe where people have other preoccupations. Men often responded that FGM/C is women's business and that they don't see any use in participating. Members of non-practicing groups often objected that FGM/C is of as little concern to them and that they have neither knowledge of nor interest in the topic.

3.6.3. Mistrust and cautiousness of participants

The interviewers encountered many immigrants who were extremely suspicious and expected the questions to be traps, in particular questions related to their socio-demographic status. Items enquiring about the region of birth, the status of the residence permit, ethnic group or marital status seemed to awaken memories of frightening experiences with the German authorities and the police. Numerous participants were worried that their responses would be handed over to the German authorities and that the nature of their answers could have a negative impact on their residence status. Thus, many participants preferred to omit certain questions from the socio-demographic section. Some participants also requested to be interviewed without the questionnaire and note taking. Persons without a residence permit were particularly tight-lipped when it came to the socio-demographic section. The interviewers were amazed to see

7 District of Hamburg.

8 More detailed information about the response strategy and the follow up project is available at Plan Germany's office.

that even close friends and people who had trusted them for many years reacted with suspicion and unease during the interview as is illustrated in the testimony of a participant of Cote d'Ivoire origin:

> "You are a Muslim like me; you are a Dioula like me. You are a man of God with good intentions. But the people who receive the data, what are they going to do with it? Maybe they will communicate the information to the Ausländerbehörde [immigration office] and tomorrow they will appear on my doorstep and get me into trouble."

The interviewers also reported that it was nearly impossible to mobilise persons living in homes for asylum seekers. They sometimes spent an entire afternoon in an asylum-seeker home without being able to find a single person willing to accept an interview.

3.6.4. The nature of the topic

The researchers grew accustomed to introducing the topic and creating an environment of trust; nevertheless, it remained challenging for them to bring up the topic and to make people talk about FGM/C. Even after accepting to be interviewed some people were uncomfortable, ashamed or embarrassed to discuss the topic saying that it was taboo and that questions related to sexuality could not be debated. Others appeared to be withholding information. For women who had been subjected to the practice, the discussion about FGM/C sometimes awoke painful memories, forgotten for many years. The questions put them in a state of sadness and despair and it was challenging for the interviewers to provide emotional support.

3.6.5. Negative or highly emotional reactions of participants to the research topic

Some participants became very unfriendly, hostile and aggressive when the topic was raised. When informed that the project was initiated by an international NGO, they stated things like, "Europeans should mind their own business," or, "this is an issue for Africans and not for Germans". Some accused the interviewers of betrayal, of having changed sides. Accusations such as "you work for the Germans now, they have bought you to help them to destroy African cultures" or "you should do more honourable work than selling our culture to the Germans" were occasional reactions from West African participants (Mali, Guinea and Gambia for example). One woman researcher reported in a meeting:

> "The man got really angry and started insulting me. He told me that my grandmother, my mother and I, myself, have been circumcised and that I should not deny our culture, our identity. He said that I am a bad woman, ill respecting the laws of my own society. I was discouraged after the interview and understood that his intention was to sabotage me."

3.6.6. Emotional strain for interviewers

Evidently, the reactions described in the previous paragraph were distressing experiences for the interviewers. Being accused of betrayal, of disloyalty and of destroying cultural values was a highly stressful experience. It created feelings of discouragement and raised doubts about whether conducting interviews on FGM/C would lead to long-term disadvantages for them and exclusion from their communities. Furthermore, the suffering of many immigrants became an additional burden for them. Participants used the conversation time to share their worries and to communicate their feelings about the difficulties they were facing as immigrants in Germany. A Nigerian man, for example, who has struggled for many years to obtain a residence permit had accumulated so much frustration and anger that he told the interviewer that his greatest wish had become to return to Nigeria and to become a sniper aiming at killing as many white people as possible. The consultations with women still suffering from post traumatic reactions related to their own FGM/C were also difficult to cope with and exposed the interviewers to a risk of secondary trauma.

Other participants used the encounters to try to chat up the women interviewers or to embarrass them with anecdotes of their sexual experiences or with dirty talk. These situations came sometimes close to sexual harassment and were not always easy for the researchers to handle.

3.6.7. Social rejection of interviewers

In addition to emotional distress, some interviewers saw themselves confronted with negative consequences in their daily lives. Community members started to talk behind their backs, to avoid them and to exclude them from meetings. Whispering started when they entered a public place and people stopped greeting them. Some interviewers reported that friends had stopped calling and inviting them. A group of musicians from West Africa, for instance, refused to play at a baptism because they did not want to do a favour for a person participating in a project against FGM/C. The fact that some interviewers experienced their social support network weakened can be considered as one of the most substantial difficulties presented by the project.

3.6.8. Few possibilities to meet immigrants from certain countries

The interviewers were not able to identify a significant number of participants from certain countries. They did not

find, for example, many participants from Liberia, Sierra Leone and Guinea Bissau. The identification of persons from very small immigrant populations (Sudan, Tanzania, Somalia) also had limited success. At the same time, the proportions interviewed from other countries were above 60%. We drew the conclusion that numerous participants from certain communities (e.g. Guinea or Mali) lived in Hamburg at the time of the interviews without registration. At the same time, it seemed that members of other communities were registered in Hamburg, but resided elsewhere.

3.6.9. Plan is an unknown organisation to migrant communities in Germany

Most participants had never heard of Plan and did not have a particular interest in a survey carried out by an institution that they were not familiar with and that had no positive reputation for supporting immigrant populations in Germany.

3.7. Limits of the study

3.7.1. Unique focus on Sub-Saharan Africa

The study focused exclusively on countries in Sub-Saharan Africa. Other countries where the practice is known to exist were not taken into consideration. We did not include the immigrant population from Egypt and Yemen in the research even though both countries have integrated the issue in the questionnaire of the Demographic and Health Surveys and have presented solid estimations for the prevalence rates of FGM/C in their countries (96% for Egypt and 27% for Yemen).

The number of registered immigrants from Yemen is very small in Hamburg (22 men and seven women). We could not focus our resources on such a small community. The Egyptian community is more relevant in terms of numbers and the high prevalence rate in the country. There are officially 1249 immigrants of Egyptian origin registered in Hamburg. Most of them are men (857), but among the 392 registered girls and women, there are 105 girls below 18 years of age. It is recommended that the further study include or investigate specifically the knowledge of, attitudes toward and ways of practicing FGM/C in the Egyptian immigrant community in Hamburg.

3.7.2. No random sampling for the quantitative survey

As described in section 3.3.2.1, we had no means to conduct a probability survey for the collection of the quantitative data. It can be assumed that the probability of getting interviewed was not the same for all immigrants from Sub-Saharan Africa. Community members outside social networks (church, mosque, integration classes, community events and meetings) or who abstain from visiting typical meeting places (Afro shops, main station, betting agencies) were less likely to be interviewed. At the same time, persons acquainted with one of the researchers were more likely to be interviewed. The snowball sampling and the efforts undertaken to collect data from various districts of Hamburg aimed to balance this effect. It is clear, however, that the unfeasibility of random sampling reduces the validity of the data and has to be taken into consideration when interpreting the results.

3.7.3. Oral reports as the only source

The qualitative and quantitative research tools allowed only the collection of data based on oral testimonies. Previous studies on FGM/C, however, have indicated that verbal reports can be biased. This is usually due to efforts of participants to provide socially desirable answers (see for example Cellule de Planification et de Statistique du Ministère de la Santé, Direction Nationale de la Statistique et de l'Informatique du Ministère de l'Économie, de l'Industrie et du Commerce et al. 2006). It can also be linked to the lack of knowledge. Circumcised women, for example, are sometimes not aware about the form of FGM/C they have undergone and give inexact descriptions of what has been done (see for example Asefaw 2007). Furthermore, some of the study participants feared negative sanctions after responding truthfully to certain questions. This makes it likely that some of the data collected during the current project is subject to reporting bias. We tried to mitigate this limitation by taking note of non-verbal reactions and interview compliance and by excluding dubious responses from the data analysis.

3.7.4. Small sample sizes for some countries

The sample sizes of immigrant populations from Eritrea, Sudan, Tanzania, Somalia, Guinea Bissau, Sierra Leone, and Liberia are too small for an in-depth analysis. For the first four countries, the small number of immigrants reached can be explained through the small population size of the communities in Hamburg. For the three other countries, we recommend further studies to gather additional information.

4 Literature review

The first part of the current chapter furnishes general information on the practice of FGM/C (section 4.1-4.5). The second part summarises knowledge of FGM/C in immigrant communities in Europe and in Germany in particular (section 4.6 and 4.7).

4.1. FGM/C and its different forms

FGM/C is defined as "all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons" (WHO, UNICEF et al. 1997). The WHO/ UNICEF/ UNFPA published an initial categorisation of FGM/C in four different types (WHO, UNICEF et al. 1997). In 2008, a group of United Nation's agencies launched a joint statement which introduces a revised version of the four types. They are defined as follows:

Type I: Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).

Type II: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).

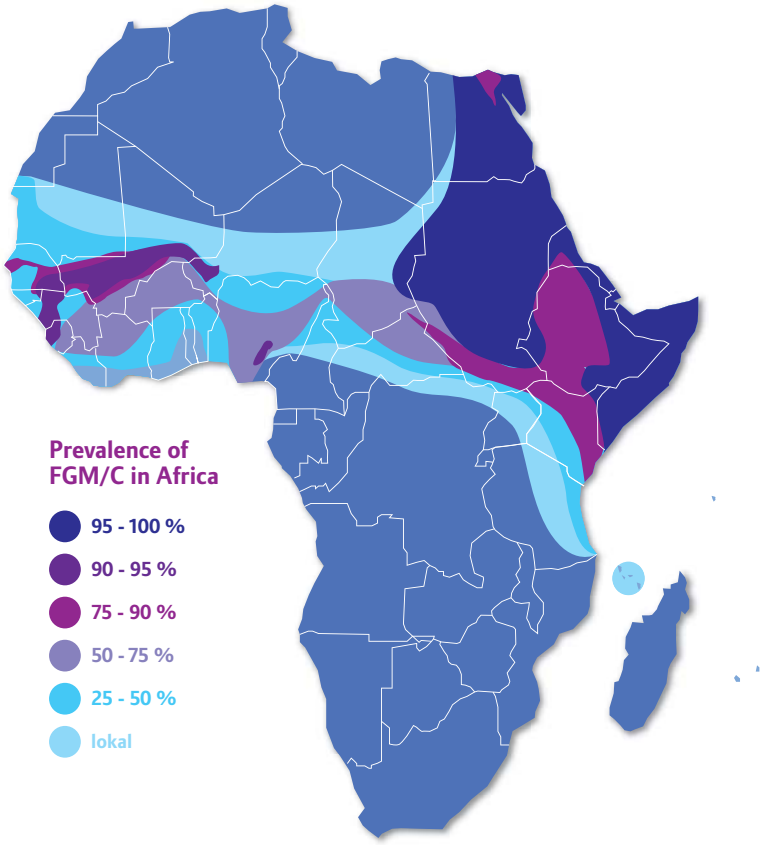
Type III: Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).

Type IV: All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterisation.

Moreover, the joint statement proposes two sub-categories for the three first types respectively in order to make it easier to classify the variety of forms of FGM/C practiced in different contexts (UNAIDS, UNDP et al. 2008).

4.2. Prevalence and geographic spread of the practice of FGM/C

According to estimations from the WHO in between 100 to 140 million women have undergone FGM/C and two to three million girls and women are at risk of being subjected to the practice every year (UNICEF 2005; UNAIDS, UNDP et al. 2008). Most of the women and girls live in Sub-Saharan Africa (UNICEF 2005). The map below gives an approximate picture of the geographic spread across the African continent. FGM/C is also practiced in Egypt and some countries of the Middle East and parts of Asia and the Pacific. Furthermore, there has been an increasing number of reports indicating that FGM/C has been practiced by African immigrant communities in Europe, Northern America and Australia in the three past decades (IOM; Grassivaro-Gallo, Araldi et al. 1998; Irujo 2001; Sala and Manara 2001; Jaeger, Schulze et al. 2002; Essen and Johnsdotter 2004; Sandberg 2008).



Source: http://www.afrol.com/Categories/Women/FGM/netscapeindex.htm

The prevalence rates of FGM/C have been assessed by all African countries concerned in the scope of the Demographic and Health Surveys (DHS) published by Macro or the Multiple Indicator Cluster Surveys (MICS) published by UNICEF. Both survey methodologies apply random household sampling and interview a representative number of women. They also provide information on attitudes, knowledge and practices on FGM/C.

Although the surveys are subject to reporting bias, they represent the only valid data available on FGM/C and they are used as the reference source by the United Nations Agen-

cies.[9] The table below displays the date of the last DHS/ MICS and the FGM/C prevalence rates for women aged from 15 -49 years.[10]

Table 1: National prevalence estimates according to the DHS or the MICS

Country	Year (of last DHS/ MICS)	Prevalence estimate
Benin	2006	13.0
Burkina Faso	2005	72.5
Cameroon	2004	1.4
Central African Republic	2005	25.7
Chad	2004	44.9
Côte d'Ivoire	2005	41.7
Djibouti	2006	93.1
Egypt	2005	95.8
Eritrea	2002	88.7
Ethiopia	2005	74.3
Gambia	2005	78.3
Ghana	2006	3.8
Guinea	2005	95.6
Guinea-Bissau	2005	44.5
Kenya	2008	27.1
Liberia	2007	58.0
Mali	2006	85.2
Mauritania	2001	71.3
Niger	2006	2.2
Nigeria	2008	29.6
Senegal	2005	28.2
Sierra Leone	2005	94.0
Somalia	2005	97.9
Sudan, northern[11]	2000	90.0
Togo	2005	5.8
Uganda	2006	0.6
United Republic of Tanzania	2004	14.6

FGM/C has been documented in a number of other countries, but the topic has not been included in DHS or MICS and national prevalence estimates are unavailable. These countries are Iraq (WADI 2010), India (Ghadially 1992), Indonesia (Budiharsana 2004), Israel (Asali, Khamaysi et al. 1995; Al-Krenawi and Wiesel-Lev 1999), Malaysia (Isa, Shuib et al. 1999) and United Arab Emirates (Kvello and Sayed 2002). There are also reports that provide anecdotal evidence on the existence of FGM/C in Colombia, Democratic Republic of Congo, Oman, Peru and Sri Lanka (UNAIDS, UNDP et al. 2008).

9 More information about the DHS and MICS of the different countries is available via the following links: MEASURE DHS http://www.measuredhs.com/gender/fgc-cd/start.cfm and http://www.ceecis.org/mics/printed_material/User_Guide_to_MICS_eng.pdf

10 The table includes only the data from African countries. Only one country outside Africa, Yemen, has integrated the issue of FGM/C in the DHS survey. The prevalence in Yemen is estimated to be 23%.

11 Approximately 80% of total population in survey.

4.3. Circumstances of FGM/C

The practice is mostly carried out on girls between the ages of 0 and 15 years. The age of the girl depends on local traditions and circumstances, the financial situation of the family and the availability of a practitioner. In the past decades, a significant age decline has been documented in many countries (UNICEF 2005; Behrendt 2006). That notwithstanding, there are also reports documenting how adult and married women undergo FGM/C (Irin 2005).

In most cases, the practice is performed with crude instruments (e.g. razor blades, traditional knives) and without anaesthesia. Most of the practitioners are middle aged or old women who have been initiated to carry out FGM/C by another woman, often a relative. They use traditional methods of wound healing although some of them have started using modern medication.

In rural areas, the girls are usually assembled in a group and brought to the place where the practice is carried out. In some areas, FGM/C is part of collective traditional initiation rites (e.g. Sierra Leone, Kenya, Guinea-Bissau) and the girls are taken for several weeks to the bush to receive their traditional education. In urban areas, group ceremonies have tended to disappear and FGM/C is performed individually. The same trend can be observed in communities where the law prohibiting the practice is feared: families carry out the practice clandestinely without any ceremony and consult a practitioner for one or a small number of girls.

Moreover, awareness-raising campaigns about the health hazards of FGM/C have lead to an increased medicalisation of the practice. In urban areas in the past decades, traditional practitioners have often been replaced by trained nurses and midwives who use sterilised instruments and modern medication (see for example Behrendt 2005).

4.4. Motives for practicing FGM/C

The motives for practicing FGM/C vary from one region to another, sometimes even from one village to the next. The practice is embedded in a complex socio-cultural and sometimes religious and political dynamic that is not easily understood by outsiders.

Up to the present time, many communities in Sub-Saharan Africa have considered FGM/C to be a sacred and ancient tradition that has been passed on from one generation to the next. It is a source of pride and identity for the women (Ahmadu 2000; Asefaw 2007). As such, it has become a collective norm. There is a strong social pressure to conform to the tradition, to belong to the circle of those who have undergone it. Non-circumcised girls and their families are often marginalised to an extent that their survival opportunities are reduced. The girls have little chance of finding a husband while parents and other family members are excluded from social support systems, community gatherings and are denied leading positions within the community.

The number of beliefs associated with the practice is long. Many of them make the practice look advantageous. It is, for instance, said to:

- facilitate sexual intercourse, to enhance the fertility of a woman and to make giving birth easier;
- increase hygiene, to purify the woman and to make her genitals look more beautiful;
- complete the girl, to make her become a true woman (while non-circumcised women are considered children);
- free the woman of a dangerous organ (in some cultures, the clitoris is considered to be a precarious organ that can make the men sterile, kill the newborn or destroy farmland);
- help a woman to have normal children;
- decrease the risk of promiscuous behaviour in women and increase their faithfulness.

The last point is the most recurrently cited motive across African communities. FGM/C is performed to preserve the virginity of the girl, to diminish her sexual appetite and to transform her into an obedient and faithful wife and mother who will not dishonour the family. In fact, the most common objective of FGM/C is to control the women's sexuality (see for example Koso-Thomas 1987; Asefaw 2007). In the network of societal rules, FGM/C is bound to values that give the woman an inferior status to the man (UNICEF 2005; Behrendt 2006).

FGM/C is a cultural practice that predates both Christianity and Islam. Numerous Christians and Muslims, however, believe that the practice is a religious requirement or recommendation (see for example Behrendt 2005; UNICEF 2005). Furthermore, many communities associate the practice with supernatural powers, demons and witchcraft. Those who discontinue the practice are said to become cursed and to be possessed by evil spirits (Behrendt 2005).

4.5. Sources for further reading

For further reading on FGM/C (e.g. on socio-cultural or religious motive, the legislative texts regarding the practice at country, regional and international level or movements for its abolition), we recommend the following documents: The controversy of Female Genital Mutilation (Irin 2005), Changing a harmful social convention: female genital mutilation/cutting (UNICEF 2005). Tradition and rights: female genital cutting in West Africa (Plan International 2006).

To deepen the understanding of the medical and psychological harm of FGM/C, we propose two documents published by the WHO:

- Eliminating female genital mutilation: an interagency statement (UNAIDS, UNDP et al. 2008)
- Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries (WHO study group on female genital mutilation and obstetric outcome 2006).

4.6. FGM/C in Europe

The European Parliament affirms in a press release in 2009 that about 18,000 women and girls living in Europe undergo FGM/C or are threatened with having to undergo the practice every year (European Parliament 2009). The rationale and sources used for establishing this number are not explained. None of the European countries has carried out prevalence studies. The available countrywide estimations are usually based on existing data from practicing countries. This method of transferring country prevalence rates to migrant populations has strong methodological limitations (Powell, Leye et al. 2004).

4.6.1. Documentation of FGM/C performed in Europe

Due to lack of accurate data, the extent of the issue among immigrant communities in Europe is unknown. The documentation of court cases is the most solid indicator for the existence of girls being subjected to FGM/C in Europe. France is the pioneer in this regard and has by far the highest incidence of prosecutions and convictions: in the past 30 years over 30 cases have been brought to court and parents as well as practitioners have been condemned to prison penalties. Isolated prosecutions have also taken place in Italy, England and Sweden (Irin 2005; Sandberg 2008). Diverse other sources report indications that FGM/C is being practiced in Europe without providing tangible evidence (see for example Black and Debelle 1995; Leye, Powell et al. 2006).

4.7. FGM/C in Germany

4.7.1. Estimates for the number of women living in Germany who have undergone FGM/C or who are at risk

According to the calculations of the German non-governmental organisation Terre des Femmes (TDF) a quorum of 17,852 women[12] over the age of 20 years estimated to have undergone FGM/C.[13] The number of girls and women younger than 20 who are either at risk of being subjected to the practice or who might have already undergone it, is assessed to be 5,031. This comes up to a total quorum estimate of 22,884 women and girls who have either undergone FGM/C or who might be at risk of undergoing it. To obtain these results, the number of women from a particular country was multiplied by the prevalence estimation of the country[14] and then divided by 100. According to these calculations, the immigrant communities with the highest number of girls and women concerned or at risk were as follows.

- Ethiopia, Egypt and Eritrea: above 3,000 women and girls;
- Somalia and Kenya: above 2,000 girls and women;
- Yemen and Nigeria: above 1,000 girls and women.

These estimations are asserted to be minimum numbers as they do not take into consideration

- women and girls with irregular residence status,
- women and girls who originate from a practicing country, but who have obtained German nationality and
- women and girls who come from countries without representative national survey data available (e.g. Indonesia or Iraq) (Terre des Femmes 2010).

These numbers give an idea of the seriousness of the issue. Nevertheless, some caution is warranted regarding their validity. For countries with low to moderate prevalence rates, the existence of FGM/C among immigrants is determined by their area of origin and their ethnic group affiliation and not by the country prevalence rate (UNICEF 2005; Leye, Powell et al. 2006). The FGM/C rates within women immigrant populations from these countries can thus vary between 0-100%. Moreover, the calculations for immigrant populations from several countries contain the methodological flaws listed below.

- Not all prevalence estimates are based on representative surveys (either MICS or DHS);
- Some calculations make use of non-updated DHS or MICS data;
- The calculation of girls at risk is based on the prevalence status of FGM/C among women between 15 and 49 years of age, and does not take into consideration certain changes that have taken place within the younger generations. Yet, in several African countries the DHS and MICS show a significant decline of the FGM/C prevalence in the cohort of daughters. In Guinea Bissau, for example, the estimated prevalence of FGM/C for women aged from 15-49 years was at 45% while it was 35% for the generation of their daughters.[15] In Burkina Faso, the trend is even stronger: 77% of the women from 15-49 years were circumcised while this was true for only 37% of the daughters. It would probably be more realistic to use the prevalence estimations for the daughters' generation – where available – than to apply the data from the adult generation for estimating the number of girls at risk in Germany.
- From a statistical point of view, it is very unlikely that the prevalence estimations of the countries can be transferred one to one to the immigrant populations living in Germany. Immigrants are a population group of a particular profile that cannot be set equal to a representative sample of the entire population. Immigrants are, for example, more often from urban areas, rarely belong to the lowest group of income and have on average a higher education level (Kohnert 2007; Lessault and Mezger 2010). There is evidence from different countries indicating that wealth, education or urban residence often correlate with lower FGM/C rates (see for example UNICEF 2005; MICS 2006; Asefaw 2007; Bureau of Statistics Sierra Leone, Ministry of Health et al. 2009; Kenyan National Bureau of Statistics and ICF Macro 2010). Thus, it is improbable that the FGM/C rates of the African countries match those of immigrant communities.

4.7.2. Documentation of the incidences of FGM/C in Germany

The results of two studies indicate the possibility of FGM/C being carried out by medical personnel in Germany. The first study was carried out ten years ago in three cities in Austria (Vienna, Graz and Linz). A total of 250 African immigrants were interviewed (130 women and 120 men). About 30% of the study participants confirmed that they had circumcised daughters. Most of the girls had undergone FGM/C in Africa, however, the parents reported that 11.5% had been subjected to the practice in Europe, more precisely in Austria (1.9%) and in Germany and the Netherlands (10.6%). The

12 Out of 68,157 women immigrants of practicing countries with available data from nationwide surveys.

13 The calculation was established for the calendar year 2010.

14 TDF used prevalence estimations from the two documents published in German: Unicef (2009) „Zur Situation der Kinder in der Welt 2009". Bedrohte Kindheit, Frankfurt (Main), 2009 (Tabelle 9, S. 194ff). Amnesty International: „Schnitt ins Leben". Report 2006 über weibliche Genitalverstümmelung, Wien 2007 (Tabelle S. 78ff)

15 The rate for the daughters represents the sum of the percentage of circumcised daughters plus the percentage of girls whose mothers intend to subject them to the practice.

study does not provide information on the original socio-demographic profile of the study subjects (Afrikanische Frauenorganisation in Wien 2000).

The second study was carried out in Germany by TDF, the Bund der Frauenaerzte (association of gynaecologists) and UNICEF. They approached the issue from a different angle and sent out a questionnaire to 13.182 gynaecologists in Germany. The response rate was at 3.7% with 493 returned questionnaires. Among the 493 respondents

- 35 (7%) knew about patients who wanted to subject their daughters to FGM/C in their home country;
- 48 (10%) claimed to have heard about girls being subjected to the practice in Germany
- 3 (1%) had been asked to practice FGM/C on the daughters of immigrants (Bund der Frauenärzte, Terre des Femmes & UNICEF 2005).

Apart from these two studies, there is anecdotal material that supports the evidence of FGM/C being carried out in Germany. Several medical doctors reported having been approached by parents to perform FGM/C. There was also an incident in Berlin regarding a medical doctor of Egyptian origin who agreed to practice FGM/C for about 600 euros. He was filmed using a hidden camera but the charges against him were dropped due to lack of evidence. In other cases, parents of Gambian and Ethiopian origin were suspected of having the intention of subjecting a daughter to FGM/C. The claims were reported by German citizens to the authorities or NGOs. Unlike in France, however, no case of FGM/C on German soil has ever been made public (Sandberg 2008; EMMA 2009).

4.7.3. Perceptions of African immigrants on FGM/C in Germany

The number of studies looking at the perceptions of African immigrants in Germany is small. We identified two relevant studies that aim at exploring the perceptions and practices of immigrant women.

The first research was conducted by a non-governmental organisation entitled “Freundeskreis Tambacounda”. The objectives were to analyse the situation regarding FGM/C in the state of Niedersachsen, to explore the personal and social perceptions of women concerned and to evaluate the nature of medical assistance provided to them. The data collection concentrated on five cities (Hannover, Braunschweig, Göttingen, Osnabrück and Oldenburg). Based on the FGM/C country prevalence rates and the official records of African immigrants in the areas of data collection, it was estimated that 340 circumcised women reside in the five targeted cities.

An analysis of the opinions of the women concerned, however did not take place: the researchers were not able to identify women from practicing families who were available and willing to give interviews. The data collection with medical doctors and midwives was more successful: their feedback included the finding that the women concerned usually seek care during pregnancy or immediately before delivery. The respondents reported that communication obstacles due to language barriers were common. This was perceived as an obstacle for explaining complications associated with FGM/C or for conducting awareness raising. As a consequence, the topic was often not discussed during the consultations. Furthermore, it had observed that episiotomy and C-sections were the most common complications of circumcised women; de-infibulation requests were reported for three women (Freundeskreis Tambacounda e.V. 2003).

The second study was conducted by Asefaw (2007), a medical doctor of Eritrean origin. Asefaw investigated the effects of FGM/C in two different samples. The participants of the first sample were women living in Eritrea. Those of the second sample were immigrant women of Eritrean origin who live in Germany.

Asefaw’s findings indicate that gynaecological treatments in Germany are often very negative, even traumatising experiences for women who have undergone infibulation. They are exposed to incomprehension, inappropriate emotional reactions and public exhibition of their status by the attending health personnel. Lack of knowledge of the effects of FGM/C and false diagnoses were further reported inconveniences. As a consequence, many of the women concerned avoid gynaecological consultations. The findings also indicated that the context of migration often changes the way the women perceive FGM/C. While the women used to consider FGM/C as something normal and positive in their home community, they start having ambiguous feelings towards the practice after arriving in Germany where people see FGM/C as a violent crime. The change of perception and the growing awareness that the organs have been severely damaged, can lead to severe emotional suffering. Asefaw highlights as a cause the one-sided focus of the public discussions on FGM/C. The practice is presented as a cruel act in which girls and women are victims of incredible suffering without mentioning the complex socio-cultural contexts that surround the practice. Testimonies and case studies illustrate that the way of dealing with FGM/C in Germany is experienced as psychological violence by the women concerned. The stigmatising and discriminative treatments often lead to feelings of depression and loss of identity. Asefaw draws the conclusion that the current public discourse against FGM/C in Germany is contra-indicated for the promotion of the abandonment of the practice. It deprives the women concerned of emotional and psychological resources instead of reinforcing their efforts to change their behaviour (Asefaw 2007).

5 Results

The results chapter is organised into eleven sections:

- Immigrant populations from practicing countries in Hamburg (section 5.1);
- Theoretical estimations about the numbers of women and girls concerned in Hamburg (section 5.2);
- Samples of the qualitative and quantitative survey (section 5.3);
- Knowledge, attitudes and practices of immigrant communities from Sub-Saharan Africa: an overview (section 5.4);
- Knowledge, attitudes and practices of communities with more than 100 immigrants in Hamburg[16] (section 5.5);
- Knowledge, attitudes and practices of communities with less than 100 immigrants in Hamburg[16] (section 5.6);
- Girls at risk in Hamburg (section 5.7);
- Suggestions on how to promote the abandonment of FGM/C among immigrant populations in Germany (section 5.8);
- Perceptions and practices regarding health care of African woman immigrants (section 5.9);
- Results regarding media preferences of African communities (section 5.10);
- Institutions working with African migrant communities in Hamburg (section 5.11).

The first two sections draw on official data sources and give an overview of how many immigrants from practicing countries officially live in Hamburg and how many women and girls are theoretically concerned when it comes to FGM/C. Section 5.3 to 5.9 explore primarily the data of the qualitative and quantitative interviews with African community members and other key informants.

5.1. Overview of immigrant populations from practicing countries in Hamburg[17]

According to the documentation of the Statistische Landesamt für Hamburg und Schleswig Holstein (State Office of Statistics for Hamburg and Schleswig Holstein), 15,712 African immigrants were registered in Hamburg at the end of 2009. Among these 15,712 persons, 12,439 come from countries where FGM/C is practiced. This number includes immigrants from Egypt and Yemen who were not included in the current study. The number of immigrants from Sub-Saharan Africa is 11,305.

The largest immigrant community in Hamburg by far is of Ghanaian origin, followed by those from Togo and Nigeria. The communities from these three countries represent about 70% of the immigrant population from Sub-Saharan Africa. The table below displays the number of immigrants disaggregated by sex for all communities for which DHS or MICS data on FGM/C rates are available (25 Sub-Saharan countries plus Egypt and Yemen).

Table 2: Number of immigrants registered in Hamburg from FGM/C practicing countries[18]

No	Country of origin	Men	Women	Total
1	Ghana	2418	2778	5196
2	Togo	847	684	1531
3	Egypt	857	392	1249
4	Nigeria	727	373	1100
5	Cameroon	270	213	483
6	Gambia	333	117	450
7	Cote d'Ivoire	250	153	403
8	Kenya	77	208	285
9	Benin	151	68	219
10	Ethiopia	99	99	198
11	Burkina Faso	154	36	190
12	Sierra Leone	151	34	185
13	Guinea	122	56	178
14	Guinea Bissau	104	64	168
15	Liberia	84	46	129
16	Senegal	74	39	113
17	Niger	70	14	84
18	Mali	49	21	70
19	Sudan	41	20	61
20	Eritrea	22	30	52
21	Tanzania	21	21	42
22	Uganda	9	26	35
23	Yemen	22	7	29
24	Mauritania	17	8	25
25	Somalia	6	6	12
26	Chad	3	1	4
27	Central African Republic	1	0	1
	Total	**6979**	**5514**	**12439**

The numbers in the table above include neither German passport holders nor, evidently, men and women residing

16 Where the practice of FGM/C is prevalent.

17 Only including the countries where DHS or MICS data are available.

18 Where DHS/MICS data for FGM/C rates exist.

illegally in Hamburg. The table is organised by immigrant community: the one with the largest number of immigrants at the top (Ghana), with the smallest at the bottom (Central African Republic). For methodological and logistical reasons explained in section 3.3.2, our data collection and analysis had little to no focus on the following countries: Chad, The Central African Republic, Yemen, Egypt, the Democratic Republic of Congo and Mauritania.

According to an empirical study from the Diakonie Hamburg (2009), an estimated 6,000-22,000 persons live in Hamburg without legal residence status. The proportion of women among them is estimated to be at 45%. The number of children under 16 years without paper is assessed to be in the range of 240-2,400 persons. The upper limit for illegal residents from Sub-Saharan Africa is estimated at 2,474 with the highest proportion coming from Ghana.

Table 3: Estimation of women concerned (18+ years) and girls (0-17 years)

Country	Nr. of women 18 years + in Hamburg	Prevalence (%) women (15-49 years in country of origin)	Estimation of women having undergone FGM/C	Girls < 18 years living in Hamburg	Prevalence among daughters in country of origin[19]	Number of girls concerned or at risk
Ghana	2322	3.8	88	456	3.8	17
Togo	448	5.8	26	236	1.0	2
Egypt	287	91.1	261	105	57.0	60
Nigeria	296	29.6	88	77	29.6	23
Cameroon	183	1.4	3	30	1.4	0
Gambia	93	78.0	73	24	64.3	15
Cote d'Ivoire	110	42	46	43	42	18
Kenya	193	27.1	52	15	27.1	4
Benin	56	12.9	7	12	3	0
Ethiopia	83	74.3	62	16	74.3	12
Burkina Faso	23	76.6	18	13	37	5
Sierra Leone	21	91.3	19	13	91	12
Guinea	46	95.6	44	10	94	9
Guinea Bissau	48	44.5	21	16	35	6
Liberia	35	58	20	11	58	6
Senegal	33	28.2	9	6	24	1
Niger	8	2.2	0	6	1.2	0
Mali	17	85.2	14	4	82	3
Sudan[20]	19	90.0	17	1	90.0	1
Eritrea	27	88.7	24	3	88.7	3
Tanzania	19	14.6	3	2	6.4	0
Uganda	23	0.6	0	3	0.6	0
Yemen	7	23	2	0	20	0
Somalia	6	97.9	6	0	46.0	0
Mauritania	6	71.3	4	2	69	1
Chad	1	44.9	0	0	39	0
Total	4404	n/a	902	1104	n/a	200

19 If the prevalence of FGM/C among daughters was not assessed in the DHS or the MICS, we used the prevalence rate of women between 15-49 years and marked the number with an asterisk *

20 The prevalence data are only from Northern Sudan and cover about 80% of the female population

5.2. Theoretical estimation of the number of women and girls concerned in Hamburg

This section presents a theoretical estimation of the number of girls and women who have undergone FGM/C or who are at risk of being subjected to the practice in Hamburg (see table 3). The source used for the calculation of women older than 18 years was the prevalence data from DHS or MICS which provide country prevalence estimations for women aged from 15 to 49 years. The number of girls (< 18 years) who have undergone FGM/C or who are at risk of undergoing it was calculated by using the prevalence rate for the cohort of daughters in the country of origin. This number is not available for all countries. In case of unavailability, the same prevalence rate as for the adult women was applied. The outcome of the calculations indicate that – theoretically – 902 women immigrants (18 years +) have been subjected to the practice and that 200 girls (< 18 years) have either undergone FGM/C or are at risk of undergoing it. This is about 20% of the women and 18% of the girls from Africa and Yemen living in Hamburg. By far the largest number of women and girls concerned is estimated to be from Egypt (261 women and 60 girls).

These numbers are useful to provide an approximate idea of the depth of the problem. From a methodological point of view, however, some caution is warranted. The prevalence rates from the DHS and MICS cannot be assumed to be equal to those of the immigrant populations. Important factions such as ethnic group proportions, education, area of origin (urban or rural) and level of income are omitted in these calculations. The findings presented in later sections highlight how these factors impact on the numbers and that the real numbers of women and girls concerned can be considerably higher (see for example the result from Nigeria in section 5.5.3.3) or lower (for instance the results on girls concerned of Ethiopian origin presented in section 5.5.9.3).

5.3. Samples of the qualitative and quantitative survey and their characteristics

5.3.1. Qualitative survey

As highlighted in the sections above, our data collection focused on immigrant communities from 21 Sub-Saharan countries. During the qualitative survey, 91 key informants with roots in the community of these countries were interviewed. The key informants included traders, Afro shop owners, religious, customary and women leaders as well as particularly open-minded and trustworthy persons who offered to share valid information on FGM/C. The proportion of men interviewed was higher (59%) than that of women (41%) which is due to the fact that most customary and religious leaders are men. The researchers did not identify key informants from the Malian, Sierra Leonean and Bissau Guinean community.

Table 4: Number of key informants by country of origin and disaggregated by sex

Country of origin	Women	Men	Total
Ghana	11	8	19
Togo	0	3	3
Nigeria	1	7	8
Cameroon	4	7	11
Kenya	4	3	7
Senegal	0	2	2
Guinea	1	5	6
Tanzania	0	1	1
Benin	0	2	2
Cote d'Ivoire	0	6	6
Ethiopia	8	3	11
Burkina Faso	3	3	6
Niger	1	0	1
Eritrea	0	1	1
Gambia	3	2	5
Somalia	1	0	1
Liberia	0	1	1
Total	37	54	91

The qualitative survey also included interviews with 27 key informants of the following profiles:

- researchers specialising in African cultures (one woman and one man),
- social workers and professionals working at intercultural centres and advisory service points for immigrants (eight women and four men),
- gynaecologists practicing in Hamburg (six women),
- other health personnel (midwives, nurses, dermatologist, paediatrician etc: four women and three men) and
- activists (one woman and one man).

5.3.2. Quantitative survey

A total number of 1,767 participants with African migration background was interviewed during the quantitative survey phase. We also talked to five persons with one African and one German parent: two women of Ghanaian/German origin, one woman (Nigerian/German) and a man (Togolese/German).

The largest proportions of interviewees were immigrants from Ghana, Nigeria and Togo. They represent about 50% of the total sample. There was a greater number of men interviewed than of women. There are two reasons for this: first, the African women population in Hamburg is considerably smaller than the men population, and, second, women participants were more difficult to recruit for interviews (see section 3.6.1).

It was difficult to estimate the total number of refusals. We could not always distinguish between people who were unavailable and those who rejected participation due to the interview topic. Altogether we noted about 50 refusals from men and a slightly higher number from women.

The interview duration ranged from 10 to 260 minutes. Overall each interview lasted on average 34 minutes, but interviews with women took significantly longer than those with men. Interviews below 20 minutes concerned usually subjects from non-practicing groups or participants who chose to terminate the interview. The interviews were conducted in 15 different languages. The most frequently used interview languages were English and French; however, German and diverse local languages were also used (see table below).

Table 5: Sample of the quantitative survey

	Country of origin	Total # of men interviewed	Total # of women interviewed	Total # interviewed	% of interviewed sample
1.	Ghana	254	264	518	29.2
2.	Nigeria	141	79	220	12.4
3.	Togo	78	61	139	7.8
4.	Cameroon	69	41	110	6.2
5.	Guinea	77	38	115	6.5
6.	Cote d'Ivoire	92	18	110	6.2
7.	Benin	68	31	99	5.6
8.	Gambia	57	33	90	5.1
9.	Ethiopia	42	36	78	4.4
10.	Burkina Faso	66	9	75	4.2
11.	Kenya	15	40	55	3.1
12.	Mali	30	10	40	2.3
13.	Niger	36	6	42	2.4
14.	Senegal	21	2	23	1.3
15.	Eritrea	7	5	12	0.7
16.	Sierra Leone	9	2	11	0.6
17.	Tanzania	3	3	6	0.3
18.	Sudan	2	1	3	0.2
19.	Egypt	2	2	4	0.2
20.	Uganda	0	1	1	0.1
21.	Guinea Bissau	4	0	4	0.2
22.	Mauritania	3	0	3	0.2
23.	Somalia	0	1	1	0.1
24.	Liberia	3	1	4	0.2
25.	Congo	3	0	3	0.2
26.	Comore Islands	0	1	1	0.1
	Total	1082	685	1767	100.0

Table 6: Frequency of interview languages used

	Interview language applied	Women	Men	Total sample
1	English	211 (30.7%)	379 (35.1%)	590 (33.3%)
2	French	91 (13.2%)	311 (28.7%)	402 (22.7%)
3	German	127 (18.5%)	85 (7.8%)	212 (12.0%)
4	Amharic	37 (5.4%)	38 (3.5%)	75 (4.2%)
5	Bambara/ Mandigo/ Malinke/ Dioula[21]	66 (9.6%)	120 (11.1%)	186 (10.5%)
6	Swahili	17 (2.5%)	6 (0.6%)	23 (1.3%)
7	Tigrinya	2 (0.3%)	4 (0.4)	6 (0.3%)
8	Moore	1 (0.1%)	20 (1.8%)	21 (1.2%)
9	Twi	102 (14.8%)	95 (8.8%)	197 (11.1%)
10	Ewe/ Mina	12 (1.7%)	5 (0.5%)	17 (1.0%)
11	Gourounsi	0 (0%)	1 (0.1%)	1 (0.1%)
12	Yoruba	2 (0.3%)	5 (0.5%)	7 (0.4%)
13	Fon	2 (0.3%)	3 (0.3%)	5 (0.3%)
14	Peulh	0 (%)	5 (0.5%)	5 (0.3%)
15	Ibo	10 (1.5%)	4 (0.4)	14 (0.8%)
	Missing data	7 (1.0%)	4 (0.4%)	11 (0.6%)

The participants resided in 54 different districts of Hamburg with higher ratios from the area of Wilhelmsburg, Veddel, Barmbek, Eimsbüttel, Harburg, Altona, Wandsbek and Billstedt. About 16% of the participants were German passport holders (14% of the men and 19% of the women). A small minority (0.6%) reported having the nationality of another European country.

As described in section 3.6.3, the questions on socio-demographic information were received with suspicion by many participants. For certain variables, the percentage of

21 The four terms relate to the same language spoken with different accents and dialects.

participants who did not want to answer represented 2%-10% of the interviewed sample:

- Item assessing the participant's age – number of refusals: 173 (9.8% of the sample);
- Item assessing the region of origin – number of refusals: 43 (2.4% of the sample);
- Item assessing the ethnic group affiliation – number of refusals: 45 (2.5% of the sample);
- Item on the participant's status regarding the residence permit – number of refusals: 174 (9.9% of the sample);
- Item on the district of Hamburg where the participant lives – Number of refusals: 119 (6.7% of the sample);
- Item on the participant's duration of stay in Germany – number of refusals: 2.4 (43% of the sample);
- Item on the participant's place of birth – number of refusals: 113 (6.4% of the sample);

The researchers also repeatedly noted doubts on the data provided for the items mentioned in the list above. Thus, the validity of some socio-demographic outcomes is uncertain.

The average age of the interview participants was 36 years. Over 88% of the interviewed participants fell in the age range from 15-44 years. Women reported a significantly lower average age than men. The average duration of stay in Germany was between 10 and 11 years (see table 7).

Table 7: Socio-demographic characteristics of the interviewed sample

Socio-demographic variables	women (*n* = 685)	men (*n* = 1082)	total sample (*n* = 1767)
Age (in years)			
Mean (standard deviation)	34.7 (9.3)	36.8 (9.3)	36.0 (9.3)
Range	16-75	15-82	15-83
Average education level (in years)			
Mean (standard deviation)	11.91 (4.9)	12.81 (5.1)	12.5 (5.0)
Range	0-27	0-27	0-27
Religion			
Muslim	183 (27.0%)	491 (45.9%)	674 (38.6%)
Christian	475 (70.1%)	539 (50.4%)	1014 (58.0%)
Traditional religion	4 (0.6%)	9 (0.8%)	13 (0.7%)
None believers	16 (2.4%)	30 (2.8%)	46 (2.6%)
Social status			
Married (monogamous)	314 (46.7%)	400 (37.3%)	714 (40.3%)
Married (polygamous)	15 (2.2%)	34 (3.2%%)	49 (2.8%)
Separated/divorced/widowed	96 (14.3%)	165 (15.4%)	261 (14.7)
Never been married[22]	248 (36.8%)	473 (44.1%)	721 (40.7%)
Average total number of children			
Girls (range)	0.69 (0-6)	0.65 (0-7)	0.67 (0-7)
Boys (range)	0.79 (0-4)	0.68 (0-4)	0.72 (0-4)
Average number of children living in Germany			
Average girls (range)	0.55 (0-6)	0.45 (0-6)	0.49 (0-6)
Average boys (range)	0.65 (0-4)	0.44 (0-4)	0.53 (0-4)
Migrated from a(n)			
Urban area	495 (72.1%)	787 (72.4%)	1282 (72.3%)
Rural area	145 (22.1%)	249 (22.9%)	394 (22.2%)
Missing data	24 (3.5%)	38 (3.7%)	62 (3.5%)
Does not want to answer	23 (2.3%)	11 (1.0%)	34 (2.0%)
Time spent in Germany (in months)			
Mean (standard deviation)	129.0 (92.5)	127.03	127.8 (89.1)
Range	1-552	0-576	0-576

Over 40% of the participants were married at the time of the interview. The large majority reported that they were married monogamously, however, almost 3% of the interviewees, 15 women and 34 men reported that they lived in a polygamous union. Out of the 15 women, four were married to an African man who had a European co-wife. The remaining nine women were married to African men who had more than one African spouse. Out of the 34 polygamous men, 14 were married to a European woman and had one or more African partners at the same time. The remaining 13 men were polygamously married to at least two African women. Another 15% of both men and women reported that they were divorced or widowed.

Almost two thirds of the participants had children, but barely half of them had their children living with them in Germany. About 56% of the women and 45 % of the men had at least one child in Germany which indicates that the children of men are more likely to remain in Africa than those of women. The birth rate among immigrants is significantly lower than in their countries of origin: the women participants reported on average 1.5 children and men 1.3 children (compare for example with NCP Nigeria and ICF Macro 2009).

22 Including participants living in a relationship without being married

Reactions to the research topic

The reactions to the research ranged from enthusiastic and appreciative feelings to indifference and negative responses of discomfort, rejection and even intimidation.

Among the positive reactions were participants who were curious to learn more about Plan, the project or FGM/C. Further encouraging responses came from committed opponents to FGM/C who expressed interest in collaborating in future activities. There were also cheering voices of participants who felt that the topic needed to be addressed among African immigrant communities.

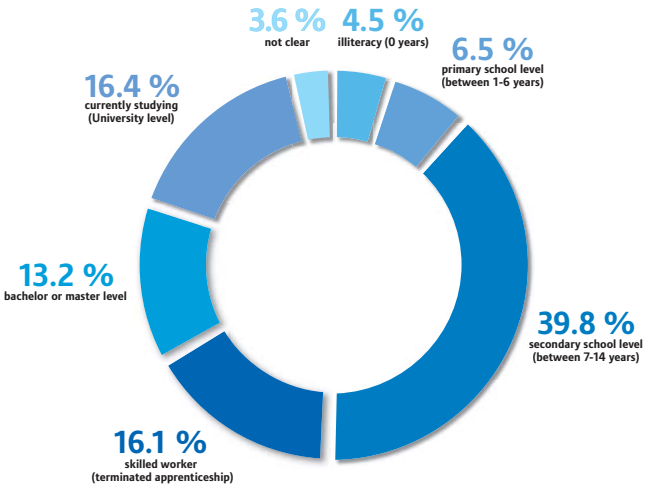
The positive reactions were, however, relatively few compared with the large number of participants who did not think of FGM/C as a relevant research topic for immigrants. They were rather surprised about the subject, stated that such research should take place in Africa or expressed the opinion that immigrants and African people in general had more important issues to attend to. One man of Burkinabe origin said for example: "It is good to work against the violation of women rights, but I think Africa has other more urgent problems to solve. Female circumcision is just one of so many things." Many men pointed out that their priorities were their residence and their work permits. They felt that the research should explore how to support them in these domains. Some women also expressed feelings of unease about the level of intimacy of the questions.

Last but not least, there was a considerable number of hostile or harsh reactions. Some participants perceived the questions like an intrusion into their private matters – or like a German intrusion into African matters like this immigrant of Nigerian origin who chose the following words to describe his feelings: "Plan International should mind their own business. This is our tradition and we don't need them to tell us anything about it."

Others became unpleasant because they feared that the project would increase discrimination, stigmatisation and prejudice against African immigrants. Many of them criticised and felt offended by the way FGM/C was treated in the German media and were apprehensive that this project would deal with the matter as other NGOs had done before. A small number of participants from Mali and Guinea felt personally offended that fellow Africans would take a role as researchers and engage in an activity that they perceived as treacherous and dangerous for their traditions. Intimidating reactions and even insults were the result.

The majority of the participants were from urban areas. The education level was 12.5 years. Men had on average one year more education than women. About 11% of the participants had less than seven years of formal education (see figure below).

Figure 2: Qualification level of the interviewed immigrant population



As shown in table 8, about one third of the immigrants reported that they were occupied as cleaners or help workers in bars, restaurants, ware houses and stores. Among the skilled workers, the common occupations were driver, craftsman (mechanics, carpenters) and hairdresser. Another common occupation is the trading business to which almost 10% of the men are committed, notably in the import/export business.

Table 8: Current occupation/work of interviewed immigrant population

Current occupation	Women (%)	Men (%)	Total sample (%)
no work[23]	10.0	12.8	11.7
student, apprentice, language classes	25.0	18.5	21.0
restaurant/bar, warehouse, cleaning, shop sale	27.0	36.8	33.0
health care assistance	5.8	1.3	3.0
skilled worker profession	8.6	12.9	11.2
trader	3.8	9.5	7.3
bachelor or master level professions	2.9	3.9	3.5
house wife	15.2	0.2	6.0
Other professions/not clear	1.8	4.2	3.3

When disaggregating the data by religion, certain significant differences become visible (see table 9): Muslim women have a significantly lower education level than Christian

23 Including participants without work permission and job seekers.

women and come significantly more often from rural areas. In the same line, Muslim men have a lower education level then Christian men, however, the proportion of men from rural areas is the same. Particularly striking is that 16% of the interviewed Muslim women and 7% of the Muslim men have never been to school while this is the case for only 2% of the Christian women and 1% of the Christian men.

Table 9: Differences in between Christians and Muslims regarding education and area of origin

Socio-demographic variables	Muslim women (*n* = 183)	Christian women (*n* = 475)	Muslim men (*n* = 491)	Christian men (*n* = 539)
Average education level (in years)	9.2	13.02	11.14	14.21
Proportion from rural areas	32.0	18.9	24.3	24.3

Key informants from Muslim communities in West Africa described a tendency among men to bring over women from rural areas for marriage. According to them, women from remote areas are easier to control, to keep at home and they don't claim their rights the way educated women do. A man of Cote d'Ivoire origin (a Muslim himself) explained during the interview:

> "A lot of men prefer women from the villages because they tell themselves that these women can be dominated more easily. Women from cities won't accept this type of practice. But the women from the villages have no capacity to argue against their husbands when there are problems. The educated woman can defend herself. She has solid arguments."

5.4. Knowledge, attitudes and practices of immigrants from Sub-Saharan Africa: an overview

5.4.1. Proportion of immigrants with roots in practicing families

An important proportion (39%) of the immigrants from Sub-Saharan Africa has roots in families practicing FGM/C. Men report more often than women that they come from a practicing family. This can be explained by the fact that the number of men from middle to high prevalence countries is proportionally much higher than that of women (e.g. Burkina Faso or Nigeria) and that the number of interviewed Muslim women is lower.

The practice is carried out in families of both Christian and Muslim origin although the percentage of Muslims from practicing families (68%) is much higher than that of Christians from practicing families (22%). The incidence of the practice decreases with the education level of the immigrants. Moreover, the practice is found less among the youngest age group of women (see table 10) which might be a sign for a gradual decline of FGM/C across the generations.

5.4.2. Proportion of women and girls who have undergone FGM/C

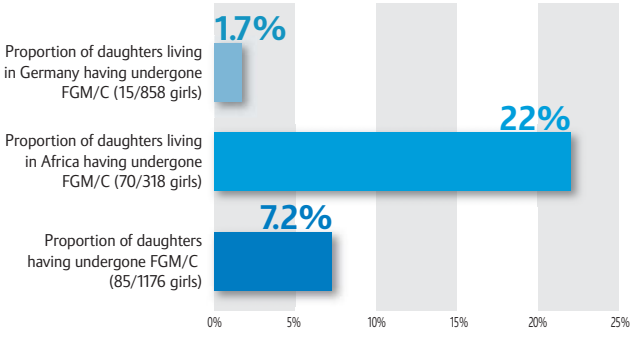
About one quarter of the women interviewed reported to have undergone FGM/C. Another 6% of the women preferred to abstain from answering the question. In 2% of the interviews, the researchers preferred not to ask the question because they felt that the interview setting would not allow it. Most women falling in the last two categories were from practicing families so that there was a strong probability that they had undergone FGM/C. Furthermore, the interviewers noted for about 6% of the women who claimed to be uncircumcised that the non-verbal communication and the socio-ethnic background indicated otherwise. It can be assumed, thus, that the number of women concerned from Sub-Saharan Africa is considerably higher than 25% and probably situated above 30%.

Table 10: Answers of women participants to the question: have you been circumcised?

	Yes	No	Does not answer	Question was not asked
Women (16-30)	44 (19.0%)	176 (75.9%)	9 (3.9%)	3 (1.3%)
Women (31-44)	87 (26.9%)	209 (64.7%)	18 (5.6%)	9 (2.8%)
Women (45+)	22 (28.2%)	54 (69.2%)	2 (2.6%)	0 (0.0%)
Total (*n* = 666)	172 (25.1%)	459 (67.0%)	39 (5.7%)	15 (2.2%)

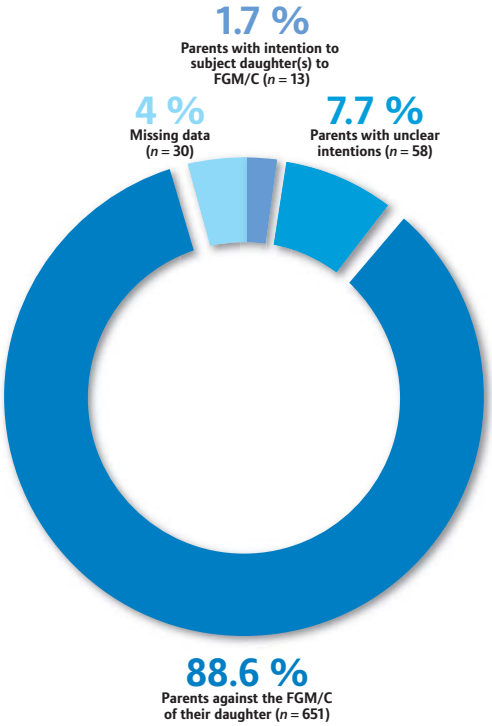
The participants reported a total of 1,172 daughters. According to the reports of the parents, 85 of their daughters had been subjected to FGM/C which is 7%. Most of them had grown up in Africa. There were, however, also 15 (out of 85) girls who resided in Germany. The profile of the parents with circumcised daughters can be summarised as follows: the majority are men, Muslims, above 30 years of age, have less than 10 years of education, and come from the West African Region.

Figure 3: Proportion of daughters (<18 years) who have undergone FGM/C



A small proportion of parents announced their intention to subject their daughters to FGM/C in the future (see figure 4).

Figure 4: Attitude of parents towards the status of their daughters



Most of the immigrants with this intention had the same profile as the parents with circumcised daughters: they were men, Muslims, with less than 10 years of formal education, above 30 years of age and from the West African region. Furthermore, 8% of the participants declared uncertainty about the future status of their daughters. In total, we identified among the respondents 13 daughters at risk of being subjected to the practice during trips to the home country. They were from the following countries: Guinea (5), Togo (3), Benin (4) and Ghana (1).

5.4.2.1. Types of FGM/C

The data collected on the types of FGM/C was limited. Many women participants (almost 30%) did not want to discuss what form of FGM/C they had undergone. In about the same number of interviews (33%), the researchers were not comfortable asking the question. Among those who answered the question, type I and type II reports were the most common. Only two women reported to have undergone an infibulation. All of the participants had undergone FGM/C in Africa, in most cases in their country of origin. The age at the moment of FGM/C varied from 0 to 24 years while 95% of the women underwent the practice before the age of ten. FGM/C was carried out in most cases by traditional female practitioners and in only three cases by medical personal (nurses, midwives). One out of ten women could not remember who carried out the practice because they were too young when it happened.

5.4.3. Perceptions related to FGM/C

Most immigrants consider FGM/C as a traditional custom without religious connotation. For one out of ten persons, however, it is perceived as a religious requirement. This perception was more common in

- men than in women,
- Muslims than in Christians and
- Immigrants with a low education level.

More than half of the immigrants do not associate any particular benefit with FGM/C. But the remaining proportion (42%) perceives that FGM/C embodies one or more advantages. The percentage of those seeing benefits in FGM/C is considerably higher among

- men,
- Muslims,
- immigrants from practicing families,
- persons older than 30 years and
- persons with less than 10 years of formal education.

The most commonly cited benefits are social acceptance of the family, better marriage prospects and the reduction of the sexual desire of the women (see table 11).

5.4.4. Awareness about the risks and consequences of FGM/C

About one third of the participants reported having no awareness of the risks and harm arising from the practice of FGM/C. The proportions were considerably higher in the groups of men, Muslims, the generation 45 years old and older, and immigrants with less than 10 years of education (see table 12). Interestingly, awareness was also lower among immigrants with roots in practicing families. This means that immigrants from non-practicing families associate FGM/C more often with health hazards and effects than those who carry it out and who are confronted with them.

The most frequently cited effect of FGM/C was the impossibility of sexual arousal experienced by women. Awareness for this particular consequence was higher among men and was more often named by immigrants with a high education level. A few participants also named sexual disadvantages for the man due to exposure to frustration after being unable to satisfy the woman. Infections were another frequently cited consequence.

5.4.5. Knowledge of German law and attitudes towards the abandonment of FGM/C

Most immigrants (70%) of the interviewed immigrants from Sub-Saharan Africa know that FGM/C is punishable by law in

Table 11: Perceptions of FGM/C among African immigrant participants

	% from practicing family	% seeing FGM/C as religious obligation	% seeing benefits in FGM/C	% associating FGM/C with the advantage of				
				Cleanliness/ hygiene	Social acceptance	Better marriage prospects	Preservation of virginity	Reduction of sexual desire of woman
Sex								
Women	34.2	6.6	38.4	9.1	21.0	19.0	13.3	18.7
Men	42.5	13.1	45.0	10.9	21.4	18.7	12.7	23.0
Age groups								
16-30	29.3	8.9	35.2	7.5	14.3	14.3	10.8	16.8
31-44	41.9	12.1	45.2	9.7	22.9	19.2	12.7	23.3
45+	40.5	9.3	45.1	11.1	20.5	17.6	23.0	27.0
Religion								
Muslim	67.5	18.9	58.9	14.8	34.4	28.7	12.5	27.3
Christian	22.8	5.3	31.7	7.5	13.2	12.3	13.1	18.0
Education (years)								
0-9	47.6	19.4	55.7	12.5	31.2	27.2	12.7	22.4
10-14	40.7	8.7	42.7	9.8	19.4	16.7	13.6	22.5
15+	30.2	7.3	36.1	9.9	18.6	16.6	12.3	20.3
Relationship to FGM/C								
Practicing family	n/a	17.7	69.2	21.6	43.6	36.4	19.1	33.8
Non-pract. family	n/a	5.1	24.7	2.8	7.1	7.9	8.5	12.8
Total	39.2	10.6	42.4	10.2	21.3	18.8	12.9	21.3

Table 12: Knowledge about risks and consequences associated with FGM/C

	No awareness	Names vague or incorrect effects	Proportion (%) reporting effects related to								
			Pain	Infections	Bleeding	Death	Sexual dis-advantages for women	Sexual dis-advantages for men/the couple	Psychological problems	Problems dur-ing child birth	Infertility
Sex											
Women	24.6	22.5	16.2	19.1	13.3	12.8	20.5	2.2	11.4	14.0	3.7
Men	36.5	18.7	9.2	17.1	8.1	9.2	27.1	2.3	8.8	9.5	2.8
Age groups											
16-30	30.3	16.0	15.8	21.4	11.5	12.4	24.8	1.9	9.6	11.8	5.1
31-44	28.7	20.5	11.2	17.3	11.7	11.2	26.2	3.0	9.6	13.2	2.6
45+	37.6	23.5	9.7	13.0	7.1	5.5	21.0	2.1	9.7	8.4	2.1
Religion											
Muslim	44.4	15.9	8.0	12.6	5.7	8.4	20.2	2.9	5.7	13.7	3.5
Christian	23.5	23.0	14.5	21.6	13.0	11.8	27.2	1.8	12.4	10.4	3.0
Education (years)											
0-9	49.3	22.4	6.0	6.0	2.1	9.9	15.8	2.7	5.4	7.5	2.4
10-14	32.4	19.0	13.9	17.4	11.4	8.3	22.6	2.0	8.9	10.7	2.3
15+	19.2	21.1	13.7	26.5	13.7	14.0	33.0	2.5	13.5	14.6	4.6
Relationship to FGM/C											
Practicing family	39.8	16.4	13.6	14.8	9.9	9.7	20.3	2.2	4.6	13.5	2.6
Non-pract. family	23.9	23.3	10.5	20.5	11.1	11.8	29.2	2.5	13.3	10.1	4.0
Total	31.9	20.2	11.9	17.9	10.1	10.6	24.6	2.3	9.8	11.2	3.2

Germany. Some participants reported that German law did not mention FGM/C and others were uncertain as to the text of the law. Even though most participants had no precise information on how FGM/C was dealt with by the German legal system, there was a strong general awareness about the fact that FGM/C was considered a crime in Germany and that those initiating it risked being sanctioned. Men were slightly more aware on the issue than women (see table below).

Awareness is also stronger among Christians than among Muslims and among immigrants with a higher education level. Interestingly, it is also higher among immigrants from non-practicing families than it is among those who adhere to the practice.

The main information sources for knowledge about German law were oral communication and the international media (RFI, BBC). The court cases which took place in France and which led to the condemnation of parents and practitioners had often been heard of. Some immigrants also reported knowledge of other persecutions of parents who were suspected of having the intention to subject their daughters to FGM/C in Germany.

Furthermore, the majority of immigrants from Sub-Saharan Africa reported being in favour of abandoning the practice (see table 13). Merely 3% of the participants advocate for the continuation of FGM/C. Besides, there are about 16% who report uncertainty regarding their position towards FGM/C. Some, from non-practicing groups, report insufficient knowledge of FGM/C in order to decide whether or not the practice should continue. Others, from practicing groups, feel that the practice should be modified, carried out under medical supervision or that it depends on the collective decision of the community. Immigrants in favour of FGM/C or with ambiguous feelings towards the practice are more strongly represented in the group of men, Muslims and among persons with a low education level.

5.5. Knowledge, attitudes and practices of communities (with > 100 immigrants)

The data analysis showed that the results for the communities of the investigated countries differ strongly. Thus, the decision was made to conduct separate data analysis for the community of each country with an important immigrant population. The passage order of the countries is organised according to the size of the immigrant population, starting

Table 13: Knowledge of German law and attitudes towards the abandonment of FGM/C

	Legislation % distribution of participants who believe that German law				Attitudes towards abandonment % distribution of participants who believe that FGM/C should			
	allows FGM/C	does not allow it	does not mention it	don't know	continue	be stopped	depends	don't know/ answer
Sex								
Women	0.4	64.7	9.9	24.9	1.0	86.4	6.6	6.0
Men	0.4	74.2	6.5	19.6	4.4	78.2	9.1	8.2
Age groups								
15-30	0.2	67.8	7.7	24.2	2.1	83.8	5.8	8.3
31-44	0.5	74.0	7.1	18.4	3.1	81.4	10.3	5.4
45+	0.4	65.8	14.4	19.4	5.8	85.4	6.7	2.1
Relationship to FGM/C								
Practicing family	0.2	66.9	5.0	27.9	6.9	68.4	12.2	12.5
Non-practicing family	0.4	74.3	9.5	15.8	0.7	93.3	3.6	2.4
Religion								
Muslim	0.5	67.9	5.0	26.6	4.5	67.7	13.4	14.4
Christian	0.3	72.8	9.7	17.2	2.2	90.7	4.2	2.8
Education (years)								
0-9	0	59.3	7.1	33.7	6.5	66.2	13.2	14.1
10-14	0.7	70.3	8.6	20.4	2.5	83.7	7.0	6.7
15+	0.2	78.8	6.6	14.5	1.9	88.2	6.5	3.5
Total	0.4	70.5	7.8	21.2	3.1	81.4	8.1	7.4

with the country presenting the highest immigrant number (Ghana) down to the countries with lower immigrant numbers.

5.5.1. Ghana

5.5.1.1. Socio-demographic profile

As illustrated in section 5.1, the Ghanaian community presents almost half (47%) of the immigrant population from practicing countries from Sub-Saharan Africa in Hamburg. The distribution of men and women is quite balanced although the number of registered women is higher.

The Ghanaian community was easily accessible to the interviewers during the qualitative and the quantitative phase and we managed to reach a representative sample size: 263 women and 254 men adding up to a total of 518 subjects interviewed.

The average duration of stay of the participants of Ghanian origin is about 15 years; many of the interviewees had been in Germany for more than 25 years and had raised their children outside of their country of origin. About one fourth of the participants were German passport holders. The large majority (almost 97%) of the participants were Christians (see table 14).

5.5.1.2. Proportion of immigrant population concerned

The overall FGM/C prevalence in Ghana is low. Practicing groups are mainly found in the Upper West (56%) and the Upper East region (13%) (see map in annex 8.7), but as a result of awareness raising campaigns, studies have reported a progressive decline (Oduro, Ansah et al. 2006). FGM/C is unknown to ethnic groups living in the five southern regions and is only practiced by migrant groups from the north-eastern and north-western parts and from neighbouring countries such as Mali, Burkina Faso or Togo (Planned Parenthood Association 1998; US. Department of State 2001).

Table 14: Socio-demographic characteristics of immigrants from Ghana

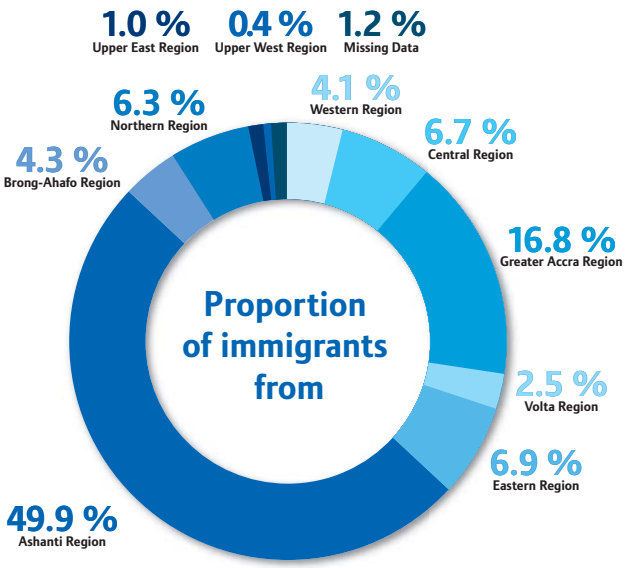
Socio-demographic variables	women (*n* = 264)	men (*n* = 254)	total sample (*n* = 518)
Age (in years)			
Mean (standard deviation)	35.9 (11.4)	39.8 (11.7)	37.8 (11.7)
Range	16-71	16-71	16-71
Average education level (in years)			
Mean (standard deviation)	12.7 (4.5)	14.2 (4.0)	13.5 (4.3)
Range	0-25	0-25	0-25
Religion			
Muslim	18 (7%)	41 (16.5%)	59 (11.7%)
Christian	232 (90.3%)	199 (79.9%)	431 (96.8%)
None believers	7 (2.7%)	9 (3.6%)	16 (3.2%)
Social status			
Married (monogamous)	104 (40.8%)	116 (46.4%)	220 (43.6%)
Married (polygamous)	7 (2.7%)	14 (5.6%)	21 (4.2%)
Separated/divorced/ widow	35 (13.8%)	42 (16.8%)	77 (15.3%)
Never been married[22]	109 (42.8%)	78 (31.2%)	187 (37%)
Migrated from a(n)			
Urban area	193 (84.6%)	192 (80.0%)	385 (82.3%)
Rural area	35 (15.4%)	48 (20%)	83 (17.7%)
Residence status			
Unbefristet (indefinite residence permission)	85 (32.8%)	102 (41.1%)	187 (36.9%)
Befristet (temporary residence permission)	75 (29%)	68 (27.4%)	143 (28.2%)
Duldung (toleration)	12 (4.6%)	16 (6.5%)	28 (5.5%)
Others/ no papers/ does not answer	12 (4.6%)	8 (3.2%)	20 (4.0%)
German nationality	75 (29.0%)	54 (21.8%)	129 (24.9%)
Time spent in Germany (in months)			
Mean (standard deviation)	174.7 (107.8)	174.1 (113.4)	174.4 (110.4)
Range	6-480	0-420	0-480

In order to determine the proportion of the Ghanaian immigrant sample affected by FGM/C, we cross-analysed the following variables:

- area of residency in Ghana,
- ethnic group affiliation,
- FGM/C existence in the family of the participant and
- Information of key informants.

The data of the quantitative survey showed that the large majority (88%) of the Ghanaian immigrants comes from the five southern regions. The highest proportion comes from the Ashanti region (see figure below). A further 11% come from the Brong Ahafo and the Northern region where prevalence rates are higher but still below 6%. Within our sample, only two participants came from the Upper West and five from the Upper East region.

Figure 5: Region of origin of immigrant sample from Ghana



The ethnic groups known for practicing FGM/C in Ghana are the Busanga, Frafra, Kantonsi, Kassena, Kussasi, Mamprusie, Moshie and Nankanne in the Upper East region and Dargarti, Grunshie, Kantonsi, Lobi, Sissala and Walas in the Upper West region (Rahman and Toubia 2000; Hashi 2001). The Kotokoli migrants from Togo and the Mossi from Burkina Faso are also strong adherents of FGM/C.

In our interviewed sample, most participants were affiliated with non-practicing ethnic groups, mostly the Ashanti (42.1%), Akan (15.6%), Fanti (6.8%), Ewe (5.0%) and the Ga (7.5%). All together, over 87% of the participants came from non-practicing groups. About further 5% of the participants came from rather small ethnic groups for which we could not find any documentation on FGM/C. Only 36 persons (7.5%), 7 women and 29 men, were from practicing ethnic groups[24]: the Busanga (2), Mamprusi (2), Frafra (2), Hausa (20), Hausa/Ashanti (1), Hausa/Ga (1), Hausa/Twi (1), Kotokoli (2), Hausa/Dendi (1), Hausa/Mossi (1), Hausa/Kotokoli (2) and Mossi (1). The key informants confirmed these results and one man summarised the situation as follows:

> "In Hamburg, the biggest group are the Ashanti. There are also some Ewe, Ga and Brong. The Northeners are only very few. The Northeners go more to the USA. There is one group that is known for practicing this FGM, the Frafra. They are mostly poorly educated. As far as I know, there is no more than a handful in Hamburg." (key informant of Ghanaian origin)

We asked all participants if they were from a group that practiced FGM/C and if the practice has taken place in their family. About 12% of the participant confirmed that FGM/C existed in their group and about 7% responded positively about its existence in their family.

5.5.1.3. Women and girls concerned

Out of the 264 women interviewed, 15 (5.7%) reported having undergone FGM/C. Three women (1.2%) decided not to answer the question. The remaining majority (93.1%) answered in the negative to the question. The 15 women concerned were between 24 and 61 years of age with an average age of 41; ten of them were Muslims, the other five were Christians. All but one came from the Northern and the Upper East region. The described types indicate type I or type II procedures. Five of the women had undergone FGM/C during infancy and five more between 5 to 8 years old. Three women claimed to have been subjected to the practice during their adolescence (around 15 years). Two women could not remember at what age they underwent FGM/C. All women reported that the practice had been performed in Ghana by traditional practitioners.

We asked all participants if they had one or more daughters and if yes, how many and where she/they lived. We then ascertained if and how many of the daughters had undergone FGM/C or if the parent had the intention of subjecting a daughter to the practice.

The participant sample of the Ghanaian community reported a total of 439 daughters, 335 of them living in Hamburg. A total of 11 daughters had been subjected to FGM/C. All of these girls were living in Ghana and had never been to Germany. They belong to Muslim families, had been subjected to the practice at the hands of a traditional practitioner and were between 0 to 8 years old. Furthermore, two partici-

24 If a participant had one parent from a practicing and one parent from a non-practicing group, s/he was categorised in the practicing groups.

Table 15: Proportion of immigrants from groups and families practicing FGM/C (Ghana)

	FGM/C takes place in my ethnic group			FGM/C has been taking place in my family			
	Yes	No	Don't know	Yes	No	Don't know	Doesn't answer
Women (*n* = 263)	29 (11.2%)	224 (86.5%)	6 (2.3%)	22 (8.6%)	228 (89.4%)	4 (1.6%)	1 (0.4%)
Men (*n* = 254)	30 (12.0%)	207 (83.1%)	12 (4.8%)	12 (4.8%)	228 (91.9%)	7 (2.8%)	1 (0.4%)
Total (*n* = 518)	59 (11.6%)	431 (84.8%)	18 (3.5%)	34 (6.8%)	456 (90.7%)	11 (2.2%)	2 (0.4%)

pants, one man and one woman expressed the intention to subject their daughters to the practice. The woman's three daughters have been living in Ghana all their lives. The man's daughter, however, is living in Hamburg. She was integrated in the follow-up project (see section 3.5.1). In conclusion, none of the girls living in Hamburg had been subjected to the FGM/C but there was one girl at risk of being subjected to it.

5.5.1.4. Perceptions related to the practice

Almost the totality of the sample (98.5%) of the interviewed participants of Ghanaian origin had heard of FGM/C. Those who had not heard about it (nine participants) were Christians from the Southern regions. Some participants of the younger generation reported having only learnt about the existence of the practice in Germany through the media, for instance, the book or the movie Desert Flower by Waris Dirie.

> "I read about this practice in Desert Flower and it made me upset. It is cruel and makes no sense." (young woman of Ghanaian origin)

A lot of participants immediately distanced themselves from the FGM/C, sharing that it was not part of their culture and that it was not done in their country at all or only in rural areas of the Northern region.

Table 16: Perceptions related to FGM/C among immigrants from Ghana

	Has heard of FGM/C	Considers the practice has benefits	Associates FGM/C with					
			Cleanliness/ hygiene	Social acceptance	Better marriage prospects	Preservation of virginity	Religious approval	Reduction of sexual desire of woman
Sex								
Women	98.1%	23.6%	2.3%	5.8%	10.5%	10.5%	0.4%	12.4%
Men	98.8%	32.1%	3.6%	8.8%	11.6%	14.9%	0.4%	14.9%
Age groups								
16-30	98.1%	20.1%	1.3%	5.0%	8.2%	9.4%	0.6%	11.3%
31-44	98.6%	28.4%	2.0%	7.8%	12.7%	12.7%	0%	14.7%
45+	98.5%	36.1%	4.5%	9.0%	11.3%	15.8%	0.8%	15.8%
Region								
South[25]	98.4%	23.6%	2.5%	6.6%	9.1%	10.7%	0.2%	12.3%
North[26]	100%	59.7%	6.5%	12.9%	25.8%	27.4%	1.6%	24.2%
Religion								
Muslim	100%	59.3%	6.8%	11.9%	20.3v	25.4%	3.4%	27.1%
Christian	98.1%	22.3%	2.6%	6.9%	9.5%	11.2%	0%	11.2%
Non-believer	93.8%	60%	0%	0v	20.0%	13.3%	0%	26.7%
Education (years)								
0-9	98.4%	35.0%	5.0%	3.3%	16.7%	11.7%	0%	11.7%
10-14	97.9%	28.3%	2.2%	6.1%	9.1%	12.6%	0%	13.9%
15+	99.0%	26.2%	3.1%	10.5%	11.0%	13.1%	1.0%	14.7%
Total	98.5%	27.8%	3.0%	7.3%	11.0%	12.6%	0.4%	13.6%

25 The category "South" designates six regions: Ashanti, Western, Central, Greater Accra, Eastern and Volta.

26 The category "North" designates the Brong Ahafo, the Northern, the Upper East and the Upper West region.

"I am against the practice. It happens in the villages in the North and I believe it is done due to lack of education. People use it for spiritual purposes or rituals. They do it out of ignorance." (man of Ghanaian origin)

Another frequently shared perception was that FGM/C had existed in Ghana, but that it had entirely disappeared since a law prohibiting the practice had been passed by the government in the early nineties.

"Regarding female circumcision, I could not have imagined that it still exists. We have a very strict law in Ghana against that. I am sorry for the victims." (woman of Ghanaian origin)

Despite the low proportion of practicing groups, almost 30% of the participants associated one or several advantages with FGM/C. Men were more likely to perceive FGM/C as an advantageous practice than women (see table 16). The most commonly cited advantages were the preservation of virginity and better marriage prospects for the girl child as well as the decrease of the woman's sexual desire. As the table below shows, the proportion of persons perceiving that there were benefits to be had from FGM/C was higher in older immigrants, among immigrants from the Northern regions, among Muslims and among participants with a low education level.

5.5.1.5. FGM/C and religion

Relatively few participants (6 women and 11 men; 3%) believed that FGM/C was a practice associated with their religion. The profile of these 17 participants is not distinct; some are Christians and some are Muslims and they come from different regions of the country, the North and the South alike. A further 10% of the participants explained that they did not know whether or not FGM/C was a religious practice. The remaining large majority (87%) rejected the idea of FGM/C being a religious practice.

5.5.1.6. Perception of disadvantages and knowledge of risk and consequences

The greater part of the interviewees reported at least one inconvenience related to FGM/C, however, the proportion of persons without any awareness is still considerable: 31% of the participants answered that they did not know any inconvenience. Women were better informed about the risks and consequences than men: almost 40% of the men reported

Table 17: Knowledge about risks and consequences associated with FGM/C (Ghana)

			Proportion (%) reporting effects related to								
	No awareness	Names broad or incorrect effects	Pain	Infections	Bleeding	Death	Sexual disadvantages for women	Sexual disadvantages for men/the couple	Psychological problems	Problems during child birth	Infertility
Sex											
Women	23.3	22.4	16.5	17.3	12.2	10..6	17.6	1.6	16.1	15.7	4.3
Men	38.6	19.1	5.8	13.7	7.9	7.9	27.4	2.9	12.4	6.6	3.7
Age groups											
16-30	28.0	17.2	21.0	22.3	11.5	13.4	17.2	1.9	15.9	12.1	5.7
31-44	25.5	20.9	7.5	16.4	14.4	10.4	27.9	2.5	15.9	13.9	3.5
45+	43.7	24.4	4.7	4.7	2.4	2.4	21.3	2.4	9.4	7.1	3.1
Region											
South[25]	27.3	21.8	11.3	16.9	10.6	9.7	23.8	2.5	15.5	12.3	4.2
North[26]	56.1	13.6	10.2	6.8	6.8	3.4	11.9	0	5.1	5.1	3.4
Religion											
Muslim	49.1	10.5	7.0	12.3	7.0	3.5	19.3	3.5	0	12.3	5.3
Christian	26.3	23.0	11.9	16.5	10.9	10.7.	23.2	1.9	16.5	11.9	4.1
Education (years)											
0-9	53.3	20.0	5.0	6.7	3.3	3.3	11.7	1.7	13.3	1.7	5.0
10-14	36.4	20.3	11.9	11.9	7.9	7.0	17.2	1.8	12.3	11.9	2.6
15+	16.7	22.0	14.0	24.7	15.1	13.4	31.7	2.7	16.7	13.4	4.8
Total	30.8	20.8	11.3	15.5	10.1	9.3	22.2	2.2	14.3	11.3	4.0

no awareness while this was the case for only 23% of the women (see table 17).

Men were less likely to know immediate effects (pain, bleeding and infections), reproductive health risks or psychological problems. They were significantly more likely, however, to highlight sexual disadvantages for the woman and the man. Their knowledge was sometimes based on assumptions, sometimes on experiences with women who had undergone FGM/C.

> "From what I know [about FGM/C], those women have never enjoyed sex in their lives like other women. I have never had contact with a circumcised women and I will never do oral sex with such a woman because I find it weird and nasty to even imagine a woman without labia." (man of Ghanaian origin)

> "In those days people used to do it, but I don't really know if they are still doing it. I once had an affair with a [....] woman in Ghana when I went for holidays from Germany. I think the woman was circumcised. I had heard about that, but never had any contact before that. It took me ages, but still the woman was not satisfied. Since then, I have this picture about all circumcised women... I want it to stop. It is a bad practice that does not do any justice to women." (man of Ghanaian origin)

Moreover, the degree of awareness of the risks and hazards associated with FGM/C was considerably lower among immigrants of certain groups:

- the older generation (45 years +),
- Muslims and
- persons with less than 10 years of formal education.

The knowledge was most developed among participants with more than 15 years of education. Interestingly, awareness was significantly lower among participants from the Northern regions than among the participants from non-practicing regions in the South.

5.5.1.7. Knowledge of German law and attitudes towards the abandonment of FGM/C

About two thirds of the participants knew that FGM/C is against the law in Germany. About 18% reported that they didn't know how the German legal system deals with the matter of FGM/C. The same proportion (18%) said that German law does not mention FGM/C. Only three participants believed that FGM/C was allowed in Germany. None of them, however, was from a practicing family.

The older generation (45 years +) showed less awareness that FGM/C was not allowed in Germany than the two younger generations. Table 18 also highlights the differences in perceptions between the regions: 48% of the participants from the North (potentially practicing groups) knew that FGM/C was prohibited in Germany while this was the case for 66% of the participants from the South. A considerable proportion (35%) of persons from the North also declared that they didn't know the position taken by the German legal system towards FGM/C. The data indicate, thus, that those who adhere to FGM/C are less often informed that the practice is prohibited by the German legislation. The same tendencies are found when comparing Muslims and Christians: Muslims are less often aware of FGM/C being interdicted in Germany and they are more often ignorant of current German legislation regarding FGM/C. Education also plays a role: a higher education level goes along with increased awareness of the law and FGM/C (see table 18).

The large majority of the Ghanaian community believes that FGM/C is a practice that should be abolished. Some consider it to be torture and a crime against women while others believe that the tradition should be abandoned because of its risks and consequences.

> "I am totally against it. I lived the disadvantages in Burkina Faso. It gives illnesses through infections or the girls can die through heavy bleeding. It can also give complications at childbirth. My religion is against it. It is not pleasant at all. They should do a major campaign to stop female circumcision not only in Africa but also sensitise the migrated Africans who have lived here for so long and are still holding on to their traditions." (man of Ghanaian origin)

"I wish that all societies who still practice female circumcision could be brought to court for a crime against humanity and the rights of girls and women. It is nothing other than a crime." (woman of Ghanaian origin)

> "I heard about the practice from a close friend of mine who told me about a girl that we both knew from the far north who was circumcised and then lost a baby during birth. I was very sad when I heard this. I think it is a very bad and useless practice. We [the men] are against it and not happy about it. I really don't know why some women do it." (man of Ghanaian origin)

Some participants emphasised that FGM/C should be abandoned because of its harmful nature, but not as part of an effort to assimilate Western culture.

> "We respect our culture very much, but in my opinion, we have to abolish female circumcision because of the side

Table 18: Knowledge of German law and attitudes towards the abandonment of FGM/C (Ghana)

	Legislation % distribution of participants who believe that German law				Attitudes towards abandonment % distribution of participants who believe that FGM/C should			
	Allows FGM/C	Does not allow it	Does not mention it	Don't know	Continue	Be stopped	Depends	Don't know
Sex								
Women	0.4	59.2	19.6	20.8	0.8	95.3	2.7	1.2
Men	0.8	68.4	15.6	14.8	2.0	90.7	5.3	1.6
Age groups								
16-30	0.6	67.3	16.7	15.4	0.6	95.5	1.3	2.5
31-44	0.5	66.2	16.9	16.4	0.5	94.1	3.9	1.0
45+	0.8	55.7	21.4	21.4	3.9	90.7	5.4	0
Region								
South[25]	0.5	65.7	18.2	15.4	0.7	94.5	3.4	1.4
North[26]	1.7	48.3	15.0	35.0	6.5	82.3	8.1	1.6
Religion								
Muslim	1.8	47.4	8.8	42.1	8.5	69.5	16.9	3.4
Christian	0.5	66.6	18.8	13.9	0.5	95.9	2.4	1.2
Education (years)								
0-9	0	46.7	16.7	37.7	3.3	85.2	9.8	1.6
10-14	1.3	62.9	18.8	16.8	1.7	94.3	2.2	1.7
15+	0	71.8	15.4	12.8	0.5	94.1	4.3	0.5
Total	0.6	63.7	17.6	17.8	1.4	93.0	4.0	1.4

effects such as complications in childbirth. But we should not adopt just anything we find here, we should not adopt things that harm us. Keep the positive and leave the negative." (man of Ghanaian origin)

Only seven persons pronounced themselves in favour of continuing FGM/C. Another small number reported that they felt neutral about it. Among the persons in favour of the continuation of FGM/C are three men and two women from practicing families of one of the Northern regions. Interestingly, there are also men and women from non-practicing ethnic groups and families who are in favour of the continuation of the practice or who feel indifferent about it. From their point of view, FGM/C concerns only those who practice it and people should be free to decide whether they want to carry on with it or not.

"Female circumcision is neither part of my culture nor of my religion. So it is not my problem. If those people think it is necessary to do it, they should do it." (woman of Ghanaian origin)

"They [the Germans] should focus on their culture and leave other people's culture alone." (man of Ghanaian origin)

Some participants also reported having too little information on FGM/C to take a decision as to whether or not it should continue.

5.5.2. Togo

5.5.2.1. Socio-demographic profile

The Togolese community is the second largest immigrant population from Sub-Saharan Africa in Hamburg. The number of registered persons is 1,531, with more men than women (847 to 684).

We reached 139 Togolese immigrants during our quantitative survey: 61 women and 78 men. This number cannot be considered representative for the Togolese immigrant population in Hamburg. We did not reach as many persons as we had intented to. The interviewers experienced difficulties in gaining access to the Kotokoli[27] populations from the central and northern areas of Togo. Many of them were reluctant to participate and showed less interest in participating than men and women from the southern regions. Muslim women were rarely found in public places and often hesitated to participate in an interview without prior authorisation of their husbands.

27 The ethnic group is also named Tem.

The interviewed women had significantly less formal education than the men (see table 19). The proportion of German passport holders was over 10%. There were slightly more Christians than Muslims in the interviewed sample.

5.5.2.2. Proportion of immigrant population concerned

FGM/C is not widespread in Togo. The national prevalence rate is estimated to be around 6%. The ethnic group affiliation is the major determinant of whether or not a family adheres to the practice. FGM/C is unknown to the two largest ethnic groups mostly living in the Southern regions, the Mina/Ewe and the Akposso-Akebou. The highest prevalence rates are found among the Mossi, Kotokoli, Peul and Lamba. The practice is found to a lesser extent among the Tschamba, Moba, Gourma, Yanga, Kabye and the Ana Ife (Amegee 1999).

According to key informants, the members of the Togolese community in Hamburg are composed of some Ewe from the South, a comparably larger number of Kotokoli from the Centre and some groups of the two northern regions (Kara and Savanes). Several observations described that the Kotokoli, a group with a particularly high prevalence of FGM/C, have a long history and tradition of migrating to Germany. It was estimated that they represent one of the biggest groups among the Togolese immigrants in Hamburg.

As highlighted in the section above, the Kotokoli were not easily accessible for interviews and might therefore be underrepresented in the quantitative survey sample.

Nonetheless, the composition of the interviewed sample from Togo indicates that groups practicing FGM/C are well represented in Hamburg. One indicator is the region of ori-

Table 19: Socio-demographic characteristics of immigrants from Togo

Socio-demographic variables	women (*n* = 61)	men (*n* = 78)	total sample (*n* = 139)
Age (in years)			
Mean (standard deviation)	35.1 (5.6)	37.1 (7.7)	36.2 (6.9)
Range	21-50	17-54	17-54
Average education level (in years)			
Mean (standard deviation)	8.7 (4.4)	12.1 (4.7)	10.6 (4.9)
Range	0-20	0-20	0-20
Religion			
Muslim	26 (42.6%)	31 (40.3%)	57 (41.3%)
Christian	29 (47.5%)	40 (51.9%)	69 (50.0%)
Traditional religion	3 (4.9%)	2 (2.6%)	5 (3.6%)
None believers	3 (4.9%)	4 (5.2%)	7 (5.1%)
Social status			
Married (monogamous)	40 (66.7%)	36 (48.6%)	76 (56.7%)
Married (polygamous)	2 (3.3%)	2 (2.7%)	4 (3.0%)
Separated/divorced/widowed	8 (13.3%)	3 (4.1%)	11 (8.2%)
Never been married[22]	10 (16.7%)	33 (44.6%)	43 (31%)
Migrated from a(n)			
Urban area	41 (70.7%)	55 (79.7%)	96 (75.6%)
Rural area	17 (29.3%)	14 (20.3%)	31 (24.4%)
Residence status			
Unbefristet (indefinite residence permission)	26 (43.3%)	28 (36.4%)	54 (39.4%)
Befristet (temporary residence permission)	25 (41.7%)	21 (27.3%)	46 (33.6%)
Duldung (toleration)	1 (1.7%)	4 (5.2%)	5 (3.6%)
Others/no papers/does not answer	5 (8.4%)	10 (13%)	15 (10.8%)
German nationality	3 (5.0%)	14 (18.2%)	17 (12.4%)
Time spent in Germany (in months)			
Mean (standard deviation)	112.4 (57.9)	119.5 (61.0)	116.4 (59.5)
Range	16-336	6-324	6-336

gin of the immigrants (see map in annex 8.8). More than half of the participants come from the four regions with higher FGM/C prevalence rates and 21% come from the region with the highest prevalence (Region Centrale).

A second indicator is the ethnic group affiliation. The proportion of participants from practicing groups is higher (48%) than that from non-practicing groups (45%). About 6% of the participants reported ethnic group affiliations for which the existence of FGM/C was unavailable. The Kotokoli represented 25% of the interviewed immigrants of Togolese origin.

When the participants were asked whether or not their group and their family practiced FGM/C, their answers confirmed that the proportion of immigrants of practicing ethnic groups is significantly higher than the country prevalence: 36% reported being aware that FGM/C takes place in their ethnic group. When asked whether FGM/C had been taking place in their family, 15% of the participants acknowledged it had, 4% preferred not to answer the question and 2% reported that they didn't know (see more details in table 20).

5.5.2.3. Women and girls concerned

About 78% of the women participants answered in the negative to the question whether or not they had been circumcised. One woman, part of a practicing ethnic group, shared the story of how her father saved her and her sisters from undergoing the practice.

> "My father was a minister of the government and highly educated. He travelled abroad a lot. I think this is why he was open-minded and did not insist on certain traditions. He threatened to divorce my mother if she took me or my sisters for female circumcision either in Togo or Burkina Faso. This is what protected us, because my mother herself is circumcised and she even wanted her grandchildren to be circumcised. Personally, I had a painful experience with a close friend who was forced to be circumcised at the age of 18 years so that she would be able to get married. She was already pregnant at 16 and had an abortion and many affairs with local men. Therefore her parents took her for female circumcision, but she almost died of excessive bleeding." (woman of Togolese origin)

Five percent of the participating women, on the other hand, reported to have been subjected to the practice. The remaining 17% of the women preferred to abstain from answering the question. The researchers working with Togolese immigrant women had the impression that the women concerned had difficulties opening up and preferred to remain silent about their own experiences relating to FGM/C. The relatively high absence of responses reflects that. In the same line, the interviewers wrote for five of the women who had given a negative answer that their reactions and non-verbal messages suggested that they had in reality been subjected to the practice. It can be assumed, hence, that the number of women concerned is considerably higher than 5%.

The participants of Togolese origin claimed to have in total 103 living daughters of which 84 were living in Germany. Only one of the women reported having a circumcised daughter. The girl lives in Togo.

The large majority (90%) also rejected the option of having their daughter(s) undergo FGM/C in the future. Most of them expressed the conviction that FGM/C should be abolished (see section 5.5.2.7), while others said that the practice could not be pursued outside its traditional context.

> "It should be stopped. It's not good. As a parent I cannot allow this to happen to my children." (man of Togolese origin)

> "I regret that I am not able to circumcise my only daughter because she was born here and will grow up here. She will only know the life here. I am not afraid to be punished for circumcising her, but I am afraid that my daughter would be unable to understand the sense of this traditional practice. But in general the practice should continue, for the good of women and the society." (man of Togolese origin)

Six persons, however, hesitated and said they don't know whether or not to have their daughter(s) circumcised and one person abstained from answering the question. After discussion with these seven parents, it became clear that four of the girls were not in any danger as one of their parents was strongly opposed to the practice. The remain-

Table 20: Proportion of women and men from groups and families practicing FGM/C (Togo)

	FGM/C takes place in my ethnic group (%)			FGM/C has been taking place in my family (%)			
	Yes	No	Don't know	Yes	No	Don't know	Doesn't answer
Women ($n = 61$)	32.8	56.9	10.3	10.3	82.8	0	6.9
Men ($n = 78$)	37.8	58.1	4.1	19.2	75.3	4.1	1.4
Total ($n = 139$)	35.6	57.6	6.8	15.3	78.6	2.3	3.8

ing three girls were considered to be potentially at risk: although their mothers had no intention to have them undergo practice, they made it clear that they had no means to protect the girls during holidays in Togo. If the family of their husband decided to subject them to FGM/C, their own status would not allow them to refuse. The three girls and their mothers were enrolled in the follow-up project.

> "I don't think that it [FGM/C] is a good thing. But I would be forced to circumcise my daughter back in Togo if the family of my husband demands that I do it in order to avoid the problems I would have if I went against the will of my family." [To the question of the interviewer if she could fight for the wellbeing of her daughter, the participant answered: "Not if it means that I would be shunned by the family and everybody I know." (woman of Togolese origin)

The findings of the last two sections indicate that the numbers of women and girls at risk residing in Hamburg are probably higher than the estimations based on the local prevalence of FGM/C in section 5.2.

5.5.2.4. Perceptions related to the practice

Most of the men (68%) and women (62%) cannot see any benefit in the practice or even feel strongly appalled by it.

> "I have never seen a circumcised girl, but I have heard people talking about the practice. It is mostly Muslims and a couple of Christians who take off the girls' organs but I would rather call it castration." (woman of Togolese origin)

> "These circumcised girls are beings that disturb the composition of the society: they are neither girls nor boys; they are humans, but of unknown sex. I really hope that this practice has ceased existing." (woman of Togolese origin)

> "Female circumcision is related to pure ignorance. There is absolutely no need to cut anything off of a woman." (man of Togolese origin)

The remaining proportion associates one or several benefits with FGM/C, in particular advantages related to the status of a woman, of her being faithful and of honour to the family (see table 21).

Surprisingly, participants of the youngest age group are more than twice as numerous in seeing benefits in FGM/C. Furthermore, the region, the religion and the education level also play a role. Muslim and participants from the Central and Northern regions (Plateaux, Central, Kara and Savanes) are more likely to see advantages in FGM/C. Moreover, 26%

Table 21: Perceptions regarding FGM/C among immigrants from Togo

	Has heard of FGM/C	Considers the practice has benefits	Associates FGM/C with					
			Cleanliness/ hygiene	Social acceptance	Better marriage prospects	Preservation of virginity	Religious approval	Reduction of sexual desire of woman
Sex								
Women	95.1	37.9	6.9	15.5	15.5	12.1	13.8	13.8
Men	96.1	32.0	6.7	14.7	14.7	14.7	10.7	18.7
Age groups								
16-30	95.8	58.3	8.3	25.0	20.8	29.2	8.3	25.0
31-44	95.1	32.1	6.4	14.1	16.7	10.3	14.1	17.9
45+	100	25.0	8.3	25.0	16.7	8.3	16.7	8.3
Region								
South	96.8	29.5	6.6	8.2	9.8	9.8	1.6	14.8
North	95.6	41.5	6.2	21.5	20.0	16.9	21.5	20.0
Religion								
Muslim	96.5	52.7	9.1	29.1	29.1	21.8	25.5	25.5
Christian	97.1	20.9	6.0	4.5	4.5	7.5	1.5	10.4
Education (years)								
0-9	96.3	44.2	3.8	25.0	23.1	21.2	21.2	19.2
10-14	93.8	30.4	10.9	10.9	8.7	6.5	6.7	13.0
15+	96.7	27.6	6.9	6.9	13.8	10.3	3.4	20.7
Total	95.7	34.6	6.8	15.0	15.0	13.5	12.0	16.5

of the Muslims believe that practicing FGM/C procures them religious approval. The data also indicate that the probability of seeing advantages in FGM/C diminishes with a growing education level.

5.5.2.5. FGM/C and religion

The greater part (62%) of the participants saw no connection between FGM/C and their faith, but almost 20% of the participants perceive FGM/C as a religious requirement. Muslims (33%) see FGM/C three times more often as a religious obligation than Christians (9%). Moreover, 18% of the interviewees of Togolese origin reported to have no knowledge of the position of their religion towards FGM/C. Most of them were Christians.

5.5.2.6. Perception of disadvantages and knowledge of risks and consequences

Most participants of Togolese origin (81%) could name at least one inconvenience or risk associated with the practice of FGM/C. The disadvantages cited ranged from immediate consequences such as pain, bleeding and infections to psychological and sexual consequences and reproductive health problems (childbirth, infertility). Some participants described personal experiences related to the negative consequences of FGM/C.

> "I have a cousin who was circumcised during her childhood and she suffered from heavy bleeding. I also know a woman from Senegal who lives here in Hamburg. She is circumcised as well and suffers from bad trauma even now, although she has two healthy children." (woman of Togolese origin)

Men showed less awareness than women: 23% of them had no knowledge of the risks and disadvantages of FGM/C while this was only the case in 14% of the women. Women (39%) were more likely, however to name very vague or incorrect negatives than men (24%). The most frequently cited negative effect of FGM/C was the experience of sexual disadvantages for the woman (pain during intercourse, lack of sexual desire, difficulties reaching orgasm etc.). Men (35%) were more likely than women (23%) to describe this consequence of FGM/C.

5.5.2.7. Knowledge of German law and attitudes towards the abandonment of FGM/C

Over 80% of the participants reported that the German legislation interdicts FGM/C. Men, persons who are 45 years and older, and participants with a high education level (15 years+) were most likely to show awareness of the position of German law on the subject. Women and the youngest age group (16-30 years) were less likely to be informed about the prohibition and many of them answered that they didn't know how FGM/C was perceived by the German legal system.

Furthermore, the findings indicated clearly that the greater part of the participants (83%) support the abandonment of FGM/C.

> "In my opinion, the practice of female circumcision has to be eradicated because it is nowadays a shame for the African woman." (man of Togolese origin)

> "I'm against female circumcision. Most Africans know the consequences and are against it. The men think that through the cutting of the clitoris the woman loses her sexual desire. But it is the opposite. The woman never gets tired of sex since she is never really satisfied. Sex is a two-way thing and both man and woman have to enjoy it. I cannot enjoy it if the woman ends up being in pain. The people have to understand that the clitoris is responsible for the peace and satisfaction of women. (man of Togolese origin)

A minority of 4% of the participants argues for the continuation of FGM/C and further 11% feel that the decision depends on the circumstances and the nature of the practice. Interestingly, those in favour of its continuation are all men, mostly Muslims and from the youngest age group. They defend FGM/C as a tradition with advantages and feel that its abandonment is imposed by Western powers. By comparing the sexual behaviour of women in Germany and in their home community, they draw the conclusion that FGM/C is what explains the less promiscuous behaviour of African women.

> "Our traditions need to be maintained. This is all we have left. The white man has taken all our treasures and now he wants to destroy our culture. This cannot be allowed." (man of Togolese origin)

> "It is good when they cut the woman so that she does not scratch herself [masturbate] and that she does not flirt around. If I have a daughter, I will cut her in Africa. I know they don't allow us to do it here but women are better behaved in Africa than here." (man of Togolese origin)

5.5.3. Nigeria

5.5.3.1. Socio-demographic profile

The Nigerian community is the third largest community from Sub-Saharan African in Hamburg. The registered number is 1,100 persons with almost twice as many men (727) than women (373). The interviewers described the Nigerian men as easily accessible for interviews. Many of them gave their opinion in a very bold manner. The women were more dif-

Table 22: Knowledge of German law and attitudes towards the abandonment of FGM/C (Togo)

	Legislation % distribution of participants who believe that German law				Attitudes towards abandonment % distribution of participants who believe that FGM/C should			
	Allows FGM/C	Does not allow it	Does not mention it	Don't know	Continue	Be stopped	Depends	Don't know
Sex								
Women	0	72.4	6.9	20.7	0	82.8	15.5	1.7
Men	0	89.3	2.7	8.0	6.7	82.7	8.0	2.7
Age groups								
16-30	0	70.8	0	29.2	8.3	75.0	16.7	0
31-44	0	84.6	3.8	11.5	3.8	82.1	11.5	2.6
45+	0	91.7	8.3	0	0	91.7	8.3	0
Region								
South	0	83.6	4.9	11.5	4.9	85.2	6.6	3.3
North	0	81.5	4.6	13.8	3.1	81.5	13.8	1.5
Religion								
Muslim	0	80.0	7.3	12.7	7.3	70..9	20.0	1.8
Christian	0	88.1	3.0	9.0	1.5	94.0	1.5	3.0
Education (years)								
0-9	0	78.8	7.7	13.5	3.8	75.0	17.3	3.8
10-14	0	76.1	4.3	19.6	4.3	87.0	8.7	0
15+	0	96.6	0	3.4	3.4	93.1	3.4	0
Total	0	82.0	4.5	13.5	3.8	82.7	11.3	2.3

ficult to reach. In total, 220 Nigerians agreed to participate in the interviews, 79 women and 141 men. This sample size cannot be considered statistically representative for the Nigerian immigrant community.

The average education level of 13 years among the interviewed immigrants of Nigerian origin is comparatively high. Another particularity is the relatively high number of men and women whose residence permit is in a state of uncertainty: almost 20% of the participants have either no papers or are at risk of being expelled at any time (see table above).

5.5.3.2. Proportion of immigrant population concerned

It is estimated that 30% of the women in Nigeria have undergone FGM/C. The practice is carried out in all regions of the country and is less common in the northern and central regions where it is estimated that between 3% and 20% of women have undergone FGM/C. The prevalence rates are considerably higher in the three southern regions where percentages range from 34% to 53%. All main ethnic groups in Nigeria practice FGM/C although the extent varies strongly from one group to another. It is least common in the group of the Fulani (< 10%). For the Hausa, Ibibio and the Ijaw/Izon, it is estimated to be less than 25% and for the Ekoi, the estimation is about 35%. The two groups with the highest rates are the Igbo (51%) and the Yoruba (58%) (Nigeria National Population Commission and ICF Macro 2009).

The data analysis of the region of origin showed that the greater part (80%) of the interviewed participants of Nigerian origin come from the South East (45%) and the South West (35%). Another 9% come from the South South region. Only 11% of the participants come from the northern and central regions (4% North Central, 1% North East and 6% North West). This means that the majority of the Nigerian immigrants in Hamburg come from the two regions with the highest FGM/C rates of the country (compare with map in annex 8.9).

The ethnic affiliations of the participants were spread over 20 different ethnic groups; over 70% of the participants, however, belonged to the two groups with the highest FGM/C rates: 51% of the participants were Igbos and 20% were affiliated with the group of the Yoruba.

All participants were asked if FGM/C was practiced by their ethnic group and if it had taken place in their family. The responses indicate that the number of Nigerian families in Hamburg affected by FGM/C is indeed high: over 80% of the participants reported that FGM/C is practiced by their ethnic group and almost 60% said that the practice had

Table 23: Socio-demographic characteristics of the interviewed Nigerian immigrants

Socio-demographic variables	women (*n* = 79)	men (*n* = 141)	total sample (*n* = 220)
Age (in years)			
Mean (standard deviation)	37.1 (9.2)	39.3 (9.6)	38.5 (9.5)
Range	23-75	19-76	19-76
Average education level (in years)			
Mean (standard deviation)	12.0 (3.6)	13.1 (4.0)	12.7 (3.9)
Range	0-22	0-26	0-26
Religion			
Muslim	16 (20.5%)	30 (22.2%)	46 (21.6%)
Christian	61 (78.2%)	101 (74.8%)	162 (76.1%)
Traditional religion	0 (0.0%)	1 (0.7%)	1 (0.5%)
None believers	1 (1.3%)	3 (2.2%)	4 (1.9%)
Social status			
Married (monogamous)	39 (49.4%)	64 (45.7%)	103 (47.0%)
Married (polygamous)	3 (3.8%)	6 (4.3%)	9 (4.1%)
Separated/divorced/widowed	13 (16.5%)	18 (12.9%)	31 (14.2%)
Never been married[22]	24 (30.4%)	52 (37.1%)	76 (34.7%)
Migrated from a(n)			
Urban area	47 (61.0%)	84 (62.7%)	131 (62.1%)
Rural area	30 (39.0%)	50 (37.3%)	80 (37.9%)
Residence status			
Unbefristet (indefinite residence permission)	22 (27.8%)	61 (43.3%)	83 (37.7%)
Befristet (temporary residence permission)	31 (39.2%)	24 (17.0%)	55 (25.0%)
Duldung (toleration)	3 (3.8%)	7 (5.0%)	10 (4.5%)
Others/no papers/does not answer	10 (12.7%)	27 (19.1%)	32 (14.5%)
German nationality	13 (16.5%)	22 (15.6%)	35 (15.9%)
Time spent in Germany (in months)			
Mean (standard deviation)	122.1 (92.1)	131.0 (92.6)	127.7 (92.3)
Range	3-552	1-576	1-576

been carried out in their family. As shown in table 24, men were slightly more likely than women to report that FGM/C takes place in their ethnic group and their family.

5.5.3.3. Women and girls concerned

The proportion of women who claimed to have undergone FGM/C was 45% in the interviewed sample. A further 11% of the women preferred to withhold their answer to the question. One woman respondent said the she did not know whether or not she was circumcised as FGM/C takes place during infancy in her ethnic group. When asked if she had never tried to find out, she responded that she had never looked at her genitals in a mirror. A study conducted in Nigeria illustrated that this woman is not an isolated case and that a certain proportion of women in Nigeria is not aware of their status (Ehigiegba, Selo- Ojeme et al. 1998). The remaining 40% of the women interviewed declared that they

Table 24: Proportion of women and men from groups and families practicing FGM/C (Nigeria)

	FGM/C takes place in my ethnic group (%)			FGM/C has been taking place in my family (%)			
	Yes	No	Don't know/ Doesn't answer	Yes	No	Don't know	Doesn't answer
Women (*n* = 79)	78.2	20.5	1.3	56.4	34.6	6.4	2.6
Men (*n* = 141)	84.2	9.4	6.4	60.0	18.6	19.3	2.1
Total (*n* = 220)	82.0	13.4	4.6	58.7	24.3	14.7	2.3

had not been circumcised, although the interviewers noted questions marks for three of the respondents as their non-verbal messages suggested otherwise. Some of the women explained how they happened to escape from the practice while other close female relatives underwent FGM/C:

> "It is only because I was born in Cote d'Ivoire that I was not cut. My other sisters who were born in Nigeria have all been circumcised." (woman of Nigerian origin)

> "I would also have been circumcised, if I had not strongly objected and refused!" (woman of Nigerian origin)

All of the women concerned had undergone FGM/C in Nigeria and reported that it had been performed by a traditional practitioner. More than half of the women did not want to talk about the type that was carried out (57%). About 17% said that it was a subtle procedure which consisted in the nicking of the clitoris. The remaining women reported Type II interventions. Almost half of the participants stated that they could not remember at what age they had undergone FGM/C. In most cases this means that the practice was carried out at a very young age so that the women had no memories of the event. Another 44% explained that it took place during infancy. Only three participants were older at the moment when they underwent the practice. Two women remembered that they were between four and five years old and one woman reported that she had undergone FGM/C at the age of 24 years during her first pregnancy. She explained that the women of her ethnic group, the Bendel-Igbos, traditionally undergo FGM/C after adolescence and usually at an advanced state of the first pregnancy (6th month).

The qualitative data gathered from key informants also confirmed that cutting of infants is widespread in Nigeria: most ethnic groups from the South practice FGM/C on babies. Furthermore, several Igbos from the Anambra State described a particular form of practicing FGM/C. During the first weeks after the birth, the labia and clitoris of the newborn are reduced by pressuring repeatedly a towel soaked with heated water on the genital organs.

> "From the day of birth, they use very, very hot water to press down the clitoris with a towel. Then they use Vaseline ointments. They baby cries so much. [...] They try to cut the sexual desire of the girl [...] it is a traditional thing, it is a routine. It has to be done to every girl child." (woman, key informant of Nigerian origin)

We interpreted this as a type IV category of FGM/C.

Unlike in many other groups, Igbo men retain an important position regarding the decision whether or not to circumcise a daughter. They are often the initiators of the practice even when the mother is against the practice. Studies from Nigeria confirm the information on infant cutting and on fathers being important decision makers (Ehigiegba, Selo-Ojeme et al. 1998).

About one third of the participants reported having a least one daughter. Altogether, the number of daughters among the interviewed Nigerian immigrants was 147 girls, 100 of them residing in Germany. The majority of the parents reported that none of their daughters had undergone FGM/C and that they had no intention of subjecting their daughters to the practice in the future. A minority of participants, however, confirmed that they had daughters who had undergone FGM/C. More precisely, six participants reported that one (of their) daughter(s) and four participants reported that two (of their) daughters had experienced the practice. Thus, the number of girls concerned, in the interviewed sample of Nigerian origin, was 14. According to their parents, all the girls had undergone FGM/C in Nigeria, mostly in infancy. Seven respondents said that their daughters had been brought to a traditional practitioner while two others said that their daughters had been brought to a health care worker. One parent did not want to answer the question under what circumstances FGM/C of his daughter had taken place. Furthermore, four parents admitted that they wished to have their daughters undergo FGM/C in the future. The daughters of two of these parents are growing up in Nigeria. The daughters of the other two parents are in Germany, but the interviewers estimated that the girls are not at risk as their fathers are well aware of the law and would not jeopardise their residence status by committing a crime.

That notwithstanding, the incidence of FGM/C in the cohort of daughters of Nigerian immigrants points out the likeliness that girls of Nigerian origin in Hamburg might have been subjected to the practice or find themselves at risk of undergoing the practice in the future. According to data collected, three settings are possible:

1) FGM/C could be carried out in Germany by immigrants of Nigerian origin. This was pointed out by two informants, one man and one woman, of Nigerian origin:

   > "If I have daughters, I will ensure that they are circumcised. [when asked on how he would perform FGM/C in Germany, he answered:] "I know people who perform female circumcision, traditional circumcisers, even here. The children are to be cut in between six months and one year. I know people who perform the circumcision, traditional circumcisers. " (man of Nigerian origin)

   > "Let me tell you that Nigerians move around with their culture wherever they go. Bear in mind, when they give

birth, their mothers come from Africa to help them out or their older friends here... so they do it on their own, even without medical practitioner. So it [FGM/C] is done here, but I don't know who does it [....] What I know is that they [the Nigerians] take their culture anywhere they go, so they will also do it here." (woman, key informant of Nigerian origin)

2) The girls are subjected to FGM/C during infancy before migrating to Europe. Some participants and key informants insisted that FGM/C was only carried out if the girls are born in Nigeria: they rejected the idea that FGM/C might be carried out in Germany and related that only those girls who are born in Nigeria undergo FGM/C. They were convinced that the fear of sanctions dissuaded parents from practicing FGM/C on their daughters in Germany.

3) The third possible scenario is that girls are subjected to FGM/C during holidays in Nigeria. One key informant, a Ghanaian midwife, shared an experience suggesting that FGM/C could be taking place during holidays in Nigeria: a former client, a Nigerian woman, had told her about the intention to take the daughter to Nigeria after she was born in order to present her to the family and to have her undergo FGM/C.

5.5.3.4. Perceptions related to the practice

Almost two-thirds of the interviewed immigrants of Nigerian origin associated at least one positive outcome with FGM/C. Of foremost importance for them was the perception that FGM/C was an aspect of their culture or even an aspect of being human.

"If you don't circumcise a woman, she is like an animal. Animals are not circumcised, they have tongues which means clitoris. It is circumcision that differentiates people from animals." (man of Nigerian origin)

Men were more likely to see FGM/C as an advantageous practice than women (see table 25). They were numerous to emphasise that the genital organs were cleaner and more appealing after a woman had undergone FGM/C.

"When it is circumcised it is hygienic and beautiful. I prefer 130% circumcised women and it is very important to me to be with a circumcised woman. I can puke when I see a non-circumcised vagina. When they use professionals – I mean old women – to cut the girls, it is always nicer at the end, it only hurts once and after putting some leaves, it is okay and looks beautiful after that." (man of Nigerian origin)

The most frequently named advantage by both women and men participants was that FGM/C leads to a decrease of sexual desire that helps women to be faithful and to abstain from promiscuous behaviour.

"Female circumcision is our culture and it is a good thing. Uncut women are always scratching themselves [masturbating], and when they scratch, it means that they have to get satisfied from one man to the next. Women need to be circumcised to stop this jumping around from one man to another." (man of Nigerian origin)

"...it has to be done because women who are not cut are not sexually satisfied and they have many partners which can lead to divorce. I can say that I never had sex with a non-circumcised woman." (man of Nigerian origin)

Some men also shared the idea that FGM/C had a positive influence on the general behaviour of women by making them respectful and submissive.

"Circumcised women are good women. They obey and respect their husbands. They don't talk rubbish and don't have big mouths. They don't look around for other men. It is up to me whether I choose to circumcise my daughter or not. It is nobody else's concern." (man of Nigerian origin)

As illustrated in table 25, the probability that a person will perceive FGM/C as an advantageous practice increases with age: about 38% of the generation from 16-30 years considers that FGM/C has benefits, 66% of the generation from 31-44 years and 86% of the participants of the oldest generation. Furthermore, Christians are more likely to see advantages in the practice than Muslims and more than twice as often perceive FGM/C as a benefit because it decreases the sexual drive of a woman.

5.5.3.5. FGM/C and religion

A solid minority (13%) of both Christian and Muslim participants believe that FGM/C is required by religion. The opinion is more common in Muslims (21%) than in Christians (12%). Interestingly, several Christians interpreted the practice of FGM/C to be a command of the Bible:

"Circumcision comes originally from the Bible. God instructed Abraham to circumcise all males and I consider all males includes both men and women. I strongly believe in the practice and when I have a daughter, the child will be immediately circumcised during the 1st week of birth before the 8th day. If I ever get married, the woman has to be circumcised or has to undergo circumcision. I am totally convinced that men and women are equal and they should both be cut for

Table 25: Perceptions regarding FGM/C among immigrants from Nigeria

	Has heard of FGM/C	Considers the practice has benefits	Associates FGM/C with					
			Cleanliness/ hygiene	Social acceptance	Better marriage prospects	Preservation of virginity	Religious approval	Reduction of sexual desire of woman
Sex								
Women	98.7	56.0	22.7	33.3	36.0	34.7	9.3	48.0
Men	99.3	66.9	32.4	27.3	30.9	29.5	30.2	45.3
Age groups								
16-30	100	37.5	12.5	17.5	25.0	17.5	7.5	22.5
31-44	98.3	66.4	27.4	29.2	32.7	28.3	7.1	48.7
45+	100	25.0	8.3	25.0	16.7	8.3	16.7	8.3
Religion								
Muslim	100	55.6	20	35.6	31.1	20.0	15.6	24.4
Christian	98.8	66.2	28.0	31.8	31.8	36.3	8.9	54.1
Education (years)								
0-9	97.0	50.0	25.0	25.0	25.0	21.9	12.5	28.1
10-14	100	71.1	28.9	36.0	36.0	36.0	10.5	53.5
15+	98.4	57.4	21.3	26.2	27.9	29.5	8.2	44.3
Total	99.1	63.1	25.7	31.8	31.8	31.8	10.3	46.3

hygienic and religious grounds." (man of Nigerian origin who studies theology)

> "Every [female circumcision] practicing person is a direct descendant of Abraham. Female circumcision just like male circumcision is a command of the Bible." (man of Nigerian origin)

Moreover, gender differences appear regarding FGM/C and religion: men are more likely than women to perceive FGM/C as a religious obligation.

5.5.3.6. Perception of disadvantages and knowledge of risks and consequences

Women participants were more likely to be aware of the risks and consequences of FGM/C than men: 68% of them named at least one disadvantage while the proportion of men was considerably lower. In fact, almost half of the men interviewed answered either that FGM/C has no disadvantages or that they didn't know whether or not there might be disadvantages. All kinds of disadvantages and risks associated with FGM/C were named more frequently by women than by men. Women participants named most often sexual problems (22%) and infections (20%) as disadvantages of FGM/C. Several women gave testimonies that showed not only their awareness of the negative effects but also their wish for the practice to be abolished.

> "Many African women suffer during childbirth. Many know sex only as a means of producing children because they don't have any sensations. Really, if there is a way to stop this, it will be more than good and Allah will bless whoever will help us." (woman of Nigerian origin)

> "Many children were being done [subjected to FGM/C] after six months or even a year of age. How do you think the mother feels when seeing her child for so many days in unnecessary pain? The fear of what may happen...Please, this tradition must be stopped." (woman of Nigerian origin)

Men cited most frequently infections (18%) and sexual problems for women (15%) as negative side effects of FGM/C.

"It is a lot of stress for men; the men also suffer from it: the women have no pleasure, it takes longer for them to get an orgasm. Some are in pain. I don't have children yet. But there is no way that I would let any of my daughters be circumcised." (man of Nigerian origin)

The awareness for many medical risks and disadvantages was low in the overall sample: the following risks and disadvantages were named by less than 10% of the participants:

- heavy bleeding
- psychological consequences
- death
- difficulties during childbirth
- sexual difficulties for the man

None of the participants named infertility as a potential problem associated with FGM/C.

5.5.3.7. Knowledge of German law and attitudes towards the abandonment of FGM/C

There is a widespread awareness within the Nigerian immigrant community that FGM/C is against the law in Germany: over 70% of the participants know about the legislation and the sanctions they would risk if they subjected their daughters to the practice. The awareness of the law is stronger in older generations and for Christians and seems to increase with the level of education. The dissuasive effect of the law is illustrated in the testimonies below.

A traditional chief, married to a German and a Nigerian wife (who has undergone FGM/C) said about his three daughters:

> "It depends on their mother. If she wants to do it why not? But in Europe the law does not allow female circumcision. Unfortunately we cannot practice our tradition of female circumcision here." (man of Nigerian origin)

> "Since the law does not allow it, we will not do it, but I pray that my children will respect themselves and know that it is their pride to preserve their culture." (man of Nigerian origin)

The greater part of the Nigerians were in favour of the abolition of FGM/C. They felt that it should disappear due to the suffering that it inflicts on women and the evolution of mankind in which traditions such as FGM/C have lost their reason for being. Some also mentioned that it was important that African women should preserve their values and faithfulness once FGM/C is no longer "taming them".

> "I don't like any African tradition because the men use them to suppress the women. I hope this will not end here with this interview. Just look, I feel pain thinking back remembering my childhood...all the same I thank God that my daughter is born here in Germany. I would like to take her home one day, but I am afraid. I pray that you people will do something against female circumcision." (woman of Nigerian origin)

> "It was very important to cut the young girls when I was small because faithfulness among women was very important in our African societies. But now we have to accept to abolish the practice because times have changed. Nothing is like before, we are now civilised. It is a bit sad, but it has to be." (woman of Nigerian origin)

> "My sister, female circumcision should be stopped because there are too many disadvantages, much more than the advantages that we are made to believe." (man of Nigerian origin)

> "I am in support of abolishing female circumcision as long as they leave politics out and only if the African women will not forget their respect and pride as married women." (man of Nigerian origin)

There was a strong minority, however, mainly composed of men (see table below) who advocated the continuation of FGM/C. They intend to preserve a tradition that they feel to be important to prevent promiscuity in women.

> "Circumcision of women should continue. If by chance I have a girl, I will circumcise her. It is our tradition and this tradition has to continue." (man of Nigerian origin)

> "They should continue with it so that the women don't misbehave. I actually wanted to circumcise my daughter here but the German law doesn't allow it.[...] It is too late now to circumcise her because she is already too old." (man of Nigerian origin)

> "The practice is very important. The new generation is not in favour any more which is deplorable. My daughter was circumcised at the initiative of my father in Nigeria. It is true, it hurts, but it is right. This practice is very important." (man of Nigerian origin)

> "We don't need the European culture. Female circumcision is our own tradition. We don't want our women to be flirting around." (man of Nigerian origin)

Next to the militant supporters of FGM/C, a proportion of about 16% of the participants expressed the idea that the continuation of FGM/C depended on the situation of the family. Most of these participants explained that they had personally decided against FGM/C, but that they were not discouraging others from preserving the practice of FGM/C as part of their cultural heritage. They felt that African traditions should not be modified under the pressure from an imposed European value system.

> "Personally, I am opposed to female circumcision, but it is a family issue. Some people are trying to force foreign ideas onto Africans. We should stand on our ground and preserve traditions. Africans can also teach the foreigners something. Europeans need to respect family values like Africans. They need to learn from us. Regarding female circumcision, the mothers have to decide whether it is worth it." (man of Nigerian origin)

> "I did not know what female circumcision was. If it really means to cut off a part of the woman's genital organs

Table 26: Knowledge of German law and attitudes towards the abandonment of FGM/C (Nigeria)

	Legislation % distribution of participants who believe that German law				Attitudes towards abandonment % distribution of participants who believe that FGM/C should			
	Allows FGM/C	Does not allow it	Does not mention it	Don't know/ Doesn't answer	Continue	Be stopped	Depends	Don't know/ Doesn't answer
Sex								
Women	1.3	74.0	1.3	23.4	1.3	81.8	11.7	5.2
Men	0.7	71.4	2.9	25.0	12.2	64.7	18.7	4.3
Age groups								
16-30	0	68.3	2.4	29.3	4.9	80.5	9.8	4.9
31-44	1.8	71.1	2.6	24.6	7.0	69.3	20.2	3.6
45+	0	82.2	15.6	2.2	13.6	72.7	11.4	2.3
Religion								
Muslim	2.2	63.0	4.3	30.4	10.9	52.2	32.6	4.4
Christian	0	74.8	1.9	23.3	7.6	76.6	11.4	4.4
Education (years)								
0-9	0	56.3	37.5	6.3	15.6	50.0	25.0	9.4
10-14	0.9	73.3	3.4	22.5	5.2	74.8	15.7	2.6
15+	1.6	79.0	1.6	17.7	9.7	75.8	12.9	1.6
Total	0.9	72.4	2.3	24.4	8.3	70.8	16.2	4.6

then I cannot see anything good in it and would never do it myself. But if it is their culture and if those who practice it are convinced that it is good, they shall do what they want to do." (woman of Nigerian origin)

5.5.4. Cameroon

5.5.4.1. Socio-demographic profile

The (officially registered) Cameroonian immigrant community in Hamburg lies at 500, with a higher proportion of men ($n = 270$) than women ($n = 213$). We reached a total of 110 participants during the quantitative survey, 41 women and 69 men. We met very few Cameroonians with an unclear residence status. Most of them (66%) are in Hamburg to pursue their university education which explains the high average education level among Cameroonian immigrants.

5.5.4.2. Proportion of immigrant population concerned

FGM/C is rare in Cameroon. The national prevalence estimate is 1.4% (Institut National de Statistiques & ICF Macro 2004). The practice is carried out by very few of Cameroon's numerous ethnic groups and even within practicing groups, the extent is less then 13% (1.4% for the Bantus in the South West and 12.7% for the Fulani/Kanuri, Arabe/Choa/Maoussa in the far North). The DHS conducted in 2004 indicated that the practice is declining further. Geographically, the practice is concentrated in the Far North and in some areas of the South Western region.

The interviewed participants were affiliated with 30 different ethnic groups. The majority is from non-practicing groups, namely the Bamileke which make up 40% of the interviewed sample. Almost 14% were affiliated with potentially practicing groups, more precisely the Bantu (11%) and the Fulani (3%).

When we asked the participants whether or not they were from a practicing group and family, gender differences became apparent: about 12 women (31%) declared that FGM/C was taking place in their group while only five men (7%) did so. Amazingly, half of these participants were Bamileke, a group that is not known for practicing FGM/C. It can be assumed that these participants simply assumed that FGM/C takes place within their group as the Bamileke represent one of the largest ethnic groups and are, as traders, found in all areas of Cameroon.

To the question whether FGM/C takes place in their family, the majority of the participants answered in the negative. Only three women and two men reported that it was practiced in their family. They were from five different ethnic groups: Hausa, Bantu, Fulani, Bamileke and Bamoun. Five other participants (two women and three men) responded that they didn't know whether or not FGM/C was taking place in their family as they never heard anyone talking about it.

Table 27: Socio-demographic characteristics of immigrants from Cameroon

Socio-demographic variables	women (*n* = 41)	men (*n* = 69)	total sample (*n* = 110)
Age (in years)			
Mean (standard deviation)	32.0 (5.3)	31.7 (4.7)	31.8 (4.9)
Range	22-42	23-53	22-53
Average education level (in years)			
Mean (standard deviation)	15.7 (3.9)	17.4 (3.4)	16.8 (3.7)
Range	5-25	8-25	5-25
Religion			
Muslim	4 (9.8%)	3 (4.3%)	7 (6.4%)
Christian	37 (90.2%)	62 (89.9%)	99 (90.0%)
Traditional religion	0 (0.0%)	1 (1.4%)	1 (0.9%)
None believers	0 (0.0%)	3 (4.3%)	3 (2,7%)
Social status			
Married (monogamous)	16 (40.0%)	16 (23.5%)	32 (29.6%)
Married (polygamous)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Separated/divorced/widowed	2 (4.8%)	3 (4.4%)	5 (4.6%)
Never been married[22]	22 (55.0%)	49 (72.1%)	71 (65.7%)
Migrated from a(n)			
Urban area	33 (80.5%)	54 (84.4%)	87 (82.9%)
Rural area	8 (19.5%)	10 (15.6%)	18 (17.1%)
Residence status			
Unbefristet (indefinite residence permission)	10 (24.4%)	10 (14.7%)	20 (18.3%)
Befristet (temporary residence permission)	24 (58.5%)	48 (70.6%)	72 (66.1%)
Duldung (toleration)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Others/no papers/does not answer	2 (4.9%)	4 (5.8%)	6 (1.8%)
German nationality	5 (12.2%)	6 (8.8%)	11 (10.1%)
Time spent in Germany (in months)			
Mean (standard deviation)	81.9 (43.3)	82.6 (50.0)	82.3 (47.4)
Range	7-216	1-240	1-240

5.5.4.3. Women and girls concerned

Out of the 41 women interviewed, two reported that they had undergone FGM/C. They are middle aged (38 and 45 years), one of the group of the Fulani and one of the Bamoun. Both of them are Muslims and their FGM/C was carried out by a traditional practitioner. Their descriptions indicate type I or type II procedures. A 32 year old key informed interviewed during the qualitative phase also underwent FGM/C. She also is from the group of the Bamoun and gave testimony of her experience:

> "[...] my clitoris was cut when I was six years old. My grandmother took me to a traditional woman in my father's village and she did it to me. All what I remember is that my mother was against it and unfortunately for me, at that time, my dad and mum had separated and so I was left home with my grandmother who wanted me to be circumcised. She took me secretly without my mother's knowledge. I was the only person when I went to the lady's house; I thought I was going to visit the old lady. I can't remember what happened after. I had lots of pain between my legs and my grandmother said that I have become a real woman and that my father would be very happy if he found out.[....] Personally, I would say it's a bad practice, I wouldn't advise anyone to go through it. It's a trauma even when I think about it, I get so angry and scared of the people who are still doing it." (key informant of Cameroonian origin)

Only 30 of the 110 participants of Cameroonian origin had daughters. The total of daughters reported was 37 girls; 30 of them living in Hamburg. None of the daughters had undergone FGM/C and all but one participant said that they had no intention of subjecting their daughter(s) to the practice. One woman from the group of the Hausa said that

Table 28: Proportion of women and men from groups and families practicing FGM/C (Cameroon)

	FGM/C takes place in my ethnic group (%)			FGM/C has been taking place in my family (%)		
	Yes	No	Don't know	Yes	No	Don't know
Women ($n = 41$)	30.8	66.7	2.6	7.7	87.2	5.1
Men ($n = 69$)	7.2	88.4	4.3	2.9	95.6	1.5
Total ($n = 110$)	15.7	80.6	3.7	4.7	92.5	2.8

she did not know whether or not to circumcise her daughter and expressed the same attitude towards the continuation of the practice. As the daughter is living in Cameroon and had never been to Germany, there was no chance of exploring the girl's situation further.

5.5.4.4. Perception related to the practice

Almost 80% of the participants emphasised that FGM/C was a practice without any advantages. The remaining participants associated at least one benefit with the practice. The reduction of sexual desire and the preservation of virginity were the most commonly named advantages and named by respectively 9% of the participants. There were no gender or age differences for the perception of positive outcomes of FGM/C.

5.5.4.5. FGM/C and religion

Three Muslims and five Christians believed FGM/C to be required by their religion. Only one of these eight participants, however, a Muslim woman, came from a practicing family. Six participants declared they lack information regarding the position of their religion towards FGM/C. The remaining majority of 87% saw no connection between FGM/C and their faith.

5.5.4.6. Perception of disadvantages and knowledge of risks and consequences

We noted a strong awareness of the risks and effects of FGM/C among the Cameroonian immigrants: more than 86% of the interviewees were able to cite one or several disadvantages of the practice. Infections and sexual problems for women were particularly well known consequences of FGM/C and were each named by more than 30% of the participants. There were no gender or age differences for knowledge of the risks and negative consequences of FGM/C.

5.5.4.7. Knowledge of German law and attitudes towards the abandonment of FMG/C

The greater part of the participants (82%) confirmed that FGM/C is outlawed in Germany. The remaining participants were uncertain: 17 men and women said that they were not informed about the position taken by German law on this subject, and two participants explained that the law abstains from mentioning the practice. All participants from practicing families were aware that FGM/C is a punishable act in Germany.

Most members of the Cameroonian community strongly advocated the abandonment of FGM/C: 90% of the men and 95% of the women interviewed consider that FGM/C should be abolished. Only one man from a non-practicing group and family declared that FGM/C should continue. Five men – all but one also from non-practicing groups – said that it depended on the context and two women declared their uncertainty vis-à-vis the continuation of the practice.

5.5.5. The Gambia

5.5.5.1. Socio-demographic profile

The Gambian community with about 450 members is the 5th largest community from Sub-Saharan Africa in Hamburg. There are almost three times more men (333) than women (117). We managed to reach 90 participants, 57 men and 33 women during the phase of quantitative interviews.

The level of professional qualification is rather low among the interviewed Gambian immigrants and most of them work in low wage jobs. A large proportion of the Gambian women are housewives. Almost 60% of the men of Gambian origin are married to German spouses.

5.5.5.2. Proportion of immigrant population concerned

In The Gambia, most ethnic groups practice FGM/C and the prevalence rate is almost 80%. The only group with a very low prevalence rate are the Wolof whose girls undergo FGM/C only if a female spouse or female family member is from a practicing group and decides to initiate her daughter to the tradition. Among the Serer group, FGM/C is known to be practiced only moderately, with a prevalence rate of 45%. All other larger groups (Diola, Fula, Mandingka etc.) have rates above 80%. FGM/C is practiced in all regions of The Gambia, but to a lesser extent in the capital Banjul (45%) and in the Kerewan region (61%). The practice is less common among mothers with secondary education (Gambia Bureau of Statistics [GBoS] 2007).

Table 29: Socio-demographic characteristics of immigrants from Gambia

Socio-demographic variables	women (*n* = 33)	men (*n* = 57)	total sample (*n* = 90)
Age (in years)			
Mean (standard deviation)	31.7 (4.8)	35.3 (6.6)	33.8 (6.1)
Range	22-40	25-54	22-54
Average education level (in years)			
Mean (standard deviation)	8.5 (5.8)	9.4 (6.8)	9.1 (6.4)
Range	0-18	0-20	0-20
Religion			
Muslim	31 (93.9%)	55 (96.5%)	86 (95.6%)
Christian	2 (6.1%)	1 (1.8%)	3 (3.3%)
Traditional religion	0 (0.0%)	0 (0.0%)	0 (0.0%)
None believers	0 (0.0%)	1 (1.8%)	1 (1.1%)
Social status			
Married (monogamous)	16 (48.5%)	22 (39.3%)	38 (43.2%)
Married (polygamous)	0 (0.0%)	1 (1.8%)	1 (1.1%)
Separated/divorced/widowed	9 (28.1%)	25 (44.7%)	34 (38.6%)
Never been married[22]	7 (21.9%)	8 (14.3%)	15 (17.0%)
Migrated from a(n)			
Urban area	13 (41.9%)	19 (35.2%)	32 (37.6%)
Rural area	18 (58.1%)	35 (64.8%)	53 (62.4%)
Residence status			
Unbefristet (indefinite residence permission)	8 (24.2%)	30 (52.6%)	38 (42.2%)
Befristet (temporary residence permission)	3 (9.1%)	4 (7.0%)	7 (7.8%)
Duldung (toleration)	0 (0.0%)	1 (1.8%)	1 (1.1%)
Others/no papers/does not answer	21 (63.6%)	17 (29.9%)	38 (42.2%)
German nationality	1 (3.0%)	5 (8.8%)	6 (6.7%)
Time spent in Germany (in months)			
Mean (standard deviation)	74.0 (40.0)	99.2 (55.4)	89.2 (51.1)
Range	36-252	13-360	13-360

Among the men and women interviewed, 96% of the participants belonged to three ethnic groups where the rates of FGM/C are known to be very high. By far the most represented group in the sample were the Mandinga[28] (90%); there were also a couple of Fula and Diola. Only four men came from groups with moderate and low FGM/C prevalence: Wolof (3) and Serer (1).

In line with the ethnic group composition of the sample, 90% of the participants declared that FGM/C has been taking place in their family. Only six persons said that FGM/C was not part of their family traditions, two persons were uncertain and one person abstained from answering. The proportions of FGM/C in the family were equally high for men and for women.

5.5.5.3. Women and girls concerned

Out of the 33 women interviewed, 27 (82%) claimed to have undergone FGM/C. One woman did not want to answer the question. In two interviews, the researchers preferred to abstain from asking the question considering that the interview setting did not allow them to enquire about such intimate details. Only three women reported not to have undergone FGM/C.

Most of the women had taken part in FGM/C at the age in between three to seven years. The procedure was carried out in The Gambia; only one woman reported that she had gone through FGM/C in Cote d'Ivoire. All reports conveyed the idea that the practice was done by traditional practitioners. One key informant interviewed during the qualitative phase described that she even underwent FGM/C two times

28 Also referred to as Mandinka, Mandingo, Bambara or Dioula.

and describes the pain she suffered, but at the same time her wish was to be part of the tradition:

> "Gambian women have to be circumcised to uphold the family honour. Myself, I have been cut two times. They said the first time it had not been properly done. I have terrifying and painful memories of it, but I also wanted to hear the Kankouran[29] screaming and to be part of the dancers." (woman of Gambian origin)

Another Gambian key informant also referred to her own FGM/C as a difficult experience, but emphasises at the same time the importance to carry on with the tradition:

> "I am part of the generation who went through female circumcision a long time ago. I can't tell you exactly when it was, but I can tell that it was a very hard experience. My memories of it? I am sorry, I cannot tell you. I prefer keeping them to myself. I know that people are against this practice nowadays, but it remains our tradition. It is a practice that gives value to the African woman." (woman of Gambian origin)

About one third of the participants (35 out of 90) had one or more daughters; the total number of reported daughters was 49. Only 16 of the girls were living in Germany. Out of the 49 girls, 24 girls had undergone FGM/C which is almost half of the cohort of daughters of the immigrants. All but one of these girls are growing up in Gambia and not in Germany. Only one of the girls living in Hamburg was concerned. She had come to Germany only a few years ago with her mother and had already been subjected to the practice prior to her arrival in Germany.

Most of the parents with affected daughters were men (12 men compared to 2 women). It seems that Gambian men tend to migrate to Germany for labour, leaving spouse and children behind. The girls are left under the guardianship of the traditional women society in Gambia and are unlikely to be spared from FGM/C.

All parents with non-circumcised girls affirmed that they had no intention of taking their daughters through FGM/C. Only one woman said that she was uncertain, but since the daughter has a German father who is opposed to the practice, it can be assumed that the girl is not at risk.

The interviews with the Gambian community members reported that girls born in Germany are at a moderate risk of being subjected to the practice. They are often considered as Europeans and parents put each other on guard to make sure that girls remain untouched when going on holidays. A Gambian man said to the researcher that there is always "need to be vigilant when a daughter is going on holidays and to sit down with the mother and explain to her that the child is born as a German and cannot undergo traditional practices."

5.5.5.4. Perceptions related to the practice

All participants had heard of the practice and the large majority (88%) considered it as an advantageous practice. The proportion of women perceiving benefits in FGM/C was higher (94%) than that of men (84%). The most frequently named benefits were social acceptance and better marriage prospects for the girls and women who have undergone FGM/C. Over 60% of the men and over 80% of the women raised these two topics when discussing the advantages. Especially women feel that FGM/C is the only guarantee of finding a husband and of becoming an accepted member of the society:

> "It is our tradition and I believe it to be a good one. Female circumcision gives a good status to the women and a good image to the women. You know that people ask a lot of questions before marriage. For getting married, you need to be circumcised; otherwise you will not get a husband. It is our tradition and it has to be continued. I know that people are nowadays against this practice, but it is a tradition that gives real value to African women."(woman of Gambian origin)

Another advantage that was raised by a significant proportion of participants (over 40%) was that immigrants of Gambian origin consider FGM/C to be a source of cleanliness, making the woman pure and ensuring her hygiene.

5.5.5.5. FGM/C and religion

A minority of 5 out of 90 participants believe that FGM/C is a religious requirement for Muslims. It seems that FGM/C is for Gambians more of a social convention than a practice associated to religious ideologies.

5.5.5.6. Perception of disadvantages and knowledge of risks and consequences

Over 70% of the participants had no knowledge about the hazards and effects of FGM/C. Thus, it can be concluded that the awareness is relatively low among the Gambian immigrants. There were no differences between men and women or different age groups. Only a handful of participants named negative effects such as difficulties during delivery, problems during intercourse, bleeding or infections.

29 In Gambia, the rites including FGM/C are usually terminated with a dancing ceremony. Afterwards a ghost called Kancouran comes to the village and only those who are part of the tradition are safe to be outside once he arrives.

5.5.5.7. Knowledge of German law and attitudes towards the abandonment of FGM/C

It is known by more than half of the interviewed Gambians (57%) that FGM/C is outlawed in Germany. A quite considerable proportion (41%) however, is uncertain about the position of the German legislative system. Two participants declare that FGM/C is not mentioned within the German legislation. There are strong gender differences regarding the knowledge about the law: twice as many women (61%) than men (30%) have no knowledge of the position of the German law.

Out of the 90 participants, only one woman speaks out for the continuation of the practice. More than half of the participants, in the samples of men and women alike, want FGM/C to stop (60%). The remaining participants answer either that "it depends" or that they feel uncertainty regarding the feasibility on how FGM/C could be abolished. A Gambian researcher summarised his experiences as follows:

> "A lot of Gambians are against female circumcision here. They know themselves that it is not a good practice. But at the same time we are attached to our traditions, not only female circumcision, but traditions in general. It is difficult for us to decide which part of the traditions are worthy to keep and which parts need to be left aside. This type of change takes time. And the change can start in the heart before it is pronounced by the mouth." (Researcher of Gambian origin)

Some women seem to have an ambiguous perception. On the one hand, they wish to put an end to a painful tradition, on the other hand, they cannot imagine that the abolition will ever be accepted by their society. They don't see any means of progress towards the abandonment. Others remain traditional and have assimilated FGM/C as part of their cultural heritage they want to pursue.

> "In our country this practice exists since a very long time. It is a tradition. Do we have to abandonment it? If yes, it will be a heavy and long lasting combat to make people understand why." (woman of Gambian origin)

> "My position is clear: it is my tradition and it should be continued. But I know that I cannot circumcise my daughter here. It is forbidden. Especially since my husband is against it." (woman of Gambian origin)

> "Our traditions are very important to us, but I also see that we need to put an end to female circumcision. But how? All I know that it has to be stopped in Africa and not in Europe. This work has to be done by Africans." (woman of Gambian origin)

The majority of the men were not in favour of FGM/C, but they did not consider its abandonment as a priority issue. Their reactions reflect two aspects. First, they consider FGM/C to be women's business. Women have to decide whether or not they want to abolish it or not. Even if they are against the practice, some men won't bother to follow-up on the status of their daughters that are growing up in Gambia.

> "I believe that this tradition will always be there and the funny thing is that we don't even see the ladies practicing it. I used to hear of some feasts in Gambia. I used to even go there and eat, but that was after it was done. You can never see such a thing. So I wonder how people found out about it. As for my part, I will not give the permission for my daughters to be circumcised." (man of Gambian origin)

> "It is the women who have to take the decision. They have to stand up and say 'no, we have suffered enough'." (man of Gambian origin)

> "One of my Gambian wives is circumcised. The second one [...] is not circumcised. My wife in Gambia had two daughters, but one died. The other one is now 24 years old and I refused for her to be circumcised, but I don't know if she is or not. Most of my girlfriends back in Gambia were circumcised, all my sisters, cousins and my mother. I came to realise that it is a stupid practice. I am against it now although it does not matter to me if I marry a circumcised or a non-circumcised woman. But I would not allow it for the next generation, the young girls to be circumcised. It was a mistake those days, it's over. Let's look at the future." (man of Gambian origin, polygamously married to two Gambians and one German wife)

The second aspect brought to light is that men feel that the initiative of abandoning FGM/C has to come from Africans and not from Europeans and that this initiative needs to start and to grow in Africa. Pressure from the European side is considered pointless.

> "The practice should be abandoned. But this has to be decided by Africans and not by Europeans." (man of Gambian origin)

> "I am for the abandonment of it [female circumcision], but this is an African and not a European business. It must not be the Europeans but the Africans to decide if and how our traditions are changed." (man of Gambian origin)

5.5.6. Cote d'Ivoire

5.5.6.1. Socio-demographic profile

The Ivorian community is the sixth largest immigrant community from Sub-Saharan Africa in Hamburg. There are 250 men and 153 women adding up to a total of 403 (registered) Ivorian immigrants. We managed to interview a significant proportion of 92 men (37% out of the registered population), but were less successful in reaching the women with whom only 18 interviews were completed. One reason for the small number of interviewed women was that the interviewers found it challenging to ask the spouse of Muslim women for an authorisation to interview their wives on the topic of FGM/C. Another reason was that the women were much less likely to be found in places of public gathering. In addition to that, both researchers of Ivorian origin were men and they found it more difficult to approach women.

5.5.6.2. Proportion of immigrant population concerned

About 42% of the women in Cote d'Ivoire are estimated to have undergone FGM/C. The practice is particularly widespread in the North West (85%), North (88%), Central North (64%) and the Western region (64%). The prevalence is higher among Muslims (76%) than among different Christian affiliations (13-15%) and believers of traditional religions (45%) (INS, Ministere de lutte contre le SIDA & ORC Macro 2006).

About half of the interviewed participants originally come from one of the Northern regions where FGM/C is highly prevalent. Further 12 participants are from the Western region. The remaining participants are from Southern regions (mainly Abidjan), the Central region and the Eastern region.

Table 30: Socio-demographic characteristics of immigrants from Cote d'Ivoire

Socio-demographic variables	women (*n* = 18)	men (*n* = 92)	total sample (*n* = 110)
Age (in years)			
Mean (standard deviation)	32.6 (5.3)	35.3 (6.3)	34.8 (6.2)
Range	24-42	18-50	18-50
Average education level (in years)			
Mean (standard deviation)	9.9 (5.0)	12.3 (5.0)	11.9 (5.0)
Range	3-19	0-25	0-25
Religion			
Muslim	11 (61.1%)	66 (72.5%)	77 (70.6%)
Christian	6 (33.3%)	17 (18.7%)	23 (21.1%)
Traditional religion	0 (0.0%)	2 (2.2%)	2 (1.8%)
None believers	1 (5.6%)	6 (6.6%)	7 (6.4%)
Social status			
Married (monogamous)	11 (61.1%)	26 (28.6%)	37 (33.9%)
Married (polygamous)	0 (0.0%)	2 (2.2%)	2 (1.8%)
Separated/divorced/widowed	1 (5.6%)	14 (15.2%)	15 (13.8%)
Never been married[22]	6 (33.3%)	49 (53.8%)	55 (50.4%)
Migrated from a(n)			
Urban area	15 (83.3%)	81 (90%)	96 (88.9%)
Rural area	3 (16.7%)	9 (10%)	12 (11.1%)
Residence status			
Unbefristet (indefinite residence permission)	2 (11.1%)	31 (34.4%)	33 (30.6%)
Befristet (temporary residence permission)	11 (61.1%)	29 (32.2%)	40 (37.0%)
Duldung (toleration)	1 (5.6%)	11 (12.2%)	13 (12.0%)
Others/no papers/does not answer	2 (11.1%)	13 (14.4%)	15 (13.9%)
German nationality	1 (5.6%)	6 (6.7%)	7 (6.5%)
Time spent in Germany (in months)			
Mean (standard deviation)	95.9 (52.7)	129.1 (63.3)	123.6 (62.7)
Range	1-192	10-264	1-264

The majority of the participants (77%) are from ethnic groups in which FGM/C is known to be widespread. Over half of the participants (54%) also report that FGM/C has been carried out in their family. Further eight participants report uncertainty about the existence of the practice in their family. The small sample of women does not allow analysing gender differences. The majority of the women (14 out of 18) assert to come from practicing families.

5.5.6.3. Women and girls concerned

Out of the 18 women interviewed, 9 asserted that they had not undergone FGM/C while 6 women stated that they had. The remaining three women were interviewed by a male researcher who did not deem it appropriate to ask the question. The three women were, however, from practicing groups. The women concerned reported that they had been taken to a traditional woman practitioner when they were school girls.

The majority of the participants were parents and 58 of them had at least one daughter. The total number of daughters was 87 of which 59 lived in Germany.

The parents reported that none of the girls living in Germany had undergone FGM/C. Among the 28 girls growing up in Cote d'Ivoire, two had been subjected to FGM/C in their home country. When the parents were asked if they planned to have their daughters undergo FGM/C in the future, a quasi totality of participants gave a negative response. One man reported uncertainty, but the girl did not seem to be at risk as the father was well informed about the German law.

5.5.6.4. Perceptions related to the practice

Despite the high proportion of participants from practicing groups, the greater part (65%) perceives FGM/C as a tradition without any positive outcome. A few men and women go further and perceive it very negatively, based on their knowledge of the consequences.

> "It is a crime. It is an act against human dignity. There are no advantages. We condemn it firmly and without conditions. Female circumcision is frustrating for the woman. It can cause barrenness. There are a lot of circumcised women who don't feel pleasure during sexual intercourse. Some cannot have children any more." (man of Ivorian origin)

But most participants seem to be rather indifferent: they consider FGM/C to be a simple tradition that has been going on for a very long time and that is of not much concern to them as immigrants living in Germany. Furthermore, there is also a considerable proportion (35%) of men and women who see benefits in practicing FGM/C. The most frequently named advantage is a more responsible sexual behaviour of girls and women (remaining a virgin until marriage and being faithful to their husbands).

> "...it helped our sisters to preserve themselves more, and on the night of their marriage all of them were virgins. [...] the advantage is there, our girls who have been circumcised and our girls who have not, you can see the difference. They behave differently. Circumcised girls have no desire for men [...], they are not thinking about sexual intercourse compared to the girls who have not been circumcised and who are always full of desire for men.[...] A circumcised girl will not commit adultery when her husband is not there, at least it happens very rarely compared with our sisters who have not undergone the practice." (man, key informant of Ivorian origin)

5.5.6.5. FGM/C and religion

The greater part of the interviewees (77%) perceived FGM/C as a cultural and not a religious practice. About 10% stated uncertainty regarding the position of their religion towards FGM/C. Only 13% of the participants (mostly Muslim, but also two Christians) perceived FGM/C to be a religious custom.

5.5.6.6. Perception of disadvantages and knowledge of risks and consequences

The participants of the Ivorian community were comparatively well informed about the risks and medical implications of FGM/C: 85% of them mentioned at least one aspect related to the harm resulting from FGM/C.

> "There are many disadvantages: the woman feels no pleasure during sex, she can become barren; there might be infections that can lead to bad illnesses and even to AIDS." (man of Ivorian origin)

The most frequent disadvantages were sexual problems and limitations for the woman and to some extent also for the man, as he sees himself confronted with the situation of not being able to satisfy the woman.

> "It s not good, the women have no feelings. For us in Abidjan, we consider the clitoris as the "petit policier" meaning when the man has done his job well then the clitoris is a great indicator that the woman is satisfied. So if you cut off the clitoris, you are depriving the woman of any sexual feelings and the man cannot know whether or not he is pleasing the woman." (man of Ivorian origin)

> "It is a bad practice as it is very important that both partners are enjoying sex. I once met a circumcised woman

and I did not succeed in satisfying her over two hours so I have preferred ever since to be with non-circumcised women." (man of Ivorian origin)

Other frequently cited consequences were infections (33%), difficulties during delivery for the mother and the baby (25%) and the risk of death (23%). Some participants also perceived that the medical risks where exaggerated by Europeans and admitted only that the equipment used during the procedure should be improved.

"It is the Europeans who say that there are disadvantages because of the equipment used to perform it. I mean when you take the same non-disinfected blade or knife for three or four girls, it can lead to illnesses of the genitals, but the advantage that we consider more is that female circumcision stabilises a lot of marriages in Africa." (man, key informant of Ivorian origin)

5.5.6.7. Knowledge of German law and attitudes towards the abandonment of FGM/C

There was a strong awareness about the position taken by German law on the subject: 95 out of 110 participants were informed that the practice of FGM/C is not allowed in Germany. A minority of 15 persons reported either that the law did not explicitly mention FGM/C or were unsure about FGM/C being punishable in Germany.

All the women pronounced themselves in favour of stopping FGM/C. Most of the men (86%) expressed the same opinion.

"Yes, female circumcision exists. It is a practice inherited from our ancestors. I witnessed it for the last time in 1990. After that it stopped. I forbid my parents to carry on with it as it is harmful to women." (man of Ivorian origin)

Only one man argued for the continuation of the practice and seven men perceived that "it depends" on the situation. There were also five men who were indecisive regarding the continuation the practice. Some perceived that FGM/C was put in a bad light by Europeans who dramatised the negative outcomes, which could be controlled by confining the practice to health professionals.

"Personally, I think that the Europeans try to demonise female circumcision. But for us it is a tradition that is to be respected. When I was born I found it going on, so did my father, my grandfather and my great-grandfather so I believe that we cannot – all of a sudden and out of the blue – wipe out this tradition, do you understand? On the other hand, I can understand that people criticise the equipment [instruments for cutting]. There is a need to make the people understand that they need to change instruments, that they need to use good equipment, clean equipment. That is something that I can understand. Apart from that it is a tradition that should be continued. [...] While living in Europe, I comply with the law and I am against practicing female circumcision. According to the way of living here, female circumcision is not allowed: because this is their way of doing it and we are not at home here. But in Africa, female circumcision will continue despite all efforts that the Europeans might make." (man of Ivorian origin)

"I believe that this topic needs to be seriously discussed. Is female circumcision really as bad as the Europeans pretend it is? Isn't there a possibility of carrying out female circumcision under the control of medical personnel?" (man of Ivorian origin)

5.5.7. Kenya

5.5.7.1. Socio-demographic profile

The Kenyan community is the only immigrant population from Sub-Saharan Africa in Hamburg with a much higher number of women than men. Out of the 285 registered Kenyans in Hamburg, 208 are women and 77 are men. We interviewed about 20% of the Kenyan immigrants during the quantitative phase, more precisely 40 women and 15 men. This sample is not statistically representative. The education level of the interviewees is generally high: all participants had at least 10 years of formal education.

5.5.7.2. Proportion of immigrant population concerned

It is estimated that about 27% of the women in Kenya have undergone FGM/C. The practice is most established in the North Eastern region where over 95% of the women are concerned, followed by the Central, Eastern, Nyanza and Rift Valley region where the proportions of women concerned vary between 25-36%. The remaining regions have lower numbers. The ethnic group affiliation is also a good marker in Kenya. While FGM/C is unknown among the Luo, Luyha and Swahili, it is quasi universal among the Kisii and the Somali (over 95% of them have undergone FGM/C). Another highly affected group are the Massai (73%). The Kikuyu, Embu, Taita, Kalenjin, Kamba and Meru are partly practicing groups with prevalence rates ranging from 21-51% (Kenya National Bureau of Statistics and ICF Macro 2010).

The interviewees came from all the regions in Kenya with the exception of the North Eastern region (which has the highest FGM/C prevalence). There were 14 participants from Nairobi, 12 from the Central region, 9 from Nyanza, 7 from

Table 31: Socio-demographic characteristics of immigrants from Kenya

Socio-demographic variables	women (*n* = 40)	men (*n* = 15)	total sample (*n* = 55)
Age (in years)			
Mean (standard deviation)	29.4 (6.4)	28.9 (9.0)	29.2 (7.3)
Range	19-49	19-48	19-49
Average education level (in years)			
Mean (standard deviation)	14.6 (2.7)	15.2 (1.8)	14.7 (2.5)
Range	10-21	13-19	10-21
Religion			
Muslim	2 (5.0%)	3 (20.0%)	5 (9.1%)
Christian	37 (92.5%)	12 (80.0%)	49 (89.1%)
Traditional religion	0 (0.0%)	0 (0.0%)	0 (0.0%)
None believers	1 (2.5%)	0 (0.0%)	1 (1.8%)
Social status			
Married (monogamous)	5 (12.5%)	3 (20.0%)	8 (14.5%)
Separated/divorced/widowed	6 (15%)	2 (13.3%)	8 (14.5%)
Never been married[22]	29 (72.5%)	10 (66.7%)	39 (71.0%)
Migrated from a(n)			
Urban area	32 (84.2%)	13 (86.7%)	45 (84.9%)
Rural area	6 (15.8%)	2 (13.3%)	8 (15.1%)
Residence status			
Unbefristet (indefinite residence permission)	12 (30.0%)	4 (26.7%)	16 (29.1%)
Befristet (temporary residence permission)	22 (55.0%)	8 (53.3%)	30 (54.5%)
Duldung (toleration)	1 (2.5%)	0 (0.0%)	1 (1.8%)
Others/no papers/does not answer	4 (10%)	0 (0.0%)	4 (7.3%)
German nationality	1 (2.5%)	20 (20.0%)	4 (7.3%)
Time spent in Germany (in months)			
Mean (standard deviation)	72.5 (51.3)	78.7 (47.6)	74.2 (50.0 %)
Range	3-240	13-168	3-240

the Western, 6 from the Coast and 4 from Rift Valley region. There were 14 different ethnic groups (e.g. Kikuyu, Kalenjin and Luo) among the men and women interviewed. The ethnic groups most devoted to the practice were underrepresented; there were three Kisii and three Massai participants but no Somali participants. These findings indicate that the Kenyan immigrant population does not have a distinct profile with dominating ethnic groups or areas of origin.

Almost half of the participants reported that FGM/C have been practiced in their family (46%). Three further participants, two men and one woman expressed uncertainty as to whether or not FGM/C existed in their family. Men were less likely to come from practicing families than women.

5.5.7.3. Women and girls concerned

Out of the 40 Kenyan women interviewed, eight reported to have undergone FGM/C, two women preferred not to share their status and 30 women answered in the negative. Interviewers noted doubts for three of the 30 women who answered in the negative due to their non-verbal reactions to the question.

The women concerned reported that the practice was carried out between 0 and 12 years of age by traditional practitioners in Kenya. One woman claimed to have undergone an infibulation. Migration helped two women to escape from the practice. One of them was staying with her mother's relatives from a non-practicing group in another area while her sisters underwent FGM/C. She later migrated to Germany. The second woman gave the following testimony:

> "I was almost circumcised 10 years ago in Kenya, but since my mother was already in Germany, I had the opportunity to come here before it happened. It was my grandmother who insisted that the practice be carried out." (woman of Kenyan origin)

The cohort of daughters was small. Nine of the participants were parents to a total of 14 daughters, 9 of which were living in Hamburg. None of the daughters had undergone

FGM/C and none of the parents expressed the intention to subject them to the practice in the future.

5.5.7.4. Perceptions related to the practice

All participants were somehow familiar with FGM/C. The greater part of the participants, 31 out of 55 felt that it was a practice without advantages:

> "It should stop. I learnt about it in the media and through Waris Dirie's book. I wonder why educated women continue to circumcise their daughters. We are in the 21st century and I see absolutely no need for such negative traditions to be practiced." (woman from a non-practicing group in Kenya)

> "I find it to be so bad. It's not a good practice". (woman from a practicing family in Kenya)

For the remaining participants, FGM/C incorporates certain positive aspects. The most frequently raised advantages were linked to the faithful and decent behaviour of the girls and women on which the family honour depended. Some women participants concluded that the decrease of FGM/C has also lead to a loss of values and indecent behaviour of women.

> "In the old days when I was young, sex was only used for pro-creation and not for enjoyment. The older women who are circumcised are well behaved and reserved compared with the younger generation. Female circumcision reduces prostitution because the woman doesn't flirt. Women are faithful to their husbands. Circumcised women dress decently and they don't provoke men the way the uncircumcised women do." (woman of Kenyan origin)

5.5.7.5. FGM/C and religion

Most participants of Kenyan origin do not perceive FGM/C as a religious practice. Only two participants, a Christian woman and a Muslim man from practicing families, stated that FGM/C was a religious requirement for them.

5.5.7.6. Perception of disadvantages and knowledge of risks and consequences

The level of awareness of the risks and negative consequences of FGM/C was high in the sample interviewed: about 83% of the participants mentioned at least one negative outcome or risk. Particularly frequent effects named were pain, infections and an impaired sexual life for the women. There were no notable differences in the degree of awareness between men and women.

> "I feel sorry for the affected ladies. I can imagine that their sexual lives are ruined and many of them never had a say in it. I want to see it stopped. My sister is lucky that she grew up in Germany. Otherwise she would have been in the same group. I believe that it is very strong on my grandmother's side, but since my mother came here a long time ago, I don't think that she would have allowed it." (young man of Kenyan origin)

5.5.7.7. Knowledge of German law and attitudes towards the abandonment of FGM/C

Most participants knew that FGM/C was not allowed in Germany (71%). One participant responded that FGM/C was not explicitly mentioned in German legislation and 15 participants were unsure about the position of the German law towards FGM/C. There were no differences in the level of knowledge of men and women.

The majority of participants reported to be in favour of abolishing the practice. Out of the total sample of 55 participants, only one man did not support the abolition of the practice. One possible explanation for the attitudes against FGM/C might be the relatively high education level of the Kenyan immigrants. As mentioned above, all interviewed participants have attained at least a secondary school education.

5.5.8. Benin

5.5.8.1. Socio-demographic profile

Benin's (registered) immigrant community consists of 219 persons with men more than twice as numerous (151) as women (68).

We did not reach many members of the Beninese community during the first month of data collection. In the second phase of data collection, the team was joined by two researchers of Beninese origin, one man and one woman, and they managed to reach out to a significant number of immigrants: 31 women and 68 men adding up to a total sample of 99 participants.

The researchers described a strong desegregation of immigrants from southern and northern regions of Benin. The immigrants from the northern region have their own immigrant association (association de Djougou) and don't open up easily to people from other areas. The two researchers came from the southern and central region respectively, and they reported limited success in reaching the community from northern Benin. According to their impressions, the people from the South are overrepresented in the sample. Several key informants told them that immigrants from the northern

Table 32: Socio-demographic characteristics of immigrants from Benin

Socio-demographic variables	women (*n* = 31)	men (*n* = 68)	total sample (*n* = 99)
Age (in years)			
Mean (standard deviation)	34.7 (6.6)	35.5 (6.7)	35.2 (6.6)
Range	18-52	24-56	18-56
Average education level (in years)			
Mean (standard deviation)	10.8 (5.0)	11.7 (4.9)	11.5 (4.9)
Range	0-20	0-23	0-23
Religion			
Muslim	10 (33.3%)	31 (46.3%)	41 (42.3%)
Christian	18 (60.0%)	34 (50.7%)	52 (53.6%)
Traditional religion	1 (3.3%)	1 (1.5%)	2 (2.1%)
None believers	1 (3.3%)	1 (1.5%)	2 (2.1%)
Social status			
Married (monogamous)	21 (70.0%)	21 (31.3%)	42 (43.3%)
Married (polygamous)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Separated/divorced/widowed	2 (6.7%)	5 (7.5%)	7 (7.2%)
Never been married[22]	7 (23.3%)	41 (60.3%)	48 (49.5%)
Migrated from a(n)			
Urban area	20 (66.7%)	51 (76.1%)	71 (73.2%)
Rural area	10 (33.3%)	16 (23.9%)	26 (26.8%)
Residence status			
Unbefristet (indefinite residence permission)	16 (51.6%)	16 (23.9%)	32 (32.7%)
Befristet (temporary residence permission)	9 (29.0%)	23 (34.3%)	32 (32.7%)
Duldung (toleration)	0 (0.0%)	15 (22.4%)	15 (15.3%)
Others/no papers/does not answer	3 (9.7%)	11 (16.4%)	14 (14.3%)
German nationality	3 (9.7%)	2 (3.0%)	5 (5.1%)
Time spent in Germany (in months)			
Mean (standard deviation)	117.3 (55.0)	101.0 (58.6)	106.0 (57.7)
Range	12-277	3-349	3-349

regions are more numerous in Hamburg than immigrants from the other regions.

5.5.8.2. Proportion of immigrant population concerned

The prevalence of FGM/C is 13% in Benin. The practice is concentrated in the regions of the North. Particularly affected districts are Alibori, Borgou and Donga where over 45% of the women have undergone FGM/C and the Atacora where about 18% of the female population is estimated to be affected. FGM/C exists also to some extent in the central region (Collines) where an estimated 11% of the women have undergone FGM/C (see map below). The ethnic groups are also a good marker: FGM/C is very common in the groups of the Bariba (74%), the Yoa and Lopka (53%), the Fula (72%) and the Dendi (16%) (Institut National de la Statistique et de l'Analyse Économique (INSAE) [Bénin] and Macro International Inc. 2007).

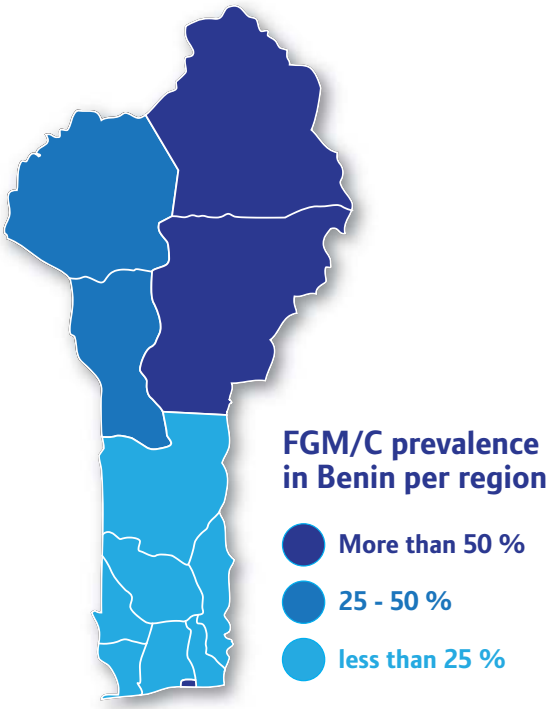
As explained in the previous paragraph, the researchers concluded that the interviewed sample is not representative for the Beninese immigrant community as the people from the Northern – and hence the most practicing regions – are underrepresented.

The sample showed indeed a strong concentration of people from southern regions (61%). Only 14% of the participants were from the central region and 25% from the northern regions. Regarding the question whether FGM/C was taking place in their family, 21 participants gave a positive answer. The proportion of women coming from practicing ethnic groups and families was higher than that of men.

5.5.8.3. Women and girls concerned

Of the 31 women interviewed, seven claimed to have undergone FGM/C, a further six women did not want to answer

Figure 6: FGM/C prevalence in Benin per region



the question; the remaining 18 answered in the negative. The women had been between 0 and 8 years old when they underwent the practice in Benin. Two of the women could not remember who carried out the procedure; the others said that it had been done by traditional practitioners. The descriptions indicated type I or type II forms.

More than half of the interviewed participants had at least one daughter, adding up to a total of 78 girls. More than half of these girls (48) live in Hamburg with their interviewed parent. According to the responses of the parents, among the 78 girls, there were three daughters who had been subjected to the practice by a traditional practitioner in Benin. One of these girls lives in Hamburg; the other two have never been to Germany.

When asked their intentions, most of the parents said that they didn't want to have their daughter undergo FGM/C. However, there were four parents, two men and two women, who expressed uncertainty about whether or not to subject their children to FGM/C. After a closer analysis of the four cases, it became evident that the daughters of the two women might be at risk of undergoing FGM/C during future holidays in Benin. The two mothers and their four daughters were integrated into the follow-up project (see section 3.5.1).

5.5.8.3. Perceptions related to FGM/C

Most participants from the South explained that FGM/C was not part of their culture and that they perceived it as a negative practice that "takes away an important part of the woman" or that "is a brutal procedure that makes the woman feel like a walking ghost".

About 26% of the participants, mostly from practicing groups, perceived that FGM/C provided certain benefits, notably social recognition, better marriage prospects and increased faithfulness among women. There was no significant difference in the perceptions of men and women regarding potential benefits of the practice.

5.5.8.4. FGM/C and religion

Five women and seven men claimed to believe that FGM/C was a religious practice. All but one of them were Muslims from practicing groups from the North (Fula, Dendi and Batouna)

5.5.8.5. Perception of disadvantages and knowledge of risks and consequences

There was considerable awareness of the harm done by FGM/C among the participants of Beninese origin interviewed: over 70% mentioned at least one negative aspect of FGM/C. The level of knowledge was significantly higher among women participants. The most frequently cited risks were death, infections and sexual disorders among the women.

5.5.8.6. Knowledge of German law and attitudes towards the abandonment of FGM/C

Only one woman from a non-practicing group asserted that FGM/C was allowed within the German legal system. The large majority (85%) is informed that FGM/C is seen as a punishable crime in German law. The remaining participants are unsure about the position of the German legal system towards the practice.

Furthermore, the greater part of the men and women interviewed pronounced themselves in favour of the abandonment of the practice. A small number expressed that they were unsure of their position and six persons – five men and one women – advocated for the continuation of the practice. Four of them come from practicing groups.

5.5.9. Ethiopia

5.5.9.1. Socio-demographic profile

There are 198 (registered) Ethiopian immigrants living in Hamburg, 99 men and 99 women. We reached about 40% of them; more precisely 35 women and 43 men. The socio-demographic characteristics of the sample interviewed are displayed in table 33.

It was not an easy task to get the Ethiopian immigrants to open up about the issue, and there is no doubt that it would have been impossible to interview so many participants without two researchers of Ethiopian origin in the team. Many of the participants knew of an incident in southern Germany where an Ethiopian woman was accused of wanting to subject her daughter to FGM/C; they shared the way they were exposed to stigmatising questions after the incident.

> "We hear that there are some Africans who go back to their country taking their children and circumcise them and come back. We know that an Ethiopian woman in Southern Germany was charged with having done this. But she didn't do it and had no intention takeoff taking her daughter to be circumcised. At the time that news was aired, a lot of Germans asked us whether we did the same." (members of group of women of Ethiopian origin)

5.5.9.2. Proportion of immigrant population concerned

According to the DHS conducted in 2005, three out of four women in Ethiopia have undergone FGM/C. The prevalence rate is particularly high (> 85%) in the regions of Affar, Oromiya, Somali, Harari and Dire Dawa. The practice is reported to be considerably lower (< 30%) in the regions of Tigray and Gambela. The prevalence rates are about 66% in the region of the capital Addis Ababa and 69% in the Amhara region.

More than half of the interviewed participants (55%) claimed to be Amhara, 17% are Oromo and 15% are affiliated with the group of the Tigre. The remaining 13% belong to different smaller ethnic groups.

Table 33: Socio-demographic characteristics of immigrants from Ethiopia

Socio-demographic variables	women (*n* = 36)	men (*n* = 42)	total sample (*n* = 78)
Age (in years)			
Mean (standard deviation)	36.6 (9.3)	37.8 (11.2)	37.2 (10.3)
Range	24-73	15-82	15-82
Average education level (in years)			
Mean (standard deviation)	12.3 (3.3)	15.6 (3.9)	14.1 (4.0)
Range	0-22	8-25	0-25
Religion			
Muslim	1 (2.8%)	2 (4.8%)	3 (3.8%)
Christian	34 (94.4%)	39 (92.9%)	73 (93.6%)
Traditional religion	0 (0.0%)	1 (2.4%)	1 (1.3%)
None believers	1 (2.8%)	0 (0.0%)	1 (1.3%)
Social status			
Married (monogamous)	20 (55.6%)	18 (42.9%)	38 (48.7%)
Married (polygamous)	1 (2.8%)	2 (4.8%)	3 (3.8%)
Separated/divorced/widowed	8 (22.2%)	4 (9.5%)	12 (15.4%)
Never been married[22]	7 (19.4%)	18 (42.9%)	25 (32.1%)
Migrated from a(n)			
Urban area	33 (94.3%)	33 (84.6%)	66 (89.2%)
Rural area	2 (5.7%)	6 (15.4%)	8 (10.8%)
Residence status			
Unbefristet (indefinite residence permission)	22 (61.1%)	16 (38.1%)	38 (48.7%)
Befristet (temporary residence permission)	9 (25.0%)	15 (35.7%)	24 (30.8%)
Duldung (toleration)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Others/no papers/does not answer	0 (0.0%)	1 (2.4%)	1 (1.3%)
German nationality	5 (13.9%)	10 (23.8%)	15 (19.2%)
Time spent in Germany (in months)			
Mean (standard deviation)	97.4 (59.3)	123.3 (95.8)	111.3 (81.6)
Range	2-288	2-360	2-360

Over 90% of the participants affirmed that FGM/C was taking part in their ethnic group and 72% reported that the practice was part of their family's tradition.

> "It is our tradition that a female should be circumcised like boys on the eighth day. Since we had it done in our infancy, we don't know whether it is painful or not. But there are regions where girls are circumcised at a later age. But thank God we went through the experience while we were infants." (three women of Ethiopian origin during a focus group discussion)

5.5.9.3. Women and girls concerned

Of the 35 women interviewed, 19 claimed to have undergone FGM/C. All of them had been subjected to the practice during infancy in Ethiopia. The practice was carried out by traditional practitioners although one woman was not sure and reported that it might have taken place in a hospital.

Two women chose not to give information on their status and in one case the interviewer preferred not to ask if the woman had undergone FGM/C. The remaining 13 women said that they had not been subjected to the practice.

Less than a third (31%) of the participants claimed to have one or more daughter(s). The total number of daughters (younger than 20 years) within the interviewed sample was 28; 21 of the girls are living in Germany.

According to the parents, none of the girls living in Hamburg had undergone FGM/C. None of the parents had the intention of subjecting their daughters to the practice in the future. There was only one parent, a father of two daughters, who refused to answer the question whether or not he intended to have his daughters undergo FGM/C.

> "It is our culture. But as to the question [do you intend to have your daughters circumcised?], the answer is no! We don't do it here. Why should we? We are living in a country where female circumcision is not practiced and there is no cultural influence or pressure to do so. [....] it is not a good culture and the girl may regret it when she becomes an adult." (five women during a focus group discussion)

> "It is difficult to think that a family living in Hamburg might be in favour of female circumcision. It would not have any meaning to have your daughter circumcised. Becoming married is not connected to women being circumcised." (woman, key informant of Ethiopian origin)

> "I have never ever heard of an Ethiopian family who practiced it here or when going back home. I think there might be some women out there who went through the practice in their childhood back home years before they came here. But I don't think that there are practitioners, as most of them are educated or from urban areas." (man, key informant of Ethiopian origin)

5.5.9.4. Perceptions related to the practice

All participants of Ethiopian origin had already heard about FGM/C and for most of them it was a practice without any benefit. About 35%, however, associated one or more advantages with the practice. There were more women (43%) who thought of FGM/C as an advantageous practice than men (28%). The most frequently perceived benefits of FGM/C were that

- it is a practice which improves hygiene and cleanliness,
- it increases the social acceptance of a girl/woman and her family and that
- it reduces the sexual desire of a woman.

The latter aspect was significantly more often named by women (17%) than men (5%).

> "There are equal hygiene benefits for both men and women when the woman is circumcised. Circumcision helps to prevent the woman's clitoris from growing so long that it blocks the passage during sex so it is better to cut early. Female circumcision also prevents complications during birth and prevents pain during intercourse for virgins. Women's sexual organs are internal and they are unclean and smell when not cut. A woman should be cut in order to be clean and acceptable in the church. I know it is painful but the benefits of tradition and religion cannot be overlooked." (man of Ethiopian origin married to a German)

5.5.9.5. FGM/C and religion

One woman and five men believed that FGM/C was an obligation of their religion. Five of them were Christians and one a practitioner of a traditional religion. They mentioned that the Orthodox Church in Ethiopia recommends the FGM/C of girls and the circumcision of boys at the age of eight days.

> "I have three circumcised sisters. They were circumcised at infancy according to the religion of the Orthodox Church in Ethiopia". (40-year-old man of Ethiopian origin married to a German)

The large majority of participants perceive FGM/C as a cultural custom as described in the following paragraph by a Christian religious leader of the Ethiopian community.

"As I said, for a number of practitioners, female circumcision wrongly represents religion. It is not religious. It has nothing to do with the worship of God. Those who do it might have their own explanations about the advantage of circumcising a woman. But to me, I only see the disadvantages in the fact that it injures not only the physical body of the girl but her mental being, too. Its impact stays throughout her life with her. When we say God created man and the woman out of him, all the body organs, they were created with what is important. So cutting away an organ is not only painful to the person who lost part of his body, but also to God who created man fully equipped with important organs." (39 year old key informant and religious leader of Ethiopian origin)

5.5.9.6. Perception of disadvantages and knowledge of risks and consequences

There was a general awareness among participants of Ethiopian origin about the harm of FGM/C: almost 85% brought up one or more risks or negative effects during the interviews. Men and women were equally well informed. The most frequently named risks or effects were pain, infections, bleeding and sexual problems. Some participants mentioned how the latter effect led to conjugal problems:

"I believe that my being circumcised contributed somehow to the divorce from my German husband." (woman of Ethiopian origin)

"My husband used to tell me that I was not motivated for union because of the circumcision I had gone through." (woman of Ethiopian origin)

5.5.9.7. Knowledge of German law and attitudes towards the abandonment of FGM/C

It is known by the majority (54 persons) of the interviewed Ethiopian community that FGM/C is not permitted by German law. Five people answered that FGM/C is not specifically mentioned in the German legislation and 19 persons declared uncertainty. Women are slightly more likely to be aware of the legislation than men.

There is a strong proportion of voices within the Ethiopian immigrant community – men and women alike – in favour of stopping FGM/C: 69 out of 78 participants pronounced themselves in favour of the abandonment of the practice. Only one woman, a 73 year old grandmother visiting her daughter in Hamburg advocated its continuation. Four participants felt that it depended on the situation and four other participants felt uncertain about their opinion regarding the future of the practice. It was communicated clearly, however, that none of the participants could imagine practicing FGM/C in Germany or subjecting their daughters to the practice during holidays in Ethiopia.

5.5.10. Burkina Faso

5.5.10.1. Socio-demographic profile

The Burkinabe community in Hamburg is mainly composed of men: among the 190 registered immigrants, there are 154 men and 36 women. We reached a solid proportion of 75 participants, but interviewed mainly men (66) and had difficulties getting hold of the women; we ended up completing the interviews with only 9 women.

5.5.10.2. Proportion of immigrant population concerned

The DHS for Burkina Faso estimates that 77% of the women in the country have undergone FGM/C. All the main ethnic groups adhere to the practice with prevalence rates of about 85%. There is only one region in Burkina Faso, the Central West, where the proportion of women who have undergone FGM/C is considerably lower than in other regions. It is at 44% while all other regions have prevalence estimates of 60% and above (INSD Burkina Faso & ORC Macro 2004).

All participants are from practicing ethnic groups and the greater part (55 out of 75 persons = 74%) is also from practicing families; 13 participants claimed to be from non-practicing families and six participants either did not know or did not answer the question.

5.5.10.3. Women and girls concerned

Five out of the nine women interviewed reported to have undergone FGM/C at between 0 and 5 years of age. One of the women stated more precisely that she had been infibulated and sewn closed.

Among the interviewees of Burkinabe origin, 30 participants were parents of daughters: the total number of daughters was 38, the majority (33) living in Germany.

Of the 38 girls, 4 daughters (of three men interviewed) had been subjected to FGM/C. The four girls are currently living in Hamburg, but were born in Burkina Faso and underwent FGM/C before arriving in Germany. They were taken to a traditional practitioner at a very young age. Two of the fathers shared the fact that the girls had been taken by members of the extended family and that the fathers had been informed only afterwards about what had happened.

"Female circumcision is a reality in my area of origin and in particular in my family. It is a woman's affair. When they circumcised my two daughters, I was only informed

Table 34: Socio-demographic characteristics of interviewed immigrants from Burkina Faso

Socio-demographic variables	women (*n* = 9)	men (*n* = 66)	total sample (*n* = 75)
Age (in years)			
Mean (standard deviation)	33.3 (7.0)	35.5 (5.7)	35.2 (5.9)
Range	24-44	20-51	20-51
Average education level (in years)			
Mean (standard deviation)	13.7 (4.4)	10.1 (5.0)	10.57 (5.1)
Range	6-18	0-25	0-25
Religion			
Muslim	5 (55.6%)	52 (80.0%)	57 (77.0%)
Christian	4 (44.4%)	12 (18.5%)	16 (21.6%)
Traditional religion	0 (0.0%)	1 (1.5%)	0 (0.0%)
None believers	0 (0.0%)	0 (0.0%)	1 (1.4%)
Social status			
Married (monogamous)	4 (44.4%)	21 (31.8%)	25 (33.3%)
Married (polygamous)	0 (0.0%)	1 (1.5%)	1 (1.3%)
Separated/divorced/widowed	2 (22.2%)	8 (12.1%)	10 (13.3%)
Never been married[22]	3 (33.3%)	36 (54.5%)	39 (52.0%)
Migrated from a(n)			
Urban area	8 (88.9%)	53 (81.5%)	61 (82.4%)
Rural area	1 (11.1%)	12 (18.5%)	13 (17.6%)
Residence status			
Unbefristet (indefinite residence permission)	3 (37.5%)	12 (18.2%)	15 (20.3%)
Befristet (temporary residence permission)	2 (25.0%)	19 (28.8%)	21 (28.4%)
Duldung (toleration)	1 (12.5%)	21 (31.8%)	22 (29.7%)
Others/no papers/does not answer	2 (25.0%)	14 (19.7%)	15 (20.4%)
German nationality	0 (0.0%)	1 (1.5%)	1 (1.4%)
Time spent in Germany (in months)			
Mean (standard deviation)	67.7 (49.5)	77.0 (53.8)	75.8 (53.0)
Range	12-131	1-252	1-252

after it happened. But I am against the practice; they are removing an important organ." (father of Burkinabe origin)

The other parents were asked if they had the intention of subjecting their daughters to FGM/C in the future. Out of 29 parents 26 answered in the negative while one participant abstained from answering the question and two participants declared themselves to be uncertain. The discussions with the three parents who had provided vague answers showed that none of their daughters was at risk.

5.5.10.4. Perceptions related to the practice

For the greater part of the interviewed participants of Burkinabe origin FGM/C is perceived as an advantageous practice (67%). Around 30% of them see as benefits the social acceptance of the girl and the diminution of the sexual desire of the woman. Better marriage prospects, religious approval and cleanliness were further benefits brought up.

"Female circumcision is a good thing for the woman because it makes her clean. I don't see any inconvenience in it. I saw it happening in my family and no one had any problems with that. I think that people are just using the issue to make politics." (man of Burkinabe origin)

Some participants don't bring up concrete benefits but have a positive perception of FGM/C or affirm that the practice should not be treated as an issue while the Burkinabe community is struggling with their residence status in Germany:

"There is no problem with female circumcision. The Germans should give us work permits; that is what is important." (man of Burkinabe origin)

"Female circumcision is and will remain a good thing for women. This is another reason why I should leave this country as quickly as possible." (man of Burkinabe origin)

About 30% of the participants do not see any benefit in FGM/C and spoke in favour of its abolition.

"I am totally against the practice. There are no positive outcomes. The practitioners are to be blamed." (man of Burkinabe origin)

"This practice is not good; and it would be a good thing to see it stop. It would be good to give practitioners an alternative." (man of Burkinabe origin)

5.5.10.5. FGM/C and religion

Among the interviewed Muslims (57 persons), 15 men and 1 women believed that FGM/C was a practice associated with Islam. None of the Christians interviewed saw a link between FGM/C and their religion.

5.5.10.6. Perception of disadvantages and knowledge of risks and consequences

Over 70% of the interviewees had a certain degree of awareness of the harm of FGM/C and could specify at least one negative outcome of the practice. The most commonly cited hazards were difficulties during childbirth and sexual disorders for the women.

5.5.10.7. Knowledge of German law and attitudes towards the abandonment of FGM/C

More than half of the interviewed Burkinabe (39 of 75 participants) are aware that the German law prosecutes FGM/C. Another significant proportion (25 participants) expressed uncertainty about the position taken by the German legal system on the subject. A few participants (four men) asserted that FGM/C is not specifically mentioned in German law. The impact of FGM/C being punishable by law in Germany has a strong dissuasive effect on parents in favour of FGM/C.

"A woman who is not circumcised has no respect for other people, she is impertinent, frivolous and can't control herself when approached by men. Nevertheless, for my daughters, I had to decide against the practice. They are born here and the Germans don't joke with their laws." (man of Burkinabe origin, father of three daughters)

Regarding the abandonment of FGM/C, the greater part of the participants confirmed their wish to see the practice abolished. There were, however, eight men advocating for the continuation of the practice and 12 participants who were undecided regarding the continuation of FGM/C. Worried about the sexual behaviour of the young girls, some people prefer to consider modifying the way the practice is done than abolishing it.

"If the practice is dangerous, then I suggest to medicalise it, to hand it over to health professionals so it can be carried out in good conditions and at the same time, we'll have fewer girls on the streets." (man of Burkinabe origin)

5.5.11. Guinea

5.5.11.1. Socio-demographic profile

There are 178 registered immigrants of Guinean origin in Hamburg with more than twice as many men (122) as women (56). With two Guinean researchers in the team, we managed to reach a significant number: 77 men and 38 women. We excluded one man from the data analysis for whom the researcher noted that "he looks too afraid to answer and rejects all questions." With one participant fewer, the total sample added up to 114 persons.

Most of the interviewed participants were either housewives, job seekers or employed in low-wage work. The level of education was low relative to the other countries. All interviewed participants of Guinean origin were Muslims. The researchers saw themselves often confronted with total lack of interest, reticence or harsh reactions to the research topic, in particular from men.

"I believe that you [speaking to the researcher] should get busy with something different because that issue is of no importance. The residence status is what counts and the Germans should give it to us. This is important and not female circumcision or the African culture in Germany." (man of Guinean origin)

"My problems are my papers and not this stupid set of questions that you are asking." (man of Guinean origin)

5.5.11.2. Proportion of immigrant population concerned

Guinea has one of the highest FGM/C prevalence rates in Africa. According to the last DHS, 96% of the Guinean female population have undergone FGM/C. The prevalence for the cohort of daughters is barely lower at 94%. FGM/C is practiced across all ethnic groups and is almost universal (99%) in the biggest ethnic groups, the Soussou, Malinke and Fula. The only ethnic group with a lower prevalence rate (68%) are the Guerze of the Forest region (DNS Guinea & ORC Macro 2006).

Table 35: Socio-demographic characteristics of immigrants from Guinea

Socio-demographic variables	women (*n* = 38)	men (*n* = 76)	total sample (*n* = 114)
Age (in years)			
Mean (standard deviation)	32.7 (5.2)	35.0 (8.0)	34.2 (7.2)
Range	23-40	19-63	19-63
Average education level (in years)			
Mean (standard deviation)	7.2 (6.1)	9.5 (5.3)	8.8 (5.6)
Range	0-18	0-25	0-25
Social status			
Married (monogamous)	25 (65.8%)	20 (26.3%)	45 (39.5%)
Married (polygamous)	2 (5.3%)	2 (2.6%)	4 (3.5%)
Separated/divorced/widowed	2 (5.2%)	12 (15.8%)	14 (12.3%)
Never been married[22]	9 (23.7%)	42 (55.2%)	51 (44.8%)
Migrated from a(n)			
Urban area	30 (78.9%)	62 (81.6%)	92 (80.7%)
Rural area	8 (21.1%)	14 (18.4%)	22 (19.3%)
Residence status			
Unbefristet (indefinite residence permission)	9 (23.7%)	25 (32.9%)	34 (29.8%)
Befristet (temporary residence permission)	21 (55.3%)	8 (10.5%)	29 (25.4%)
Duldung (toleration)	1 (2.6%)	20 (26.3%)	21 (18.4%)
Others/no papers/does not answer	4 (10.5%)	17 (21.4%)	21 (18.5%)
German nationality	3 (7.9%)	6 (7.9%)	9 (7.9%)
Time spent in Germany (in months)			
Mean (standard deviation)	111.7 (43.9)	133.0 (54.3)	125.5 (51.7)
Range	36-218	2-276	2-276

The greater part (82%) of the interviewed participants belong to the two biggest ethnic groups living in Guinea: the Fula (35%) and the Malinke (47%).

All female participants confirm that FGM/C is part of the traditions of their ethnic group. The majority of men (91%) declared the same, although seven male participants either refused to answer or said that they didn't know whether or not FGM/C was practiced by their group. The proportion of immigrants for whom FGM/C is part of the family tradition is lower (see table below) whereas women report more often than men the existence of FGM/C in their family. Almost 30% of the men were uncertain about the existence of FGM/C in their family while this was only the case of 11% of the women.

5.5.11.3. Women and girls concerned

Of the 38 women interviewed, 28 claimed to have undergone FGM/C. Six women gave a negative response although the researchers noted doubts regarding the validity of the response for two of these interviewees. The remaining four women participants did not want to answer the question. The woman researcher of Guinean origin who conducted most of the interviews with the Guinean women affirmed that "there are no uncircumcised women in the Guinean community". Exceptions seem to be rare, but can be found if the woman migrates at an early age to Europe as the participant in the testimony below:

> "I escaped from female circumcision because I was badly ill during the time of the year it was done. The year after, I was already in Paris. I was 12 or 13 years at that time and I have been living in Europe ever since. I feel that this practice is a crime." (woman of Guinean origin who migrated to Paris at the age of 13 years)

Based on these findings, it can be assumed that the prevalence rate among women immigrants in Hamburg resembles the prevalence rate of country.

All of the women concerned had undergone FGM/C in Guinea with exception of one woman who was in Cote d'Ivoire at the time the practice was carried out. The age when FGM/C was being carried out varied from 0 to 10 years.

Almost half of the participants (*n* = 53) had at least one daughter. The total number of daughters was 80, of whom

Table 36: Proportion of women and men from groups and families practicing FGM/C (Guinea)

	FGM/C takes place in my ethnic group (%)			FGM/C has been taking place in my family (%)			
	Yes	No	Don't know/ Doesn't answer	Yes	No	Don't know	Doesn't answer
Women (*n* = 38)	100	0	0	76.3	7.9	10.5	5.3
Men (*n* = 76)	90.8	0	9.2	59.2	7.9	28.9	3.9
Total (*n* = 109)	93.9	0	7.1	64.9	7.9	22.8	4.4

63 were living with the interviewed parent in Germany. This number is much higher than the number of officially registered girls in Hamburg (see table 3). Of the 80 daughters, 15 girls had been subjected to FGM/C (¬ 20%); 9 of these girls are living in Germany and the other 6 in Guinea. Their age at the time they had undergone FGM/C varied from 3 to 13 years and all of the girls were in Guinea (and one in Cote d'Ivoire) when the practice was carried out. Most of the girls had been brought to traditional practitioners; however, four fathers responded that they had no information on how FGM/C was being practiced. In fact, some girls were taken for FGM/C by female family members without the consent of the father living in Germany:

> "I wished for my daughter not to be circumcised but my wife and the mother of my wife have already done it. I am here, there was nothing I could do. They told me afterwards that they had already done it." (man of Guinean origin)

The data does not provide any information on how long the girls concerned have been in Germany and whether or not they had already undergone FGM/C when they first arrived in Germany or whether their FGM/C had occurred at a later date during holidays in Guinea.

When the researchers asked the parents of the 65 other girls whether or not they had the intention of having them undergo FGM/C, one woman participant responded that she was determined to subject her daughters to the practice. She explained her reasons and the plan for her nine year old daughter as follows:

> "I was in Guinea this year and wanted to circumcise my third daughter, but I was afraid that she would tell what happened to her back in Germany. So I am waiting a little bit and once she knows and understands that it is dangerous to tell the Germans ...I will circumcise her. The trace of the blade has to be put on her body. That is very important." (woman of Guinean origin)

Ten further participants said that they were uncertain what to do, and six participants refused to answer the question.

After a closer analysis of all critical cases, we integrated four parents with a total of five daughters in the follow-up project. The remaining cases did not need a follow-up. Their daughters were either living in Guinea or were married to a spouse of European origin.

With 20 out of 80 girls either being cut or at risk of being subjected to the practice, the findings indicate that awareness raising and follow-up activities are needed in about 25% of the Guinean families living Hamburg.

5.5.11.4. Perceptions related to the practice

The testimonies of the Guinean participants show that the practice of FGM/C is perceived as part of their identity and closely associated with the status of the woman.

> "It is not we who brought this practice into being and it will not be we either who will end it. It is our tradition, a part of us. God put us into this world and made us part of this culture and tradition and we will respect God's decision and follow this tradition. (woman of Guinean origin)

FGM/C is considered as a necessary stage of suffering in the preparation for womanhood and becoming a strong person. A woman researcher also shared a saying of the ethnic group of the Malinke which illustrates how FGM/C is perceived as an act of submission of the woman to the man. The saying goes as follows: when the man is sexually excited, his penis stands upright. When the woman is sexually excited, it is the same for the clitoris. But as women shall not be standing at the same time as men, they need to have their clitorises cut off.

Many participants of Guinean origin expressed awareness of how the European mentality perceives the practice of FGM/C. But the greater part of the participants interviewed didn't share this perception. Frequently expressed thoughts were:

- "there is no problem with female circumcision",
- "the practice is not as bad as Europeans pretend" or
- "female circumcision is not a crime".

Furthermore, 68% of the women and 60% of the men interviewed associated one or more benefits with the practice. The most commonly named advantages were social acceptance (mentioned by 46%) and the decrease of the sexual desire in the women, facilitating faithfulness (43%).

"The uncircumcised women suffer more often from sexually transmitted diseases. The older generation was faithful, but nowadays the women sleep around and bring home sicknesses. Uncut women taste good, but for a relationship, they are a problem." (man of Guinean origin)

5.5.11.5. FGM/C and religion

For 27% of the men and 16% of the women interviewed, FGM/C was perceived as a practice required by Islam. Although the majority seemed to be aware that FGM/C was not mentioned in the Quran itself, participants felt there was a strong correlation between FGM/C and certain Islamic values (e.g. preservation of virginity).

"This practice is not written in the Quran, but the Quran teaches us that a girl should not touch a man when she is not married, so I think that FM has a religious foundation because the respect for our religion is one of the reasons for doing it." (man of Guinean origin)

The remaining majority of participants perceived FGM/C as a purely cultural and not a religious practice.

"Female circumcision is not good for the woman or society and should be stopped. Globally, it has nothing to do with religion and it is not in the Quran. I have studied the Quran and the prophet does not mention anything about the circumcision of women." (man of Guinean origin)

5.5.11.6. Perception of disadvantages and knowledge of risks and consequences

The awareness of risks and consequences was relatively low. More than half of the women and 67% of the men interviewed were uncertain about negative effects or declared that FGM/C poses no disadvantages. Especially women were likely to insist that the practice was harmless and that the outcome was part of the will of God or of other supernatural powers. This might be linked to the relatively low education level of the Guinean women immigrants. Several women used themselves as examples, pointing out that they never experienced any difficulties after undergoing FGM/C.

"To say that female circumcision has dangerous consequences means not to believe in God. In cultures where it is not practiced, there are also infertile women, infant mortality, pain, problems with the menstrual cycles and so on. It is God who is deciding about that. If there was a case of a girl dying during female circumcision, it means that God meant it to happen. If female circumcision was fatal, there would be no women left in Africa nowadays." (woman of Guinean origin)

"This practice is not as bad as you and the white people think. I, personally, have undergone it and I don't even know when and where, and I never had a problem. Up to today, I never experienced an inconvenience. I think it is the white people who create a drama around the topic, but it is not a bad thing." (woman of Guinean origin)

"I was very lucky because I never had a single problem after undergoing female circumcision, not a single one. It was different for my niece who needed to have surgery afterwards. People said that she was a victim of witchcraft because the cut clitoris started swelling and becoming big. There was nothing that could be done to ease her suffering; they had to bring her for surgery." (woman of Guinean origin)

5.5.11.7. Knowledge of German law and attitudes towards the abandonment of FGM/C

More than 60% of the interviewed Guinean immigrants know that FGM/C is not allowed in Germany. Women are, however, significantly less likely to know about the interdiction (see table below) and over 40% claimed not to be informed about the position of the German legal system towards FGM/C.

Almost half of the interviewed participants showed an attitude in favour of abandonment of the practice. However, almost the same proportion of participants stated that they were uncertain whether or not the practice should continue or that the response to the question depended on various factors. One of the researchers observed:

"They say that they would like to see it stopped, but without their hearts. There is no commitment. I often felt total indifference." (woman researcher of Guinean origin)

Another aspect influencing the attitudes towards the abandonment of FGM/C is the impression that the decision to abandonment the tradition is imposed by outsiders and not left up to those who practice it. Feeling attacked and criticised for what they consider part of their cultural identity, some Guinean immigrants resist the idea of abandoning the practice simply to make a point against European intrusion.

"These people will never stop putting their noses in our business. Female circumcision is our culture; it us practicing it, it is our decision to abandon it when we feel that it is the right time, but for that we don't need any professor." (man of Guinean origin)

"The whites are not like us and you can never become one of them. They have deprived us of our culture and

Table 37: Knowledge of German law and attitudes towards the abandonment of FGM/C (Guinea)

	Legislation % distribution of participants who believe that German law				Attitudes towards abandonment % distribution of participants who believe that FGM/C should			
	Allows FGM/C	Does not allow it	Does not mention it	Don't know	Continue	Be stopped	Depends	Don't know
Sex								
Women	0	47.4	10.5	42.1	2.6	52.6	23.7	21.0
Men	1.4	70.3	5.4	23.0	3.9	47.4	15.8	32.9
Total	0.9	62.6	7.1	29.5	3.5	49.1	18.4	28.9

at the same time they have preserved their own practices. This is why they keep a superior status." (woman of Guinean origin)

5.5.12. Senegal

5.5.12.1. Socio-demographic profile

The Senegalese community in Hamburg is small; there are only 74 men and 39 women. Having no researcher of Senegalese origin in the team, we reached only 23 people during the quantitative survey and only two of them were women. Our sample is therefore far from being representative. The interviewees were all middle aged (between 27 and 47 years) with an average age of 37 years. About one third were married, one third were divorced and one third had never been married. Their level of education varied from 0 to 23 years and more than half of them were working in low wage positions as cleaners or as labourers in restaurants or warehouses. About half of the interviewees came from rural areas.

5.5.12.2. Proportion of immigrant population concerned

According to the DHS finalised in 2005, 28% of the women in Senegal have undergone FGM/C and the rate is almost as high for the cohort of daughters. The practice is very prevalent in the areas of Ziguinchor, Kolda, Tambacounda and Matam where it ranges from 51-94%. It exists to a lesser extent in the regions of Kaolack, St. Louis and Dakar (11-50%) and is not common in the remaining regions (Fatick, Thies, Diourbel and Louga). The ethnic group is also a good marker: the Wolof and the Serer are non-practicing groups while the practice varies from 46-78% in the other groups and is most prevalent in the group of the Soninke, Mandinga, Fula and Diola (Ndiaye and Ayad 2006).

The participants interviewed were from five different ethnic groups: Fula (2), Serer (1), Diola (6), Mandinga (8) and Wolof (6). The presence of practicing families was strong: 17 out of 23 participants stated that FGM/C has been carried out in their family. One of the two women had undergone FGM/C. In the sample of daughters (13 girls), half of them had undergone FGM/C. None of these six girls, however, was living in Germany. No parent declared their intention to subject their daughter(s) to the practice.

5.5.12.3. Perceptions related to the practice

For 16 of the 23 interviewed participants, FGM/C was perceived as an advantageous practice, ensuring the social integration of a woman in the society and guaranteeing her faithfulness once married. Furthermore, three of the participants perceived FGM/C as a religious obligation.

"After this ceremony [of FGM/C], the woman reaches maturity and can be considered a real woman. She attains social power. It is as though she enters the stage of wisdom. It is as though she has endured an initiation to wisdom during the period of female circumcision. That also opens doors for marriage to her. She is well thought of within her community." (man of Senegalese origin)

5.5.12.4. Perception of disadvantages and knowledge of risks and consequences

More than half (13 out of 23) of the participants showed a certain degree of awareness on the dangers of FGM/C and were able to explain one or more effects of the practice. Others insisted that FGM/C was free of negative outcomes with the exceptions of some accidents.

"Like I explained before, there are no disadvantages. When I was still back home, I never saw any disadvantage. I know that this is good in 90% of the cases. But nothing can be perfect. Some isolated cases are work accidents. These isolated cases presenting inconveniences are very rare cases that happen in any profession." (man of Senegalese origin)

"I was explained that after having been circumcised a woman is self-sufficient and faithful. She is satisfied with her husband unlike European women who always want to have sex. The circumcised women can go weeks and

weeks without having sex and are still not complaining." (man of Senegalese origin)

5.5.12.5. Knowledge of German law and attitudes towards the abandonment of FGM/C

The interviewed participants were mostly aware of the law prohibiting the practice of FGM/C. The greater part (16 persons) wanted to see the practice stopped. Participants from practicing groups, however, emphasised that it was very difficult for them to oppose the tradition.

> "This kind of practice is just like hurting somebody. It is a crime. Have you heard positive medical information about it? Never. It's a big risk, but no one can say stop. If you try to be against the practice then you'll be the bad spirit against the tradition." (man of Senegalese origin from a practicing group)

One person advocated FGM/C and six persons were ambiguous in their attitude.

> "I can't speak for others. Personally, I think that female circumcision just like male circumcision is a good thing that needs to continue. Where I come from, I know that people were not forced to do it. It is the women themselves who want it. When the time of year approaches, they ask for it because they see their friends who have already had it done." (man of Senegalese origin)

5.5.13. Guinea Bissau, Liberia and Sierra Leone

We were not successful in interviewing significant proportions of the immigrants from Guinea Bissau, Liberia and Sierra Leone. The researchers completed interviews with nine men and two women from Sierra Leone, with four men from Guinea Bissau and three men and one woman from Liberia. Most of them were from practicing families and the two Sierra Leonian women interviewed had undergone FGM/C. There was no girl who had been subjected to the practice or who was at risk in the small sample of daughters.

5.6. Knowledge, attitudes and practices of communities (with < 100 immigrants)

5.6.1. Niger

The registered Nigerien immigrant community is very small in Hamburg (84 persons) and mainly composed of men (70). Moreover, FGM/C is rare in Niger and according to the last DHS only about 2% of the women (15-49 years of age) have undergone FGM/C. The percentage is even lower in the cohort of daughters (Institut National de la Statistique Niger and Macro International Inc. 2007).

We managed to reach a sample of 42 participants of Nigerien origin, 36 man and 6 women. Two of them were from families were the practice has been carried out, but the large majority had only heard about FGM/C through the media.

> "I have never heard of such a practice. It does not exist in Niger. Or maybe in the group of the Hausa, but I have never seen or heard of it." (man of Nigerien origin)

None of the women interviewed was from a practicing family and none of the participants' daughters had undergone FGM/C. The parents also expressed no intention of subjecting their daughters to the practice. The majority of the participants knew that FGM/C was not allowed in Germany and advocated for its abandonment.

> "It is not good. The woman has no desire for sex and she cannot hold her urine. The man has to work a lot during sex." (man of Nigerien origin)

> "I don't like this practice. It's a tradition and not a religious practice. This thing is not good and it should be stopped." (man of Nigerien origin)

> "I can't imagine that thing [FGM/C] to be done on a young baby or girls. It is an evil practice that women and those who force it upon their girls should be ashamed of; they should be punished. I strongly believe that it is not a religious practice. It is not in the Quran because God could never ask us to do such thing." (woman of Nigerien origin)

5.6.2. Mali

According to official records, the Malians are few in Hamburg: 49 boys/men and 21 girls/women. Despite this small number, we deployed efforts to reach the community as FGM/C is widespread in Mali and more than eight out of ten women are estimated to have undergone FGM/C. In the regions of Kayes, Koulikoro, Sikasso, Segou and the capital Bamako, almost all women have been subjected to the practice. The practice is less common in the three Northern regions (Kidal, Gao and Tomboctou). All ethnic groups practice FGM/C but the extent is considerably lower in the group of the Tamachek and the Sonrai (Cellule de Planification et de Statistique du Ministère de la Santé, Direction Nationale de la Statistique et de l'Informatique du Ministère de l'Économie, de l'Industrie et du Commerce et al. 2006).

A total of 40 immigrants from Mali, 10 women and 30 men, agreed to participate in an interview. They were mainly Muslims between 18 and 45 years of age, with an average age of 35 years. All but four of the participants had roots in practicing ethnic groups and 29 of the 40 participants reported

that FGM/C had been carried out in their family. Half of the women interviewed reported to have undergone FGM/C while three women said they had not. The question was not posed by the researchers to the remaining two women.

The participants claimed to be parents of 18 daughters, 13 of them living in Germany. None of the girls living in Hamburg had undergone FGM/C, but two daughters who had grown up in Mali had been subjected to the practice. According to the responses of the parents, none of the daughters living in Hamburg was at risk.

A minority of seven participants considered FGM/C to be a religious practice. The greater part of the participants (27) were informed that FGM/C was not allowed in Germany and pronounced themselves against its continuation. The remaining 12 persons were ambiguous about whether or not FGM/C should continue. It seemed like they accepted the idea of stopping FGM/C while living in Europe, but that they were in favour of its continuation in their country of origin and some men were quite intimidating towards the researchers.

> "There might be a law prohibiting female circumcision here, but we can still continue our traditions in Africa." (man of Malian origin)

> "My sister, be careful with the interviews. Whatever your tradition is, it is what gives you an identity. And we can never change our traditions. Being circumcised is part of who you are." (man of Malian origin)

Among the women participants, there were two strong advocates for the abandonment of the practice. The first woman comes from a practicing family while the second woman has not undergone FGM/C:

> "Female circumcision must be considered a crime because it makes a woman suffer and can make her unhappy all her life. She suffers from pain during intercourse, from haemorrhage after getting circumcised, and then there are problems at delivery; 90% of obstetrical fistulae are due to female circumcision. It can even cost lives." (woman of Malian origin)

> "Female circumcision is a crime and has to be condemned by all means and the culprits should receive the same judgement as murderers. Their saying that female circumcision reduces the sexual desire of the woman is not based on reality. I have not been circumcised, but I can live more than five years without having sexual intercourse." (woman of Malian origin)

5.6.3. Tanzania

The community from Tanzania is only 42 head strong with an equal proportion of women and men. The FGM/C prevalence for the country is 15%. The practice is most widespread in the Western and Northern regions (Dodoma, Arusha, Singida and Manyara (41-81% prevalence).

We interviewed three women and four men from Tanzania, but none of them were from families in which FGM/C was still practiced. None of them could provide significant information on the topic.

5.6.4. Eritrea, Sudan, Somalia

The immigrants from Eritrea, Sudan and Somalia in Hamburg are few, but have in common that they come from countries with FGM/C prevalence rates above 85%. We reached only 16 participants from these countries as well as one key informant from Eritrea and one from Somalia. The education level of the participants was high (an average of 15 years of formal education).

All but one of the women interviewed had undergone FGM/C. The practice had been carried out in their country of origin by traditional practitioners. The non-circumcised woman was born in Germany and had never been to her country of origin.

The participants had a total of four daughters, but none of them had been subjected to the practice and the parents expressed no intention to do so in the future.

All but one participant were in favour of the abandonment of the practice; only one man from Eritrea reported being unsure as he considered that he did not have enough information on the topic to make a decision.

5.7. Girls at risk in Hamburg

The current section aims at exploring several questions:

- Is FGM/C practiced in Hamburg (and in other parts of Germany)?
- Are girls of African origin who grow up in Hamburg at risk of being subjected to FGM/C outside Germany?
- What are the risk factors and protective factors (factors that help ensure protection) for girls from practicing families?
- Are girls with one European and one African parent (from a practicing family) at risk of being subjected to the practice?

The main part of the data indicate that the answer to the first question is "no". There were only four interviewees who believed or had heard that FGM/C was taking place in Hamburg or other parts of Germany. Three of the interviewees referred to the Nigerian, Somalian and Eritrean communities. The anecdotes provided open doors for speculation, but were unspecific, lacked concrete details and need further investigation:

- Two sources were members of the Nigerian community: one man and one woman reported the possibility that girl infants of Igbo origin are subjected to the practice in Hamburg (see section 5.5.3.3). These cases might include a type IV (non classified) procedure which consists of searing the clitoris and adjacent tissue with a towel soaked in boiling water.
- The other source was a gynaecologist of Eritrean origin who had heard that traditional practitioners of Eritrean and Somalian origin had been flown to Kassel and Frankfurt to carry out FGM/C on daughters within immigrants communities of the two countries.
- The last source was a German gynaecologist who had heard of the existence of two traditional woman practitioners of unknown origin in Berlin.

All the other African key informants were convinced that FGM/C was not carried out in Hamburg or other parts of Germany. Most of them were even surprised by the question and considered it to be something that had never crossed their minds:

> "People from my country? Are they doing here? In this country? I cannot imagine that. Maybe in Africa but not here." (man of Senegalese origin)

But the nonexistence or rarity of FGM/C in Hamburg, does not exclude the possibility that girls of African origin are subjected to the practice of FGM/C outside Germany. The key informants pointed out two possible approaches that might be used by families who intend to have their daughters undergo FGM/C. The first one was to send the daughter back to the country of origin for a stay with the extended family.

> "If you would want to do it while living here, it is better to go back to your country or to go to France and do it there clandestinely. The European media have created a strong fear of going to a doctor here and asking for it. You would have to fear immediately repressive charges. The best solution is to go back to your country and do it there." (key informant of Senegalese origin)

> "If a family wants to circumcise a daughter, they will send her back to Africa. They tell her that she is going to spend the holidays in Africa, to see her grandmother, the grandfather, uncles... the extended African family. Now, if there are cousins who have to go through the same thing, they will make a plan on how to circumcise the girl together with them. If she is of the same age as the other girls, she will simply be obliged to go without asking her opinion. This is how things would be done!" (key informant of Ivorian origin)

The second scenario was to send the girl to another European country, notably to France or Italy. Several sources confided that FGM/C is practiced by communities of Senegalese, Malian, Guinean and Ivorian origin in these two countries. The practicing African communities are well organised and carry out FGM/C in total secrecy. One participant from Guinea, for example, shared the fact that her brother had recently subjected his three daughters to FGM/C in Paris. Others pointed out the existence of traditional practitioners in France.

> "Do it here? That would be difficult. The family would go to Africa with the child or to France. In France, you can find women who take care of that. They have learnt to do it in Mali. In Hamburg, there is no such possibility. The perpetrators are not organised in that sense. There are not many Africans here." (key informant of Ivorian origin)

Although the two approaches were mentioned by numerous key informants, they also pointed out that both scenarios are rather uncommon. First of all, a considerable proportion of immigrants lack the financial means to take their daughters home on holiday. But mostly, they fear that:

- the act could be discovered during medical controls, examinations or treatments,
- the Social Services or teachers could ask for a medical check up after a stay in a home country or that
- the girls could talk about the experience in school or in presence of Germans.

The conclusion among the researchers was that if a girl was sent back to Africa to undergo the practice, then she would probably stay there for a longer period of time than just a holiday season. Incidentally, it is an established practice among African immigrants to send their children – boys and girls alike – for a period of several years to their country of origin to have them receive a traditional African education and to get to know their family and culture. In the course of these prolonged stays, young girls from practicing families are evidently at risk of undergoing FGM/C. The data does not furnish information, however, on how common it is to send girl children for extended stays to Africa for educational reasons.

5.7.1. Protective factors

The findings allowed the identification of several factors that decrease the probability that girls from practicing immigrant families will be subjected to FGM/C.

5.7.1.1. Fear of sanctions

We learnt from the findings presented throughout section 5.4 that the majority of African immigrants is aware that FGM/C is punishable in Germany. The fear of repression is one of the factors that dissuade immigrants from continuing the practice of FGM/C and that have a protective effect on girls from practicing families.

> "No one would practice this in Hamburg. No one would dare to bring this over here, due to the strict laws and their application. The fear of the police and the law are ways too big for that. What is more, the rites are much too complex and time-consuming to practice in Germany." (Key informant of Beninese origin)

5.7.1.2. Profile of the immigrants

A comparative analysis from UNICEF showed that those supporting the continuation of the practice are more often women with no education than those who have been to school. The same analysis also illustrated that residents of urban areas are less likely to favour continuing the practice of FGM/C than women living in rural areas (UNICEF 2005). The findings of the current study revealed that the greater part of African immigrants is educated and from urban areas. In fact, almost 80% of the interviewees in the quantitative survey had at least 10 years of formal education which is far above the national average of Sub-Saharan countries, and the majority was from urban areas. It can be assumed that the high level of education and the high proportion of urban residents among African immigrants lower the risk for girls growing up in Hamburg.

> "I have never ever heard of an Ethiopian family who practiced it here or while on a trip back home. I think there might be some women out there who went through the practice in their childhood back home, years before they come here. But I don't think that there are practicing immigrants here as most of them are educated or from urban areas." (key informant of Ethiopian origin)

5.7.1.3. Absence of the societal setting embedding FGM/C

The tradition of FGM/C is perceived as advantageous and mandatory as long as a person evolves in the settings of a practicing society. As soon as an African migrant arrives in Germany, this setting disappears or is at least strongly modified. Without the societal context that embeds FGM/C in Africa, many immigrants become receptive to the abandonment of the practice.

> "As far as I know, there is no Eritrean who lives in Hamburg who practices FGM. Don't get me wrong. There might be some people who practice it when they go home. But to the best of my knowledge, there is no one who does it. Why? This is not Eritrea." (key informant of Eritrean origin)

> "I regret that I am not able to circumcise my only daughter because she was born here and will grow up here. She will only know the life here. I am not afraid to be punished for circumcising her, but I am afraid that my daughter would be unable to understand the sense of this traditional practice. But in general the practice should continue, for the good of women and society." (man from a practicing group in Togo)

For the immigrants of most Sub-Saharan countries, a significant piece of the puzzle in the practice of FGM/C is the availability of traditional practitioners who are the bearers of the knowledge regarding FGM/C. Interviewees declared that it was impossible to carry out the practice in Hamburg due to the absence of these key actors.

"They can't do it here because you need a woman who is used to doing it. For example, you could also not ask just anyone to shave the baby's head.[30] You need a traditional woman practitioner and where could you find one? Pay the money for a round trip to bring one over here just for that? I don't believe that. Maybe some would use the occasion of home travels to circumcise their girls." (key informant of Ivorian origin)

5.7.2. Risk factors

While there are factors which decrease the probability that a girl of African origin will be subjected to FGM/C, there are also factors that raise the risk. This is what we treat as 'risk factors'. The data analysis enabled us to identify four major risk factors.

5.7.2.1. A large and badly integrated immigrant community

The first major risk factor for a girl is to grow up in large immigrant community that exists in a state of segregation from the host society. Key informants described that practicing FGM/C was feasible in France because the communities are large enough to recreate the setting of their traditional

30 The key informant is referring to religious practice of Muslims which consists of shaving the head of the new born during the day of baptism on the 7th day after birth.

society and to seclude themselves from the host society. According to them, all Africans had heard about the court cases in France in which practitioners of FGM/C were condemned to prison. Besides, the French integration politics of the past decade have worsened the living situation of many African immigrants and made them feel rejected and unwelcome. As a consequence, a parallel society has emerged in certain big cities of France in which African stick to each other and find ways of practicing their traditions, including FGM/C, without being reached by the law.

A key reason for the non-existence of FGM/C in Hamburg is, thus, the small size of the immigrant communities: the smaller a community is, the less likely it becomes isolated from the rest of the society. Some key informants concluded that FGM/C is not taking place in Germany yet. If the communities started to grow and if their level of integration decreased, the same phenomenon as in France would commence: once one family starts, others will follow.

> "It is also a matter of integration. As long as people stay isolated among themselves, there is a possibility that doors will be opened for practicing FGM/C. We as Africans, we try to open up to the Europeans, but they don't grant us access to their society. Their world is closed to us. That makes people think: 'We are not respected. It is better to stick to our own people.' So we stay among ourselves and this type of idea flourishes. If one person tries to circumcise a girl and it works out, it will encourage others to follow and do the same. I think if people feel accepted and when they are integrated, they can find the strength to let go of their traditions. But everywhere where the community is closed to the outside world, it [FGM/C] can always happen. This is what we have observed in France. There [in France], the Africans have decided 'let's keep our culture, let's practice female circumcision' and it works out. (key informant of Ivorian origin)

5.7.2.2. No culture of denunciation

Key informants also affirm that the respect for traditions and the rule not to interfere in family matters make it extremely unlikely that a member of the African community would report a case to the German authorities. Any African handing over private information about another African family to the Germans would risk severe sanctions in his/her own community. This is why even strong opponents among the immigrants of FGM/C would not consider denouncing a family who is planning to subject a daughter to FGM/C. This attitude puts girls at risk of being subjected to the practice.

> "Tradition is something very important. That is why no one could simply prohibit a tradition. Generally, the Ghanaians are against it [FGM/C]. But no one would interfere either. Even here in Germany, no one would dare to put their oar in other people's traditions. Even if Ghanaians were informed about a planned circumcision of a girl, no one would denounce it to the Jugendamt [Social Affairs] or the police. A family trying to interfere could be in great danger. Interfering is taboo." (key information from a non-practicing community in Ghana)

5.7.2.3. Perceived sexual debauchery and immorality of women in Europe

As described in sub-section 5.4, many immigrants consider the decrease of promiscuous behaviour in women as a benefit of FGM/C. The preservation of virginity before marriage and of faithfulness during wedlock are crucial to most African Muslim immigrants – men and women alike. Upon arrival in Germany, the immigrants start observing and experiencing the attitudes and sexual practices of women in Europe. Many of the Muslim participants perceive that girls in Europe become involved in sexual activities too early and that most European women are unfaithful and promiscuous. When comparing the sexual practices in Europe with those of their country of origin, a lot of men jump to the conclusion that girls and women who have undergone FGM/C are less likely to display sexually debauched behaviour. When the immigrants experience the sexual practices of European women, some tend to believe even more firmly in traditions, including FGM/C, than they did before coming to Europe.

> "When you look at life in Europe and how girls behave. People start having sex early. That really makes you think and it makes me sceptical.[...]. I am 80% against female circumcision, but 20% of me is in favour of it. Because when you look at the women here, you see that they don't respect anything. It is total debauchery everywhere. That really makes you think about how Europeans think about sex..." (man, Muslim, of Ivorian origin)

> "Personally, I think this practice has to stop. But while I think it necessary to be stopped, I am asking myself how we could protect our African values and have women who are not promiscuous. It is very important to every family that the daughters not engage in immoral behaviour." (man, Muslim, of Ivorian origin)

> "Who would not wish the greatest honour for his family which lies in the virginity of the daughter? That is honour for us! The virginity of our girls and the faithfulness of our women.[...]. And we have seen that circumcised women don't commit adultery. At least not as often as non-circumcised women." (key informant of Ivorian origin)

5.7.2.4. Low awareness and indifference of men

Among the main practicing groups in francophone West African countries, namely the Mandinga, Malinke, Bambara, Dioula and the Fula, FGM/C is considered to be "women's business". Fathers are often not consulted before a girl is subjected to the practice and the act is only communicated to them afterwards.

> "... it depends on the family [who decides on how to circumcise the daughter]. The father is often not informed. It is done by the grandmother who informs only the mother without considering the opinion of the girl." (key informant and Dioula of Ivorian origin)

The findings from section 5.4 illustrate that a solid proportion of men perceive FGM/C as an advantageous practice and/or that they have little or no knowledge of how the practice is carried out and what negative outcomes can derive from it. As a consequence, they don't take sufficient precautions to protect their daughters even if they are personally not interested in seeing the practice continue. Within practicing families, fathers who have poor knowledge of FGM/C and an indifferent attitude towards it can be considered a risk factor for daughters even when these fathers have no personal intention of subjecting their daughter to the practice.

> "It is women's business. My two daughters were circumcised without my being informed. It was only when it was done that I was told. My position is that this practice should be abandoned." (man of Burkinabe origin)

> "I wished for my daughter not to be circumcised, but my wife [living in Guinea] and her mother have already done it. I am here; there is nothing I could have done. They only told me after they had already gone ahead with the act." (man of Guinean origin)

5.7.3. Are girls of half African and half European origin at risk of being subjected to FGM/C?

The findings revealed that girl children of "mixed couples" are generally not at risk of being subjected to FGM/C. During the data collection, two profiles of immigrants living in a relationship with a European partner appeared:

- The highly integrated immigrants, often intellectuals, who are in most cases married to European women of the same intellectual background. They consider traditional practices such as FGM/C to be harmful and protect their daughter effectively from it even if their extended family members in Africa continue it. Their daughters are not at risk.
- The rather poorly integrated migrants, often with no profession, who engage in a relationship with a German partner frequently with the motive of obtaining a residence permit. The risk for their daughters can be considered quasi non-existent as well. Even if the African parent is in favour of the practice, he or she is usually aware that the European partner would not accept it and instead report the case to the police. This could endanger the status of the residence permit of the African parent and at the same time the support given to his or her family in the country of origin. As most immigrants constitute one of the principal sources of income for their families in Africa, they cannot put their residence status at stake. One researcher put it in very simple words "Papers are always more important than traditions". By the same token, it is unlikely that immigrants would take the risk of loosing their children by committing an act considered a crime in the host country.

  > "They [the daughters of mixed couples] would not be at risk: not here or elsewhere. They will not do it due to the fear of losing their children. Africans, the way I know them, will do and agree to anything in order not to lose contact with their children. Even when some, very few of them, still believe in it, as long as they are in a mixed relationship, they will never try it." (woman researcher of Nigerian origin)

- Another aspect of the mixed couple dynamic is that most children with one African parent are habitually raised as Germans. They grow up totally detached from their African origins. Another researcher summed up her observations as follows:

  > "Most of these mixed couples actually come together because of immigration issues. The children born as a result of these relationships or marriages are automatically regarded as Germans and not as Africans or half Africans. So the African culture and traditions do not affect them at all. Very few parents actually allow their daughters to have contact with people in Africa, so they rarely go to Africa and this means less risk for them." (woman researcher of Kenyan origin)

The interviews with several participants of half African/half European origin confirmed these observations. All of them showed interest in the African culture and their origins, but perceived themselves to be Germans and had learnt about FGM/C through the media or the book by Waris Dirie. Just like any other German, they perceived FGM/C as a violent practice that has no reason for being.

The exception to the rule: a case description

One researcher shared an experience that showed that an element of risk can remain for girls of half African origin. He interviewed a man from Benin who said he was married to a German woman. The latter has two daughters by different fathers from previous relationships. One of the daughters has a Guinean and the other an Ivorian father. The Beninese participant explained that the Guinean father had planned to send his daughter to Guinea on holiday. While this was being arranged, the Beninese companion was approached by another Guinean immigrant who advised him to put a stop to the project as the daughter might be at risk of participating in traditional practices. The Beninese man, himself from a non-practicing group, did not understand what the man was alluding to. During the interview, he shared the story with the researcher who explained to him that the girl might be at risk of FGM/C. The Beninese participant informed the mother and the she vetoed her daughter's trip to Guinea.

5.8. Suggestions from participants on how the abolition of the practice could be promoted among immigrant communities in Hamburg

Many key informants and participants could not think of any suggestions that would be useful in the German context. As they did not believe that FGM/C was practiced within immigrant communities in Germany, they recommended that the work be focused entirely on the African continent. The view was often expressed, too, that immigrants were in need of help regarding more urgent issues (e.g. work permission, residence status). Others, however, provided a variety of strategies that are outlined in the following paragraphs.

5.8.1. Finding the right entry point to communities

In order to be able to reach the communities of practicing origins and to communicate a message, getting a foot in the door is crucial. The key African informants recommended two door-opening strategies:

- One element in the door-opening strategy can be a person who is recognised and well known to the community concerned. Ideally, this person is from the same or a close ethnic group and comes from a family with the same traditions and language as the targeted family. Women who have undergone FGM/C but decided to break with the tradition are particularly strong agents of change. In order to be listened to this person must not be too young and inexperienced. It is also important that the person not be perceived as too "Germanised". This should be someone who respects and adheres to traditional African values.

  "The success of the approach varies, but most of the time I succeeded by showing or letting them know that I am part of their culture." (woman researcher explaining how people opened up during the interview)

- Another entry point is through the country associations. There is at least one and sometimes several immigrant associations for most Sub-Saharan countries. They represent the network and platforms for immigrants from a given country. The members of these associations meet on a regular basis and organise cultural and other activities. In order to start working with the communities, it was suggested that the representatives of these organisations be contacted and that opportunities for collaboration be explored.

  "Personally, I think that we can reach the target groups by contacting the focal points of the communities concerned. Among the Beninese, for example, you could involve the representatives of the association of Beninese from the North. This topic concerns them the most. The people from the South don't know this tradition." (researcher of Beninese origin)

5.8.2. Conduct awareness raising and discussion sessions

The most common recommendation was to conduct awareness raising on

- The risk and consequences of FGM/C (medically, psychologically, sexually),
- The position of Islam and Christianity on the practice,
- The perception of FGM/C as a crime to be punished severely within the German legal system.
- Activities and trends regarding FGM/C around the globe (progress in different countries and global movements).

The participants emphasised that the content of the awareness-raising discussions had to be adapted to the beliefs and practices of the targeted community. While awareness raising was recommended, participants often highlighted the importance of transferring information without judgement or pressure:

"Let the women who practice this [FGM/C] know the advantages and the disadvantages. But let us not decide for the people what is good and what is bad. Let's listen to the opinion of people. No one should be forced to do it or not to do it." (man of Sierra Leonean origin)

Furthermore, participants suggested establishing platforms for discussing traditions in general. In order to enable people to question the positive aspects of FGM/C, there is a need to exchange and elaborate on culture and identity in the context of immigration.

"The problem of female circumcision is complex. We need to sit down together as Africans and look at our culture. There is need to determine what needs to be preserved, what is good and what is bad. We have to make the decision which parts of our culture we want to leave behind. There has to be a reflection on the advantages and disadvantages." (man of Gambian origin)

5.8.2.1. Inclusion of major stakeholders

Successful awareness raising includes the implication of different stakeholders. The recommended parties to involve in activities were:

- Health care workers: paediatricians, midwives, gynaecologists and social workers in contact with immigrants,
- Existing migrant projects (such as MIMI, the Aids-Hilfe, Adefra),
- African entrepreneurs,
- Representatives of African associations (women groups, cultural groups etc.) and
- Religious leaders (imams, priests and pastors).

5.8.2.2. Adopt a gender-sensitive approach

The participants also emphasised the need to adopt different strategies when approaching men and women. As FGM/C is a very sensitive topic that is associated with very intimate details, it was recommended that men's and women's groups be worked with separately during activities related to FGM/C. Furthermore, immigrant women are more difficult to mobilise for group activities and should be encouraged to participate in activities over a long period of time. Men, on the other hand, can be easily brought together for sporadic activities.

"Another suggestion would be, when you discuss questions of an intimate nature, that you work separately with men and women and to have women work with women and men work with men." (man of Beninese origin)

"Women need a long-term project and awareness-raising program. Men are more flexible." (woman of Kenyan origin)

5.8.2.3. Work with groups and not with individuals

Several participants also recommended that we focus on group activities rather than on sensitising individuals. As a social convention, the abolition of FGM/C demands a change in social values and behaviour. Such changes are possible only if the group as a whole starts to question the convention and to decide to abandon it.

"How to encourage abandoning it? [...] the focus should be on the community and not an individual family. Mostly, at least to the society I came from, tradition is the constitution. Everybody abides by that constitution. Therefore, it is good to focus on the general public rather than on an individual. One may invest much time and resources to convince a single family. But it might seem that that individual family is convinced and has expressed its willingness to abandont a practice. But as long as that family is within its society, it has no chance of abandoning the practice that it was advised to stop. Impossible! So the first mechanism should be to focus on the group rather than on the individual." (man, key informant of Ethiopian origin)

5.8.2.4. Use traditional resources of the practicing society

One participant from Ethiopia also suggested that we modify the traditional sayings and legends of their community. These folklores are perceived as traditional laws and cannot be disrespected. He suggested that the folklore encouraging FGM/C should be rewritten and disseminated as counter-sayings to FGM/C.

"The second suggestion is that you produce counter folklore which challenges the current folklore that justifies the practice. When I talk to German friends, they don't understand how folklore should be so important to us. They are unwritten laws everybody should abide by. I knew a lot of folklore justifying the importance of FGM. This folklore should be collected and then counter-folklore produced and carefully injected into the society. The new folklore can later become the unwritten laws to followed." (man, key informant of Ethiopian origin)

5.8.2.5. Communication channels

Some participants suggested that we make use of media that is commonly used by Africans to communicate messages. We were advised, for instance, to post information on web pages or radio channels of specific African countries or to publish information in printed media like the journal "Jeune Afrique" (for more details on media preferences of African communities, see section 5.10). Other ideas were to spread messages via common meeting sites of African immigrants such as Afro Shops, hair dressing saloons and African restaurants.

5.8.3. Provide assistance to women and men who need help with problems related to FGM/C

Assisting women and men affected by the harmful effects of FGM/C was also recommended as a strategy to promote the abandonment of FGM/C. Social workers or gynaecologists

with roots in practicing groups could offer support in the form of of consultation hours.

5.9. Perceptions and practices regarding health care practices of African women immigrants

This section is structured in two parts. The first paragraph outlines the perceptions and practices as reported by African women immigrants. The second paragraph describes the perspectives of the gynaecologists interviewed.

5.9.1. Perceptions and practices of African women immigrants

Very few women described (reproductive) health and sexual problems that they associated with FGM/C. One of the exceptions was a woman from Eritrea, who stated, for example, that it was very painful for her to have a union with her husband and that she suffered from recurrent infections that she believed to be associated with the FGM/C she had undergone. A small number of women explained that they experienced sexual intercourse as frustrating as it did not give them feelings of satisfaction or that the partner had to "work hard and for a long time" to get them sexually aroused. A few women also described that they had little or no interest in sex which was, however, not necessarily experienced as a negative.

When asked about reproductive health care practices, all key informants from the African community said that they either consult a gynaecologists or go to a hospital. The main reason for visiting a gynaecologist was pregnancy. Some also cited reasons such as bladder infections or problems conceiving. Preventive care was cited only rarely.

Their experiences with reproductive health care providers were two-fold. Some women reported satisfaction with the services and expressed trust in their doctors. Others felt that the health care workers took little time to listen to them and to explain the rationale of treatments.

Several women who had undergone FGM/C felt that the topic was dealt with inappropriately. As a consequence, they changed the doctor – sometimes several times – and often looked for gynaecologists of non-European origin. One reason was the experience of curious or pitying reactions of German health care workers. One participant of Burkinabe origin described, for instance, that a German gynaecologist (a woman) looked at her with so much pity and irritation after the physical examination that she felt for the first time in her life that she was not normal. The gynaecologist did not address the issue of FGM/C, but the women felt that she was treated like a victim who could not be talked to rationally. The participant decided after the treatment to abstain from consulting German doctors. Other women reported the lack of knowledge among German doctors about FGM/C. They described that their gynaecologists were only aware of the most extreme form of FGM/C (infibulation) and did not deal appropriately with less invasive types. A woman of Ethiopian origin described how her gynaecologist did not see that she had undergone FGM/C, but told her that she was lucky to have been spared from the practice:

> "I want to tell you my experience in Hamburg. The gynaecologist who is my doctor told me after her physical examination that I am lucky since I am not circumcised. I was surprised but I didn't dare tell her that I was circumcised. I think there is a misunderstanding about female circumcision. Most people know the film or the book entitled Desert Flower or Wüstenblume. I think this has misled them. What is common in Ethiopia is not the one [form] mentioned in the book. Sewing or stitching the vagina after circumcision and not to let the child move for a certain number of days is not common in Ethiopia. I think the doctor referred to this type of circumcision. Yes, I am lucky I did not have such an experience." (woman of Ethiopia origin)

5.9.2. Experiences of gynaecologists with African women immigrants

Among the six interviewed gynaecologists, four claimed to have encountered few or no direct experiences with women who had undergone FGM/C. One of them was Dr. med Cornelia Goesmann[31] who, in collaboration with Prof. Dr. med. Heribert Kentenich, published the recommendations of the German Medical Association on how to treat women who have undergone FGM/C. She reported that all efforts to gain access to the African community in Niedersachsen had been without success and that she had never treated a woman who had undergone FGM/C. Her conclusion was that African female immigrants from practicing countries probably consult their own doctors and avoid German gynaecologists. One other gynaecologist (also of German origin) had never been in contact with women who had undergone FGM/C despite having participated in a training seminar on FGM/C. Two other gynaecologists claimed to have been consulted by a small number of affected women:

- The first, a German gynaecologist, reported to have provided services to two Ethiopian women who had undergone FGM/C and
- The second, a gynaecologist of Iranian origin, had many African patients, but had only met six women affected by FGM/C (also mostly from Ethiopia) over more than two decades of practicing her profession. She had helped one woman who suffered from complications due to an infibulation. The other five women had undergone type I or II and had no complications. She reported that African women rarely come for preventive care visits.

The two remaining gynaecologists had more substantial information to provide. One of them was of Eritrean origin. She had for a couple of years run an FGM/C-consultation at the University clinic of Hamburg, and had later worked as a senior physician in the delivery ward of a hospital in Hamburg. She confirmed the fact that some gynaecologists might not be able to recognise type I and II forms of FGM/C due to lack of training and the variable physics of the vagina. According to her, determining the status was more like a puzzle in which certain signs as well as the country of origin can point to a conclusion. She had assisted several women in the scope of her FGM-consultation hour who came with urinary tract and vaginal infections as well as sexual problems. There were also a few cases of infibulated women who were pregnant and needed to be advised on how to give birth; they either wanted to deliver with a C-section or asked to be reinfibulated. The patient had a significant need for counselling and advice during the FGM/C consultation hour, but the offer for free consultation was terminated after a certain period. During her time at the delivery ward, she gathered further experience assisting women who had undergone FGM/C, notably cases of tearing during childbirth that required closure by suture. She trained the medical staff in the hospital on FGM/C and prepared and advised the women concerned during their pregnancy.

She was also contacted three times by teachers who suspected that one of their students had been subjected to FGM/C over the holidays. All three girls were of Eritrean origin. Control examinations revealed that the girls had not undergone FGM/C.

The second gynaecologist was of German origin and employed by the Familienplannungszentrum [Family Planning Centre], an institution providing reproductive health care to immigrants and other beneficiaries without health care coverage. There is a strong demand for the institution's services. It is consulted by about 350 African immigrant women per year, of whom approximately one third have undergone FGM/C. The women concerned are mainly from West African countries, e.g. Cote d'Ivoire, Togo, Nigeria, Benin, Burkina Faso and Sierra Leone. Despite the high rate of women with FGM/C, they registered only two cases of infibulation. Most women have undergone type I or type II forms and the institution has rarely seen complications associated with the practice. The gynaecologist interviewed estimated that they situations involving medical complications linked to FGM/C, such as extremely rare forms of scarification that hinder the process of delivery, are encountered on average once a year. She had never been informed about FGM/C being practiced in Germany, though she knew there was hearsay that there were two traditional women practitioners in Berlin.

She noted that the women with unclear residence status were under heavy pressure to remain invisible and to get their lives in Germany organised. Many of them wish to have children. Her conclusion was that the women have other problems and priorities than FGM/C. She also emphasised that the institution had limited time for each patients. Communication problems arise from time to time due to language barriers. There is not always time to build up a relationship of trust with the patients. Her impression of the training seminars from the Berufsverband der Frauenärzte [professional association for gynaecologists] was that there is more focus on demonising the practice than on teaching an appropriate and sensitive approach to dealing with the feelings and needs of the women concerned.

Both gynaecologists confirmed the impression that African women immigrants usually consulted them only when they were pregnant or when they had acute symptoms. Preventive care visits are rare and mostly limited to women with a high level of education and integration.

5.10. Media preferences and information networks of immigrant communities from Sub-Saharan Africa in Hamburg

We asked all key informants what means and places the African immigrants use to become informed about what is going on and which media they use the most. Not a single key informant named the German media as a source of information.

In terms of media, the key informants stated the following preferences:

- **Internet:** When using the internet for information updates, many immigrants consult web pages of their country of origin such as www.seneweb.com (Senegal), www.icilome.com (Togo), www.ghanaweb.com (Ghana) or www.abidjan.net for immigrants from Cote d'Ivoire.
- **Television:** Preferred television choices are international news channels (BBC, Al Jazeera, TV5), African channels (e.g. Africable) or the national channels of their countries of origin (for example RTS for Senegal/Gambia, RTI for Cote d'Ivoire).
- **Radio:** As with television, the preferences are either for international channels (BBC or RFI) or for Africa-based radio stations (Africa Nr. 1).

The remaining information sources are places of public or private gathering. Information is mostly disseminated by word of mouth. Important meeting places are the Afro

31 Vice-president of the "Bundesärztekammer" [German Medical Association]

Shops: they are the hubs of information exchange to which most Africans go several times a week. Beyond that, the most significant such places are the church and the mosque, betting agencies, hairdressers and barber shops. Traders also use business premises as a source of information exchange. Other occasions for getting the latest are the preparation for and attendance at traditional gatherings (such as baptisms, weddings and funerals), political meetings and soccer games. The phone is also mentioned as an important tool for communication and it is not rare to find an African immigrant with several cell phones at hand. Among the younger generation, information is also diffused in night clubs and bars.

The above-listed information channels are important to keep in mind when planning activities with the immigrant communities.

5.11. Meetings with institutions working with African immigrant communities in Hamburg

During the implementation of the research, we talked with the representatives of different institutions offering support to immigrants in Hamburg.[32] The list below provides an overview of the institutions visited and the outcome of the meetings.

- **Flüchtlingszentrum:** The Centre for Refugees offers advisory services to refugees. They had never been consulted for an issue related to FGM/C and had never heard about the existence of the practice in immigrant communities.
- **Fluchtpunkt:** Fluchtpunkt is a contact centre for immigrants and provides legal support and referral services for social and medical matters to refugees and immigrants. The representative from Fluchtpunkt said that immigrants from Africa come for support but in low numbers relative to other immigrant communities. The representative also said that Fluchtpunkt had provided advise during the court cases of a small number of women from Nigeria and Burkina Faso who had received asylum in Germany as a result of having been subjected to FGM/C in their countries of origin. The institution had no information on FGM/C being practiced by immigrant communities in Hamburg.
- **Café Exil:** a drop-in centre opposite the Ausländerbehörde (registration office for foreign nationals) that provides advice to immigrants and chaperonage for visits to the authorities. The representative of the Café was not aware that the initiative had ever had to deal with a case related to FGM/C and had no information to share regarding the issue.
- **Interkulturelle Begegnungsstätte (IKB) Eimbüttel, In Via (Harburg) and Verikom (Altona):** these three institutions offer advice and support to female immigrants from all over the world. They offer various services including language and computer classes as well as integration courses to facilitate adaptation to life in Germany. They organise cultural events and collaborate/network with institutions working in the same domains. More detailed information is available at www.ikb-integrationszentrum.de and www.verikom.de. We learnt that none of the institutions had ever been confronted with the topic of FGM/C. The IKB has established close collaboration with a Malian women's association and offers support to victims of sexual violence within the scope of a project implemented jointly with other organisations. All three institutions expressed interest in collaborating on future activities involving African immigrants on the subject of FGM/C.
- **Mit Migranten für Migranten (MIMI):** The project MIMI aims at increasing the knowledge of immigrants on health issues and the use of the German health services. Their approach is to train immigrants as peer educators on different health topics who disseminate the information in their communities during awareness-raising events. The representative of the project expressed interest in discussing the possibility of integrating a module on FGM/C in their training program for African peer educators.
- **AIDS-Hilfe:** the institution is committed to HIV prevention and the support of people living with HIV. They implement a large range of activities (see www.aidshilfe-hamburg.de) including a special project targeting migrants working through Gesundheitsbotschafter [health ambassadors] with an approach involving peer education and capacity building similar to the one used by MIMI. Their focal point, a man of Burkinabe origin, reported that they had never been consulted on the issue of FGM/C, but he showed interest in networking and joint activities.
- **Familienplanungszentrum:** the family planning centre assists women without residence permits in the domains of preventive care during pregnancy and gynaecological problems. The institution is struggling to handle the strong demand for their services. They treat around 350 African women per annum and reported that one out of three women coming for consultation had undergone FGM/C.

The institutions consulted in Hamburg showed interest in the FGM/C project and some of them wanted to be involved in future collaborations, but – with the exception of the Familienplanungszentrum – they had little information to share regarding the research topic. Most organisation representatives emphasised that the African communities and African women in particular were more difficult to reach than the other immigrant populations (such as Russians or Afghans).

32 We tried in vain to organise a meeting with the representative of the Africa Club.

6 Synthesis of Results and Conclusions

6.1. What do immigrants from Sub-Saharan Africa think about FGM/C? Are they in favour of it or against it?

Based on the findings, two groups of immigrants from FGM/C practicing countries emerge:

1. Immigrants from non-practicing groups and/or non-practicing families: The results indicate that more than half of the immigrants from Sub-Saharan Africa belong to this category. The tradition of FGM/C is not part of their social conventions. Most of them reject the practice in the same way as Europeans do: some find it shocking and cruel, others uncivilised. Especially among immigrants from younger generations, the perceptions of FGM/C are often more influenced by the media than by first-hand encounters with members of practicing groups. The findings also revealed a small but considerable proportion of men and women in this category who have tolerant attitudes towards FGM/C. They do not want to interfere with what they perceive as other people's traditions. They feel that other people have a right to maintain their traditions and that FGM/C should not be abolished on the ground that the "Western world" is demanding it. This category includes a small fraction of immigrants who have never heard of FGM/C or who have only fragmentary information on the issue.

2. Immigrants with roots in practicing families: the findings indicate that about 40% of the immigrants are from families who belong to communities that practice FGM/C. Many of them have grown up in communities where FGM/C is considered a normal or positive part of coming of age for girls. They carry positive and negative memories related to FGM/C and have assimilated values justifying and supporting the practice. Over the course of their education and migration most of them have come to realise that FGM/C bears risks and consequences and that carrying it out is considered harmful by many people. Upon their arrival in Germany, they become orphans of their communities of origin and the context in which FGM/C is favoured disappears. They are exposed to new values and ways of live. Many factors determine the evolution of their attitudes towards FGM/C: their education level, their experiences with the host community, their process of integration, the level of organisation of the immigrant community of their country of origin and the profile of their spouse are just a few examples. This category also includes a small number of immigrants, mostly men, who are uncertain whether FGM/C (still) takes places in their family.

No matter what category we are looking at, most immigrants from all Sub-Saharan countries are against the continuation of FGM/C. The findings of the research bring to light the fact that most immigrants have adopted a disapproving attitude towards the practice. Nevertheless, in each of the communities there is a minority of supporters. The size of this minority varies: it is very small in some communities (e.g. Cameroon and Kenya), fairly large in some West African communities, notably Togo, Guinea and Nigeria.

Who are the strongest supporters of FGM/C?

The profile of the strongest supporters of FGM/C can be narrowed down to two characteristics: they are men and Muslims. The large majority of them have graduated from secondary school, but have no qualifictions for any particular profession. The supporters are found across all age groups and religious affiliations, but are most likely to be Muslims. The proportion of single and married persons is also about equal.

Moreover, all immigrant communities have a fraction of immigrants who have ambiguous feelings towards FGM/C: they haven't decided whether FGM/C should be abandoned or condoned. This group is mostly made of silent supporters, indifferent outsiders and all those who are still weighing the pro's and con's, who are still embracing the principal values of their community of origin, and who are still gathering and evaluating information on FGM/C. The size of these fractions varies from one community to the next:

- The fraction is rather small (≤ 10%) in communities from Ghana, Cameroon and Ethiopia.
- It is moderate (≤ 20%) in communities from Togo, Cote d'Ivoire, Nigeria and Burkina Faso.
- It constitutes about 40% of the immigrant population in communities from The Gambia and Guinea.

6.1.1. How important is FGM/C for African immigrants living in Hamburg?

The practice of FGM/C does not play an important role in the lives of immigrants in Hamburg. It is not a priority issue to them. No matter what their attitude toward FGM/C, it ranks lowest in a long list of topics of importance to them. It does not cause a lot of thought or worry and it is hardly ever discussed. The findings illustrate clearly that the lives of African immigrants are focused on other things: obtaining a residence and work permit, finding accommodation

and an acceptable job, uniting the family or getting married and having children. Moreover, most of them are exposed to immense pressure to be successful and to provide financial support to the family left behind.

Furthermore, African immigrants quickly become part of the network of their country of origin. This network becomes their new community; this is where they find familiar practices, acceptance and support. As a minority, they are confronted with considerable challenges during the integration process. Their encounters and experiences with the host society are often marked by discrimination and misunderstandings. This opens doors to negative emotions: feeling disrespected, rejected, sad, angry or fearful about their future. The willingness to integrate and to accept the values of the host society decreases; at the same time identification with African values and customs becomes more intense.

The defence or support of conservative traditions is often a reaction to the perceived rejection of the host society. When immigrants perceive an "attack" against African values or traditions by Europeans, they retaliate in order to protect themselves – not because they are in favour of the tradition, but to reject the interference from the unwelcoming host society. Immigrants from practicing families might be personally against FGM/C and provide effective protection to their daughters. But when seeing FGM/C condemned by Europeans, they start making tolerant or even positive remarks about the practice. This can be for various motives:

- They don't believe that Europeans understand the nature and cultural values attached to the practice;
- They believe that the aim of Europeans is to destroy and dominate African culture;
- They feel stigmatised and discriminated against or see the condemnation as another attempt to discriminate against Africans by focalising once more on a negative aspect of African culture.

Thus, immigrants can tend to become silent or open supporters of FGM/C because the practice is criticised by Europeans. The position advocating the preservation of harmful traditional practices including FGM/C is often used simply to make a case against Europeans who they feel are imposing their own culture and control on Africans. In the context of this dynamic, there are many immigrants who consider FGM/C to be harmful or simply "useless" or "backward", but it is not an issue that they would advocate against. Furthermore, the findings indicate a trend among some West African immigrants to become more conservative and centred on traditional values after their arrival in Europe. One woman researcher resumed

> "They start living traditional values that they didn't even believe in or follow when they were still in Africa."

By the same token, their attitudes towards FGM/C become more indulgent.

These results speak against a leading role of Europeans in the interventions against FGM/C. Their involvement might only inject more fuel into the polemical discussions on power dynamics between Africa and the Western World.

6.2. What positive outcomes do people associate with FGM/C and how common are these perceptions?

The majority of immigrants from practicing families associates one or several advantages with FGM/C. One important point is social acceptance: those adhering to the tradition occupy a different status within practicing societies, including benefits such as better marriage prospects and increased influence in community decisions. Further perceived advantages are linked to the fundamental values of many African societies: the preservation of virginity until marriage and the faithfulness of women to their husbands. Many immigrants, men and women alike, consider it as a benefit that – as they believe – circumcised women have less sexual desire and are therefore less inclined to engage in sexual experiences that are socially disapproved of. The findings showed that this belief is often reinforced after arriving in Germany. When observing the lifestyle of German women and the way they handle their sexuality, numerous African immigrants are taken aback or even shocked. They draw the conclusion that German women are not faithful because they have not undergone FGM/C.

Some immigrants, mainly from Gambia, Ethiopia and Nigeria also mentioned the aspect of hygiene and cleanliness. They feel that the act makes the genital organs cleaner and more attractive.

For a minority of participants, FGM/C is also associated with religious beliefs and practices, some even go so far as to consider it a requirement of their religion. This perception is considerably more common in men then in women. There are both Muslims and Christians who see a religious component in practicing FGM/C, although the perception is more common among Muslims.

6.3. What do they know about the risks and harmful consequences of FGM/C?

The greater part of the participants showed a certain degree of awareness about the risks and harmful consequences of FGM/C. Pain, infections and sexual disadvantages for the women were most commonly known harms. It was notable,

however, that awareness was significantly lower among immigrants from practicing families than among families by whom FGM/C is not carried out. The level of awareness of men and women was comparable although men from practicing families showed less knowledge than women from practicing families. The level of education plays a role: the degree of awareness increases with the education level. The immigrant communities with the lowest level of awareness come from two countries with very high prevalence rates: Guinea and Gambia. This might be due to the relatively low education level of immigrants from these two countries. Men from Nigeria also showed a relatively low level of awareness. The knowledge of harm and risks was particularly high among immigrants from Cote d'Ivoire, Cameroon, Togo, Kenya and Ethiopia.

6.4. Do they know that practices such as FGM/C are illegal in Germany?

There is a strong awareness among immigrant populations that FGM/C is not tolerated in Germany. The awareness was slightly lower among women from practicing groups and generally lower in practicing families from high prevalence countries in West Africa.

The court cases in France in which parents and practitioners of FGM/C were condemned have not gone unnoticed. Other cases of prosecution have also become public and the media and word-of-mouth communication have helped to spread the word. Although most of the immigrants have no specific knowledge of how the German legal system considers or refers to FGM/C, they know that "the Germans are against it." Furthermore, many immigrants from Sub-Saharan Africa have had recurrent adverse experiences of how strictly the rules and regulations are applied in Germany (passport and ticket controls, restrictions of their residence permit). They quickly assimilate that – unlike in their country of origin – there is little or no room for negotiation when rules are broken.

These experiences combined with the knowledge that FGM/C is condemned by Europeans have a strong dissuasive effect on practicing families. They fear that subjecting their daughters to the practice could jeopardise their status, so they opt either to abstain from the practice or to send the girl to the country of origin in order to subject her to FGM/C.

6.5. How many girls and women have undergone FGM/C?

6.5.1. The proportion of adult women who have undergone FGM/C

The results of the current study indicate that about 30% of the total immigrant women population in Hamburg has undergone FGM/C. The prevalence rate of the country of origin is not always a reliable indicator. While it worked well for countries with high prevalence rates (> 70%), it proved to be misleading for women and girl populations from countries with low and moderate prevalence rates:

- **Countries of origin with high prevalence rates:** The prevalence rate among the women interviewed who were from countries with a high prevalence of FGM/C such as Guinea and Gambia was comparable to the prevalence rate of the country of origin.
- **Countries of origin with low to moderate prevalence rates:** The prevalence rates are of little use when estimating the number of immigrant women concerned. In Hamburg, the prevalence rates among women immigrants from some countries is much higher than the national prevalence rate of the country of origin. In Nigeria, for example, the national prevalence rate is about 30%. Most immigrants living in Hamburg, however, come from the strongly practicing Southern regions, and at least 50% of the women of Nigerian origin in Hamburg have undergone FGM/C. Similar tendencies became apparent among Togolese and Beninese women.

6.5.2. The proportion of girls who have undergone FGM/C or who are at risk of being subjected to the practice (< 18 years)

The prevalence rates of the countries of origin are not a useful indicator for determining the number of girls living in Hamburg who have been subjected to the practice. In the cohort of immigrants' daughters, the proportion of girls concerned is significantly lower. Nevertheless, an important distinction has to be made between (1) daughters who grew up in the country of origin, (2) daughters who were born in Africa and who migrated with their parents to Europe and (3) daughters who were born in Germany.

Daughters of practicing families who grew up in the country of origin have little or no protection from FGM/C. The migrating parent is often not even informed when the daughter is subjected to the practice. As a consequence, the number of circumcised daughters growing up in Africa among immigrants from Gambia, Guinea, Mali or Nigeria is high.

Daughters who were born in Africa and who migrate during childhood to Europe often undergo the practice before arriving in Europe. The probability depends on the age of the girl at the moment of migration and the age at which FGM/C is usually carried out in the community of origin.

Daughters who were born in Germany are the lowest risk group. Depending on their family in the country of origin (or in France or Italy), they might be subjected to the practice during holidays or extended stays in the country of origin.

The girls growing up in Hamburg belong – of course – to the second and third group. The findings showed that there is a small, but considerable number of girls who underwent FGM/C before coming to Hamburg. Further, the research team judged that 13 daughters of immigrants were at risk for FGM/C during trips home. This indicates that other older girls have already taken that path and returned to Hamburg after undergoing FGM/C. There is therefore a relatively small number of girl children in Hamburg who have been subjected to the practice or risk being subjected to it in the future.

The research could not establish any evidence that FGM/C has been carried out in Hamburg or other locations in Germany. There were only vague indications that it could be practiced on infants from the ethnic group of the Yoruba or Igbo of Nigerian origin.

If girls are subjected to the practice, the parents prefer to send them for an extended stay to the country of origin or, in some cases, to France. In order to determine whether a particular girl is at risk, numerous factors have to be taken into account. The prevalence rate of the region of origin is just one of many factors. The place of residence (urban/rural), the ethnic group affiliation, the education level of the parents, the socio-demographic profile and opinions of the two parents, the level of integration into German way, their attachment to their home community are just a few variables to be assessed. The findings illustrate, however, that the group of girls at risk are a rather small minority. Most immigrants in Hamburg from practicing families abstain from subjecting their daughters to FGM/C for one or more of the following reasons:

- Fear of punishment, as the act might be discovered for example during health check ups or swimming lessons. When immigrants have to decide between jeopardising their status and continuing the practice of FGM/C, they will opt in favour of maintaining their status. Having migrated for labour, they have large families to support in Africa and returning to Africa without having made a fortune is not an option for them.
- High level of education and integration and awareness about the risks and harmful consequences of FGM/C;
- The other parent is from a non-practicing community and is opposed to the practice;
- Lack of opportunities due to the absence of the societal setting of the community of origin, including a network of traditional or modern practitioners;
- Flights to Africa are expensive and many immigrants don't have the means to fly the daughter home for this reason exclusively;
- Other more urgent preoccupations related to their status as immigrants (e. g. linked to accommodation, residence or work permit).

Nonetheless, if a girl is from a practicing group, the risk can never be totally eliminated.

6.6. Summary of the situation of the immigrant populations (per country of origin)

6.6.1. Typologies of different immigrant communities

The analysis of the immigrant populations by country and by region of origin enabled to classify most countries and some particular regions in a typology based on the three elements: the FGM/C prevalence in the country or region of origin, the proportion of women who have undergone FGM/C as well as the degree of risk experienced by girls growing up in Hamburg that they might be subjected to the practice. For three countries – Ghana, Benin and Togo – the national FGM/C prevalence proved to be an unreliable indicator and preference was given to distinguishing immigrants from these countries according to their region of origin.

The typologies according to the three elements named above allow the determination of the need for intervention against FGM/C.

- **First,** there are immigrant populations with a pressing need for intervention: many women have been subjected to the practice and might be in need of assistance and the findings indicated the existence of girls at risk of being subjected to the practice.
- **Second,** there are communities with moderate need for intervention: there is a moderate or high number of women concerned, but due to the level of education and integration or other characteristics of the immigrant community, the immigrants show little or no interest in continuing to practice FGM/C.
- **Finally,** there are immigrant populations from Sub-Saharan Africa with little or no need for intervention: FGM/C is not part of their cultural practices. It still makes sense to include these populations in campaigns against FGM/C as they can make valuable contributions to the discus-

sions questioning the practice and encouraging attitude changes. Furthermore, immigrants belonging to these populations need to be informed about FGM/C in case that they marry into a practicing family.

The table below provides important indications on how to direct awareness-raising activities. The second column gives an approximate estimate of the total number of immigrants living in Hamburg from a particular community. The estimates are founded on impressions gathered during the research and might, thus, be inadequate. The following countries are not included in the typology due to insufficient data: Eritrea, Sudan, Senegal, Liberia, Guinea Bissau and Sierra Leone. We recommend that more information be collected on the immigrant populations from these countries. The data from Burkina Faso and Benin might also need to be completed with more interviews.

Apart from the typologies, the following paragraphs outline a brief summary of the findings for the various immigrant communities from Sub-Saharan Africa by country of origin.

6.6.2. Ghana

The Ghanaian immigrant population affected by FGM/C is very small. Except for a handful of supporters, the community is against FGM/C or indifferent towards the practice. The results indicated that FGM/C is not practiced in Hamburg by Ghanaian immigrant communities and that the risk for girls of Ghanaian origin is low.

6.6.3. Togo

A significant part of the Togolese immigrants in Hamburg has roots in practicing ethnic groups, in the group of the Kotokoli[35] in particular. The members of the practicing families are mostly Muslim and segregate themselves from the German population. The findings indicate that the proportion of women and girls at risk living in Hamburg is considerably higher than the prevalence rate for their country of origin.

The status of women is low within the Togolese Muslim communities. Even if against FGM/C, the women lack decision-

Table 38: Typology of FGM/C of immigrant populations from Sub-Saharan Africa in Hamburg

Countries/Regions	Estimation of number of immigrants in Hamburg	Profile of country or region		
		FGM/C prevalence	Proportion of concerned women	Risk for girls[36] to be subjected to FGM/C
Immigrant populations with little or no need for interventions				
Ghana (Southern region)	> 5000	Low	Zero to low	Very low
Togo (Southern region)	¬ 600	Low	Zero to low	Very low
Benin (Southern region)	¬ 200	Low	Zero to low	Very low
Cameroon	¬ 500	Low	Zero to low	Very low
Niger	< 100	Low	Zero to low	Very low
Immigrant populations with moderate need for interventions				
Kenya	< 300	Moderate	Moderate	Low
Ethiopia	< 200	High	High	Low
Cote d'Ivoire	¬ 500	Moderate	Moderate to high	Low to moderate
Northern Ghana	¬ 30	Moderate	Moderate	Low to moderate
Immigrant populations with high need for interventions				
Nigeria	¬1500	Moderate	High	Moderate to high
Guinea	> 200	High	High	Moderate to high
Gambia	¬ 500	high	High	Moderate
Northern and Central Togo	¬ 800	Moderate	Moderate	Moderate
Northern Benin	¬ 250	Moderate	High	Moderate
Burkina Faso[33]	¬ 250	High	High	Moderate
Mali[34]	< 100	High	high	Moderate

33 The practices of the immigrant communities from Burkina Faso need to be further explored.

34 The practices of the immigrant communities from Mali need to be further explored.

35 Also named Tem

36 Girls growing up in Hamburg. The estimate does not include girls growing up in Africa

making power to protect their daughters from harmful traditional practices during holidays in Togo. It is therefore imaginable that girls could be subjected to the practice in their community of origin during holidays. There was no indication, however, that FGM/C is carried out by the Togolese community on German soil.

6.6.4. Nigeria

The findings indicate that more than half of the immigrants of Nigerian origin are from practicing families. Furthermore, the proportion of immigrants perceiving FGM/C as an advantageous practice is high and, at the same time, the knowledge of risks and disadvantages of FGM/C is weak and rather superficial, particularly among men. Although most immigrants of Nigerian origin are aware of the law, a minority displays a strong determination to preserve FGM/C as a tradition. The proportion of men advocating for the continuation of FGM/C is considerably higher than that of women.

Almost half of the women interviewed had undergone FGM/C and it can be assumed that the prevalence among immigrant women in Hamburg is notably higher than the prevalence rate for their country. The findings concerning the status of daughters imply that there are girls in Hamburg at risk of being subjected to FGM/C. The law, however, has a strong dissuasive effect. One of the researchers summarised her impressions as follows:

> "Without the law, certain Nigerian men would definitely do it [FGM/C]. But as immigrants in Germany, they would not jeopardise their status. Although they speak strongly in favour of the practice, their status and survival in Germany is their priority and not FGM/C. Status always comes first. The women, on the other hand, none of them is really in favour. Those over 45 years of age are very strong leaders." (woman researcher of Kenyan origin)

6.6.5. Cameroon

The majority of immigrants living in Hamburg are from non-practicing groups. Nonetheless, there is a small number of women who underwent FGM/C in Cameroon before migrating to Germany. There were, however, no signs of girls at risk.

Furthermore, most Cameroonian immigrants are university students with solid knowledge of the consequences of FGM/C and about the position of the German legislation towards the practice. It can be concluded that the need for awareness raising and follow-up in the Cameroonian immigrant community will be limited to a couple of isolated cases.

6.6.6. The Gambia

Most Gambian immigrants associate FGM/C with one or several advantages while the awareness of hazards and negative outcomes is low. The findings indicate also that the large majority of Gambian women have undergone FGM/C. Daughters of immigrants growing up in The Gambia are at high risk of having undergone FGM/C or of undergoing it in the future. Girls born in Germany benefit from more protection, but can be at risk of being subjected to the practice during holidays in their country of origin. The Gambian community is well organised and individuals have started to put the parents of daughters planning to travel on guard by advising them to protect their children from FGM/C. This type of initiative should be strengthened to effectively prevent FGM/C among Gambian immigrant daughters.

6.6.7. Cote d'Ivoire

The greater part of the Ivorian community has roots in practicing groups and families and it can be assumed that a significant proportion of Ivorian women immigrants has been subjected to the practice. In the cohort of daughters growing up in Germany, however, FGM/C seems to be limited to a few exceptional cases. Most Ivorian immigrants are from urban areas, comparatively worldly and express openness to compling with the rules of the host society including respecting the prohibition of FGM/C. Their awareness of the risks and medical complications is relatively high.

6.6.8. Kenya

The interviewed sample was too small to draw definite conclusions regarding the situation of FGM/C in the Kenyan immigrant community in Hamburg. It can be assumed that the proportion of women who have undergone FGM/C is close to the estimate of prevalence in Kenya. There is strong awareness of the harm posed by FGM/C and of the prohibition of FGM/C in Germany among the Kenyan immigrant population. The probability of a daughter growing up in Hamburg being subjected to FGM/C seems to be very low.

6.6.9. Benin

The immigrant community from Benin is divided into two segments: those who identify with ethnic groups from one of the four northern regions (mostly Muslims) and those who are affiliated with one of the southern regions (mostly Christians and traditional religions). Among Muslim immigrants from the northern regions, FGM/C is widespread and the number of women concerned is significant. Key informants estimated that immigrants from the northern regions are more numerous than those from the South. It can be concluded, hence, that the number of women and girls concerned is

higher than the prevalence rate for the country. Furthermore, we identified several girl children who had either undergone FGM/C or were at risk of being subjected to the practice. There is a great need to identify persons in favour of the abolition of FGM/C among immigrants from the North who are motivated to raise awareness among their people.

6.6.10. Ethiopia

The Ethiopian community members interviewed had relatively high levels of education and integration. The findings indicated that Ethiopians showed a strong willingness to leave the tradition of FGM/C behind in the context of migration. Although many of the adult women have undergone FGM/C – mostly during infancy – in Ethiopia, they don't have any interest in subjecting their daughters growing up in Germany to the practice. A religious leader made the following statement which summarises suitably the findings of this study:

> "If we speak of the parents, I think most of them might have gone through the practice themselves. But I don't think that they are in favour of FGM being practiced on their daughters. I have never ever heard of an Ethiopian here or anywhere in Germany who let their daughter be circumcised. Of course, I recently heard a report through the Deutsche Welle that a certain Ethiopian family was intending to go home to circumcise their daughter. And it was proved to be a false accusation. So my conclusion is that Ethiopians living in Hamburg are not in favour of FGM and don't want to see it practiced on their daughters. But that doesn't mean that the parents are not circumcised. I am sure a lot of them were circumcised while they were babies. (39-year-old religious leader and key informant of Ethiopian origin)

6.6.11. Burkina Faso

Girls and women arriving in Hamburg from Burkina Faso are likely to have undergone FGM/C. The immigrant community of Burkina Faso is relatively well aware of the risks and consequences of FGM/C and the greater part speaks out for the abandonment of the practice. It is not of importance to them to maintain the tradition of FGM/C while living in Germany. One of the researchers of Burkinabe origin concluded, "It would not even cross their minds; they have other issues to deal with." Nonetheless, there is a minority of men who argues firmly for the need to continue FGM/C so as to prevent Burkinabe women from becoming promiscuous.

6.6.12. Guinea

The topic of FGM/C is very difficult to address with members of the Guinean community. Most of the participants expressed either indifference or strong negative reactions when asked about their perceptions of FGM/C. Although the greater part said that they wanted the practice to be stopped, there were no strong voices advocating particular actions. The findings indicated that almost all Guinean women in Hamburg had undergone FGM/C. Among the daughters of the parents interviewed, 15 girls had already undergone FGM/C in Guinea and five girls were estimated to be at risk of being subjected to the practice in the future. The number of Guinean girl children living in Hamburg seems to be considerably higher than the 10 girls officially registered.

6.6.13. Senegal

The interviewed sample was too small to draw conclusions about the Senegalese community in Hamburg. The data indicates that a solid proportion of the immigrants is from practicing families for whom FGM/C is a cultural and sometimes religious practice that initiates the women into the adult society of their ethnic group. Further research is recommended to establish a more representative assessment of the Senegalese immigrant community.

6.6.14. Niger

The immigrant population of Niger is very small and very few participants have roots in practicing groups. There were no indicators for women and girls concerned, although the existence of isolated cases cannot be excluded.

6.6.15. Mali

The findings reveal that there is a small but significant proportion of conservative traditionalists in the Malian immigrant community who consider FGM/C to be a tradition to preserve. Most women immigrants from Mali have undergone FGM/C. There is no evidence, however, that supporters of the practice would go as far as to subject their daughters growing up in Germany to FGM/C. Further studies are recommended to explore the practices of the Malian immigrant community regarding FGM/C in Hamburg.

6.6.16. Sierra Leone, Liberia and Guinea Bissau

We only reached a handful of immigrants from Sierra Leone, Liberia and Guinea Bissau. As the prevalence rates of the three countries are moderate to high, we recommend conducting further research with the immigrant communities of these three countries.

6.6.17. Tanzania

There are only 42 Tanzanians registered in Hamburg. Gathering data from such a small community is methodologically

challenging and requires reaching virtually all members in order to draw definite conclusions. We had no indications of the existence of women or girls concerned, but this cannot be ruled out.

6.6.17.1. Sudan, Eritrea and Somali

The communities are very small and its members seem to be fairly well integrated. It can be assumed that the women who left their country of origin as adolescents or at older ages have undergone FGM/C. There were no indications that girls growing up in Hamburg were at risk of being subjected to FGM/C; however, the existence of isolated cases cannot be excluded.

7 Recommendations

These recommendations are the foundation for an action plan against FGM/C within immigrant communities from Sub-Saharan Africa in Hamburg. They take into account the recommendations of the African community members interviewed during the research. The recommendations are based on a behaviour change model presented on page 98. The chapter is structured into four domains. More detailed information on each of the domains is provided in the following sections:

- the **context of the action plan**, outlining the target groups and supporting factors and barriers for the implementation of the action plan;
- the **preparatory stage** which gives an overview of whom to involve in the action plan against FGM/C in Hamburg, and how to involve them;
- the **implementation of the action plan** including the main actors and their roles;
- the **previewed outputs, outcomes and impact** at the level of the target population.

More detailed information on each of the domains is provided in the following sections.

7.1. Recommendations regarding the context of the action plan

We propose to focus on men and women **with roots in practicing ethnic groups and families** as primary target groups. The immigrant communities with moderate and high intervention needs (high: Nigeria, Guinea, Gambia, Central and Northern Togo, Northern Benin and Burkina Faso; moderate: Cote d'Ivoire, Ethiopia, Kenya, Northern Ghana) should receive particular attention and resources. It is recommended that stakeholders from each of the communities be encouraged to write up a specific action plan for their community.

The secondary target groups should all be immigrant communities from Sub-Saharan Africa, including low-risk communities (Southern Ghana, Southern Togo, Southern Benin, Cameroon and Niger) as well as small immigrant populations from areas of high prevalence (e.g. Sudan, Eritrea). As these communities either fall into a low risk category or are represented in small numbers, the members of these communities can be targeted with sporadic large-scale awareness raising events.

The supporting factors should include the large proportion of immigrants who are against the practice. They can support the implementation of activities, disseminate information at community level and establish so-called watch-dog committees inside their communities that accompany and provide guidance to families that are considering subjecting their daughters to FGM/C.

The implications of the barriers outlined below are multifolded and generate the following recommendations.

- The development and implementation of the action plan should take place under African leadership. German and international organisations can provide technical and financial support, but should abstain from becoming involved in frontline activities.
- The "approach of proximity" should be respected for all community based interventions (as far as possible). The "approach of proximity" has been identified as a best practice of projects against FGM/C in Africa and consists of selecting community facilitators who have the same socio-demographic and ethno-linguistic profile than the target population. To approach the members of the Muslim communities from Northern Benin, for instance, it is crucial that the activities against FGM/C be lead by immigrants who come from the same area, who speak the same or similar local languages and dialects and who share the same cultural traditions. This implies that the immigrant community from each Sub-Saharan country needs at least one community facilitator responsible for the implementation of activities against FGM/C in his/her community. The recommendations from African community members included opting for community facilitators whom others listen to and who have a certain amount of life experience. Women who have undergone FGM/C but have decided to break with the tradition are ideal candidates.
- As FGM/C is a very sensitive issue of little interest to most immigrants, it is recommended that a multi-sectorial approach be used. The multi-sectorial approach has been recognised as another best practice in Africa. Instead of focusing on a single issue, the project integrates FGM/C in a series of other project topics that respond to various needs of the target population. This approach helps to build a relationship of trust with the project participants before addressing delicate topics such as FGM/C. Other key topics to be addressed with female and male immigrants from Sub-Saharan Africa could be reproductive health care, family planning, on-the-job training, computer classes, assistance with immigration issues and any other needs expressed by the targeted immigrant populations.

- In order to encourage an attitude of change relative to FGM/C, the target populations need discussion forums to question the numerous benefits associated with FGM/C. This is why a one-dimensional approach based on awareness raising of the risks and harmful consequences of FGM/C will have limited reach. Parallel to providing information on the medical, sexual and psychological effects of FGM/C, it is indispensable to encourage debates in which prejudices towards non-circumcised women and the positive perceptions of FGM/C are questioned. This can be done within the scope of a multi-dimensional approach which comprises a focus on awareness-raising, but also an emphasis on creating spaces in which to discuss the myths and beliefs related to the practice and to question the benefits perceived by men and women of different origins.
- Open and silent supporters of the practice are found among both men and women. Although the practice is often called "women's business", this is far from being the truth. Both men and women contribute to the dynamic maintaining FGM/C, both have a right to be informed about the risks and harmful consequences of the practice, and both have a role to play in its abandonment. We recommend, thus, the involvement of both women and men immigrants of all ages in the activities and to adapt the nature of the activities to gender-specific needs. Girl and boy children are a very receptive target group and it is suggested that child and youth-friendly activities be included in the action plan.

7.2. Recommendations regarding the preparatory stage

The recommendations for this stage stem from the idea of organising the preparations in four chronological phases:

The first phase consists of the establishment of a **Pan-African Committee (PAC)**. The idea of setting up a committee with representatives from immigrant communities of multiple Sub-Saharan countries arose during the research. Most members of the research team shared a common vision and expressed a strong willingness to continue promoting the abolition of FGM/C. They had gathered and exchanged many experiences during the two months of data collection and established a strong network of contacts across the immigrant communities. The recommended activities for the founding members of the PAC are to define their mission, their vision and their intervention domains at this stage, and to work toward making their organisation functional. It is suggested that at least one member be mobilised per country (from Sub-Saharan Africa) and to invite the research participants who expressed interest in contributing to activities against FGM/C to join the organisation.

The second phase of the preparatory stage will be the **dissemination of the research** results. The suggested target groups for dissemination are stakeholders of the immigrant communities from the participating countries (including religious and customary leaders, focal points of country and regional/state immigrant associations and women's groups). The activities should try to reach as many immigrants as possible and invite them to debate the results. In the process of dissemination, we recommend that the participants from the various communities be asked whether any of them is interested in writing up an action plan against FGM/C for their community of origin.

Further proposed target groups for information dissemination are the German authorities and government representatives, the civil society (e.g. NGOs, human rights activists) as well as relevant professional groups (teachers, social workers, reproductive health professionals).

The third phase takes place after the information has been disseminated. Interested representatives of immigrants' associations from different countries of origin are supported in the development of action plans for the abolition of FGM/C. The recommended elements for the specific action plan are:

- Provision of general support and orientation for the targeted immigrant populations;
- Cultural activities acknowledging the values of African traditions;
- Awareness raising through films, radio spots, information leaflets, theatre and other strategies on the risks and harmful consequences of FGM/C, the position of religion towards the practice, the position taken by the German legal system and global trends and initiatives on FGM/C;
- Debates and round-table discussions on the advantages and disadvantages of the practice;
- Community-based advocacy for the abandonment of FGM/C encouraging community leaders to speak out against the practice;
- The establishment of watchdog committees with the aim of sensitising parents who travel with a daughter to their country of origin.
- The recommended meeting locations are Afro Shops, African restaurants and hairdressers or barber shops.

In the fourth stage, **the specific action plan will be revised and compiled into one general action plan by the PAC.** We propose that two main sections be included in the general action plan: (1) the specific action plans targeting members of particular communities and (2) capacity-building activities (for the immigrant associations, the PAC, reproductive health workers etc.) as well as large-scale awareness raising and advocacy at city, national and international levels. Once the general action plan is finalised, it can be submitted to the City of Hamburg and donor organisations for funding.

Ideally, the government of Hamburg and Plan and/or other donor organisations will agree to partner the project.

7.3. Recommendations regarding the implementation of the action plan

Once the general action plan established by the PAC is approved for financial and technical support, a start-up workshop should be held, uniting the different actors in order to allow them to clarify and define their roles, and to put in place effective monitoring and evaluation mechanisms. The following reporting lines are recommended: the community-based activities should be implemented as defined in the specific action plans by the immigrant associations. They will report on their progress to the PAC which is responsible for the monitoring of their work. The PAC will compile a report summarising the activities of all immigrant associations as well as their own doings and submit it on a regular basis to the financial and technical partners.

7.4. Recommendations regarding the previewed outputs, outcomes and impact

The typical process of abandoning FGM/C can be broken down to three stages: (1) increased awareness on the issue, (2) attitude change favouring the abandonment of the practice and (3) abolition of the practice and protection of young girls from the supporters of FGM/C. The stages take place at individual as well as community level. It is possible that individuals might decide to abandon FGM/C while the community continues to practice it. It also happens that the community decides collectively to abandonment FGM/C while individual members choose to continue. In both cases, the behaviour change cannot be considered as stable and it can take years, even decades to consolidate it. The recommendations at this level revolve around the nature of behaviour changes:

As a gradual process, the definite abandonment of FGM/C takes time. It is recommended to design a pilot project of two years that can be extended into a long term project after the testing and adjustment phase.

In order to be able to measure the outputs of the activities, the definition of solid monitoring indicators is crucial. We recommend that evaluation indicators measuring potential changes of awareness be defined in the first phase of the project. Indicators assessing individual and collective attitude changes can be evaluated in the second phase of the project (once the awareness of the target population has significantly increased). Evaluations from projects implemented in Africa can provide useful guidance for the definition of monitoring and evaluation indicators.

Last but not least, we recommend initiating further research projects in order to gather relevant information relating to FGM/C from immigrants of the following countries: Egypt, Sierra Leone, Liberia and Guinea Bissau. We also propose that additional data be collected for the communities from Northern Benin, Northern Togo and Burkina Faso.

BEHAVIOR CHANGE MODEL: Abolition of FGM/C among immigrant communities in Hamburg

Context of the action plan

Primary target population

- Immigrants from practicing families and groups.

Secondary target population

- All immigrants from countries where FGM/C is prevalent.
- Parents of girls of half-African origin (one parent from a practicing family).

Contextual factors

Supports

- There are many opponents of FGM/C among the immigrants from practicing groups in Hamburg.
- Relatively high education level of immigrant populations.
- German legislative framework strongly discourages FGM/C.
- Multiple opportunities to network with immigrant associations and non-governmental structures.
- Absence of societal pressure and traditional structures for carrying out FGM/C.

Barriers

- Suspicious attitude of immigrants towards any activity initiated by Germans.
- FGM/C is not a priority issue for immigrants and for men in particular (indifferent/unreceptive attitudes).
- Difficulty getting access to Muslim women from practicing groups.
- Many immigrants associate various advantages with FGM/C.
- Girls are sent to Africa for long periods of time for education.
- Limited time, budget, knowledge or intercultural skills of key actors (Social Affairs, medical personnel etc.).

Preparative stage

Foundation of a Pan African Committee (PAC)

- Composed of committed members of the research team and further interested immigrants from Sub-Saharan Africa.
- Development of a vision and a mission.
- Identification of core intervention domains and key strategies in terms of advocacy and community-based interventions.

Dissemination of study results by PAC at the level of:

- The immigrant communities from Sub-Saharan Africa.
- Particular stakeholders such as religious and traditional leaders and representatives of immigrant associations.
- The German authorities and representatives of relevant professional groups.
- The NGOs working on FGM/C.

Immigrant associations (country associations, women's groups etc.)

- Development of action plans for the abolition of FGM/C within specific immigrant communities (e.g. Guinea, Nigeria).
- Submission of action plans to the PAC.

PAC produces overall action plan for the city of Hamburg

- PAC revises action plans from immigrant communities in Sub-Saharan Africa and compiles them in one document.
- Submission of the compiled action plan to the city of Hamburg and interested donors.

Action plan implementation

Immigrant associations

- Implement their action plans in communities of practicing origin.
- Participate in skill building workshops.
- Network with other immigrant associations in Hamburg and across Germany.
- Report to the PAC.

Pan-African Committee (PAC)

- Advocate and educate at city and (inter-) national level in behalf of the African community for the abandonment of FGM/C.
- Participate in skill building workshops.
- Provide feedback and monitor activities of immigrant associations.
- Network with other relevant organisations at city, national, European and global level.
- Report to partners offering technical and financial assistance.

Technical/financial partners (City of Hamburg, NGOs such as Plan, Terre des Femmes etc.)

- Organize skill-building workshops.
- Provide financial and technical support for the activities.
- Ensure documentation of best practices and lessons learnt.
- Disseminate approach among NGOs and authorities of other cities in Germany.

Expected outputs & impact

Outputs: Increased knowledge about FGM/C among immigrants in Hamburg

- Increased capacity among key stakeholders
- Increased numbers of community members have knowledge of the risks and harm inherent in FGM/C, the position of religions and the German legal system.
- Better health care services for women suffering from complications from FGM/C.

Outcomes: gradual attitude change towards FGM/C

- Decreasing numbers of community members considering FGM/C as an advantageous practice
- Increased acceptance and less prejudice towards non-circumcised girls.
- Opinion leaders of practicing origin condemn the practice.
- Communities mobilise themselves against FGM/C.

Impact: behaviour change

- Efficient community mechanisms to protect girls from FGM/C.
- The prevalence of daughters at risk decreases.
- Immigrants communicate against FGM/C in their countries of origin.
- accelerated decline of the practice of FGM/C.

8 Annex

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8.2. Question list for key informants: African community members

[Possible introductory question: what traditional practices are common in your community?/ Which traditions do people from our community continue to practice in Germany and which traditions are difficult to be done here?]

1. What do you know about people from _____ (fill in respective country)/ our country? And about girls and women in particular? Are they more from rural or urban areas? From what **ethnic groups** and from what **regions** do they come from?
2. What **sources** do people from _____ (fill in respective country) use **to get information** on what is going on? *[Probe for different sources such as media (radio, internet, journals as well networks, afro-shops etc.]*
3. Have you **heard of the practice of female circumcision**? What do you know about it?
4. **For women only**: have you **taken part in female circumcision**? How, where and when was it done? How do you remember it?
5. What does the practice of female circumcision **represent for people** [from your/ our country] here in Hamburg/Germany? What do they see as advantages and disadvantages? And what does it mean to you personally? *[if necessary, probe for medical risks, legislation, motives, reasons etc.]*
6. **Is it a religious practice?** For Christians? For Muslims?
7. Who **in the family decides** whether or not it is practiced?
8. If families in Hamburg are in favor of the practice, **how do they do it**?
9. In your opinion, is it possible to abandon the practice of female circumcision? If yes, how **would you recommend doing** this in Hamburg? How and by whom could the people of your community be reached and convinced?
10. What do **women** do **to go through pregnancy** and where do women go with **gynecological problems**?

8.3. Question list for key informants: medical staff

Do you know someone who was/ has been **directly or indirectly involved in** carrying out female genital cutting/ circumcision in Germany?
For medical staff from practicing countries: do you come from **a community which practices female genital cutting**? If yes, at what age is the practice carried out?
Have you already **come across a women or girl** who had undergone female genital cutting? If yes, about how many times (approximately)? What was exactly cut? Did they suffer from medical complications linked to the practice?
Do African women come **regularly to do gynaecological/ health check ups**? Do they come for pre and post natal control visits? The women who come here are from which countries in Africa?
If women come to you **with related complications** how to do you advice or deal with them? With their babies/ girl children? What about patients with psychological problems?
How do you **deal with a sensitive case** in relation to your doctor'oath?
11. What is your **personal opinion** regarding this topic?
12. What are your **suggestions to reduce/ abandon this practice** among African immigrant populations living in Hamburg/ Germany?

8.4. Question list for key informants: researchers, activists, social workers etc.

Is it possible for African immigrants to **maintain their cultural values and practices**? How do they adapt to their new life in Germany?
What do **you know about** the practice of female genital cutting/ mutilation (choose appropriate term)?
What is **your opinion** on the practice?
Tell me (more) **about your work related** to the practice of female genital cutting?
What **do you know about the practice** of female genital cutting among African immigrants **in Hamburg**?
How, where and by whom is the practice of female genital cutting carried out in Hamburg/ Germany? Who are the girls at risk? Where are they?
How could the situation be improved? What strategies do you propose to protect the girls at risk to be cut?

8.5. Questionnaire for quantitative interviews – Men

Interview setting

IS1. Name of interviewer		
IS1a: Code of participant *(filled out by us!)*		
IS2. Interview date	_____/_____//_____	
IS4. Interview language		
IS5. Interview duration	_____ minutes	
SOCIODEMOGRAPHIC VARIABLES		
QUESTIONS AND FILTERS	**CODING CATEGORIES**	**SKIP**
ID01 Age of participant	_____ years O does not want to answer	
ID02: Country of origin		
ID03: From which region in your country do you come from?		
ID04: Current nationality:		
ID05: Ethnic group/ tribe	O does not want to answer	
ID06: residence permit status	unbefristete AE ……..….1 befristete AE….....……...2 Bewilligung.....3 Befugnis .....4 Gestattung.....5 Duldung.....6 Sonstige, ungeklärt....……7 Does not want to answer .....8 German nationality……..9	
ID07 Stadtteil (where participant lives) :		
ID08 For how long has the participant lived in Germany?	_____months	
ID09 Place of birth (name of location)		
ID010 Place of birth (urban or rural?)	Urban…… ……..1 rural..…….....2	
ID011 **Social status**	Married (not polygamous)……..……..……1 Married (polygamous)……:..……..……2 Separated/divorced……..……...3 Widow…….....4 Never been married ……...5 Other (precise)……. ……	If 3,4,5 → ID12
ID011a) If married, what is the country of origin of your spouse?		
ID012 Number of years in school (including university education)	_____ years	
ID013 Profession?		
ID014 What type of work is the participant currently doing?		
ID015 **Religion** (only one answer)	Muslim…….. ..1 Christian ……2 Traditional religion...3 non-believer…..……4	
ID016 Do you have children?	Yes……...……..1 No……..……..……2	If no, →Q200
ID017 If yes, how many living children do you have (girls and boys)?	_____girls _____ boys	
ID 018 How many of your children are living with you in Germany?	_____girls _____ boys	

Questions related to female genital mutilation/ cutting / circumcision

QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
Q200. Have you ever heard about female circumcision?	Yes.……1 No ……2 Does not want to answer…3	If yes, → 202
Q201. In some countries, there is a practice in which a girl may have part of her genitals cut. Have you ever heard about this practice?	Yes.……1 No ……2 Does not want to answer…3	If no, → Q300
Q202: Does it take place in your ethnic group?	Yes.……1 I don't know ……..3 No ……2 Does not want to answer…4	
Q203: Has it taken place in your family? *(Are there any family members who have undergone the practice?)*	Yes.……1 I don't know ……..3 No ……2 Does not want to answer…4	
Q204 What benefits do girls themselves get if they are circumcised? *Probe: any other benefits?* RECORD ALL MENTIONED ANSWERS	Cleanliness/ hygiene……..1 Social acceptance……...2 Better marriage prospects……..3 Preserve virginity……...4 Religious approval……5 Reduces sexual desire…….6 Other (specify): _____7 No benefits……8	
Q205 What are the disadvantages for girls, women, men and families? *Probe: medical risks and list all given answers. If participant does not know any disadvantages, tick "I don't know"*	I don't know ……..1	
Q206 Do you believe that this practice is required by your religion?	Yes.……1 I don't know ……..3 No ……2 Does not want to answer…4	
Q207. What does the German law say about the practice?	German law allows it……...1 German law does not allow it ……2 German law does not mention it……..…3 I don't know……...……4 Participant does not answer……5	
Q208 Do you think the practice should be continued, or should it be stopped?	Continued……..…1 Stopped……..……2 Depends……..…..3 Don't know……..….4 Does not answer.….5	
Q220. For your marriage, do you prefer a woman who is circumcised or one who is not circumcised?	Circumcised..…….1 Does not matter…3 Not circumcised …….2 Depends……..…...4 Don't know……5 Does not answer…5	
Q221. If participant is married to a woman/women from a practicing country (ID011a): has your wife been circumcised?	Circumcised..……...….1 Not circumcised ……...…2 Don't know……..….3 Does not answer……..….4 Question was not asked…..5	

Evaluation of girls at risk

Q214 CHECK ID017: number of living daughters: ☐☐			If 00, → Q300
Q215 Status of living daughters: if participant does not want to be answered, go to Q219 or Q300			
One living daughter:	**More than one living daughter:**	**Fill in answer for Q215 here!**	
Has your daughter been circumcised? If yes, record 01; if no, record 00	Have any of your daughters been circumcised? If yes, how many?	Number circumcised ☐☐ No daughter circumcised:…00	If 00 → Q219
Q216 In which country was the circumcision performed?			
Q217 Who performed the circumcision?	Traditional practitioner ……..……1 Doctor……..……..2 Trained nurse/ midwife……..3 Other (precise)_____.4 Don't know……..……5 Does not answer……...6		
Q218 How old were/ was your daughter(s) when this occurred? (list ages for all circumcised daughters)	_____years don't know……..2 does not answer……...3		
Q219. Do you intend to have your daughter/ any of your daughters circumcised?	Yes..……1 Don't know……..3 No ……2 Does not want to answer…4		

Acculturation

	1. STRONGLY DISAGREE	2. DIS-AGREE	3. AGREE	4. STRONGLY AGREE
Q300. German people make me feel welcome.				
Q301. I prefer to eat African food.				
Q302. I have frequent contact with German people.				
Q303. I consider it important to pass our traditions on to the next generations.				
Q304. In my experience, encounters with the Germans are fine.				
Q305. It is important to me to celebrate our traditional feasts in Germany.				
Q306. I belong here less than in my homeland.				
Q307. When I go out, I usually go to places where I can meet people from the same cultural background.				
Q308. I have difficulties understanding and reading the German language.				
Q309. I have to depend on other people to show me how things are done here.				
Q310. I am familiar with the German politics.				
Q311. I feel the German woman is too free.				
Q312. I feel homesick.				
Q313. Life in Germany is easier than in my home country.				
Q314. At home, we speak mostly other languages than German.				
Q315. I have fewer career opportunities than German people.				

1) Body language, non-verbal messages
3) Other comments/ observations

8.6. Questionnaire for quantitative interviews – Women

Interview setting

IS1. Name of interviewer		
IS1a: Code of participant *(filled out by us!)*		
IS2. Interview date	_____/_____//_____	
IS4. Interview language		
IS5. Interview duration	_____ minutes	
SOCIODEMOGRAPHIC VARIABLES		
QUESTIONS AND FILTERS	**CODING CATEGORIES**	**SKIP**
ID01 Age of participant	_____ years O does not want to answer	
ID02: Country of origin		
ID03: From which region in your country do you come from?		
ID04: Current nationality:		
ID05: Ethnic group/ tribe	O does not want to answer	
ID06: residence permit status	unbefristete AE ……..….1 befristete AE….....……...2 Bewilligung.....3 Befugnis .....4 Gestattung.....5 Duldung.....6 Sonstige, ungeklärt...……7 Does not want to answer .....8 German nationality……..9	
ID07 Stadtteil (where participant lives) :		
ID08 For how long has the participant lived in Germany?	_____months	
ID09 Place of birth (name of location)		
ID010 Place of birth (urban or rural?)	Urban…… ……..1 rural..…….....2	
ID011 **Social status**	Married (not polygamous)……..……..……1 Married (polygamous)……:…..…….……2 Separated/divorced…….…….……...3 Widow…….....4 Never been married ……...5 Other (precise)……. ……	
ID011a) If married, what is the country of origin of your spouse?		
ID012 Number of years in school (including university education)	_____ years	
ID013 Profession?		
ID014 What type of work is the participant currently doing?		
ID015 **Religion** (only one answer)	Muslim…… ..1 Christian ……2 Traditional religion...3 non-believer…..……4	
ID016 Do you have children?	Yes……...……..1 No……..……..…..…2	If no, →Q200
ID017 If yes, how many living children do you have (girls and boys)?	_____girls _____ boys	
ID018 If yes, how many of your children are living with you in Germany?	_____girls _____ boys	

Questions related to female genital mutilation/ cutting / circumcision

QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
Q200. Have you ever heard about female circumcision?	Yes..……1 No ……2 Does not want to answer…3	If yes, → 202
Q201. In some countries, there is a practice in which a girl may have part of her genitals cut. Have you ever heard about this practice?	Yes..……1 No ……2 Does not want to answer…3	If no, → Q300
Q202: Does it take place in your ethnic group?	Yes..……1 I don't know ……..3 No ……2 Does not want to answer…4	
Q203: Has it taken place in your family? *(are there any family members who have undergone the practice?)*	Yes..……1 I don't know ……..3 No ……2 Does not want to answer…4	
Q204 What benefits do girls themselves get if they are circumcised? *Probe: any other benefits?* RECORD ALL MENTIONED ANSWERS	Cleanliness/ hygiene……..1 Social acceptance……...2 Better marriage prospects……..3 Preserve virginity……...4 Religious approval…….5 Reduces sexual desire…….6 Other (specify): _____7 No benefits……8	
Q205 What are the disadvantages for girls, women, men and families? *Probe: medical risks and list all given answers. If participant does not know any disadvantages, tick "I don't know"*	I don't know ……..1	
Q206 Do you believe that this practice is required by your religion?	Yes..……1 I don't know ……..3 No ……2 Does not want to answer…4	
Q207. What does the German law say about the practice?	German law allows it……..1 German law does not allow it ……2 German law does not mention it……..…3 I don't know……...……4 Participant does not answer……5	
Q208 Do you think the practice should be continued, or should it be stopped?	Continued……1 Stopped……2 Depends……...3 Don't know…….4 Does not answer….5	
Q209. Have you yourself ever been circumcised?	Yes..……1 Does not want to answer…3 No ……2 Question was not asked.....4	If no, →Q214
Q210. Now I would like to know what was done to you at that time. Was any flesh removed? Was your genital area closed by sealing or sewing?	No, just nicking.……..…...…1 Yes, flesh removed ……..2 Yes, flesh removed and closed…..……...3 Does not want to answer……..…4 Question was not asked...……..5	
Q211 How old were you when you were circumcised?	Age in years: _____ During infancy……..2 Don't know……..3	
Q212 In which country was the circumcision carried out?		
Q213. Who performed the circumcision?	Traditional practitioner ……1 Doctor……..2 Trained nurse/ midwife……3 Other (precise):_____ 4 Don't know……5	

Evaluation of girls at risk

Q214 CHECK ID017: number of living daughters: ☐☐			If 00, → Q300
Q215 Status of living daughters: if participant does not want to be answered, go to Q219 or Q300			
One living daughter:	**More than one living daughter:**	**Fill in answer for Q215 here!**	
Has your daughter been circumcised? If yes, record 01; if no, record 00	Have any of your daughters been circumcised? If yes, how many?_____	Number circumcised ☐☐ No daughter circumcised:…00	If 00 → Q219
Q216 In which country was the circumcision performed?			
Q217 Who performed the circumcision?	Traditional practitioner ……1 Doctor……..…2 Trained nurse/ midwife……3 Other (precise) _____4 Don't know……..……5 Does not answer……..6		
Q218 How old were/ was your daughter(s) when this occurred? (list ages for all circumcised daughters)	_____years don't know……..2 does not answer……...3		
Q219. Do you intend to have your daughter/ any of your daughters circumcised?	Yes..……1 Don't know…….3 No ……2 Does not want to answer…4		

Acculturation

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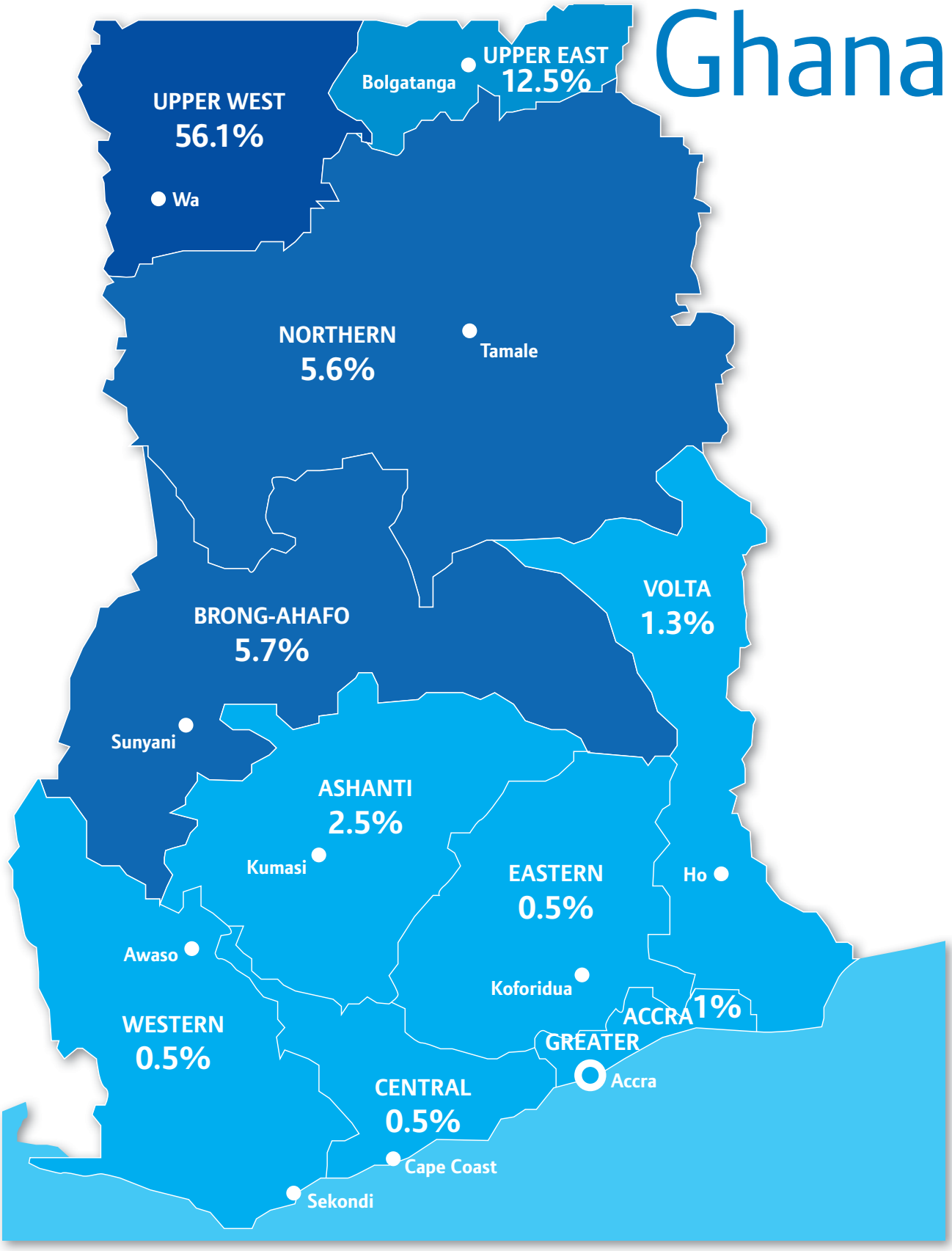
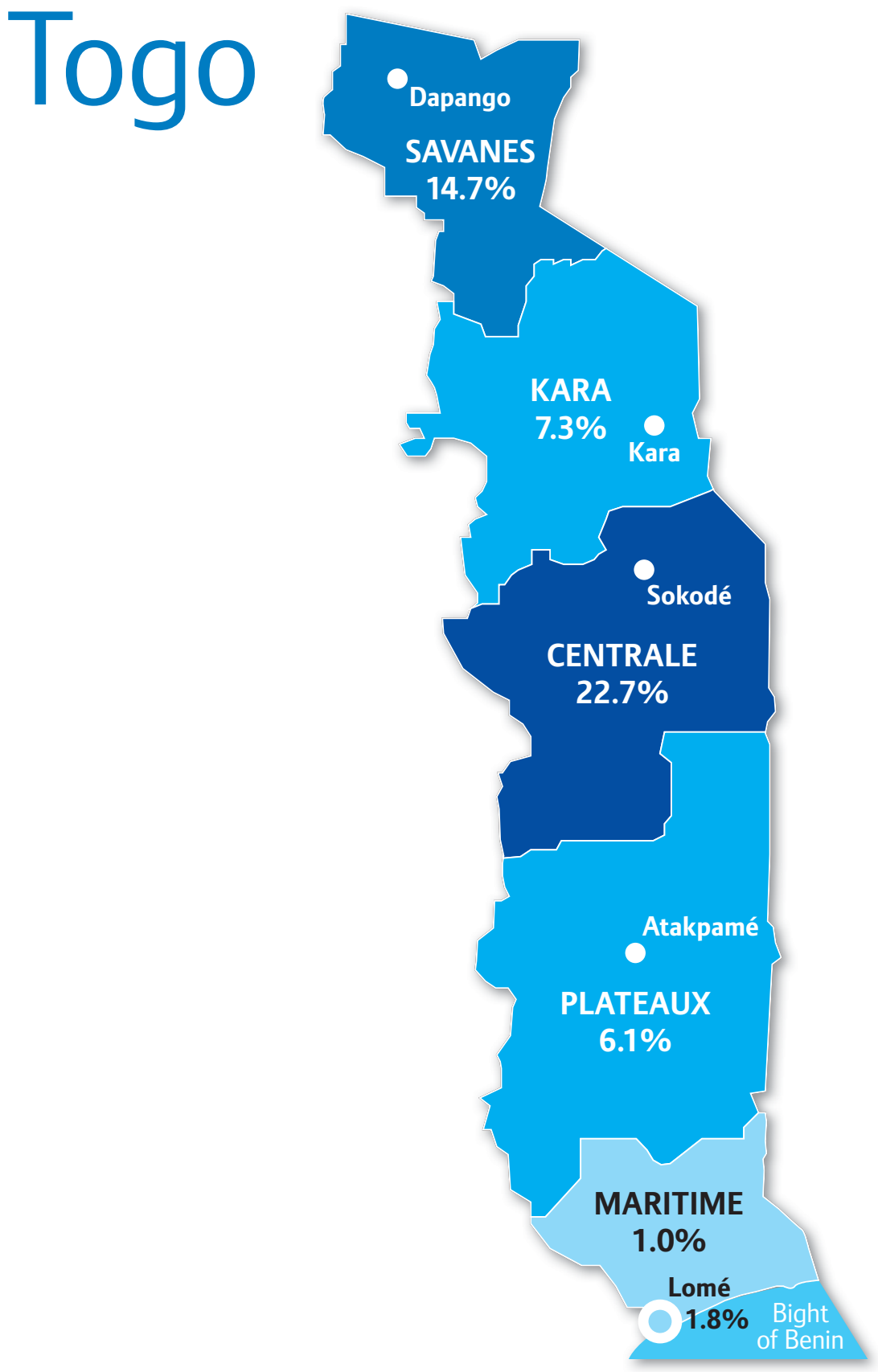
Q304. In my experience, encounters with the Germans are fine.				
Q305. It is important to me to celebrate our traditional feasts in Germany.				
Q306. I belong here less than in my homeland.				
Q307. When I go out, I usually go to places where I can meet people from the same cultural background.				
Q308. I have difficulties understanding and reading the German language.				
Q309. I have to depend on other people to show me how things are done here.				
Q310. I am familiar with the German politics.				
Q311. I feel the German woman is too free.				
Q312. I feel homesick.				
Q313. Life in Germany is easier than in my home country.				
Q314. At home, we speak mostly other languages than German.				
Q315. I have fewer career opportunities than German people.				

2) Body language, non-verbal messages

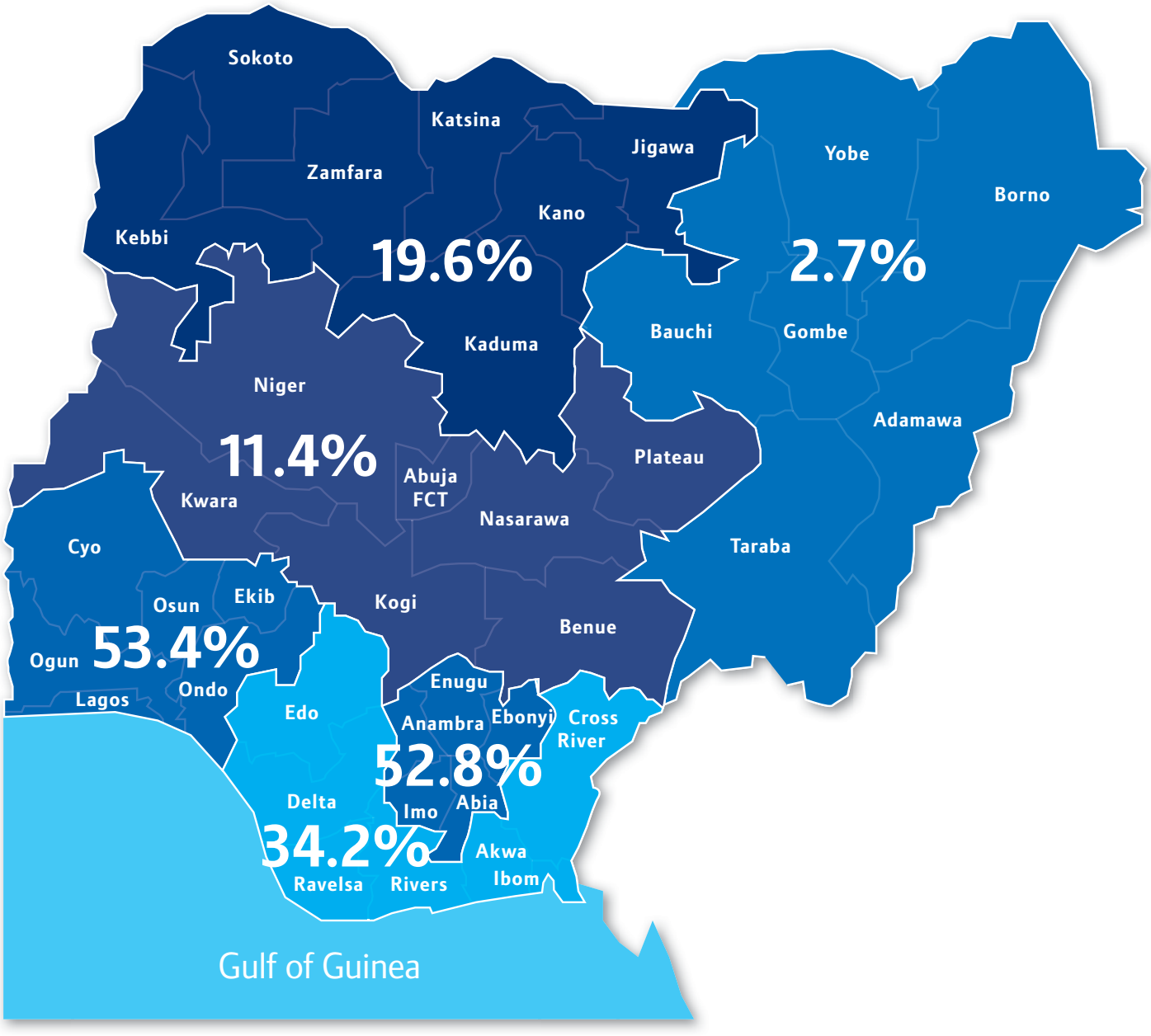
4) Other comments/ observations

8.7. Map of the geographical spread and prevalence rates of FGM/C in Ghana




Togo
Dapango
SAVANES
14.7%
KARA
7.3%
Kara
Sokodé
CENTRALE
22.7%
Atakpamé
PLATEAUX
6.1%
MARITIME
1.0%
Lomé
1.8%
Bight
of Benin

Nigeria


Sokoto
Katsina
Jigawa
Yobe
Zamfara
Borno
Kano
Kebbi
19.6%
2.7%
Kaduma
Bauchi
Gombe
Niger
Adamawa
11.4%
Plateau
Abuja
FCT
Kwara
Nasarawa
Taraba
Cyo
Kogi
Ekib
Osun
Benue
53.4%
Ogun
Ondo
Lagos
Enugu
Edo
Anambra
Ebonyi
Cross
River
52.8%
Delta
Imo
Abia
34.2%
Akwa
Ibom
Ravelsa
Rivers
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