European Institute for Gender Equality

Estimation of girls at risk of female genital mutilation in the European Union

Belgium, Greece, France, Italy, Cyprus and Malta

Report

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Acknowledgements

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This report is accompanied by other publications related to EIGE's work on combating female genital mutilation (FGM, or 'cutting'). More information and these resources can be found at http://eige.europa.eu/gender-based-violence/eiges-studies-gender-based-violence/female-genital-mutilation

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A list of contributors to the study is available in Annex 2 to this report.

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Foreword

Foreword

Female genital mutilation (FGM) is a severe form of gender-based violence, leaving deep physical and psychological scars on the lives of victims around the world. It is a violent form of subordination affecting women and girls and it stands in gross contradiction to the principles of gender equality. Ending the practice will require joint efforts that engage communities — both women and men — policymakers and civil society, to ensure prevention strategies and awareness-raising campaigns work.

The European Union strongly condemns all forms of violence against women. It has undertaken broad actions and adopted a multidimensional approach to tackling FGM. One of the priorities of the European Commission (the Commission), as outlined in its communication on the elimination of female genital mutilation (COM(2013) 0833 final of 25.11.2013), is to improve the understanding of the practice in the European Union. To achieve this objective, the European Institute of Gender Equality (EIGE) plays a key role in developing a sound methodology to estimate risk among women and girls living within Europe's borders.

With this third study on FGM, EIGE is building upon previous work to complete the picture of the prevalence of FGM in Belgium, Greece, France, Italy, Cyprus and Malta. One of the challenges for Member States is dealing with migratory flows from FGM-practising countries and the way to respond to asylum claims made on the grounds of FGM and organise reception conditions. A gender-sensitive asylum system is crucial to ensure victims and those at risk are protected upon arrival and given specialised care.

Our research captures the impact of migration on FGM in the European Union and gives essential insights into the factors motivating or discouraging the practice. While we might observe changes in attitudes and differences in the types of FGM performed, the underlying cause, rooted in gender inequality, too often remains deeply embedded in societies.

On behalf of EIGE and its team, I would like to thank all the institutions and experts who contributed to this important research. I firmly believe that our research and recommendations will help the European Union and Member States to strengthen their legal provisions, policies and services to prevent the practice from happening in the first place. We want to see an end to FGM in the European Union and all over the world, so that women and girls can live free from gender-based violence and achieve their full potential.

Virginija Langbakk,
Director
The European Institute for Gender Equality (EIGE)

Abbreviations

EU Member State abbreviations

BE	Belgium
BG	Bulgaria
CZ	Czech Republic
DK	Denmark
DE	Germany
EE	Estonia
IE	Ireland
EL	Greece
ES	Spain
FR	France
HR	Croatia
IT	Italy
CY	Cyprus
LV	Latvia
LT	Lithuania
LU	Luxembourg
HU	Hungary
MT	Malta
NL	Netherlands
AT	Austria
PL	Poland
PT	Portugal
RO	Romania
SI	Slovenia
SK	Slovakia
FI	Finland
SE	Sweden
UK	United Kingdom

Other abbreviations

CEAS	Common European Asylum System
DHS	demographic and health surveys
EIGE	European Institute for Gender Equality
FGM	female genital mutilation
MICS	multiple indicator cluster surveys
Unicef	United Nations Children's Fund

Contents

Introduction

Introduction

Female genital mutilation (FGM) refers to all procedures involving the partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons (World Health Organisation, 2008). The European Union is strongly committed to eliminating female genital mutilation and protecting women and girls from this violence. In 2013 the European Commission issued a communication entitled 'Towards the elimination of female genital mutilation' (European Commission, 2013a) and the European Parliament released a new resolution calling to 'mainstream the prevention of female genital mutilation into all sectors, especially health including sexual and reproductive health, social work, asylum, education including sex education, law enforcement, justice, child protection, and media and communication' (European Parliament, 2018).

Since 2012, EIGE has mapped the situation of female genital mutilation in the European Union, identified good practices to tackle it and developed a methodology to estimate the number of women and girls at risk. Risk estimations of female genital mutilation are articulated in the abovementioned 2013 European Commission communication, where EIGE is mandated to develop a methodology. This common methodology was originally presented in 2015, pilot-tested in three Member States (EIGE, 2015a) and further refined and applied in this report to an additional six Member States: Belgium, Greece, France, Italy, Cyprus and Malta. These countries are home to a mix of more established FGM-practising communities, as well as more recent arrivals. The views of 11 different communities living in these Member States were included into the risk estimations and this variety comes across in the results.

The overall objective of this report is supporting the European institutions and all EU Member States in providing more accurate qualitative and quantitative information on female genital mutilation and its risks among girls, taking into account new patterns of migration.

Firstly, the report outlines recent developments regarding female genital mutilation legislation, policies and research since January 2014, i.e. since the end of the data collected in EIGE's previous report on the matter (EIGE, 2015a). Secondly, the methodological approach used to estimate the number of girls at risk of female genital mutilation is described, alongside a presentation of improvements to further refine the methodology. Thirdly, detailed chapters summarise the estimated number of girls at risk of female genital mutilation in Belgium, Greece, France, Italy, Cyprus and Malta. Fourthly, a comparative analysis of the findings across the six Member States of the present study is conducted, together with a comparison to the data from the findings of EIGE's 2015 report and other similar research. Finally, tailor-made recommendations are proposed to support the European Union, its institutions and its Member States in reducing the risk of female genital mutilation and to protect girls at risk.

1. Recent developments in the European Union and its Member States

1. Recent developments in the European Union and its Member States

This chapter provides an overview of the recent legal and policy developments in combating female genital mutilation in the EU and in its 28 Member States. In general, this overview starts where EIGE's previous report, *Estimation of girls at risk of female genital mutilation in the European Union* ends (EIGE, 2015a).

1.1. European Union

The European Union has articulated its commitment to combating and eliminating female genital mutilation intensively and repeatedly. The European Commission's communication of 25 November 2013, entitled 'Towards the elimination of female genital mutilation' (European Commission, 2013a), sets out a clear framework for action covering internal and external policy, calling for a holistic and integrated approach and emphasising the need for prevention, prosecution and protection.

The Council of Europe's Convention on preventing and combating violence against women and domestic violence — signed by the EU and in force in 19 Member States ([1]) — criminalises female genital mutilation and provides the most comprehensive legal framework to combat the practice in the European Union. The convention calls for all state parties to set up integrated policies to prevent, protect, investigate and prosecute gender-based violence against women, including female genital mutilation (Council of Europe, 2011). The Council has developed, together with Amnesty International, a tool to design policies and measures to better address female genital mutilation (Council of Europe, 2014).

Directive 2012/29/EU of the European Parliament and of the Council of 25 October 2012 (the Victims' Rights Directive) establishes minimum standards on the rights, support and protection of victims of crime and ensures that persons who have fallen victim of crime are recognised and treated with respect, including victims of female genital mutilation ([2]). Furthermore, the Victims' Rights Directive confers rights on victims of extra-territorial offences in relation to criminal proceedings that take place in the EU.

The European Parliament resolutions of 8 February 2018 on zero tolerance for female genital mutilation, of 6 February 2014 on the Commission communication entitled 'Towards the elimination of female genital mutilation', and of 14 June 2012 on ending female genital mutilation all call for strong action towards combating the practice (European Parliament, 2018, 2014 and 2012).

Each year, the Commission re-emphasises its commitment to combating female genital mutilation on the International Day against Female Genital Mutilation. Moreover, when the European Commission declared 2017 the year to combat all forms of violence against women, female genital mutilation was part of this action. An EU-wide web platform, available through the European eJustice Portal, was thereby launched. This platform trains professionals encountering victims and girls at risk of female genital mutilation, such as teachers, doctors, lawyers and asylum officers (UEFGM, 2017).

Common European Asylum System

The Common European Asylum System (CEAS) aims at harmonising fair and effective asylum procedures throughout the European Union. EU legislation, in the form of revised Directive 2013/32/EU of the European Parliament and of the Council of 26 June 2013 on common procedures for granting and withdrawing international protection ([3]), revised Directive 2013/33/EU of the European Parliament and of the Council of 26 June 2013 laying down standards for the reception of applicants for international protection ([4]) and Directive 2011/95/EU of the European Parliament and of the Council of 13 December 2011 on standards for the qualification of third-country nationals or stateless persons as beneficiaries of international protection, for a uniform status for refugees or for persons eligible for subsidiary protection, and for the content of the protection granted ([5]), have strengthened protection for refugees and asylum seekers at risk of female genital mutilation.

European Union and Member State legislation now specifies that the 1951 convention must be interpreted in a gender-sensitive way, including treating the risk of gender-based violence as possible grounds for asylum. Under the directives, women and girls at risk of female genital mutilation, survivors of female genital mutilation and parents at risk of persecution if they refuse female genital mutilation for their children can qualify for protection. Authorities are encouraged

([1]) For readability, the listing of Member States are provided in footnotes if the total number exceeds three Member States. BE, DK, DE, EE, EL, ES, FR, HR, IT, CY, MT, NL, AT, PL, PT, RO, SI, FI, SE. The other 9 EU Member States have signed the convention.
([2]) OJ L 315, 14.11.2012, p. 57.
([3]) OJ L 180, 29.6.2013, p. 60.
([4]) OJ L 180, 29.6.2013, p. 96.
([5]) OJ L 337, 20.12.2011, p. 9.

to seek advice from specialists to determine which applicants are at risk of or have suffered female genital mutilation, and specialised training is required for officials who are in contact with applicants who are victims of gender-based violence. Asylum seekers affected by female genital mutilation are also entitled to specific reception conditions.

To support Member States in implementing their obligations under these directives, the European Asylum Support Office has developed an online 'Tool for the identification of persons with special needs' (EASO, 2016). This tool allows for the timely identification of persons with special procedural and/or reception needs, including victims of female genital mutilation and girls at risk of it.

The need for gender-sensitive asylum procedures is also articulated in the Istanbul Convention under Article 60(3) (Council of Europe, 2011).

External action

Combating female genital mutilation is an important goal of the European Union's external action programme as highlighted under the EU action plan on human rights and democracy 2015–2019 (Council of the European Union, 2015a) and the gender action plan 2016–2020 on 'Gender equality and women's empowerment: transforming the lives of girls and women through EU external relations 2016–2020' (Council of the European Union, 2015b). The gender action plan prioritises female genital mutilation under objective 7 'Girls and women free from all forms of violence against them […] both in the public and in the private sphere'.

The European Commission funds several transnational projects dedicated to preventing violence against women and children linked to harmful practices (European Commission, 2014). Furthermore, through several joint initiatives with the United Nations, the European Union is supporting the fight against female genital mutilation and other harmful practices worldwide. The European Union contributes to the 2030 agenda for sustainable development, where target 5.3 refers to eliminating all harmful practices, such as child, early and forced marriage and female genital mutilation (United Nations, 2015). In this regard, the European Union and the United Nations are partnering up through the multi-year spotlight initiative 2017–2023 on eliminating all forms of violence against women and girls (European Union and United Nations, 2017). Moreover, the European Union contributes to the Unicef-UNFPA joint programmes on the abandonment of FGM/C: accelerating change.

1.2. Member States' legal frameworks

Female genital mutilation is a crime in all Member States

All Member States criminalise female genital mutilation, which is either incorporated in general criminal law or explicitly mentioned in a specific provision or law. According to the findings presented in EIGE's reports *Female genital mutilation in the European Union* (EIGE, 2013) and *Estimation of girls at risk of female genital mutilation in the European Union* (EIGE, 2015a), 13 Member States had introduced a specific criminal law to prosecute female genital mutilation by June 2014: Belgium, Denmark, Germany, Ireland, Spain, Italy, Cyprus, Hungary, Malta, the Netherlands, Austria, Sweden and the United Kingdom. Since then, Estonia, Greece, Portugal, Romania and Finland have each issued a specific law to criminalise female genital mutilation, bringing the total number of specific legal provisions to 18.

Four Member States have entire legislative acts devoted to tackling female genital mutilation: Ireland, Italy, Sweden and the United Kingdom. They outline specifically and in detail how the practice is punishable. Other Member States, such as France, use general criminal law provisions to criminalise female genital mutilation, referring to bodily injury and serious harm or mutilation.

Table 1.1. EU Member States with a specific reference to female genital mutilation or 'mutilation' in their law by 2018

Periods covered	EU Member States with a specific criminal law on (female genital) mutilation
January 1980–February 2012	SE (1982), UK (1985), AT (2001), BE (2001), CY (2003), DK (2003) ES (2003), IT (2006)
March 2012–June 2014	IE (2012), DE (2013), HR (2013), NL (2013), MT (2014)
July 2014–April 2018	RO (2014), PT (2015), FI (2015), EE (2017), EL (2018)

Extraterritoriality

The principle of extraterritoriality, criminalising female genital mutilation when committed abroad, is applied in 25 Member States but not in Bulgaria, the Czech Republic or Luxembourg. Omission of the extraterritoriality principle significantly limits the protection of girls at risk of female genital mutilation and the ability to prosecute perpetrators if female genital mutilation is committed abroad. Countries vary in the extent to which they apply this principle to citizens, residents and non-residents, with some countries that have ratified the Istanbul Convention having introduced reservations to Article 44 1.e to limit the scope of the extraterritoriality principle so that it either does not apply to habitual residents, or only applies in certain cases (Council of Europe, 2011).

Court cases

Few criminal cases are brought to court in Member States. The underreporting of female genital mutilation is likely to be higher than that of any other form of gender-based violence, as it involves children, it has a secretive nature in closed communities and there is limited awareness of all aspects of the law among perpetrators, professionals and society as a whole. Furthermore, cases may not reach court due to a lack of first-hand witnesses or fear of disproportionate punishment of parents (European Commission, 2015).

Monitoring of the prosecution of cases of female genital mutilation is limited and scattered and it is challenging to obtain data, as there is no uniform data collection system in most Member States. Table 1.2 presents the available information on court cases, prosecutions and protection orders related to female genital mutilation in nine Member States.

Child protection

General legal provisions regarding child protection exist in all EU Member States and can be used in cases of female genital mutilation. Child protection law explicitly referring to female genital mutilation only exists in Luxembourg, in the Law on Children and Family Support. However, specific guidelines for professionals have been developed in Spain, the Netherlands and Portugal providing information about

Table 1.2. Data available on FGM-related court cases, prosecutions and protection orders in Member States ([6])

Member State	Data available on court cases and prosecutions		Data sources ([7])
Belgium	**21**	Number of protection cases for FGM brought to the correctional courts (years 2008–2016) (of which 10 classified and one reclassified between 2013 and 2016)	Institute for the Equality of Women and Men
Denmark	**2**	Number of convictions (up until end of 2017)	Consultation with Danish academics
Germany	**0**	Number of convictions (years 2013 and 2014)	Federal Statistical Office Destatis
	4	Number of detainees — including three convictions (2015)	
Estonia	**0**	Number of judicial investigations, court cases or prosecutions related to FGM (up until end of 2017)	Department for Equality Policies
Greece	**1**	Number of allegations — no prosecutions	Expert consultation ([8])
France	**30**	Number of court cases — more up-to-date statistics not available (up until end of 2012)	EquiPop
Croatia	**0**	Number of cases of FGM since 2013 (when Article 116 was included in the Criminal Code)	Ministry of Justice and the national registration system (eSpis)
Sweden	**0**	Number of prosecutions (years 2015 and 2016)	Swedish Council for Crime Prevention
United Kingdom	**179**	Number of protection orders for potential victims of FGM, out of 205 applications (July 2015-September 2017) (England and Wales, and Northern Ireland)	Ministry of Justice, 2017 and UK Department of Health
	1	Number of completed prosecutions — not guilty verdict (July 2015-September 2017)	

procedures to follow when encountering a case of (risk of) female genital mutilation.

The notion of parental responsibility refers to whether parents or legal guardians can be held accountable if female genital mutilation is performed on a child for whom they are responsible. Parental responsibility is recognised in 21 Member States ([9]) and differences exist in the ways parents are penalised for allowing and/or being complicit in female genital mutilation. For example, in Malta, the punishment for an FGM-related offence (including aiding and abetting) is increased if it is committed by a family member or person cohabiting with the victim (Criminal Code, Article 521e). In Finland, a parent is not be sentenced for failure to report if they would have had to denounce their present or former spouse or cohabiting partner (Criminal Code, Chapter 15, Section 10).

There is little information available on the number of child protection interventions related to female genital mutilation that have taken place across the EU; reported cases are rare, with an undisclosed number of incidents occurring in Belgium, Spain and France (EIGE, 2015a).

Asylum provisions

In the European Union today, women from FGM-practising countries continue to seek asylum. EU international protection directives can be used to grant international protection in cases of (fear of) female genital mutilation. These directives are legally binding for EU Member States. Denmark, France, Luxembourg, Hungary and Portugal have developed asylum laws that specifically mention female genital mutilation. Other Member States rely on general asylum laws to incorporate female genital mutilation, often including victims under vulnerable groups, recognising it and making specific provisions for it in their procedures.

There are differences between Member States in accepting gender-based asylum applications and their reception provisions, which has implications for the treatment received by women seeking asylum on the grounds of female genital mutilation. For example, in Italy, if the asylum seeker is known to be a victim of female genital mutilation then special care is granted, such as the applicant being entitled to appropriate healthcare during their application period (Decreto Legislativo, 142/2015). Likewise, Romania has produced guidance for refugee reception centres to provide advice on how to handle asylum

([6]) Data collected through formal monitoring systems and/or expert consultation in Member States. As data is not collected in different ways and through different channels, it is indicative rather than comparable.

([7]) Information is based on the results of consultation with experts from all Member States and/or formal monitoring systems. Data was requested, but not provided for Spain and Hungary; it is not clear whether these Member States monitor this data. All remaining Member States either did not respond to the request for data or confirmed that they do not monitor this data.

([8]) EIGE, experience-sharing meeting, 'Policy responses to female genital mutilation in the context of migration', 14 November 2017, Athens.

([9]) BE, DE, IE, EL, ES, FR, HR, IT, CY, LV, LT, LU, HU, MT, NL, AT, PT, SI, FI, SE and UK. Data collected through expert consultation (missing data for BG DK, PL, RO and SK).

requests based on gender abuse (Romanian National Council for Refugees, no date).

Except for Luxembourg, no EU Member State has a specific registration system in place for monitoring FGM-specific asylum applications. In Belgium and France, fragmented data is available on the number of asylum applications received and granted.

Professional secrecy provisions

EU Member States' general professional secrecy provisions can be applied to report cases of female genital mutilation or to protect girls at risk, and in Belgium, Germany, Luxembourg, Malta, the Netherlands, Sweden and the United Kingdom (England and Wales) there are specific legal provisions with regard to reporting cases of performed or planned female genital mutilation.

In addition, Belgium, Ireland, Spain, France, Malta, the Netherlands, Portugal, Sweden and the United Kingdom have developed guidance and protocols for healthcare providers and other service professionals on how to report a suspected case of female genital mutilation.

1.3. Member States' policy frameworks

Portugal and Finland are implementing specific national action plans to combat female genital mutilation, while Belgium, France and the United Kingdom have included extensive measures in their general national action plans to combat violence against women. An additional 14 Member States integrate female genital mutilation more broadly into national strategies on promoting gender equality, human rights and/or tackling gender-based violence ([10]). On the other hand, female genital mutilation is not explicitly mentioned in recent action plans in Denmark, Cyprus, Latvia or Lithuania, but could be covered by initiatives to tackle broader forms of violence, such as harmful traditional practices and violence in the family.

Furthermore, Poland, Romania and Slovenia have no recent policies at national level to eradicate female genital mutilation or related forms of gender-based violence. The remaining two Member States, Germany and Malta, have no national action plans on female genital mutilation, but actions have been undertaken, namely awareness-raising campaigns in Malta (European Commission, 2013b) and strategies on female genital mutilation developed by the German federal working group Bund-Länder-NRO AG in 2014 (UEFGM, 2016b).

Table 1.3. Overview of national strategies to tackle female genital mutilation in Member States ([11])

Member State	Name of strategy	Period covered	Issuing authority
A specific national action plan for combating female genital mutilation			
Portugal	Third programme of action for the elimination of female genital mutilation	2014–2017	Commission for Citizenship and Gender Equality
Finland	Action plan for the prevention of circumcision of girls and women	2017–2019	Ministry of Social Affairs and Health
United Kingdom (Scotland)	National action plan to prevent and eradicate female genital mutilation	2016–2020	The Scottish government
National action plans that include detailed measures to combat female genital mutilation			
Belgium	National action plan to combat all forms of gender-based violence	2015–2019	Institute for the Equality of Women and Men
France	Fifth interministerial plan to combat all forms of violence against women	2017–2019	Ministry of Social Affairs, Health and Women's Rights
United Kingdom (England and Wales)	Ending violence against women and girls	2016–2020	Home Office
National action plans that mention female genital mutilation			
Bulgaria	National programme for the prevention of violence against children and child abuse	2017–2020	State Agency for Child Protection
Czech Republic	Action plan for the prevention of domestic and gender-based violence	2015–2018	Office of the Government of the Czech Republic
Estonia	Violence prevention strategy	2015–2020	Ministry of Justice
Ireland	Second national action plan on women, peace and security	2015–2018	Government of Ireland
Greece	National action plan on gender equality	2016–2020	General Secretariat for Gender Equality

([10]) BG, CZ, EE, IE, EL, ES, HR, IT, LU, HU, NL, AT, SK, SE. References to all action plans are in the bibliography of this report.

([11]) The full references of the national action plans and strategies are given in the bibliography of this report.

Table 1.3. (Continued)

Member State	Name of strategy	Period covered	Issuing authority
Spain	National Agreement to Combat Gender-based Violence	2017	Congress of Deputies
Croatia	National strategy for protection from domestic violence	2017–2022	Government of Croatia
Italy	Special action plan against sexual and gender-based violence	2015–2017	Council of Ministers
Luxembourg	Plan for equality between women and men	2015–2018	Ministry of Equal Opportunities
Hungary	Government resolution on the national strategy to promote equality between women and men	2010–2021	Government of Hungary
Netherlands	Action plan against domestic violence and child abuse	2018–2021	Ministry of Health, Well-being and Sports and Ministry of Security and Justice
Austria	National plan on violence against women and implementation report	2014–2016 2018	Austrian Federal Government
Slovakia	National action plan for the prevention and elimination of violence against women	2014–2019	Government of the Slovak Republic
Sweden	National strategy to prevent and combat men's violence against women	2017–2027	Government of Sweden

When taking a closer look at the detailed action plans to combat female genital mutilation, as presented in Belgium, France, Portugal, Finland and the United Kingdom, a focus on **health** (within multidisciplinary teams) can be observed, including guidelines, treatment services, information for pregnant women, reversal procedures and aftercare for victims. Awareness, information and training for healthcare professionals are highlighted. The United Kingdom has developed a GBP 3 million female genital mutilation prevention programme in partnership with National Health Service England to improve health-based responses (i.e. prevention and safeguarding). Portugal, Finland and the United Kingdom have incorporated the need for psychological support for cases of female genital mutilation into their action plans. Also, Sweden outlined the National Board of Health and Welfare's actions to develop a new permit code in 2015 to ensure cases related to female genital mutilation can be identified.

Another focus in action plans from Belgium, France, Portugal, Finland and the United Kingdom is on **education** and providing information in different languages on female genital mutilation laws, or awareness-raising in education institutions and in communities where it is practised. The Belgian plan recommends distributing 'prevention kits' in schools. Austria mentions raising awareness of female genital mutilation support systems in schools.

Working with **migrant communities** to tackle female genital mutilation is highlighted in the strategies in Portugal, Finland and the United Kingdom. Some Member States list different strategies for engagement, such as organising workshops and offering information leaflets in different languages providing advice on laws relating to female genital mutilation. In Finland, for example, non-governmental organisations working with immigrant communities are asked to inform beneficiaries about Finnish legislation on female genital mutilation. In Greece, cooperation with migrant communities is highlighted in awareness-raising campaigns.

Only the United Kingdom includes specific actions targeted at **engaging men** in combating female genital mutilation in its national policy.

Several Member States mention **asylum and increased migration** in different capacities. The United Kingdom calls for gender sensitivity when interviewing persons applying for international protection. Belgium, Portugal and Finland focus on using the avenue of asylum and migration to raise awareness and offer information about female genital mutilation. The national policy in Bulgaria on violence against children and in Slovakia on violence against women highlight that female genital mutilation could be a challenge within migrant communities, although no specific measures are outlined.

Belgium, Portugal and the United Kingdom explicitly mention **attempts to raise awareness** of the harmful practice of female genital mutilation. Belgium, as an example, highlights the importance of marking the International Day for Zero Tolerance of Female Genital Mutilation, on 6 February. Awareness-raising takes many forms in the United Kingdom, including sharing intelligence between the border force, police and airlines to detect 'high risk' flights with girls travelling to undergo female genital mutilation.

Several **other actions** are included in national strategies to tackle female genital mutilation or gender-based violence. Portugal and the United Kingdom refer to the need to engage religious leaders. Further research on the prevalence of female genital mutilation is called for in the national strategies of the Czech Republic, Denmark, Portugal and Finland. The United Kingdom (England and Wales, and Northern Ireland) introduces protection orders which place restrictions on

potential offenders (e.g. preventing them from travelling abroad), and protecting the anonymity of victims within the Serious Crime Act (2015). Croatia and Sweden also reference the addition of relevant criminal laws introduced to tackle female genital mutilation.

Portugal and the United Kingdom point to the importance of **international cooperation** to eradicate female genital mutilation, in terms of learning from other countries but also working with countries where female genital mutilation is practised. Spain, Italy and Sweden have developed **regional initiatives** to tackle female genital mutilation ([12]).

In addition to these national action plans, several Member States have developed national guidance for professionals on how to deal with female genital mutilation, namely Belgium, Ireland, Spain, France, Italy, Malta, the Netherlands, Portugal, Sweden and the United Kingdom (England and Wales) ([13]). These guidelines include information on the applicable legislation, the warning signs, and the conditions under which professionals should report suspected cases.

1.4. Research on female genital mutilation in the European Union

Since EIGE's latest overview up until 2014 (EIGE, 2015a, p. 22), 18 studies have been conducted on the prevalence and/or risk of female genital mutilation across the EU and in Member States. Ten studies in five Member States (Belgium, Germany, Italy, Portugal and the United Kingdom) and Norway estimated prevalence and/or risk, using extrapolation methods. The number of girls at risk estimated by these researchers varied between 4 084 in Belgium (Dubourg and Richard, 2014) and 13 320 in Germany (Terre des Femmes, 2017). Other research in Germany presented the number of girls at risk of female genital mutilation as an estimated interval of between 1 558 and 5 684 girls at risk (Integra, 2017). In the same way, Norway estimated between 3 000 and 7 000 girls were at risk (Ziyada et al., 2016).

In general, these studies relied on data on the female population obtained from a number of official datasets, including national censuses; data collected by a national statistical office; statistics generated by Unicef and birth registration data. However, in some cases (Italy, 2016; Finland, 2016), ad hoc survey data was also obtained from small-scale, targeted research. In this case, the Finnish study (Koukkula et al., 2016) used data obtained from the Migrant Health and Well-being Study carried out in 2010–2012, based on interviews with women originating from Somalia and women of Kurdish origin. Likewise, the Italian methodology encompassed direct estimation using the results of the first survey on women at risk of female genital mutilation carried out in Italy in 2010, involving 1 000 migrants from the main FGM-practising countries aged 15–49 living in the Italian region of Lombardy, as well as indirect estimates for other communities using the method of extrapolating from FGM-practising countries' prevalence data, corrected according to the selection hypothesis (Ortensi et al., 2015).

The Norwegian study (Ziyada et al., 2016) aimed to estimate two key groups affected by female genital mutilation in Norway: those already affected and potentially in need of healthcare, and those at risk of female genital mutilation. Register data was combined with population-based survey data on female genital mutilation, adopting an extrapolation methodology. This study estimated prevalence from the total resident population originating from the 29 FGM-prevalent countries in Norway, consisting of first- and second-generation immigrants. Girls with only one parent from an FGM-practising country were excluded from the calculation, as they considered the risk for those girls to be quite uncertain or low. To calculate the risk, the authors modified EIGE's definition slightly, by including only first-generation minor girls arriving in Norway who were younger than the customary age at which female genital mutilation is practised in their country of origin, whereas for the second generation, all those under 18 were considered at risk. Moreover, the authors estimated the number of type II ([15]) female genital mutilation cases.

The challenges faced in the extrapolation studies are similar to those encountered in this report. For example, the Norwegian research (Ziyada et al., 2016) noted the lack of data on the ethnicity and regional origin of migrants, producing bias and under- or overestimations. Absence of data on irregular migrants was identified across all studies, except the Italian research (Farina et al., 2016), which included data on undocumented migrants. Most of the extrapolation studies do not explicitly consider girls aged 0–18. Some studies exclude, or only partially include, this age group (e.g. Van Baelen et al., 2016; Farina et al., 2016). Others do not make particular assumptions for this group (e.g. Teixeira and Lisboa, 2016).

Table 1.4. Recent research focusing on the estimation of FGM prevalence and/or risk ([14])

Research using extrapolation		Research estimating FGM prevalence/risk without extrapolation	Other studies on FGM
Research estimating FGM prevalence	Research estimating FGM prevalence and risk		
Transnational (Van Baelen et al.,2016), United Kingdom (Macfarlane and Dorkenoo, 2014 and 2016), Italy (Farina et al., 2016), Portugal (Teixeria and Lisboa, 2016)	Belgium (Dubourg and Richard, 2014), Germany (Terre des Femmes, 2015, 2016, 2017; Integra, 2017) Not EU: Norway (Ziyada et al., 2016)	Finland (Koukkula et al., 2016) Denmark (Christoffersen et al., 2017) United Kingdom (Clinical Audit and Registries Management Services, 2017)	Bulgaria (Tisheva and Nikolova, 2015), Italy (Surico et al., 2015), Estonia (Kase, 2016), Spain (Kaplan Marcusan and Lopez Gay, 2017)

([12]) The full references of the regional-level action plans and protocols are given in the bibliography of this report.

([13]) The full references of the national guidance for professionals on female genital mutilation are given in the bibliography of this report.

([14]) References of these studies are given in the bibliography of this report.

([15]) Definitions of the different types of female genital mutilation are provided in the glossary in Annex 1 to this report.

However, some studies clearly state that not all girls considered at risk will be cut (Dubourg and Richard, 2014; Macfarlane and Dorkenoo, 2016). Dubourg and Richard, for example, consider second-generation girls as being at risk while first-generation girls are considered to be already excised. Studies that include girls aged 0–18 apply the prevalence observed in countries of origin for girls aged 15–19. The main difference with EIGE's methodology is in the use of the median age of cutting that is customary in a particular country of origin as a key variable for defining girls at risk. The Belgian study defines the difference between girls at risk and cut girls according to their place of birth (Dubourg and Richard, 2014). The Norwegian study assumes that those first-generation immigrants older than the customary age of cutting upon arrival in host countries were already subjected to female genital mutilation in a similar proportion to the prevalence rates in their countries of origin (Ziyada et al., 2016). Other studies (e.g. Teixeira and Lisboa, 2016; Macfarlane and Dorkenoo, 2016) do not place a particular emphasis on the distinction between girls at risk and girls that are expected to be cut.

The German study (Integra, 2017) applied EIGE's methodology and added specificities. To calculate the number of girls at risk of female genital mutilation, all girls aged 0–18 were considered instead of those under the median age of cutting in the country of origin. According to this research, excluding girls of a certain age might underestimate the actual number of girls at risk of female genital mutilation in Germany. Also, the study bases its calculation of the prevalence rate of female genital mutilation in the country of origin on the age cohort 15–49, instead of 15–19, for the same reason. For comparison with EIGE's research, the results are presented using EIGE's original methodology as well.

The Norwegian study (Ziyada et al., 2016) was able to distinguish between girls with one and two parents from FGM-practising countries, as data on this was available in the country. Those with one parent from an FGM-practising country were excluded from the category 'potentially at risk'.

As for the use of a coefficient to correct prevalence, most studies do not apply a factor similar to EIGE's migration and acculturation impact factor ([16]) (EIGE, 2015a, p. 43). The Italian study applies a correction for selection hypothesis (Farina et al., 2016 and Ortensi et al., 2015). The rationale for the correction is that migrants are not a random cross-section of the populations from which they originate. For this reason, the proportion of women with female genital mutilation is also likely to be different from the estimated national level. In fact, there is evidence from practising countries indicating that lower age, higher levels of wealth and education or urban residence are usually correlated with lower occurrence of female genital mutilation. As a consequence, the application of the prevalence in the country of origin to overseas communities is likely to bias first-generation indirect estimates of female genital mutilation occurrence.

([16]) 'Acculturation can be defined as a culture learning process experienced by individuals who are exposed to a new culture or ethnic group', (Balls Organista, P. Marin, G. and Chun, K.M. (2010), 'Acculturation' in *The psychology of ethnic groups in the United States*, SAGE, Thousand Oaks, available at: http://www.sagepub.com/upm-data/30900_Chapter4.pdf).

2. Methodology to estimate the number of girls at risk of female genital mutilation

2. Methodology to estimate the number of girls at risk of female genital mutilation

EIGE has established a common methodology to estimate the number of girls at risk of female genital mutilation in the European Union (EIGE, 2015a). This **original methodology** was developed in 2015, pilot-tested in the same year in three Member States and further applied to the six Member States of this report. A step-by-step guide is available describing in detail how to implement the methodology (EIGE, 2015b).

As a next step, based on the findings in this report and following latest research in the field, the methodological approach was further improved and a **refined methodology** for future risk estimations is presented in this section.

> **Female genital mutilation risk estimation** in an EU Member State is defined as:
>
> 'the number of minor girls (either born in, or born to mothers from, FGM risk countries), aged 0–18, living in an EU Member State who might actually be at risk of female genital mutilation, expressed as a proportion of the total number of girls, living in an EU country, who originate from or are born to a mother from FGM risk countries'
>
> (EIGE, 2015a)

Essentially, the methodology extrapolates data on the prevalence of female genital mutilation in FGM-practising countries to migrant girls living in the European Union. A mixed-method approach of quantitative and qualitative data further estimates the number of girls at risk of female genital mutilation.

2.1. Quantitative component

As a first step in the methodology, quantitative data is collected from: (1) countries where female genital mutilation is documented (i.e. countries of origin); and (2) EU Member States (i.e. countries of destination). In order to have comparable figures across countries, data is collected for 2011, the year of the latest available EU-wide population and housing census (Eurostat, 2011) and for following years, whenever data is available.

Country of origin

The data sources on the prevalence rate and age of female genital mutilation in the country of origin are the demographic and health surveys (DHS), published by ICF International, and the multiple indicator cluster surveys, published by Unicef. The national prevalence rates of female genital mutilation for women/girls of the 15–19 age cohort are used in the estimation, as they are the youngest group of adults considered to be in 'final cut status', being either cut or not at risk anymore (EIGE, 2015a, p. 35). As these international surveys use 5-year age groups (0–4, 5–9, 10–14, 15–19) to present data on female genital mutilation, the number of girls aged 0–18 is estimated.

The following indicators are used for data collection from DHS and MICS:

- ✓ national prevalence rates of female genital mutilation for women/girls (aged 15–19);
- ✓ regional prevalence rates of female genital mutilation for women/girls (aged 15–19);
- ✓ national median age of female genital mutilation (calculated).

Countries of destination

Data is collected on resident migrants and asylum seekers. The definitions in use are based on Eurostat's terminology of a resident migrant as 'a person born in an FGM-practising country to one or more parents born in these countries and who is a usual resident in an EU Member State (first generation) or a person who was not born in an FGM-practising country, but has at least one parent born in an FGM-practising country and who is a usual resident in a EU Member State'. Asylum seeker (or asylum applicant) is defined as 'a person having submitted an application for international protection or having been included in such application as a family member during the reference period' (Eurostat, no date).

The main data sources on the resident migrant and asylum-seeking population are Eurostat, national statistical offices, birth registration offices and border and immigration authorities. This data is collected disaggregated by: sex, generation, country and region of origin, exact age and age of arrival. If data is unavailable, a number of 'proxies' are used, such as live-birth data.

The following indicators were used for data collection on the resident migrant and asylum-seeking population:

- ✓ the number of female resident migrants (aged 0–18) from FGM-practising countries;
- ✓ the number of female asylum seekers from FGM-practising countries;
- ✓ the number of female live births to mothers from FGM-practising countries.

Data on female asylum seekers and refugees is kept separate, as far as possible, from data on the resident migrant population. The estimation of the number of asylum-seeking girls at risk of female genital mutilation is conducted separately as the push factors for migration are different when compared to resident migrants (EIGE, 2015a, p. 79).

A number of challenges exist when collecting data in Member States on the number of female resident migrants and female asylum seekers.

- Data is rarely publicly available and specific disaggregated data is therefore requested from different authorities.
- Data on the region of origin of migrants is not available. This information would allow for more precise estimations since female genital mutilation rates vary widely within the different regions of the countries of origin.
- Data on ethnicity is not available as a result of national legislation in several Member States.
- Data disaggregated by generation is not always available and records from the national censuses are often used for the calculation of estimations.
- Official data on irregular/undocumented migrants is not available and data from unofficial sources provided proxies. Irregular/undocumented migrants had to be excluded from the estimations because of the lack of reliable data.
- The use of different national terminologies on 'first-generation migrant' and 'irregular migrant' hampers data collection.
- Data on the number of migrants that enter or leave the country is difficult to collect, with Belgium and Italy having the closest available data.
- Data on the number of FGM-related asylum applications received and granted in a Member State disaggregated by sex is difficult to collect, with Belgium and France providing limited data.
- Data beyond 2011, the year of the European population and housing census, is not available everywhere, hampering the observation of trends over time in all six Member States of the report.
- Data by father's country of origin is unavailable, therefore only data about the mother's origin is used.

These challenges on data collection and availability align with the findings from EIGE's previous work on estimating the risk of female genital mutilation (EIGE, 2015a), showing that improving data collection is a slow process whereby data collection systems at national and EU level need to be sensitised and informed further. However, to overcome data gaps, proxies were successfully used, particularly to complete data on the second generation and the need to project the size of this population using live-birth data.

2.2. Qualitative component

As a second step in the methodology, quantitative information is supplemented with qualitative research. Therefore, focus group discussions were organised with women and men from communities originating from FGM-practising countries and residing in a Member State. In this way, insights on female genital mutilation were captured and the impact of migration on attitudes and behaviours towards female genital mutilation in Europe was assessed. The level of impact varies among communities and Member States, depending on, inter alia, the length of stay, the country of origin, size of communities and the existing legal and policy framework in the country of destination.

A topic guide structured the group discussions and several aspects were covered: current meaning of female genital mutilation at

Table 2.1. Country of origin of the participants of the 24 focus group discussions

	Women aged 25 first generation	Young women aged 18–25 second generation	Men aged 25+ first and/or second generation	Women all ages hard-to-reach or recent migrants
Belgium	Somali	Guinean	Somali (first generation)	Iraqi (first generation)
Greece	Egyptian and Sudanese	Nigerian and Egyptian	Egyptian, Iraqi (first and second generation)	Somali (first generation)
France	Malian	Malian	Malian (first and second generation)	Guinean (first generation)
Italy	Egyptian	Ethiopian, Nigerian, Eritrean, Egyptian	Egyptian (first and second generation)	Nigerian (first and second generation)
Cyprus	Somali	Somali	Somali (first generation)	Somali, Ethiopian, Nigerian, Ivorian, Gambian (first generation)
Malta	Nigerian	Egyptian	Nigerian (first generation)	Egyptian (first generation)

personal and societal levels; personal views and attitudes on the practice of female genital mutilation; how the impact of migration affects (or does not affect) decisions to engage in the practice; expectations and social pressure for subjecting girls to female genital mutilation; awareness of the legal framework in Member States and countries of origin; awareness of anti-FGM campaigns; girls at risk of female genital mutilation; decision-making process to perform female genital mutilation; education; effectiveness of prevention and protection policies and services.

Different target groups were defined in order to engage with community members with different backgrounds. The criteria for the target groups were based on the variables of age (+ 18), sex (women and men), generation (first and second) and country of origin (FGM-practising countries) and four groups were predefined for each Member State (see Table 2.1).

Due to difficulties in recruiting second-generation participants in some Member States, the recruitment criteria for the session with young women were enlarged. Girls who arrived in Europe under the age of five were added to the second-generation focus group discussion. In cases where this still did not allow for a big enough pool of recruits who were over 18 (Cyprus and Malta), the focus group discussion with young women was held with all first-generation women aged 18–25.

The choice of the variable 'country of origin' in each Member State was based on: communities with a high prevalence of female genital mutilation in the country of origin (and thereby likely to contain a higher number of girls at risk of female genital mutilation) and the overall size of the migrant population from FGM-practising countries (with preference given to the biggest communities in a Member State).

In many cases, the community with the biggest population also originated from a country with high prevalence rates of female genital mutilation. If this was not the case, preference was given to engaging communities with high prevalence rates of female genital mutilation in the country of origin, but with a smaller overall population. The focus group discussions with recent migrants were an exception to this rule, as here the objective was to gain information about newer communities, about whom less is known on the practice of female genital mutilation. As such, it was more acceptable in these instances to engage communities with a lower level of female genital mutilation recorded in the origin country (such as Iraq). Communities were combined in the same session when it was judged that this could aid understanding and in a way that was both culturally and linguistically sensitive. The choice to mix communities was decided on a case-by-case basis.

Purposive and snowball sampling techniques were used to select participants. The identification and recruitment of participants according to the predefined criteria was facilitated by advertising via different channels in cooperation with local civil society organisations (including charities, migrant networks and others) to engage participants. Cultural mediators, peer educators and translators played an important role in the delivery of the sessions, building upon established relationships with some participants.

A number of challenges exist when collecting qualitative information through focus group research on the attitudes and beliefs of first and second-generation migrants living in an EU Member State.

- Difficulties in recruiting second-generation girls aged 18+, particularly in Italy, Cyprus and Malta. In Italy and Malta this was primarily due to the relatively small number of young women in this subgroup.
- A reluctance among participants to discuss such a sensitive subject hampered recruitment, due to fear and stigmatisation.
- Logistical obstacles in terms of work, transport and childcare hampered participation.
- Difficulties in involving 'hard-to-reach' groups due to their limited contact with existing services.
- A possible bias in the perspectives of participants: the very decision to discuss female genital mutilation assumes that the participants are willing to question it and some may fear expressing pro-FGM views in light of possible criminal consequences.
- Peer pressure and dynamics established among the participants hampering free speech.

These challenges when conducting focus group research align with EIGE's previous work on estimating the risk of female genital mutilation (EIGE, 2015a), showing that difficulties in recruiting and engaging with migrant communities are recurrent in different Member States. However, to overcome different levels of disengagement, several actions were put in place: the definition of second generation was, in exceptional cases, widened to first-generation girls arriving before the age of five; cultural mediators assisted in recruitment and discussions; logistical support was provided via transport, childcare and meals, and anonymity and confidentiality were ensured, in line with the respective legal frameworks.

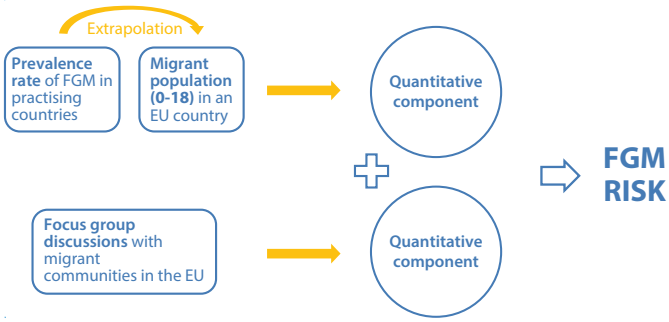
2.3. How to estimate the risk of female genital mutilation

This section outlines how the numbers of girls at risk of female genital mutilation are estimated. The general approach is described and, where relevant, a comparison is given between the **original methodology** (EIGE, 2015b) and the improvements in the **refined methodology** under this report.

Extrapolation method

To estimate the number of girls at risk of female genital mutilation in an EU Member State, a 'country of origin's female genital mutilation prevalence rate' (of the age cohort 15–19) ([17]) is multiplied by the total

Figure 2.1. Summary of the 'extrapolation-of-FGM-practising-countries-prevalence-data method'



([17]) Data sources: DHS published by ICF International and MICS published by Unicef.

number of girls coming from, or born from a mother originating from, a particular country where female genital mutilation is commonly practised and who have reached the median age of cutting (according to the customary age of cutting in the country of origin). To this, a qualitative research component is added, in order to take into account the impact of migration on the practice of female genital mutilation in the calculation.

For the variable 'country of origin's female genital mutilation prevalence rate', the DHS and MICS data for the 15–19 age cohort is used instead of the 15–49 age cohort, as the latter overestimates the true risk for girls from those countries where there has been a decline in female genital mutilation prevalence in recent years. Girls in the age range 15–19 are considered to have reached 'final cut status', i.e. either having undergone female genital mutilation or no longer being at risk (EIGE, 2015a).

The variable of the 'median age' of female genital mutilation

The variable 'median age' of female genital mutilation is an important variable in the risk-estimation calculation, as it avoids overestimation. It is defined as the age that divides the population at risk of female genital mutilation into two numerically equal groups: half the people are below this age and half are older than this age. This median age is usually lower than the average age of female genital mutilation.

✓ The **original methodology** (EIGE, 2015a) included in its calculation only girls whose age is under the median age. The **refined methodology** in this report includes in the calculation girls who have reached the median age.

The DHS and MICS do not provide an exact age of female genital mutilation, only percentages of cases disaggregated by age groups (0–4, 5–9, 10–14, 15+, unknown). This implies that the median age of cutting has to be calculated.

✓ In the **original methodology** (EIGE, 2015a) the median age was calculated as follows: firstly, the 'unknown' were redistributed over the age categories and secondly, the highest boundary of the age group in which 50 % falls (median interval) was selected as the median age.

When working with 5-year intervals, a minor change in the percentages can move the median interval to the next age interval and imply that the median age increases by 5 years, when in reality it has barely changed.

✓ To avoid high variability, the **refined methodology** in this report calculates the median value of the median interval considering the hypothesis of uniformity, which is based on a proportion that takes into account the width and the size of the median interval in relation to the previous one. As this method considers not only the median interval but also the distribution of the previous interval, it reaches a more robust estimation of the median age of female genital mutilation.

Furthermore, the qualitative research in this report — the focus group discussions — found that the use of the median age of cutting in the country of origin to estimate the risk of female genital mutilation in the country of destination was too low. For some communities, girls/women are at risk until they are married or face other social pressures. These findings build upon EIGE's previous research (EIGE, 2015a, p. 45) and recent research conducted in Germany (Integra, 2017).

✓ To further incorporate the research findings in the estimations, the **refined methodology** in this report uses the median age increased by its deviation as the reference age. This approach has the advantage of considering the age variability of cutting in each country of origin. Girls who have reached the median age of cutting are added in the calculation of the number of girls at risk of female genital mutilation, up until the last day when they are this age.

The 'migration and acculturation impact factor'

The risk of female genital mutilation in an EU Member State is expressed as a percentage between a low-risk and high-risk scenario. As the methodology applies an extrapolation of data, a girl's level of risk in an EU Member State is related to the level of risk she would have if she lived in the FGM-practising country of origin. However, there is uncertainty about the extent to which the experience of migration affects her risk. To account for this uncertainty, a low and high estimate of the number of girls at risk of female genital mutilation in an EU Member State is calculated, by applying the 'migration and acculturation impact factor'.

✓ The migration and acculturation impact factor in the **original methodology** (EIGE, 2015a) was expressed as a binary, being either 0 (no impact of migration) or 1 (impact of migration). The results of this report suggest the measurement of the migration and acculturation impact factor should be modified and its binary nature should be overcome in the **refined methodology**, taking into account the availability of data and comparability among countries. The focus group discussions in this report suggest that the impact of migration on female genital mutilation risk can be linked to many factors, including (but not limited to) macro factors (such as the legislation and policies in the country of origin/destination); meso factors (such as community expectations, the region of origin or ethnic group); and micro factors (such as an individual's age, gender, generation, length of stay or level of education). The relationship between these factors and female genital mutilation risk is complex and not easily measured. Qualitative research indicates that individuals from the second generation may consider female genital mutilation as less acceptable, and that awareness-raising and enforcement of anti-FGM legislation may be discouraging factors for communities when deciding whether to have girls cut. Nonetheless, girls from the second generation continue to face risk of female genital mutilation, so it is unrealistic to exclude them from the low-risk scenario altogether. Therefore, the refined methodology considers half of the second generation still at risk in the low-risk scenario. This option provides a more realistic estimation and shows differences among Member States based on the size of the second generation.

The following formula is applied to estimate the risk of female genital mutilation in an EU Member State:

$$x_c = (a_{c=first} \times p_c \times (1 - m)) + (a_{c=second} \times p_c \times (1 - m))$$

- x_c = is the number of girls at risk of FGM originating from a particular country (c) where FGM has been documented and living in an EU Member State
- $a_{c=first}$ = first-generation girls from country c, in a particular year, who have reached the median age of cutting that is customary in a particular country of origin

- $a_{c=second}$ = second-generation girls (born in an EU Member State from mothers originating from a particular country where FGM is documented), who, in a particular year, had reached the median age of cutting that is customary in a particular country of origin
- p_c = national prevalence rate of the age cohort 15–19 for the country of origin
- m = migration and acculturation impact factor

An interval between low and high risk

In order to accommodate the uncertainties around the calculation of the risk of female genital mutilation in the EU, the statistical results of the female genital mutilation risk estimation are expressed in an interval (i.e. the number of girls at risk in a given country varies between x (low value) and y (high value)). The estimations are provided in both full numbers and percentages (i.e. expressed as the percentage of the absolute number of girls aged 0–18 originating from FGM risk countries and living in an EU Member State).

The **high-risk scenario** assumes that there is no influence of migration whatsoever, and that the number of girls originating from an FGM-practising country and living in an EU Member State at risk of female genital mutilation is the same as if they had never migrated. In this scenario, even in a migration context, migrants would keep their traditions and practices as if they were still living in their countries of origin. This hypothetical scenario is seen as constituting the highest possible risk scenario, for which the calculation of girls at risk would yield the upper boundary. Thus, for the calculation of the girls at risk in this scenario, it is assumed that regardless of their generation, the female migrant population aged up until the median age as per country of origin is at risk according to the prevalence rate for the particular country of origin. In this scenario, the migration and acculturation impact factor is 0 (m = 0).

The **low-risk scenario** assumes that migration and acculturation have an influence on changing attitudes and behaviours towards performing female genital mutilation. In this case, second generation girls (i.e. those born in an EU Member State) experience a lower risk of being subjected to female genital mutilation. Therefore, for calculation purposes, only half of the second generation is considered at risk. On the other hand, first-generation girls are still considered to be at risk. In this scenario, the migration and acculturation impact factor for first-generation girls is 0 (m = 0) and for second-generation girls it is 0.5 (m = 0.5). This hypothetical scenario yields the lower boundary of estimated number of girls at risk.

Approach for asylum seekers

With regards to the asylum-seeking population, only the high-risk scenario is applied, as data on the female asylum-seeking population only covers foreign-born girls (i.e. the first generation), and not girls born in reception centres to asylum-seeking women.

The **high-risk scenario for asylum seekers** assumes no effect of migration on the practice of female genital mutilation. In this case, it is assumed that the entire female asylum-seeking population (first generation) whose age has reached the median age of female genital mutilation in their country of origin faces the same level of risk of female genital mutilation as in their country of origin. In numerical terms, this means the migration and acculturation impact factor is 0 (m = 0).

Data for female asylum seekers, refugees and irregular migrants aged 0–18 in an EU Member State originating from countries where female genital mutilation is practised need to be disaggregated referring to the reference year and subsequent years (if data is available). In the six Member States of the study, data on asylum seekers was generally provided by broader age classes than those for the general migrant population, so assumptions are to be made to harmonise the age ranges.

✓ Data on asylum seekers is generally provided by Eurostat in the 0–13 and 14–17 age format. If this is the most disaggregated age data available, the **refined methodology** under this report proposes to harmonise the age groups, applying the age structure observed for the regular migrant population of foreign-born girls of the same nationality. This makes the process of risk estimation possible for this group, although it rests upon the assumption that the age patterns among asylum seekers and the regular migrant population from a particular country are similar or the same.

2.4. Conclusion

The methodology proposed aims to estimate, as accurately as possible, the risk of female genital mutilation in a certain Member State. It can be concluded that the methodology that has been applied for the present risk-estimation study is valid and sound. It is valid because it has allowed a risk analysis to be carried out for all six Member States. It is sound because combining quantitative and qualitative methods provides a more accurate and comprehensive picture than that which would be obtained through quantitative or qualitative analysis alone (EIGE, 2015a, p. 47). However, risk estimations of female genital mutilation remain affected by many uncertainties, and this is why estimations need to be interpreted cautiously, to avoid the misuse of data and the stigmatisation of the communities affected.

In this light, an important endeavour of this study has been to further refine the methodological approach and test calculations to improve its overall soundness. Three main adaptations in the approach used to estimate the number of girls at risk of female genital mutilation are proposed for future estimations: (1) a more robust calculation of the median age of cutting and an increase of the median age by its standard deviation; (2) adding girls who have reached the median age of cutting in the calculation and (3) considering half of the second generation still at risk of female genital mutilation in the low-risk scenario. These recommendations follow both the quantitative and qualitative results of this study in order for estimations to be more accurate and sound.

3. Female genital mutilation risk estimation in Belgium

3. Female genital mutilation risk estimation in Belgium

This section presents the estimated number of girls at risk of female genital mutilation living in Belgium. Firstly, the female migrant population originating from FGM-practising countries is presented. The study population includes the number of girls aged 0–18 living in Belgium in 2011 (the year of the European population and housing census), 2012 and 2016 (latest available years), and who come from FGM-practising countries (first generation), or were born to a mother who originates from a country where female genital mutilation is documented (second generation). The resident population is separated from asylum seekers, as the push factors for migration are different when compared to resident migrants (EIGE, 2015a, p. 79). Secondly, a summary of the findings from the focus group discussions organised in Belgium is provided. Finally, the data is processed to determine the high and low boundaries of the interval for female genital mutilation risk estimation.

3.1. Female migrant population aged 0–18 originating from FGM-practising countries

Recent data on the female migrant population broken down by sex, age and generation is available in Belgium for the years 2011, 2012 and 2016. The main **data sources** used for each of the reference years are the following:

- 2011: European population and housing census (Eurostat) for data on the first generation and Belgian birth register (Office de la Naissance et de l'Enfance and Kind en Gezin) for data on the second generation;
- 2012 and 2016: Belgian population register (Statbel) for data on the first generation and Belgian birth register (Office de la Naissance et de l'Enfance and Kind en Gezin) for data on the second generation;
- data on asylum seekers for 2012, 2015 and 2016 from the Belgian federal agency for the reception of asylum seekers (Fedasil).

To further **improve** the availability and comparability of data on the female migrant population in Belgium, the following actions are recommended.

- Align the terminology on the migrant population with Eurostat and the definitions in use in this report (see Chapter 2, Section 2.1). Specifically, for example, the length of stay of 'usual residence' is 12 months, but some migrants can be in Belgium for less than 12 months and be registered in the Belgian population register if their residence permit allows them to be in the country.
- Capture information on girls born from a naturalised migrant mother in the Belgian population register, as now only current and previous nationalities are covered and if a mother has been naturalised, her daughter is registered as Belgian.
- Distinguish in the Belgian population register those granted refugee status from other resident migrants from the first generation.
- Collect data on irregular/undocumented migration.

Resident population

In Belgium, there were 14 815 girls (aged 0–18) originating from FGM-practising countries within the female **migrant resident population** in 2011. Of these, 5 556 (38 %) were first generation and 9 259 (62 %) were second generation. Girls in the younger age category are more likely to be from the second generation, whereas the reverse is true for older girls.

In 2012, the number of girls (aged 0–18) originating from FGM-practising countries slightly increased to 16 723. Of these, 5 912 (35 %) were first generation and 10 811(65 %) were second generation. As in 2011, the same pattern holds that younger girls are far more likely to be drawn from the second generation.

Four years later, in 2016, the number of girls originating from FGM-practising countries rose to 22 544 girls (aged 0–18). Of these, 4 714 (21 %) were first generation and 17 830 (79 %) second generation. In all, 78 % of these girls (both generations) were below the age of 10, although a higher proportion of the second generation were under 10 and among the first generation there were more girls aged 10–18.

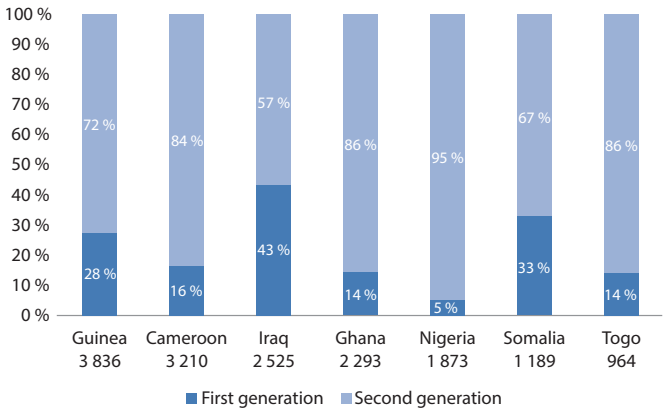
As the 2011 data from the European population and housing census on the number of second-generation girls includes only those aged 0–13 and the 2012 and 2016 population register data only 0–14, data was supplemented with female live births information collected through the birth registers. Due to an incomplete database, data on female live births is not available prior to 1998. As data for 1997 is not available, data on those aged 15 and above is missing for 2012 and data on those aged 14 and above is missing for 2011. Furthermore,

Table 3.1. Age distribution of the female migrant population (aged 0–18) in Belgium originating from FGM-practising countries (2011, 2012 and 2016)

	TOTAL (% of all)	First generation (% of age group)	Second generation (% of age group)
2011			
TOTAL	**14 815 (100 %)**	**5 556 (38 %)**	**9 259 (72 %)**
0–9	11 721 (79 %)	3 571 (30 %)	8 150 (70 %)
10–18	3 094 (21 %)	1 985 (64 %)	1 109 (36 %)
2012			
TOTAL	**16 723 (100 %)**	**5 912 (35 %)**	**10 811 (65 %)**
0–9	11 322 (86 %)	2 006 (18 %)	9 316 (82 %)
10–18	5 401 (14 %)	3 906 (72 %)	1 495 (28 %)
2016			
TOTAL	**22 544 (100 %)**	**4 714 (21 %)**	**17 830 (79 %)**
0–9	15 646 (78 %)	1 770 (11 %)	13 876 (89 %)
10–18	6 898 (22 %)	2 944 (43 %)	3 954 (57 %)

Source: Eurostat, Statbel and Office de la Naissance et de l'Enfance/Kind en Gezin.

Figure 3.1. Number of migrant girls (aged 0–18) living in Belgium by generation and most represented countries of origin (2016)

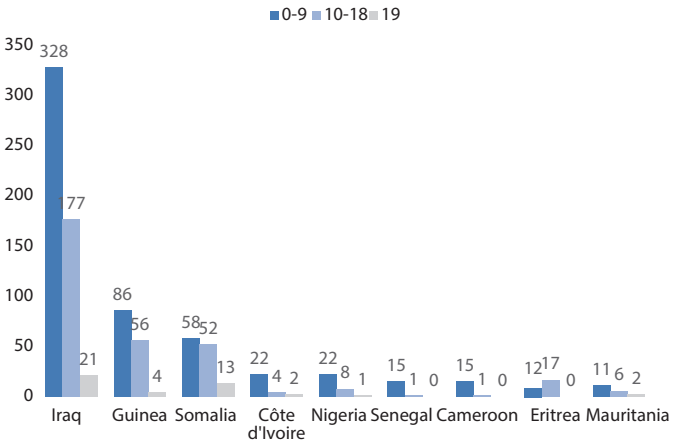


Source: Statbel and Office de la Naissance et de l'Enfance/Kind en Gezin.

female live births were available only at aggregate level and not broken down by age. Therefore, the age structure for the female live births was assumed following the age structure of the first generation.

As regards the origins of the first- and second-generation girls, the FGM-practising countries most represented in 2016 were Guinea, Cameroon, Iraq, Ghana, Nigeria, Somalia and Togo. Guinea, Cameroon, Iraq and Ghana represent 50 % of the total population of girls (aged 0–18) originating from a FGM-practising country.

Figure 3.2. Number of asylum-seeking girls (aged 0–19) living in Belgium by age and by most represented countries of origin (2016)



Source: Federal agency for the reception of asylum seekers.

According to the DHS and MICS (see Annex 3), national prevalence rates of female genital mutilation within the age group 15–19 years in these countries range from very low (Ghana: 1.5 %), to medium (Nigeria: 15 %) to high (Somalia: 97 %). Information on the region of origin of the girls (or their mothers) living in Belgium is unavailable. Thus, for countries with a lower prevalence rate, the risk of bias may be high when applying the national prevalence rate of female genital mutilation to the migrant population living in Belgium.

Asylum seekers

In 2016, the total number of female **asylum seekers** (aged 0–18) originating from FGM-practising countries was 969, versus 627 in 2012. Three countries, Iraq, Guinea and Somalia, represented 78 % of the total female asylum-seeking population (0–18). Overall, 61 % of the asylum-seeking population presented in Figure 3.2 were below the age of 10 and 32 % were below the age of five. Most asylum seekers from each of these countries were also younger than 10.

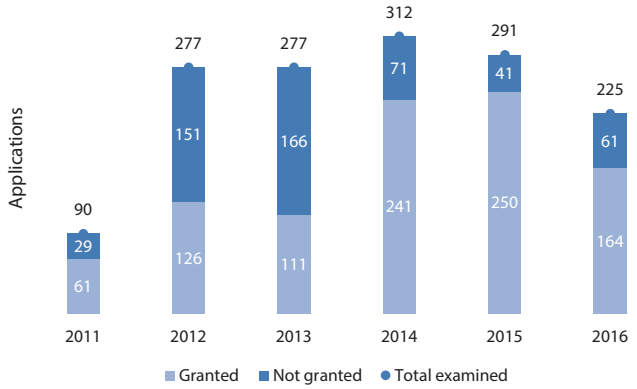
Data on the age of arrival of asylum seekers is not available for all asylum seekers and therefore cannot be used for analysis. Data on the female asylum-seeking population is available for 2012, 2015 and 2016.

In Belgium female genital mutilation is recognised as a form of gender-based persecution and child-specific persecution and can be considered as grounds to claim asylum. The Office of the Commissioner General for Refugees and Stateless Persons keeps yearly records of the number of **FGM-related asylum applications** which have been examined and for which a decision has been taken: refugee status or subsidiary protection.

The number of granted applications on the basis of female genital mutilation generally increased progressively from 2011 to 2015 but decreased in 2016 (from 250 to 164). The proportion of granted applications varies (a lowest of 40 % in 2013 and a highest of 86 % in 2015), with a trend towards a higher percentage in recent years.

Data provided by the Office of the Commissioner General for Refugees and Stateless Persons states that on 29 September 2017, there were

Figure 3.3. Examined ([18]) FGM-related asylum applications in Belgium since 2011 for girls aged 0–18, from the 30 FGM-practising countries, broken down by those that were granted and not granted



Source: Office of the Commissioner General for Refugees and Stateless Persons.

1 803 girls aged 0–10 in Belgium with a status of international protection due to female genital mutilation: 1 703 were intact (granted protection against female genital mutilation) and 100 had already undergone female genital mutilation (application accepted on the grounds of the consequences of FGM or risk of re-excision). Data on the number of FGM-related awarded applications is not included in the estimates of the number of asylum seekers at risk.

Other records collecting information on female genital mutilation in Belgium

Birth certificates

Tracing second-generation persons in the Belgian population register is difficult, as the register covers current and previous nationalities, and if a mother has been naturalised, her daughter is registered as Belgian only. In other words, a girl (second generation) born to a mother who became Belgian by naturalisation before the birth of her daughter is not captured by the research based on the nationality of the girl. To overcome this, data on female live births was added to the data from the Belgian population register to collect information on the second generation, using the birth certification information (registering the country of origin of the mother) collected by the Belgian birth register. Data is available from 1998. The estimation of the second generation using this data is approximate, as the oldest girls may have moved and left the country (54 girls from FGM-practising countries left Belgium in 2016, according to the register).

Hospital records

Female genital mutilation can be listed as a primary or secondary diagnosis in the summary hospitalisation report filled out for every hospitalisation and analysed by the Belgian Federal Service of Public Health ([19]). Available data shows only a small number of first or second diagnoses of female genital mutilation for girls (aged 0–18) who have been hospitalised and this suggests underreporting and problems in identifying female genital mutilation among children. The percentage of complete data increases after training of maternity staff (International Centre of Reproductive Health, 2014). For now, hospital data is not used in the estimates of girls at risk as the data is limited and the methodological approach in this report uses indirect risk estimation.

Police and judiciary records

Since 2008, Belgian correctional prosecutors have encoded cases of female genital mutilation under the generic code '43 K — Sexual mutilation'. According to the database of the College of Prosecutors (as of 10 June 2017), 21 cases of female genital mutilation were brought to the correctional courts between 2008 and 2016. Analysis of the years 2013 to 2016 shows that 10 cases had been classified without further action and one had been classed for disposition (reclassified under another number). Seven of the defendants were men and four were women. Out of the ten cases classified without further action, two were classified for lack of a criminal offence, four for insufficient charges, one for prescription (termination of prosecution), one for incompetence (inadmissibility of prosecution) and two for insufficient investigative capacity. To allow for better understanding of female genital mutilation and an accurate perception of statistical data on the subject, two separate codes were created in June 2017, with the implementation of the new circular of the Minister of Justice and the Council of General Prosecutors on female genital mutilation (COL 06/2017) (Ministère Public (Public Prosecutions Department), 2017). Police and judicial records are not used in the estimates of girls at risk of female genital mutilation, because data is limited and the methodological approach in this report uses indirect risk estimation.

Child protection records

Girls living in Belgium, including girls born there, may be at risk of female genital mutilation when travelling to the country of origin of their parents where female genital mutilation is practised. A protocol for the prevention of female genital mutilation and tools have been developed by specialised civil society organisations (GAMS and Intact) together with the network Concerted strategies for fighting female genital mutilation (*Stratégies concertées de luttes contre les mutilations génitales féminines*). A registration system is in place monitoring risk situations that are brought to their attention (19 cases in 2016). However, trained professionals also use the protocol independently without monitoring. Child protection records are not used in the estimates of girls at risk of female genital mutilation, because data is not collected systematically and the methodological approach in this report uses indirect risk estimation.

Migration patterns

To get a sense of migratory flows over time, the inflows and outflows from FGM-practising countries can be considered. A positive net inflow indicates that more people are arriving than leaving Belgium within a given year. Data from Statbel, the Belgian statistical office, suggests that the net inflow in 2016 was positive (1 171 female migrants aged 0–19). Fifty-four girls (aged 0–19) left and 1 225 entered the country in 2016. Ideally, it is necessary to know their age and country of destination to estimate the risk of being subjected to female genital mutilation (in case of return to the country of origin). This data is not used in the estimates of girls at risk of female genital mutilation as it is a 'flow' variable rather than a 'stock' variable.

([18]) Examined applications do not cover all those received: some are not examined because they are not complete or not accepted.

([19]) The summary hospitalisation report (*Résumé Hospitalier Minimum*) is a mandatory report filled out for every hospitalisation and sent to the Ministry of Health with standardised information about the patient characteristics, diagnosis and treatment received. The analysis of this data helps to determine the financial endowment of hospitals and to guide health policies and research.

Table 3.2. Overview of focus group discussions and sociodemographic profile of participants in Belgium

Key characteristics of focus groups	Older women	Younger women	Men	Hard-to-reach/ recent migrants
Number of participants	9	5	10	3
Countries of origin represented ([20])	Somalia	Guinea	Somalia	Iraq
Age range	26–47	18–20	21–39	25–53
Generation (first/second)	First	First (arrived at maximum age of 5) and second	First	First
Average residence (number of years/ months) and previous residence in other countries	83 months (7 years), 0 months in other countries	158 months (13 years), 2.8 years in other countries	17.3 months (1.4 years), none had lived in other countries	0.8 months, 4 months in another country
Number of second-generation participants who have lived in their parents' country of birth	n/a	4 (before moving to the EU)	n/a	n/a
Civil status of participants	5 divorced 4 married	All unmarried	9 married, 1 no information	2 married 1 widow
Number of participants with/without children	9 with children (8 with daughters)	0 with children	9 with children (6 with daughters)	3 with children (1 had daughters)
Religion	All Muslim	All Muslim	All Muslim	All Muslim
Ethnic groups (if available)	Asharaf, Haweyé (3), Bide 4 participants did not answer	Fulani	n/a	n/a
Level of education	No formal education (1) Primary education (6) Secondary education (2)	Secondary education (3) Higher education (2)	No formal education (2) Quranic (3) Secondary (4) Higher (1)	Primary (1) Secondary/higher (1)
(For first generation): shortest and longest amount of time residing in Belgium	Shortest: 1.5 years Longest: 17 years	Shortest: 3 years Longest: 16 years	Shortest: 3 months Longest: 2 years and 3 months	Shortest: 1 day Longest: 1.5 months
(For first generation): shortest and longest amount of time residing in another EU Member State	Shortest: n/a Longest: 1 year	Shortest: n/a Longest: 14 years	Shortest: 3 months Longest: 2 years and 3 months	Shortest: 5 days Longest: 1 year
Date of session	23 September 2017	26 September 2017	16 September 2017	28 September 2017

Irregular migration

No official data on the number of irregular migrants is available in Belgium. Other data can provide indicative information, however, without being statistically valid. For example, civil society organisations providing healthcare or social support to undocumented persons collect data on their beneficiaries. Médecins du Monde reported that 38 girls aged 0–19, originating from an FGM-practising country, came to seek care at one of their dispensaries (between 20 September 2016 and 20 September 2017). Twenty-three were from Iraq (60 %). This data was not used in the estimates of girls at risk of female genital mutilation, because its statistical validity is low.

3.2. Summary of findings from focus group discussions organised in Belgium

Four focus group discussions took place in Belgium in September 2017. Discussions were held with first-generation women and men from Somalia, second-generation young women from Guinea and first-generation women asylum seekers from Iraq. The countries of origin of the participants represent the largest populations from FGM-practising countries living in Belgium (Guinea and Somalia) and largest populations of newly arrived asylum seekers potentially affected by female genital mutilation (Iraq). Table 3.2 presents an overview of the profile of the participants in the four focus group discussions.

Identity and attitudes about the importance of female genital mutilation

All Somali, Guinean and Iraqi women, and most Somali men, were personally opposed to all types of female genital mutilation. Several

([20]) This is the country of birth of first-generation migrants (FGM-practising countries), or the country of birth of the parents of second-generation migrants (FGM-practising countries). Here, someone is second generation if that person was not born in an FGM-practising country but has at least one parent born in an FGM-practising country.

Somali women and men were protecting their daughters from female genital mutilation. However, some Somali men had ambiguous feelings and a few were opposed to infibulation (referring to FGM type III) but did not oppose, or were indifferent to, 'sunna' (a term used to refer to FGM type I or II) or pricking (referring to FGM type IV). They saw 'sunna' as equivalent to not undergoing female genital mutilation, as beneficial for women, required by Islam or a tradition to be respected. Somali and Guinean participants said female genital mutilation is a strong **traditional practice in the country of origin**. Likewise, Iraqi women explained that the practice, as performed at the time of their grandparents or great-grandparents, was a traditional practice, transmitted between generations. They were unsure whether it was regional or a tradition of specific ethnic groups. According to them, female genital mutilation is currently practised by a few communities for whom it is a tradition, but it is also propagated by armed groups as a means of controlling the population and, as such, has no importance for the identity of the communities. Several participants considered female genital mutilation to be more important to older generations (women) and in rural sectors. Men said that some men in Somalia now preferred women who had not undergone infibulation.

The older, first-generation Somali women said that there is no discussion in the Somali community living in Belgium on whether to have their daughters circumcised. According to them, Somalis **living in Belgium** adopt a 'different lifestyle compared to when living in Somalia'. Moreover, many women are already aware of the negative consequences of female genital mutilation when in Somalia, and therefore they stop practising it when moving to Europe. Somali women and men agreed that the practice is mandatory in Somalia. When moving to Belgium, people gain new information about the practice and the law, and they no longer feel socially obliged to practise it. Moreover, the results from the focus group discussion also indicated that second-generation Guinean women (or women who arrived in Belgium as children) would not practise female genital mutilation as they have grown up with the social norms prevalent in Belgium, where female genital mutilation is strongly rejected.

Participants agreed that not being cut is viewed negatively in Guinean and Somali societies. Uncut girls are seen as 'impure', 'sexually promiscuous' and 'not to be trusted to stay virgins until they get married'. However, several participants said that these norms are changing.

Several Somali women and men spoke about strong **social pressure** to have their daughters cut, from their families in Somalia, causing tensions with family members. Three men were afraid that their (ex-) wives or the family would force their daughters living in east Africa to undergo female genital mutilation. A Somali woman shared the story of her family regularly asking for money to practise female genital mutilation on her three daughters living in Somalia. In the case of another woman, her own daughter — who stayed in the country of origin — is pressuring her to have the younger daughters undergo female genital mutilation. When visiting Guinea, second-generation Guinean women were sometimes asked by female relatives or community members if they were cut. **Coping strategies** include lying about having undergone female genital mutilation or mothers not leaving daughters alone with persons they do not trust. It can be difficult for Guineans and Somalis living in Belgium to discuss female genital mutilation with communities living in the country of origin as their peers may have undergone the practice while they have not.

The reasons underlying the practice in all countries of origin related to **controlling women's sexuality**. According to Somali women and men, infibulation is seen as a guarantee for virginity. Female genital mutilation also relates to purity; according to participants, the word used in Iraqi, *tohor*, means 'purity', and in Somali the word for infibulation is *halalese*, meaning 'purification'. Men participants explained that, in Somalia, difficulties in having sexual intercourse with an infibulated woman prove a woman's virginity and a man's virility. Nevertheless, results from the focus groups suggest that there is a transition from 'infibulation' (type III) to 'sunna' (type I or II). It was said that this transition started in the 1990s as a result of campaigns and awareness-raising about complications deriving from infibulation. Some Somali men thought that infibulation was mostly practised today in rural areas and that younger men prefer women who are not infibulated.

Perceptions about the risk of the practice in the host country and beyond

Participants in all focus groups thought that female genital mutilation was not practised in their communities in Europe. Whether or not to have daughters cut was not seen as a relevant issue for women and men whose daughters lived in Europe because, according to the participants, the **mentality** of Somali and Guinean people **changes** when they live in Europe. The reasons for this are not fully clear but appear to relate mainly to the different social norms, the law and the process of learning about the health consequences of the practice.

In the Somali and Guinean groups, women, and especially 'older women', were seen as the main **decision-makers** for female genital mutilation. Information about the **health consequences** of female genital mutilation and the fact that it is **not a religious requirement** were said to be key to abandoning the practice. Iraqi women also said that the practice had been abandoned in their communities over time as people were becoming more educated.

While Guinean women agreed that excision is traditionally practised to guarantee virginity, they did not think that it was a pre-requisite any longer for persons living in Europe. Rather, they stressed the importance of **traditional gender roles** for girls; that they behave 'well' and keep their virginity. According to them, a Guinean man living in Belgium would not expect his wife to be circumcised. However, virginity remains important to the Guinean diaspora.

None of the young women expressed fears or concerns about female genital mutilation, or difficulties dealing with the expectations of the community regarding the practice.

Key risk factors for female genital mutilation

Very few participants in the four focus group discussions had heard of parents living in Belgium wanting to practise female genital mutilation in the host country or when **returning to the country of origin**. One example was given by a participant in the discussion with Guinean women. She had heard of a mother wanting to have her daughters cut in Guinea, but who was stopped before leaving Belgium. Nevertheless, the young women would not be surprised if female genital mutilation did happen in Belgium.

In Iraq, the presence of **armed forces**, such as ISIL/Da'esh, was seen to represent a risk factor in terms of female genital mutilation, particularly for young unmarried women. However, this differed for Somali women, who argued that ISIL/Da'esh were opposed to infibulation in Somalia as it is against Islam. According to participants, since ISIL/Da'esh preaches against female genital mutilation, some Somali women maintain a negative view of female genital mutilation when they leave the country for Europe. Moreover, Somali women and men

Table 3.3. Estimated number of girls (aged 0–18) at risk of female genital mutilation living in Belgium (2011, 2012 and 2016)

	Resident population					
	HIGH-RISK SCENARIO			LOW-RISK SCENARIO		
	TOTAL	First generation	Second generation	TOTAL	First generation	Second generation
2011						
Total 0–18	**3 400**	**1 100**	**2 300**	**1 100**	**1 100**	**0**
0–9	3 351	1 087	2 264	1 087	1 087	0
10–18	49	13	36	13	13	0
2012						
Total 0–18	**3 175**	**523**	**2 652**	**523**	**523**	**0**
0–9	3 115	501	2 614	501	501	0
10–18	60	22	38	22	22	0
2016						
Total 0–18	**4 618**	**597**	**4 021**	**597**	**597**	**0**
0–9	4 539	586	3 953	586	586	0
10–18	79	11	68	11	11	0

Source: Present study.

argued that since mothers are often aware of the negative health consequences of female genital mutilation, they stop practising it once they escape from the pressure of mothers-in-law or grandmothers.

Participants in the three first focus groups were generally aware of the **existence of a law** against female genital mutilation in Belgium. The law was frequently put forward as a reason to abandon the practice when living in Europe, together with the change of mentality. Many Somali participants had **received information** about female genital mutilation when living in asylum centres or through integration classes. However, three of the Somali men had never been informed of female genital mutilation in Belgium, two of whom had been in the country for over 2 years.

3.3. Estimating the number of girls at risk of female genital mutilation in Belgium

First, this section presents the estimates of the number of girls at risk of female genital mutilation within the regular migrant population; then the estimates for asylum-seeking girls are presented. The estimates are first presented according to the **original methodology** (EIGE, 2015a) and then the **refined methodology** is applied following the improvements outlined in Chapter 2 of this report. The estimates according to the refined methodology present the final outcomes of the numbers of girls at risk of female genital mutilation in Belgium.

Resident population

With regard to the low- and high-risk scenarios, the number of girls (aged 0–18) at risk of female genital mutilation in Belgium varied between 1 100 and 3 400 in 2011, between 523 and 3 175 in 2012 ([21]) and between 597 and 4 618 in 2016.

Despite the reduction in the proportions at risk, the number of second-generation girls at risk has substantially increased (from 2 300 in 2011 to 4 021 in 2016), whereas the number of first-generation girls at risk has decreased (from 1 100 in 2011 to 597 in 2016).

For girls aged 0–9 from FGM-practising countries, between 9 % and 29 % of girls were at risk in 2011, and between 4 % and 29 % were at risk in 2016. By comparison, relatively low proportions of girls aged 10–18 were at risk in both 2011 and 2016 (approximately 2 % or less). The total number of girls at risk aged 0–9 increased from 2011 to 2016 in the high-risk scenario (from 3 351 in 2011 to 4 539 in 2016), as it did for those aged 10–18 (from 49 in 2011 to 79 in 2016).

When applying the **refined methodological approach** ([22]), as described in Chapter 2 of this report, an increased number and proportion of girls at risk of female genital mutilation can be observed in Belgium for the reference year 2011 (year of the European population and housing census) and 2016 (the latest available year).

([21]) For 2012 retrospective data on births is missing and therefore it is not possible to have the full range of data from 0 to 18 years. This means the high-risk scenario of girls at risk in this year (3 175) is likely to be an underestimate.

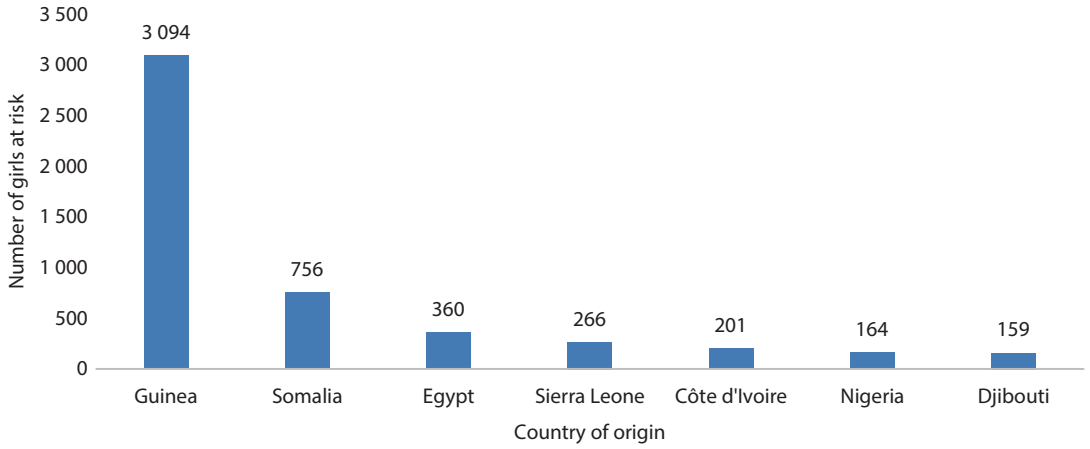
([22]) Three adaptations are applied: (1) a more robust calculation of the median age of cutting and an increase of the median age by its standard deviation; (2) adding girls who have reached the median age of cutting into the calculation and (3) considering half of the second generation still at risk of female genital mutilation in the low-risk scenario.

Table 3.4. Final estimated number of girls (aged 0–18) at risk of female genital mutilation living in Belgium according to the refined methodological approach (2011 and 2016)

TOTAL	LOW-RISK SCENARIO Proportion of girls at risk		HIGH-RISK SCENARIO Proportion of girls at risk		LOW-RISK SCENARIO No of girls at risk		HIGH-RISK SCENARIO No of girls at risk	
	Original	Refined	Original	Refined	Original	Refined	Original	Refined
2011								
14 815	7 %	19 %	23 %	28 %	1 100	2 762	3 400	4 124
2016								
22 544	3 %	**16 %**	20 %	**27 %**	597	**3 579**	4 618	**6 122**

Source: Present study.

Figure 3.4. Estimated number of girls (aged 0–18) at risk of female genital mutilation living in Belgium by most represented countries of origin (2016) ([23])



Source: Present study.

Table 3.5. Female genital mutilation risk in Belgium in 2016 (latest available year)

High-risk scenario	In 2016, a total number of 22 544 girls aged 0–18 originating from FGM risk countries (born in the country of origin or in Belgium) were residing in Belgium, of which 6 122 girls were likely to be at risk of female genital mutilation. **Proportionally, 27 % of girls aged 0–18 originating from FGM risk countries (born in the country of origin or in Belgium) were at risk of female genital mutilation.**
Low-risk scenario	In 2016, a total number of 22 544 girls aged 0–18 originating from FGM risk countries (born in the country of origin or in Belgium) were residing in Belgium, of which 3 579 girls were likely to be at risk of female genital mutilation. **Proportionally, 16 % of girls aged 0–18 originating from FGM risk countries (born in the country of origin or in Belgium) were at risk of female genital mutilation.**

The majority of the girls who are at risk (in the latest available year 2016) originate from Guinea (3 094), followed by Somalia (756). Smaller groups of girls at risk originated from Egypt, Sierra Leone, Côte d'Ivoire, Nigeria and Djibouti.

Table 3.5 summarises the results of the female genital mutilation risk estimations for both the high- and low-risk scenarios. In the high-risk scenario, both first- and second-generation girls are considered at risk of female genital mutilation, while the low-risk scenario considers the first generation and half of the second generation still at risk of female genital mutilation.

Table 3.6. Estimated number of asylum-seeking girls (aged 0–18) at risk of female genital mutilation living in Belgium (2012, 2015 and 2016)

	TOTAL	Total number at risk	Proportion of girls at risk
2012	627	215	34 %
2015	982	151	15 %
2016	969	173	18 %

Source: Present study.

([23]) The figure is based on the high-risk scenario data.

Asylum seekers

With regard to the high-risk scenario, the number of asylum-seeking girls (aged 0–18) at risk of female genital mutilation was 215 in 2012, 151 in 2015 and 173 in 2016. A decrease can be observed in the percentage of girls at risk of female genital mutilation since 2012, although the numbers have remained fairly similar.

If we apply the **refined methodological approach** ([24]), as described in Chapter 2 of this report, an increased number and proportion of asylum-seeking girls at risk of female genital mutilation can be observed in Belgium for 2012 and 2016 (the latest available year).

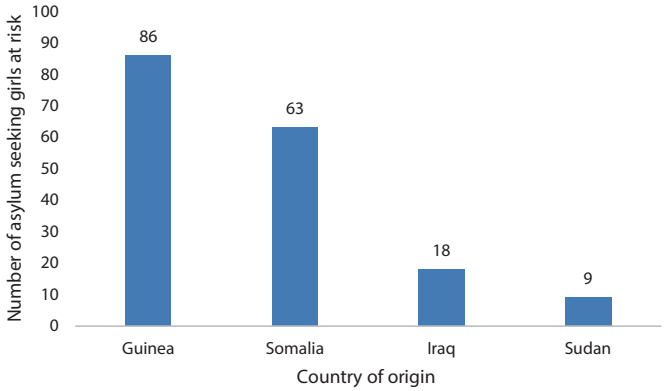
The four top countries of origin for asylum-seeking girls at risk of female genital mutilation (in the latest available year 2016) are Guinea, Somalia, Iraq and Sudan.

Table 3.7. Final estimated number of asylum-seeking girls (aged 0–18) at risk of female genital mutilation living in Belgium according to the refined methodological approach (2012 and 2016)

TOTAL	HIGH-RISK SCENARIO Proportion of girls at risk		HIGH-RISK SCENARIO No of girls at risk	
	Original	Refined	Original	Refined
2012				
627	34 %	**41 %**	215	**255**
2016				
969	18 %	**23 %**	173	**219**

Source: Present study.

Figure 3.5. Estimated number of asylum-seeking girls (aged 0–18) at risk of female genital mutilation living in Belgium by most represented countries of origin (2016) ([25])



Source: Present study.

([24]) Three adaptations are applied: (1) a more robust calculation of the median age of cutting and an increase of the median age by its standard deviation; (2) adding girls who have reached the median age of cutting into the calculation and (3) considering half of the second generation still at risk of female genital mutilation in the low-risk scenario.

([25]) The figure is based on the high-risk scenario data.

3.4. Main findings in Belgium

In 2016, a total number of 22 544 girls aged 0–18 originating from FGM-practising countries (born in the country of origin or in Belgium) were residing in Belgium, of which **16 % to 27 % were at risk** of female genital mutilation.

Looking at **trends** over time, the percentage of girls at risk in the high-risk scenario slightly decreased from 28 % in 2011 to 27 % in 2016. However, the total population has increased and almost 2 000 more girls are at risk in 2016. This growth relates to an expanding second generation within FGM-affected communities living in Belgium.

The largest **communities** from FGM-practising countries living in Belgium do not necessarily represent the countries from which the most girls at risk originate. While the largest communities are, in descending order, from Guinea, Cameroon, Iraq and Ghana, girls at risk originate, in descending order, from Guinea, Somalia, Egypt and Sierra Leone. When designing targeted policies in Belgium, it is important to take this reality into account.

All women and most men from the Guinean and Somalian communities expressed their opposition to female genital mutilation in the focus group discussions and viewed the practice as something occurring in their countries of origin, but far less in their communities in Europe. However, Somali participants recounted the social pressures to get daughters cut when they returned to their country of origin, particularly from older women. Iraqi women stated that female genital mutilation is practised by armed groups as a means to control the population. From the focus group discussions it is clear that female genital mutilation takes place secretly and on return to the country of origin, a key **risk factor**.

Acquiring new information about the practice, the law and social norms against female genital mutilation are all factors contributing to female genital mutilation being abandoned in Belgium. Therefore integration and migration policies should consider these **discouraging factors**.

When looking at **asylum seekers**, a total number of 969 girls were residing in Belgium in 2016, of which 23 % were at risk of female genital mutilation. While proportions at risk have decreased from 41 % in 2012 to 23 % in 2016, their actual number is on the rise.

Female genital mutilation is recognised as a ground to claim asylum and 1 703 young girls (aged 0–10) were living in Belgium in 2017 under **international protection** status because of the risk of female genital mutilation. This significant number adds further evidence to the real risks imposed on young girls in their country of origin. Refugee status does not necessarily offer absolute protection and there is also a risk of undergoing female genital mutilation in the EU (European Commission, 2017). Systematic information on female genital mutilation is needed for all newcomers and the efforts of the Federal agency for the reception of asylum seekers in supporting reception centre staff in this matter is a promising practice.

To **tackle female genital mutilation in Belgium**, a specific criminal provision on female genital mutilation has existed in Belgium since 2001 and the principle of extraterritoriality is applied, criminalising the practice even when committed abroad. General child protection

provisions can be used in cases of female genital mutilation and parents can be held accountable if female genital mutilation is performed on their child. A specific legal provision with regard to reporting cases of female genital mutilation is in place, as well as reporting guidelines for relevant professionals. Furthermore, policy measures and campaigns against female genital mutilation — mainly focusing on health and education —are included in Belgium's national action plan to combat all forms of gender-based violence.

Focus group discussions with communities living in Belgium suggest that **awareness of the law** prohibiting female genital mutilation in Belgium has a clear positive effect in favour of the abandonment of the practice. Very few cases have surfaced in recent years: between 2008 and 2016, 21 cases of female genital mutilation were registered at the Criminal Court but most were dismissed and none have resulted in a conviction. However, there is no clarity about whether this means that the practice is not performed in Belgium or whether it is not identified or reported.

The level of outreach of **information and awareness-raising campaigns** appears to be differentiated as revealed in the focus group discussions. Some participants were satisfied with the information they had received about the practice, either from asylum reception centres, integration courses, a doctor, or a civil society organisation. Others were unaware of specific female genital mutilation services as, for example, specialised clinics providing reconstructive surgery. Furthermore, among women who had gone to school in Belgium, none had received any information on female genital mutilation at school.

4. Female genital mutilation risk estimation in Greece

4. Female genital mutilation risk estimation in Greece

This section presents the estimated number of girls at risk of female genital mutilation living in Greece. Firstly, the female migrant population originating from FGM-practising countries is described. The study population includes the number of girls aged 0–18 living in Greece in 2011 (the year of the European population and housing census) and 2016 (the latest available year), and who come from FGM-practising countries (first generation), or were born to a mother who originates from a country where female genital mutilation is documented (second generation). The resident population is separated from asylum seekers, as the push factors for migration are different when compared to resident migrants (EIGE, 2015a, p. 79). Secondly, a summary of the findings from the focus group discussions organised in Greece is provided. Finally, the data is processed to determine the high and low boundaries of the interval for female genital mutilation risk estimation.

4.1. Female migrant population aged 0–18 originating from FGM-practising countries

Recent data on the female migrant population is available in Greece for the years 2011 and 2016. The main **data sources** used for each of the reference years are the following:

- 2011–2016: European population and housing census data (Eurostat) and data on migrants with valid residence permits (Eurostat and the Hellenic Ministry of Migration Policy);
- data on asylum seekers and refugees for 2011 and 2012 (Eurostat) and as from 2013 (Hellenic Ministry of Migration Policy).

To further **improve** the availability and comparability of data on the female migrant population in Greece, the following actions are recommended:

- collect data on the entire female migrant population, not only those with a valid residence permit;
- provide for the necessary generational breakdowns in the data on migrants with a legal residence permit to identify first and second generations;
- consider the availability of data on female live births to mothers originating from FGM-practising countries before 2004 and for all countries of origin;
- provide data on asylum-seeking girls aged 18;
- collect data on FGM-related asylum applications;
- disaggregate police data on irregular migration by sex and age.

Resident population

In Greece, there were 1 896 girls (aged 0–18) originating from FGM-practising countries within the female **migrant resident population** in 2011. Of these, 72 % (1 365) were aged 0–9 and 28 % (531) were aged 10–18. This number remained relatively stable from 2011 onwards and reached a total number of 1 787 girls in 2016. In terms of the distribution of the age band, there is a clear decreasing trend in the proportion of girls aged 0–9 within this population, starting from 72 % in 2011 and decreasing to nearly 50 % in 2016.

Data on the female migrant population in Greece is only available on permit-holders, defined as foreign nationals who have received a residence permit or another form of authorisation to reside in the country. Furthermore, these data are not disaggregated by generation and approximation was used to identify generations for the risk estimations described later on in this chapter. No data is available on young women who did not need a residence permit to live in the country, such as second-generation girls who have acquired Greek citizenship.

In Greece, according to the data for 2016, most girls who originate from countries where female genital mutilation is documented are from (in descending order): Egypt, Nigeria, Iraq, Ethiopia, Ghana, Kenya and Sudan.

Information on the region of origin of the girls (or their mothers) living in Greece is unavailable. Thus, for countries with a lower prevalence rate, the risk of bias is high when applying the national prevalence rate of female genital mutilation to the migrant population living in Greece.

Asylum seekers

Greece has seen significant overall increases of asylum seekers (of all ages) from all countries, with over 51 000 applicants in 2016 (fourfold increase from 2015) (Asylum Information Database, 2016).

Table 4.1. Age distribution of the female migrant population (aged 0–18) in Greece originating from FGM-practising countries (2011–2016) ([26])

	TOTAL	TOTAL (%)
2011		
TOTAL	**1 896**	**100**
0–9	1 365	72
10–18	531	28
2012		
TOTAL	**1 786**	**100**
0–9	1 207	68
10–18	579	32
2013		
TOTAL	**1 831**	**100**
0–9	1 168	64
10–18	663	36
2014		
TOTAL	**1 734**	**100**
0–9	974	56
10–18	760	44
2015		
TOTAL	**1 813**	**100**
0–9	954	53
10–18	859	47
2016		
TOTAL	**1 787**	**100**
0–9	887	50
10–18	900	50

Source: Eurostat.

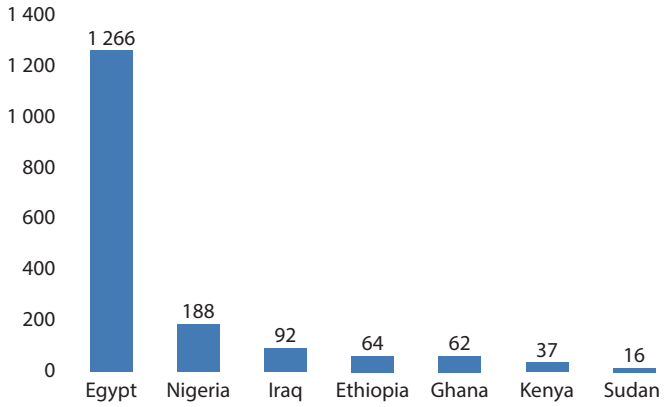
In 2016, the total number of female **asylum seekers** (aged 0–17) originating from FGM-practising countries was 1 123. Out of these, over 98 % (1 103) were asylum-seeking girls from seven FGM-practising countries, as presented in Figure 4.2. Within this group of asylum seekers from seven countries, 84 % (928) were aged 0–14.

The seven FGM-practising countries most represented among the female asylum-seeking population were (in descending order): Iraq, Eritrea, Somalia, Yemen, Cameroon, Egypt and Nigeria. These countries have been the most represented within the asylum-seeking population since 2011. However, there are significant differences when it comes to the number of applications for each year since 2011. In 2016, the number of female applicants aged 0–17 with citizenship in FGM-practising countries was 1 123. In 2015, the number was 114, in 2014 it was 44, in 2013 it was 41, in 2012 it was 15 and in 2011 it was 10. However, the data sources differ, which makes comparison difficult ([28]).

For 2016, Iraq, Egypt and Nigeria are also the most represented FGM-practising countries among regular female migrants, as shown in Figure 4.1. Moreover, six out of the seven countries in Figure 4.2 (all except Yemen) are the countries from which the largest nationality groups of arrested irregular migrants (not disaggregated by sex and age) were recorded in 2016 by the Hellenic police.

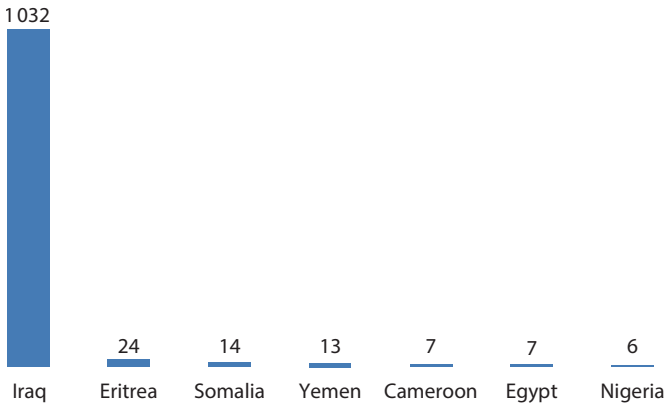
Regarding FGM-related asylum applications received and granted in Greece, there is no data available. There is data available regarding the **reasons invoked** by **asylum** seekers, but reasons related to female genital mutilation are included in a wider category according to the applicable legal framework, which includes all vulnerable groups. An additional difficulty with collecting data related to asylum applications received and granted is that, in most cases, female genital mutilation is one of multiple reasons why an asylum seeker applies for asylum. Furthermore, when authorities accept an individual's application for asylum status (or subsidiary protection), this is not categorised according to the specific reasons for granting asylum.

Figure 4.1. Number of girls (aged 0–18) living in Greece by most represented countries of origin ([27]), 2016



Source: Eurostat.

Figure 4.2. Number of asylum-seeking girls (aged 0–17) living in Greece by most represented countries of origin (2016) ([29])



Source: Hellenic Ministry of Migration Policy.

([26]) Available data is disaggregated only in 5-year age intervals (0–4, 5–9, 10–14 and 15–19), so the number of girls aged 10–18 has been approximated.

([27]) Country of origin defined by country of citizenship. Generation breakdowns not available.

([28]) Data from 2013–2016 is provided by the Hellenic Ministry of Migration Policy as they started collecting as from 2012. The 2011 and 2012 is provided by Eurostat.

([29]) Data unavailable on girls aged 18. Country of origin defined by country of citizenship.

Other records collecting information on female genital mutilation in Greece

Migration patterns

Data on migration flows is collected and published by the Hellenic Statistical Authority (Elstat). Data available on inflows is not disaggregated by country of origin, but by groups of countries. Therefore, female migrants from FGM-practising countries cannot be identified. Data available on outflows (i.e. those leaving Greece in a particular year) is not disaggregated by country of origin or by group of countries of origin either.

General data for the year 2015 shows that 44.8 % of incoming migrants from all countries — not only FGM-practising countries — were women (28 857 out of 64 446) and that 21.2 % of those women were aged 0–19. Similarly, since 2011, data on the inflow of migrants shows that the percentage of women ranged between 45.5 % and 46.6 % of all incoming migrants. The data available for the outflows of migrants shows that, since 2011, the estimated number of emigrants has increased. In 2015, 40.3 % of the total number of emigrants were women and 21.6 % of these women were aged 0–19.

Irregular migration

Data on irregular migration is collected and published by the police. On an annual basis, the Hellenic police publishes data — provided by police and port authorities — presenting the number of persons arrested for illegally entering or staying in Greece. Available data is disaggregated by country of citizenship, but not by sex or age. Since 2011, 163 950 persons originating from FGM-practising countries have been arrested in Greece. 102 818 of them were arrested in 2015, which is the year when irregular migrants/asylum seeker inflows reached the highest level. Since 2011, the vast majority of irregular migrants who originated from FGM-practising countries have been from Iraq. Besides Iraq, the six largest groups of irregular migrants from FGM-practising countries were from Somalia, Eritrea, Egypt, Nigeria, Cameroon and Côte d'Ivoire. As this data is not disaggregated by sex and age, it is not used in the estimates of girls at risk of female genital mutilation.

Table 4.2. Overview of focus group discussions and sociodemographic profile of participants in Greece

Key characteristics of focus groups	Older women	Younger women	Men	Hard-to-reach/recent migrant women
Number of participants	7	9	7	9
Countries of origin represented ([30])	Egypt and Sudan	Nigeria and Egypt	Egypt, Iraq, Syria ([31])	Somalia
Age range	Over 25	18–25	25–60	21–40
Generation (first/second)	First	Second	First and second	First
Average residence (number of years/ months) and previous residence in other countries	33 years-10 years	19–20 years	24 months	12 months
Number of second-generation participants who have lived in their parents' country of birth	One from Egypt: came to Greece when she was very young	0	0	n/a
Residence status of participants	Long-term residence permits	Migrants with residence permits	Migrants with residence permits and two asylum seekers (Syrian and Iraqi)	Asylum seekers
Number of participants with/without children	Six with children One without children	Nine without children	Five with children Two without children	Three with children Six without children
Religion	Muslim and Christian	Christian and Muslim	Muslim and one atheist (Iraqi)	Muslim
Ethnic groups (if available)			one Iraqi Kurd	
Level of education	Secondary education (3) Higher education (4)	Higher education	Primary education (2) Secondary education (3) Higher education (1)	No formal education (1) Primary education (2) Secondary education (4) Higher education (1)
(For first generation): shortest and longest amount of time residing in Greece	Shortest: 10 years Longest: 33 years	n/a	Shortest: 1 year Longest: 10 years	Shortest: 6 months Longest: 2 years
(For first generation): shortest and longest amount of time residing in another EU Member State	None resided in another EU Member State	n/a	None resided in another EU Member State	None resided in another EU Member State
Date of session	10 October 2017	11 November 2017	17 October 2017	13 September 2017

([30]) This is the country of birth of first-generation migrants (FGM-practising countries), or the country of birth of the parents of second-generation migrants (FGM-practising countries). Here, someone is second generation if that person was not born in an FGM-practising country but has at least one parent born in an FGM-practising country.

([31]) One participant was from Syria, not one of the 30 recognised FGM-practising countries.

Refugees

The Office of the United Nations High Commissioner for Refugees in Greece collects, provides and regularly publishes primary and secondary data (demographics, arrivals, most common nationalities, etc.) on refugees' situations in the country.

Data from civil society

In recent years, the refugee crisis and ongoing migration flows have become a catalyst for the activation of Greek civil society and international organisations in the field. In particular, many organisations provide accommodation services and other supporting services in reception and identification centres, as well as collecting relevant data. A report by Médecins Sans Frontières (2017) presents data collected by teams providing medical care on the island of Lesbos: almost half of the 245 women who received gynaecological consultations (January-mid-June 2017) had been victims of sexual violence (one third in their country of origin and two thirds during their journey). Although this data offers useful information, its accuracy cannot be assessed and it is not used in the estimates of girls at risk of female genital mutilation.

4.2. Summary of findings from focus group discussions organised in Greece

Four focus group discussions were conducted in Greece from September to November 2017. Discussions were held with first-generation older women from Egypt and Sudan; second-generation women from Nigeria and Egypt (all of whom were brought up in Greece); men from Egypt and Iraq and women from Somalia. In particular, participants offered the perspective of the community in Greece with the most girls at risk (Egypt), as well the perspective of countries for which less is known about the practice of female genital mutilation (Iraq). Table 4.2 presents an overview of the profile of the participants in the four focus group discussions.

Identity and attitudes about the importance of female genital mutilation

In general, there were significant **differences and similarities among communities**. Female genital mutilation was considered far more important among the Somali and Sudanese participants than the Egyptian, Iraqi or Nigerian ones. The Somali and Sudanese women discussed female genital mutilation much more openly and were more outspoken about its implications on women and girls' sexual and reproductive health than the Egyptian and the Nigerian participants. Although in Egypt female genital mutilation is widely practised, the Egyptian participants — both women and men — mostly considered female genital mutilation as a 'private issue' that is not usually openly debated. Egyptian women showed more reluctance and shame in participating in the discussions and expressed their views on sexual and reproductive questions only with reference to friends. The Egyptian men participants were more open about the practice.

Attitudes varied with **age and generation** across the communities. Although older women (over the age of 40) were more open about their own personal experiences and often discussed anatomical details and problems related to sexual and reproductive life, younger women were more reserved and did not discuss female genital mutilation as a personal experience. Findings from focus groups indicate that female genital mutilation may be becoming less acceptable among younger generations of women, especially in Egypt, Nigeria, Somalia and Sudan, than in the past. The second-generation women shared common interests and cultural codes, although they originated from different community and religious backgrounds (for example Nigerian Christian and Egyptian Muslim).

In all focus groups, there was consensus that female genital mutilation is more widely practised in **rural areas** than in urban ones. Women from rural areas were more likely to have undergone female genital mutilation than women from urban areas, especially young ones.

Most of the women who participated in the focus groups considered female genital mutilation as a cultural and **not a religious practice**. Some Sudanese and Somali women argued that female genital mutilation originated from the ancient Egyptians, but the Egyptian participants rejected this story. However, two participants maintained that female genital mutilation is practised only by Muslims in Egypt. They stated that the Prophet Muhammad dictated female genital mutilation when asked about female purity, arguing that this dictation cannot be found in the Quran but in the hadiths (as opposed to certain hadiths against the practice). Although expressing strong objection to the 'old' practices of female circumcision, they insinuated that a 'lighter' version may not be harmful for Muslim women and girls. The reaction of the other participants was extremely negative towards the suggestion that female genital mutilation is something that Muslim religion dictates. This was the same for Egyptian and Iraqi women participants, who rejected suggestions that female genital mutilation is a religious practice.

Women from Egypt, Sudan and Somalia were all very aware of the negative **health implications** of female genital mutilation. All participants agreed that women who have already undergone female genital mutilation should receive more information and medical assistance on health problems, surgery and sexuality. Second-generation girls from Egypt and Nigeria were aware of the sexual and reproductive health risks of female genital mutilation, mostly from documentaries, as the practice was not discussed in their families or communities. They argued, however, that they were not under pressure to undergo female genital mutilation, because in their migrant communities girls' chastity is mainly protected through religious education and discipline.

Abandoning the practice affects relationships with elderly **family members in the country of origin**. For example, a Sudanese woman said that younger generations are resisting female genital mutilation but that grandmothers insist on doing it to their granddaughters. Another woman explained that in her village grandmothers secretly take their granddaughters to local 'cutters', performing the circumcision against the will of the parents. When she made a complaint to the village leader — a respected male elder — he said he could not intervene because older women perform female genital mutilation in secret even now that it is illegal. Moreover, Sudanese women said that older women in villages tempt girls by giving them presents and although this was said to be done more often in the past, today it is still occasionally practised by the elderly.

Regarding the notions of **purity** and expectations for marriage, there are still derogatory expressions used in the countries of origin to describe women and their daughters who have not been cut as impure. Apparently, mothers in Somalia chose female genital mutilation for their daughters because it relieved them from the burden of protecting their chastity. Also, a Somali participant stated: 'The women who do the cuttings do not want to stop because it is their job. They do not want it to be illegal.'

The **views against female genital mutilation** are not necessarily linked to women's emancipation. Women who might be very conservative with regard to women's role in society are mostly against female genital mutilation because of the physical pain and suffering and the lack of sexual pleasure.

Social norms against female genital mutilation in Greece tend to affect migrant women more than migrant **men**. In comparison to Egyptian women, who were all against it, some Egyptian men maintained a positive view of female genital mutilation, even though they had resided in Greece for more than 2 years. This indicates that attitudes towards female genital mutilation may change more rapidly among women than among men. Factors that contribute to this are the silencing of female genital mutilation as a 'private' issue and the fact that women who have undergone the practice face the immediate consequences on their bodies. For men, it is mostly a question of tradition and morality that dictates the protection of women's and girls' purity. Younger boys who grow up in Greece are against female genital mutilation, according to both mothers and second-generation women from all ethnic groups. One Sudanese woman said that her sons watched a documentary on television about female genital mutilation and they were horrified, saying 'What have they done to you?'. An interesting finding from the focus group with men is that Muslim male migrants may be influenced by Muslim cultures other than their own in favour of female genital mutilation. More specifically, those who come from countries with little or no prevalence may come to view the practice in a positive light either because they have resided in countries or come into regular contact with members of communities practising female genital mutilation.

Women participants expressed concerns about the **impact on their intimate relationships**. As one participant said, husbands often turn against their wives for not enjoying intercourse: 'My husband gets angry because I do not feel anything and I don't like it. He tells me that he will leave me and go with a woman who is uncut.' Participants agreed that this happens very often. A second-generation Egyptian woman argued that in Egypt the high divorce rate, male adultery and polygamy are all phenomena that are caused by the consequences of female genital mutilation. Somali participants were interested to learn whether or not stories about reconstructive surgery allowing women to 'feel' were true.

Social pressure regarding marriage appears to be exercised by young men and their families in countries of origin, especially in Sudan and Somalia. Although both Sudanese and Somali women said that younger generations of men increasingly want their women not to be circumcised, they had many stories to tell about brides who were sent back because they had not undergone female genital mutilation. In most of these stories the girls end up being circumcised, but there is a negotiation between the girls' families and the groom on what type of female genital mutilation they will perform.

Perceptions about the risk of the practice in the host country and beyond

With regard to the **impact of migration** on female genital mutilation, all the participants — both women and men — said that they did not think that female genital mutilation was widely practised in the Egyptian, Nigerian, Sudanese, Syrian and Somali communities in Greece and Europe in general, irrespective of whether they were for or against the practice. They all agreed that there are no people performing female genital mutilation among migrant communities. Second-generation participants from Nigeria and Egypt argued that parents in European countries have realised that female genital mutilation is harmful for their children while first-generation Somali participants argued that change has to do with coming into contact with civil society organisations.

There were, however, stories about friends and relatives who had female genital mutilation performed on their children while **travelling to the country of origin**. For example, one Somali woman participant said that her sister, who resides in Germany, 'cut' her daughter during a trip back to Somalia. However, she also noted that in Sweden it is illegal to return to the country of origin to do 'cuttings' and that families who do so lose their residence permits and are denied the right to re-enter. The view that there is no evidence that female genital mutilation is widely practised in Greece by migrant communities may also be linked to the fact that many second-generation children born in Greece have been unable to travel to their parents' country of origin, because they lacked travel documents to enter their country of origin, and there was no legal procedure for granting them citizenship until 2016. Although this was more common in the past, some participants, especially from Sudan, Egypt and Somalia, were concerned that older relatives may take the initiative to circumcise girls if they return to the country of origin without their parents.

Unlike second-generation girls, older women participants from Somalia and Sudan were all aware of the different types of female genital mutilation. Older Egyptian participants were mostly aware of the version that is practised today, which includes cutting off the tip of the vagina. A Sudanese woman said that in the area where she comes from they use the Arabic term *Pharon* (FGM type III). According to most participants, *Pharon* is not a common practice anymore, except in remote villages. Most of the Somali and Sudanese women over 30 had undergone *Pharon* when they were young. Some of them reported that they were **treated negatively by medical staff** in Greece**,** described as being abnormal during medical examination. These examples indicate the need for training for doctors to recognise and treat cases of female genital mutilation properly. The women said they felt intimidated and ashamed while being objectified by medical professionals.

Participants expressed the common view that, in their countries of origin (Sudan, Somalia, Egypt, Nigeria and Iraq), 'heavy' types of female genital mutilation are no longer practised in urban areas, but they are sometimes practised in rural areas. They emphasised that even milder forms of female genital mutilation have declined because of new laws and campaigns against it. Nonetheless, there were disagreements among participants over how widespread the practice is in African countries other than their own.

Key risk factors for female genital mutilation

Factors increasing the risk of female genital mutilation include the possibility of return to the country of origin without parental supervision, secrecy about female genital mutilation within households, pressure to conform to stereotypes about purity and chastity in the country of origin, perceptions about the sexual development of young girls (i.e. that girls who are more sexually 'developed' at an early stage may be more at risk) and the lack of campaigns against female genital mutilation in Greece and in countries of origin.

In terms of **factors that decrease** the risks for young girls, participants identified: when travelling to the country of origin, having close supervision of parents who are against female genital mutilation, discussing the practice and its negative effects on female reproductive and sexual rights openly in households, tackling misconceptions

about the sexuality, and about the chastity and purity of female bodies, as well as raising awareness on the negative effects of 'lighter' forms (such as type I), which are considered 'safe' by some women and men who are against female genital mutilation, and promoting information disqualifying claims that it is a religious practice that the Prophet Muhammad dictated.

4.3. Estimating of the number of girls at risk of female genital mutilation in Greece

First, this section presents the estimates of the number of girls at risk of female genital mutilation within the regular migrant population; then the estimates for asylum-seeking girls are presented. The estimates are first presented according to the **original methodology** (EIGE, 2015a) and then the **refined methodology** is applied following the improvements outlined in Chapter 2 of this report. The estimates according to the refined methodology present the final outcome of the numbers of girls at risk of female genital mutilation in Greece.

Resident population

With regard to the low- and high-risk scenarios, the number of girls (aged 0–18) at risk of female genital mutilation in Greece varied between 161 and 817 in 2011, 141 and 715 in 2012, 133 and 666 in 2013, 107 and 536 in 2014, 102 and 519 in 2015 and 92 and 454 in 2016.

The trend from 2011 to 2016 is negative in both scenarios, i.e. the total number and proportion of girls at risk appears to be dropping. In all of these years, the vast majority of girls at risk are in the 0–9 age group.

Decreasing numbers and levels of risk might be related to the lack of data. Data sources used combine data on the female population holding residence permits (Eurostat) and data from the 2011 European population and housing census. As the permits data is not broken down by generation, the distinction between first and second generation is estimated using the proportion observed in the 2011 census data, comparing the proportion of first-generation (foreign-born) girls to the total number of residence permits (in the few cases where the foreign-born population outnumbers those with residence permits, the proportion of foreign-born girls is considered 100 %). Due to the lack of sufficient births data, the second generation is estimated as a fraction of the total residence permit-holders. This estimate does not include girls without residence permits (for example, with an EU father, born to asylum seekers, or born to naturalised or undocumented mothers). The number of second-generation girls at risk is likely to be a significant underestimation.

Table 4.3. Estimated number of girls (aged 0–18) at risk of female genital mutilation living in Greece (2011–2016)

	Resident population					
	HIGH-RISK SCENARIO			LOW-RISK SCENARIO		
	TOTAL	First generation	Second generation	TOTAL	First generation	Second generation
2011: TOTAL (0–18)	**817**	**161**	**656**	**161**	**161**	**0**
0–9	815	161	654	161	161	0
10–18	2	0	2	0	0	0
2012: TOTAL (0–18)	**715**	**141**	**574**	**141**	**141**	**0**
0–9	713	141	572	141	141	0
10–18	2	0	2	0	0	0
2013: TOTAL (0–18)	**666**	**133**	**533**	**133**	**133**	**0**
0–9	664	133	531	133	133	0
10–18	2	0	2	0	0	0
2014: TOTAL (0–18)	**536**	**107**	**429**	**107**	**107**	**0**
0–9	534	107	427	107	107	0
10–18	2	0	2	0	0	0
2015: TOTAL (0–18)	**519**	**102**	**417**	**102**	**102**	**0**
0–9	516	102	414	102	102	0
10–18	3	0	3	0	0	0
2016: TOTAL (0–18)	**454**	**92**	**362**	**92**	**92**	**0**
0–9	452	91	361	91	91	0
10–18	2	1	1	1	1	0

Source: Present study.

Table 4.4. Final estimated number of girls (aged 0–18) at risk of female genital mutilation living in Greece according to the refined methodological approach (2011 and 2016)

TOTAL	LOW-RISK SCENARIO Proportion of girls at risk		HIGH-RISK SCENARIO Proportion of girls at risk		LOW-RISK SCENARIO No of girls at risk		HIGH-RISK SCENARIO No of girls at risk	
	Original	Refined	Original	Refined	Original	Refined	Original	Refined
2011								
1 896	8 %	32 %	43 %	54 %	161	615	817	1 020
2016								
1 787	5 %	**25** %	25 %	**42** %	92	**453**	454	**748**

Source: Present study.

Figure 4.3. Estimated number of girls (aged 0–18) at risk of female genital mutilation living in Greece by generation and most represented countries of origin (2016) ([33])

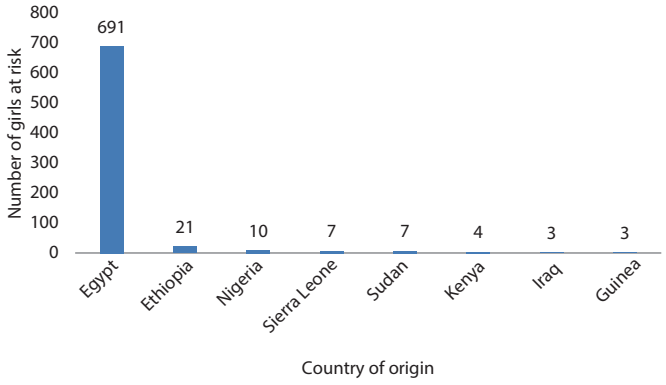


Table 4.5. Female genital mutilation risk in Greece in 2016 (latest available year)

High-risk scenario	In 2016, a total of 1 787 girls aged 0–18 from FGM-practising countries were residing in Greece, of which 748 were likely to be at risk of female genital mutilation. **Proportionally 42 % of girls aged 0–18 from FGM risk countries (either born in the country of origin or in Greece) were at risk of female genital mutilation.**
Low-risk scenario	In 2016, a total of 1 787 girls aged 0–18 from FGM-practising countries were residing in Greece, of which 453 were likely to be at risk of female genital mutilation. **Proportionally 25 % of girls aged 0–18 from FGM risk countries (either born in the country of origin or in Greece) were at risk of female genital mutilation.**

When applying the **refined methodological approach** ([32]), as described in Chapter 2 of this report, an increased number and proportion of girls at risk of female genital mutilation can be observed in Greece for the reference years 2011 (year of the European population and housing census) and 2016 (the latest available year).

The majority of the girls who are at risk (in the latest available year 2016) originate from Egypt: 691 girls. This pattern is stable from 2011 to 2016.

Table 4.5 summarises the results of the female genital mutilation risk estimations for both the high- and low-risk scenarios. In the high-risk scenario, both first- and second-generation girls are considered at risk of female genital mutilation, while the low-risk scenario considers the first generation and half of the second generation still at risk of female genital mutilation.

Asylum seekers

With regard to the high-risk scenario, the number of asylum-seeking girls (aged 0–17) at risk of female genital mutilation was 0 in 2011 and 33 in 2016. As from 2012, a decrease can be observed in the percentages of girls at risk, although the numbers have been increasing. For 2016, the top country of origin for girls at risk was Iraq (23 girls at risk), followed by Somalia (six girls). The remaining FGM-practising countries accounted for two or fewer asylum-seeking girls at risk in 2016.

If we apply the **refined methodological approach** ([34]) as described in Chapter 2 of this report, an increased number and proportion of asylum-seeking girls at risk of female genital mutilation can be observed in Greece in 2016 (the latest available year).

The four top countries of origin for asylum-seeking girls at risk of female genital mutilation (in the latest available year 2016) are Iraq, Somalia, Egypt and Eritrea.

([32]) Three adaptations are applied: (1) a more robust calculation of the median age of cutting and an increase of the median age by its standard deviation; (2) adding girls who have reached the median age of cutting into the calculation and (3) considering half of the second generation still at risk of female genital mutilation in the low-risk scenario.

([33]) The figure is based on the high-risk scenario data.

([34]) Three adaptations are applied: (1) a more robust calculation of the median age of cutting and an increase of the median age by its standard deviation; (2) adding girls who have reached the median age of cutting into the calculation and (3) considering half of the second generation still at risk of female genital mutilation in the low-risk scenario.

Table 4.6. Estimated number of asylum-seeking girls (aged 0–17) at risk of female genital mutilation living in Greece (2011–2016)

	Total	Total number at risk	Proportion of girls at risk
2011	10	0	0 %
2012	15	6	40 %
2013	41	6	15 %
2014	44	6	14 %
2015	114	11	10 %
2016	1 123	33	3 %

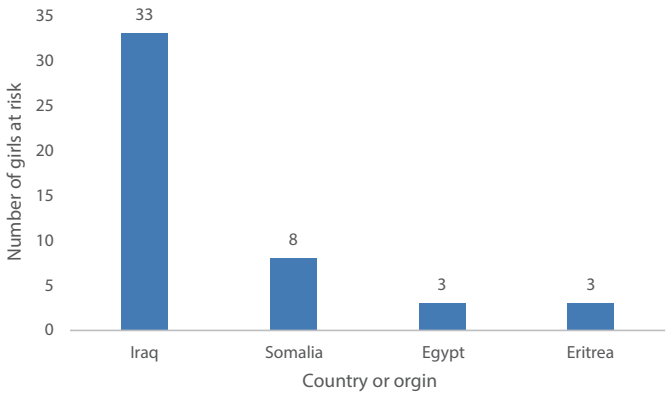
Source: Present study.

Table 4.7. Final estimated number of asylum-seeking girls (aged 0–17) at risk of female genital mutilation living in Greece according to the refined methodological approach (2011 and 2016)

TOTAL	HIGH-RISK SCENARIO Proportion of girls at risk		HIGH-RISK SCENARIO No of girls at risk	
	Original	Refined	Original	Refined
2011				
10	0 %	0 %	0	0
2016				
1 123	3 %	**5 %**	33	**51**

Source: Present study.

Figure 4.4. Estimated number of asylum-seeking girls (aged 0–18) at risk of female genital mutilation living in Greece by most represented countries of origin (2016) ([35])



([35]) The figure is based on the high-risk scenario data.

4.4. Main findings in Greece

In 2016, a total number of 1 787 girls aged 0–18 originating from FGM-practising countries were residing in Greece, of which **25 % to 42 % were at risk** of female genital mutilation.

Looking at **trends** over time, the percentage of girls at risk in the high-risk scenario decreased from 54 % in 2011 to 42 % in 2016. The same is true for the absolute numbers of girls at risk, while the total population of migrant girls from FGM-practising countries has remained stable (1 896 in 2011 and 1 787 in 2016).

To further **improve data** on the female migrant population in Greece it is recommended to collect information about the female migrant population who do not require a residence permit, for example second-generation girls who may be Greek citizens, as they are currently not captured by the available data.

The most represented country of origin by far among migrants living in Greece from FGM-practising **communities** is Egypt, and the most girls at risk also originate from this country. The focus group discussions offered the perspectives of five different communities, including women and men originating from Egypt and the views of men from Iraq, a country for which less is known about the practice of female genital mutilation. Overall, female genital mutilation appeared to be a more important community issue in the Somali and Sudanese communities, than in the Egyptian, Iraqi or Nigerian communities. However, the Somali and Sudanese communities were also more open to discussing female genital mutilation, as opposed to Egyptian and Nigerian participants, who viewed the issue as a private matter, with more men in favour of the practice. None of the participants thought that female genital mutilation was widely practised in Greece, although stories about girls taken to the country of origin to have the practice carried out emerged, evidencing it as a key **risk factor**. In this regard, it can be useful to take into account that up until 2016 second-generation children born in Greece could not travel to the country of origin due to a lack of granted citizenship. Travelling might thus increase in coming years, calling for effective policies to protect girls at risk.

Facilitating open discussions about female genital mutilation and its negative consequences — especially with men —, tackling misconceptions about women's sexuality, awareness-raising on all forms of the practice and the misbelief about the practice being a religious requirement are **discouraging factors** revealed in the discussions.

To **tackle female genital mutilation in Greece**, the practice has been criminalised through a specific legal provision since 2018. The recent ratification of the Istanbul Convention accelerated this process and the application of the principle of extraterritoriality to allow for prosecution for crimes committed abroad will be applied in the coming years. General child protection provisions can be used in cases of female genital mutilation and parents can be held accountable if female genital mutilation is performed on their child. The national action plan on gender-based violence 2016–2020 calls for holistic services supporting victims of female genital mutilation and awareness-raising campaigns targeted at the general public and in cooperation with communities. Affected women may access general services, but focus group discussions showed that many women had negative experiences with untrained medical staff.

When looking at **asylum seekers**, a total of 1 123 asylum-seeking girls were residing in Greece in 2016, of which 5 % were at risk of female genital mutilation. The country of origin most represented among asylum-seeking girls is Iraq and the most girls at risk among asylum-seeking girls originate from this country.

Greece has clearly been affected by **migratory flows** towards the European Union in recent years. Despite precise data on women from FGM-practising countries crossing borders not being available, general data from the Hellenic police indicates that, since 2011, 163 950 persons from FGM-practising countries have been arrested in Greece, coming from Iraq, Somalia, Eritrea, Egypt, Nigeria, Cameroon and Côte d'Ivoire. General **asylum** law in Greece can be applied to grant asylum to women and girls who have undergone female genital mutilation or who are in danger of being subjected to female genital mutilation. However, no information is available on the number of FGM-related applications received and granted, and a focus on the prevention of female genital mutilation through the asylum services, such as gender-specific asylum procedures, should be implemented.

5. Female genital mutilation risk estimation in France

5. Female genital mutilation risk estimation in France

This section presents the estimated number of girls at risk of female genital mutilation living in France. Firstly, the female migrant population originating from FGM-practising countries is described. The study population includes the number of girls aged 0–18 living in France in 2011 and 2014 who come from FGM-practising countries (first generation), or were born to a mother who originates from a country where female genital mutilation is documented (second generation). The resident population is separated from asylum seekers, as the push factors for migration are different when compared to resident migrants (EIGE, 2015a, p. 79). Secondly, a summary of the findings from the focus group discussions organised in France is provided. Finally, the data is processed to determine the high and low boundaries of the interval for female genital mutilation risk estimation.

5.1. Female migrant population aged 0–18 originating from FGM-practising countries

Recent data on the female migrant population broken down by sex, age and generation is available in France for the years 2011 and 2014 (the latter is the median year for the 2012–2014 period ([36]). The main **data sources** used for each of the reference years are the following:

- 2011: data from the European population and housing census (Eurostat), French population census (INSEE) and the National Archive of Data from Official Statistics (ADISP);
- 2014: data from the French population census (INSEE) and birth register data (INSEE);
- data on asylum seekers for 2011–2016 from the French Office for the Protection of Refugees and Stateless People.

To further **improve** the availability and comparability of data on the female migrant population in France, the following actions are recommended:

- align the terminology on the migrant population, specifically regarding the second generation, to the definitions in use in this report (see Chapter 2);
- provide data disaggregated by 1-year intervals in age instead of 5-year groupings (0–4, 5–9, 10–14, 15–19);
- complete the missing data on the second generation aged 10–18 in 2011;
- collect data on irregular/undocumented migration.

Resident population

In France, there were 41 552 girls (aged 0–18) originating from FGM-practising countries within the female migrant resident population in 2011. Of these, 31 547 (76 %) were first generation and 10 005 (24 %) were second generation. Within the second generation, all were aged 0–9.

For the year 2014, there were 205 683 girls (aged 0–18) originating from FGM-practising countries within the female migrant resident population. Of these, 34 620 (17 %) were first generation and 171 063 (83 %) were second generation. Within the second generation, around 113 086 (55 %) were aged 0–9 and 92 597 (45 %) were aged 10–18. The vast majority of girls aged 0–9 were second generation (90 %) and the percentage is similar, although slightly lower, for those aged 10–18 (75 %).

To estimate the age distribution of the first and second generation for 2014, the age structure of the data on foreign-born girls, available from the 2011 European population and housing census, was used.

The data presented below shows a very high increase in the total number of female migrants from 2011 to 2016, mainly due to missing data on the second generation aged 10–18 and an overall expanding second generation.

As regards the origins of the first- and second-generation girls, the seven countries most represented in 2014 were Senegal, Côte d'Ivoire, Mali, Cameroon, Guinea, Egypt and Togo. For each of these seven countries, the number of second-generation girls is at least three times as high as the number of first-generation girls.

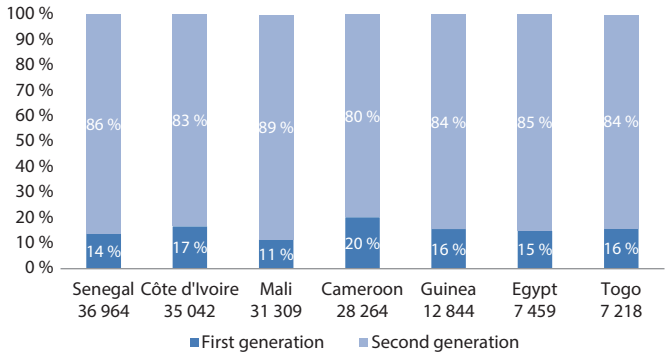
([36]) As the yearly population census covers only selected municipalities, a 5-year span is necessary to cover all of them. Therefore the median year 2014 was considered the reference year for the last 5 years (2012–2016).

Table 5.1. Age and generation distribution of the female migrant population (aged 0–18) in France originating from FGM-practising countries (2011 and 2014) ([37])

	TOTAL	First generation	Second generation	TOTAL (%)	First generation (%)	Second generation (%)	TOTAL generation (%)
2011 TOTAL	**41 552**	**31 547**	**10 005**	**100**	**76**	**24**	**100**
0–9	20 470	10 465	10 005	49	51	49	100
10–18	21 082	21 082	0	51	100	0	100
2014 TOTAL	**205 683**	**34 620**	**171 063**	**100**	**17**	**83**	**100**
0–9	113 086	11 591	101 495	55	10	90	100
10–18	92 597	23 029	69 568	45	25	75	100

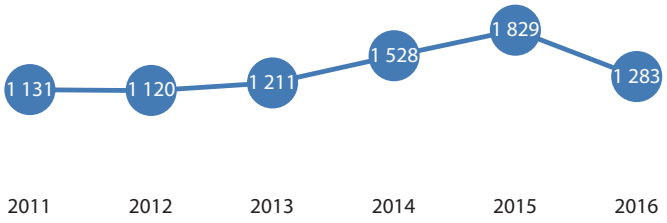
Source: National Institute of Statistics and Economic Studies (INSEE).

Figure 5.1. Number of girls (aged 0–18) living in France by generation and seven most represented countries of origin (2014)



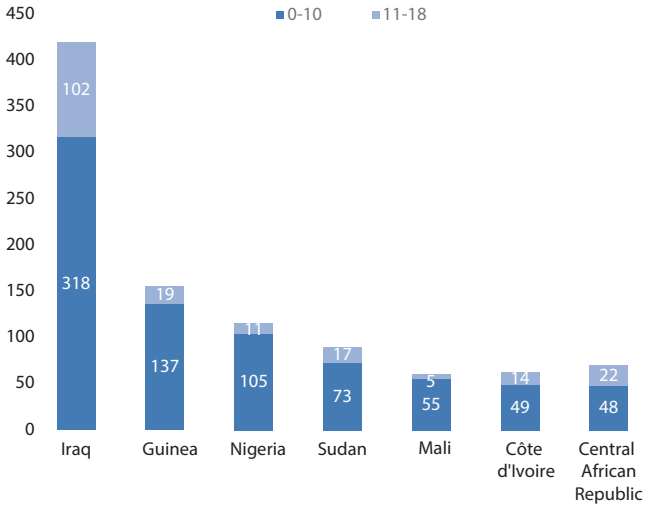
Source: INSEE.

Figure 5.2. Total number of asylum-seeking girls (aged 0–18) from FGM-practising countries living in France (2011–2016) ([38])



Source: French Office for the Protection of Refugees and Stateless People.

Figure 5.3. Number of asylum-seeking girls (aged 0–18) living in France by age and most represented countries of origin (2016)



Source: French Office for the Protection of Refugees and Stateless People.

Information on the region of origin of the girls (or their mothers) living in France is unavailable. Thus, for countries with a lower prevalence rate, the risk of bias is high when applying the national prevalence rate of female genital mutilation to the migrant population living in France.

Asylum seekers

The total number of female **asylum seekers** from FGM-practising countries increased from 1 131 in 2011 to 1 829 in 2015, and then dropped to 1 283 in 2016. The majority of female asylum seekers from FGM-practising countries in France between 2011 and 2016 were aged 0–10.

Looking closer at the latest available year, 2016, the seven FGM-practising countries which the largest number of female asylum seekers (aged 0–18) originated from were Iraq, Guinea, Nigeria, Sudan, the Central African Republic, Côte d'Ivoire and Mali. For each country of origin, girls aged 0–10 from the majority of these female asylum seekers.

([37]) One-year age disaggregation is not available due to statistical confidentiality and data is provided in 5-year groupings instead (0–4, 5–9, 10–14 and 15–19), therefore the number of girls aged 0–18 has been statistically estimated.

([38]) Data concerns only minors aged 0–18 years, as the statistical unit of this data is 'accompanying female minor'. The country of origin covers the country of birth of the parent of this minor. In most cases, the country of birth of the minor and the parent will be the same.

Comparing over the years, Iraq was one of the largest countries of origin from 2014 onwards among asylum-seeking girls. In 2016, the Central African Republic appears in the first seven countries with a more unusual trend: girls aged 10–18 represent approximately one third of the total, compared to less than 20 % for the other countries. Since 2011, the most frequent countries of origin for asylum seekers have been similar, for example Guinea, Mali, Côte d'Ivoire, Nigeria and Sudan. These numbers concern only girls who are accompanying others.

The number of **FGM-related asylum applications** granted in France increased from 2011 to 2014 (from 440 to 705) and lowered in 2016 (591). Since 2011, 70 % of the applications granted concern two countries, Guinea and Mali, which have very high female genital mutilation prevalence rates (more than 90 %) ([39]).

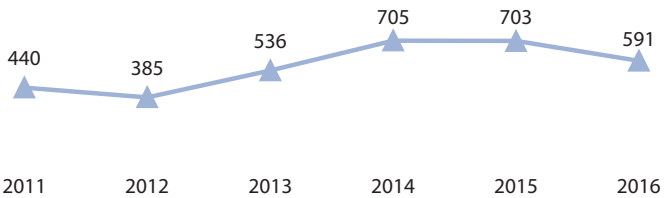
From the data collected by the French Office for the Protection of Refugees and Stateless People it is not possible to ascertain the differential between FGM-related asylum applications received and those granted and the numbers in Figure 5.4 concern only girls accompanying adults.

Other records collecting information on female genital mutilation in France

Hospital records are collected by hospitals specialised in reconstructive surgery after female genital mutilation in the cities of Saint-Denis and Montreuil. Data is collected on identified cases of female genital mutilation. This data covers only women who have experienced female genital mutilation and have chosen to have reconstructive surgery. This hospital data could be considered in direct prevalence estimations, but was not used in the estimates of girls at risk as the methodological approach in this report uses indirect estimations.

Official data regarding **inflows and outflows** of immigrants and emigrants from FGM-practising countries is not available in France. Also, official records on the total number of **irregular/undocumented migrants** are lacking and cannot be used to calculate the female migrant population in France.

Figure 5.4. Number of FGM-related asylum applications granted in France since 2011 for girls (aged 0–19) from FGM-practising countries



Source: French Office for the Protection of Refugees and Stateless People.

([39]) According to the latest data from the DHS, FGM prevalence in Guinea is 96.9 % (Demographic and Health Survey, 2012) and in Mali 91.4 % (Demographic and Health Survey, 2012–2013) (https://www.statcompiler.com/en/index.html).

5.2. Summary of findings from focus group discussions organised in France

Four focus group discussions took place in France in September 2017. Two discussion groups were held with first-generation women and first- and second-generation men from Mali, respectively. Another group combined younger second-generation women from Mali, Senegal and Gambia and a fourth group included older, hard-to-reach women from Guinea.

The countries of origin were chosen according to data on the largest populations from FGM-practising countries living in France, namely Guinea and Mali. Table 5.2 presents an overview of the profile of the participants in the four focus group discussions.

Identity and attitudes about the importance of female genital mutilation

In the focus group discussion with younger women, as with men, nearly all participants were unanimous: in their country of origin, female genital mutilation continues to be important and is practised in rural areas and in urban areas. Once in France, however, social norms appear to affect migrants' identities and values. Older women and men from Mali consistently distinguish between their perception of female genital mutilation in France and in their country of origin. Some older Malian women in the first focus group discussion, for example, said that they feel they are forbidden even from talking about their community of origin. The concept of group membership and reference plays an important role here. In the country of origin, female genital mutilation is argued to be a social norm, whereas in the host country it does not correspond to tradition and is prohibited by law. This **conflict between expectations and norms in the host country and country of origin** is captured by the words of participants. As an older Malian man explained: 'As soon as we get back to the country of origin, we do what we want, so no problem.' Others appear to adopt the norms in France and claim the ban as their own.

The practice relates to family expectations in terms of female **purity and marriage** in the country of origin and host country and the aspect of **virginity** seems to be essential. Women from Guinea explained, for example, that much of the Guinean diaspora try to respect these customs at the time of marriage.

According to all the participants in the mixed focus group discussion with younger, second-generation women, female genital mutilation is practised especially for **religious reasons and family honour**. Female genital mutilation represents a form of respectability for the circumcised girl. One first-generation Guinean woman talked about religion as a means of resistance: 'We thought it was religion and when we knew it was not, it gave us the strength to stop and that's how we can stop.' This woman's perspective reflects the fact that there can be conflicting perceptions about what religion requires when it comes to female genital mutilation, given that other focus group participants (also Muslim) saw religion as a reason in favour of the practice.

It appears that some older Malian women consciously resist **social pressure** and refuse female genital mutilation for their children. For example, many referred to the law and its application. One such participant (with children) explained that: 'In my village they practice excision and refuse to drop the practice of excision. And twice when I went, I refused to excise my girls. When I came back to France each time a review was conducted by the hospital'. For these women, French **law was acting as a deterrent** and was known to the families

Table 5.2. Overview of focus group discussions and sociodemographic profile of participants in France

Key characteristics of focus groups	Older women	Younger women	Men	Hard-to-reach/recent migrant women
Number of participants	7	8	9	4
Countries of origin represented ([40])	Mali	Mali, Senegal, Gambia	Mali	Guinea
Age range	Over 25	18–25	25–60	28–61
Generation (first/second)	First	Second	First and second	First
Average residence (number of months) and previous residence in other countries	19.5	0	Average number of months in France: 210.7 (approx. 17.5 years)	Average number of months in France: 228 (19 years)
Number of second-generation participants who have lived in their parents' country of birth	n/a	0	n/a	n/a
Civil status of participants	divorced (1) married (6)	married (1) unmarried (7)	divorced (1) single (1) married (7)	All married
Number of participants with/without children	7 with children	8 without children	1 without children 8 with children	4 with children
Religion	Muslim	Muslim	Muslim	Muslim
Ethnic groups (if available)	4 Soninke 2 Bambara 1 Arabic	6 Bambara 1 Serere 1 Diakhanke	9 Soninke	3 Diakhanke 1 Peulh
Level of education	No formal education (3) Primary education (1) Secondary education (1) Quranic school (1)	Students	No formal education (4) Madrassa (1) Secondary education (3) Higher education (1)	No formal education (3) Secondary education (1)
(For first generation): shortest and longest amount of time residing in France	Shortest: 4 years Longest: 30 years	n/a	Longest: 43 years Shortest: 5 years	Longest: 25 years Shortest: 7 years
Date of session	16 September 2017	16 September 2017	13 September 2017	28 September 2017

living in the country of origin. For the Malian men, there was a certain degree of conformity with social pressure. Among younger women of the second generation (mixed communities), there was some fatalism about the practice of female genital mutilation, even though all the participants in the focus group were positioned openly and firmly against it. These women were very pleased that there is a law in France banning the practice of female genital mutilation. Furthermore, their families are well aware that it is prohibited. However, the young women felt that, in practice, this is weak protection against the decisions of families and the importance of maintaining the customs of the country of origin.

Perceptions about the risk of the practice in the host country and beyond

All the communities believed that female genital mutilation has **disappeared from the French territory** among their own community and among other communities. To these participants, if female genital mutilation persists, it is because families take children and adolescents to the country of origin to perform the practice. Some families in France are afraid of the law and stop practising it. Others continue due to social pressures, a desire to respect the religious prescription that they believe exists, or because their families in their countries of origin practise female genital mutilation on their children without consulting them. However, on an individual basis, many participants were sincerely opposed to the pursuit and maintenance of female genital mutilation.

On the other hand, the communities in three out of four focus groups considered that female genital mutilation among communities living in their country of origin was much more extensive. **Female genital mutilation remains a common practice**, according to several men participating in the focus group discussion, even in Malian villages that have openly called to stop the practice. In fact, only Guinean migrants indicated that the practice had decreased in their country of origin.

Participants in the focus group discussions did not appear to distinguish between the **types of female genital mutilation** carried out among the community. Malian men spoke of the difference between female circumcision and infibulation (type III), to 'ensure virginity' before the marriage of young girls.

([40]) This is the country of birth of first-generation migrants (FGM-practising countries), or the country of birth of the parents of second-generation migrants (FGM-practising countries). Here, someone is second generation if that person was not born in an FGM-practising country but has at least one parent born in an FGM-practising country.

Table 5.3. Estimated number of girls (aged 0–18) at risk of female genital mutilation living in France (2011 and 2014)

	Resident population					
	HIGH-RISK SCENARIO			LOW-RISK SCENARIO		
	TOTAL	First generation	Second generation	TOTAL	First generation	Second generation
2011: TOTAL (0–18)	**5 875**	**1 936**	**3 939**	**1 936**	**1 936**	**0**
0–9	5 780	1 841	3 939	1 841	1 841	0
10–18	95	95	0	95	95	0
2014: TOTAL (0–18)	**23 885**	**2 266**	**21 619**	**2 266**	**2 266**	0
0–9	23 558	2 168	21 390	2 168	2 168	0
10–18	327	98	229	98	98	0

Source: Present study.

Table 5.4. Final estimated number of girls (aged 0–18) at risk of female genital mutilation living in France according to the refined methodological approach (2011 and 2014)

TOTAL	LOW-RISK SCENARIO Proportion of girls at risk		HIGH-RISK SCENARIO Proportion of girls at risk		LOW-RISK SCENARIO No of girls at risk		HIGH-RISK SCENARIO No of girls at risk	
	Original	Refined	Original	Refined	Original	Refined	Original	Refined
2011								
41 552	5 %	16 %	14 %	20 %	1 936	6 473	5 875	8 444
2014								
205 683	1 %	**12 %**	12 %	**21 %**	2 266	**24 660**	23 885	**44 106**

Source: Present study.

Key risk factors for female genital mutilation

Motivating factors contributing to the maintenance of the practice were highlighted by the participants. Many spoke of the difficulty, on return to the country of origin, in opposing social pressure from their family members. Younger women from the second generation repeatedly stressed the important role of elders and, to some extent, appeared fatalistic about their prospects. Another factor mentioned was the desire to respect a religious prescription.

Conversely, the focus group discussion results indicate clear **discouraging factors** that reduce the risk of girls experiencing female genital mutilation. The law and its application have played an essential role in the reduction of the practice of female genital mutilation in France. The reporting of trials and prosecutions in the media and checks carried out in hospitals and maternal and infant protection centres were mentioned as further contributing to the abandonment of the practice. Focus group participants also pointed to awareness-raising and prevention campaigns — in France and abroad — as discouraging, including on African television in regions where excision is practised.

5.3. Estimating the number of girls at risk of female genital mutilation in France

First, this section presents the estimates of the number of girls at risk of female genital mutilation within the regular migrant population; then the estimates for asylum-seeking girls are presented. The estimates are first presented according to the **original methodology** (EIGE, 2015a) and then the **refined methodology** is applied following the improvements as outlined in Chapter 2 of this report. The estimates according to the refined methodology present the final outcomes of the numbers of girls at risk of female genital mutilation in France.

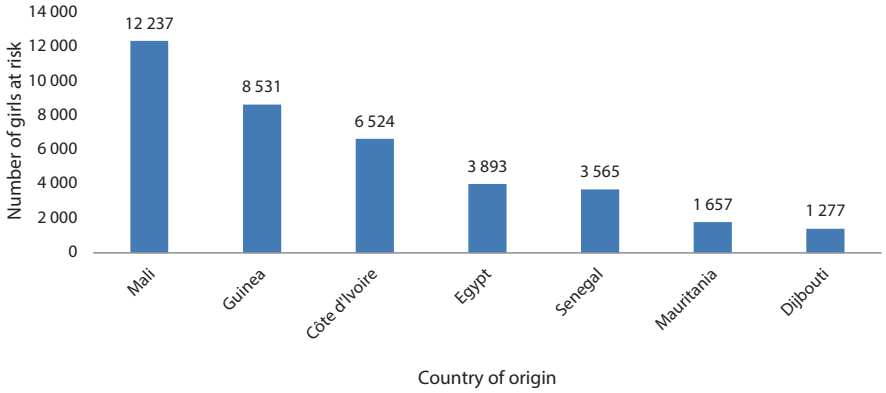
Resident population

With regard to the low- and high-risk scenarios, the number of girls (aged 0–18) at risk of female genital mutilation in France varied between 1 936 and 5 875 in 2011 and between 2 266 and 23 885 in 2016.

The increase in the number of girls at risk between 2011 and 2014 is significant; the number is almost four times higher for the high-risk scenario. The scale of the increase in real terms may be partly related to missing data on the second generation in 2011. The percentages of girls at risk have decreased, suggesting that, similarly to Belgium, the expansion in the number of girls at risk is related to a growing population of FGM-affected communities living in the country.

For both 2011 and 2014, most girls at risk are younger than 10. For girls aged 0–9, between 9 % and 28 % of girls were at risk in 2011, while between 2 % and 21 % were at risk in 2014.

Figure 5.5. Estimated number of girls (aged 0–18) at risk of female genital mutilation living in France by most represented countries of origin (2014)



Source: Present study.

When applying the **refined methodological approach** ([41]) as described in Chapter 2 of this report, an increased number and proportion of girls at risk of female genital mutilation can be observed in France for the reference year 2011 (year of the European population and housing census) and 2014 (the latest available year). By considering half of the second generation still at risk of female genital mutilation in the low-risk scenario, the expanding of this generation over recent years is more realistically taken into account in the estimation.

The largest number of girls who were at risk (in the latest available year 2014) originated from Mali, followed by Guinea and Côte d'Ivoire. Smaller groups of girls at risk originated from Egypt, Senegal, Mauritania and Djibouti.

Table 5.5. Female genital mutilation risk in France in 2014 (latest available year)

High-risk scenario	In 2014, a total number of 205 683 girls aged 0–18 originating from FGM risk countries (born in the country of origin or in France) were residing in France, of which 44 106 girls were likely to be at risk of female genital mutilation. **Proportionally, 21 % of girls aged 0–18 originating from FGM risk countries (born in the country of origin or in France) were at risk of female genital mutilation.**
Low-risk scenario	In 2014, a total number of 205 683 girls aged 0–18 originating from FGM risk countries (born in the country of origin or in France) were residing in France, of which 24 660 girls were likely to be at risk of female genital mutilation. **Proportionally, 12 % of girls aged 0–18 originating from FGM (born in the country of origin or in France) were at risk of female genital mutilation.**

([41]) Three adaptations are applied: (1) a more robust calculation of the median age of cutting and an increase of the median age by its standard deviation; (2) adding girls who have reached the median age of cutting into the calculation and (3) considering half of the second generation still at risk of female genital mutilation in the low-risk scenario.

Table 5.5 summarises the results of the female genital mutilation risk estimations for both the high- and low-risk scenarios. In the high-risk scenario, both first- and second-generation girls are considered at risk of female genital mutilation, while the low-risk scenario considers the first generation and half of the second generation still at risk of female genital mutilation.

Table 5.6. Estimated number of asylum-seeking girls (aged 0–18) at risk of female genital mutilation living in France (2011–2016)

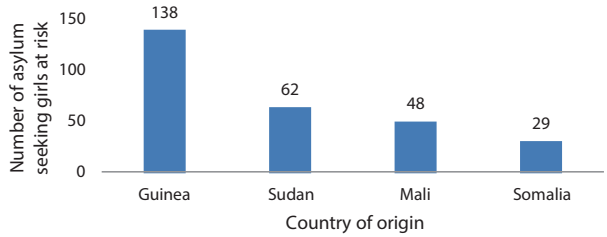
	Total number of girls (aged 0–18) from FGM-practising countries	Total number at risk	Proportion of girls at risk
2011	1 131	521	46 %
2012	1 120	505	45 %
2013	1 211	538	44 %
2014	1 528	633	41 %
2015	1 829	602	33 %
2016	1 283	324	25 %

Source: Present study.

Table 5.7. Final estimated number of asylum-seeking girls (aged 0–18) at risk of female genital mutilation living in France according to the refined methodological approach (2011 and 2016)

TOTAL	HIGH-RISK SCENARIO Proportion of girls at risk		HIGH-RISK SCENARIO No of girls at risk	
	Original	Refined	Original	Refined
2011				
1 131	46 %	56 %	521	632
2016				
1 283	25 %	**33 %**	324	**1 283**

Figure 5.6. Estimated number of asylum-seeking girls (aged 0–18) at risk of female genital mutilation living in France by most represented countries of origin (2016) ([43])



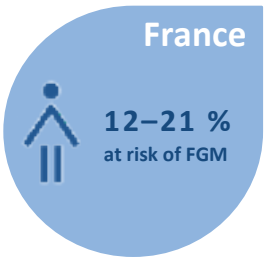
Asylum seekers

With regard to the high-risk scenario, the number of asylum-seeking girls (aged 0–18) at risk of female genital mutilation ranged from 1 131 in 2011 to a high of 1 829 in 2015, before decreasing to 1 283 in 2016. Overall, between 2011 and 2016, the proportion of asylum-seeking girls at risk of female genital mutilation decreased.

If we apply the **refined methodological approach** ([42]) as described in Chapter 2 of this report, an increased number and proportion of asylum-seeking girls at risk of female genital mutilation can be observed in France in 2011 (the year of the European population and housing census) and 2014 (the latest available year).

In 2016, the countries of origin with the most asylum-seeking girls estimated to be at risk of female genital mutilation were Guinea, Sudan, Mali and Somalia.

5.4. Main findings in France



In 2014, a total number of 205 683 girls aged 0–18 from FGM-practising countries (born in the country of origin or in France) were residing in France, of which **12 % to 21 % were at risk** of female genital mutilation.

Looking at **trends over time,** the proportion of girls at risk decreased between 2011 and 2014 in the low-risk scenario and slightly increased in the high-risk scenario. When looking at the exact numbers, for both risk scenarios the numbers of girls at risk have grown significantly. Most of this growth is due to an increase in the size of the second generation.

The largest **communities** from FGM-practising countries living in France do not necessarily represent the countries which the most girls at risk originate from. While the largest numbers of girls originate, in descending order, from Senegal, Côte d'Ivoire, Mali, Cameroon and Guinea, girls at risk (there are many more second-generation migrant girls at risk than first-generation migrant girls) originate in descending order from Mali, Guinea, Côte d'Ivoire and Egypt. When designing targeted policies in France, it is important to take this reality into consideration.

In the focus group discussions, women and men from the highest risk communities — originating from Mali and Guinea — shared the idea that female genital mutilation is occurring in their country of origin, in both rural and urban areas. Social pressure to carry out female genital mutilation was connected with marriage and virginity by the senior women and women from Guinea, while younger women attributed the practice to religion.

First- and second-generation women had fully absorbed the notion of the illegality of the practice on French territory. Change is apparently slower among Malian men, who were the only focus group to insist significantly on the importance of maintaining female genital mutilation, with many feeling the pressure to conform to avoid their daughters being perceived negatively. Younger women also expressed concern that French protection measures were not enforced adequately in the country of origin, particularly due to the sizeable influence held by older generations and the role of extended family members in encouraging female genital mutilation. There is no doubt among focus group participants that the law and its application play a role in **decreasing female genital mutilation**. The 30th court case on female genital mutilation took place in France in May 2012 (Gilette-Faye, 2017); however, more recent data and official monitoring systems on judicial investigations and prosecutions have not been established.

To **tackle female genital mutilation in France**, the practice is criminalised through the Penal Code and the principle of extraterritoriality is applied in a broad way, making it possible to sanction and punish female genital mutilation practised on French girls when they are abroad, even if they originated from another country. General provisions for child protection and professional secrecy can be applied in cases of female genital mutilation and specific guidelines for professionals are in place. Specific policies to tackle female genital mutilation are thorough in France's fifth interministerial plan for the prevention of violence against women (2017–2019), setting out specific actions related to health and education, including developing a partnership between the ministries in charge of public health and education, alongside civil society.

Awareness of available services for women who have experienced female genital mutilation or who are at risk was rather weak among all focus group participants, with only health services being known. The results reveal on the other hand that **awareness of the law** in France prohibiting female genital mutilation is much higher, except for the extraterritoriality principle criminalising the practice if carried out abroad. The training of professionals so they can inform affected communities on all aspects of the French legislation on female genital mutilation is important.

Looking at asylum seekers, a total number of 1 283 girls were residing in France in 2016, of which **33 % were at risk** of female genital mutilation. While proportions of girls at risk are lowering over the years, the actual numbers are on the rise.

The 2015 reform of France's asylum law includes a specific provision for female genital mutilation to be considered in asylum claims. Looking at the numbers of **FGM-related asylum applications** granted in France, an increase can be observed from 2011 to 2014 (440 to 705), lowering again in 2016 (to 591).

([42]) Three adaptations are applied: (1) a more robust calculation of the median age of cutting and an increase of the median age by its standard deviation; (2) adding girls who have reached the median age of cutting into the calculation and (3) considering half of the second generation still at risk of female genital mutilation in the low-risk scenario.

([43]) The figure is based on the high-risk scenario data.

6. Female genital mutilation risk estimation in Italy

6. Female genital mutilation risk estimation in Italy

This section presents the estimated number of girls at risk of female genital mutilation living in Italy. Firstly, the female migrant population originating from FGM-practising countries is described. The study population includes the number of girls aged 0–18 living in Italy in 2011 (the year of the European population and housing census) and 2016 (latest available year) who come from FGM-practising countries (first generation) or were born to a mother who originates from a country where female genital mutilation is documented (second generation). The resident population is separated from asylum seekers, as the push factors for migration are different when compared to resident migrants (EIGE, 2015a, p. 79). Secondly, a summary of the findings from the focus group discussions organised in Italy is provided. Finally, the data is processed to determine the high and low boundaries of the interval for female genital mutilation risk estimation.

6.1. Female migrant population aged 0–18 originating from FGM-practising countries

Recent data on the female migrant population is presented in Italy for the years 2011 and 2016. The main **data sources** used for each of the reference years are the following:

- 2011–2016: European population and housing census (Eurostat) and birth register data (municipal population registers);
- data on asylum seekers for the period 2011–2016 from the Italian National Statistical Office (Istat).

To further **improve** the availability and comparability of data on the female migrant population in Italy, the following actions are recommended:

- disaggregate data on the age by 1-year intervals instead of 5-year age groupings;
- provide births data for the year 2016 for more accurate information on the number of second-generation girls;
- provide data on generational breakdowns for permits data;
- collect data on FGM-related asylum applications;
- collect data on irregular/undocumented migration.

Resident population

In Italy, there were 59 720 girls (aged 0–18) originating from FGM-practising countries in 2011. Of these, 65 % (39 058) were second generation. Of the total number of girls aged 0–18, more than half (71 %, 42 220) were aged 0–9 and 29 % (17 500) were aged 10–18. Of the girls aged 0–9, 80 % were second generation; this fell to 30 % for those aged 10–18. The youngest girls tended to be more likely to be drawn from the second generation than the first.

The number of girls from FGM-practising countries for 2016 reached 76 040, which represents a 27 % increase compared to 2011. By 2016, the generation distribution followed a similar pattern but was even more pronounced, with 75 % (56 931) as second generation and 25 % (19 109) as first. Of the girls aged 0–9, 85 % were second generation, 5 percentage points higher than in 2011. The proportion of girls aged 10–18 who were second generation doubled to 60 % in 2016, suggesting a growing second generation within FGM-affected communities (both in absolute terms and as a proportion of all girls).

Data on births for 2016 is not available, so the number of second-generation girls is underestimated. Moreover, as births data is available only as far back as 1999, some data on older girls (i.e. born before 1999) is missing.

In 2016, girls younger than 10 years old from FGM-practising countries living in Italy represented 60 % of the total number of female migrants from these countries, while girls aged 10 and above represented 40 % of the total. Over the period 2011–2016, there was an overall and steady increase in the number of girls aged 0–18 in Italy from the 30 FGM-practising countries.

However, the number of first-generation migrants decreased over time. The data in Figure 6.2 represents the total number of first-generation girls aged 0–18 from the 30 FGM-practising countries in Italy in the period 2011–2016. Here, the individuals' migration status is based upon being born in an FGM-practising country.

In Italy, in 2016, the seven FGM-practising countries which the largest number of female migrants (aged 0–18) originated from were: Egypt, Nigeria, Senegal, Ghana, Côte d'Ivoire, Burkina Faso, and Ethiopia.

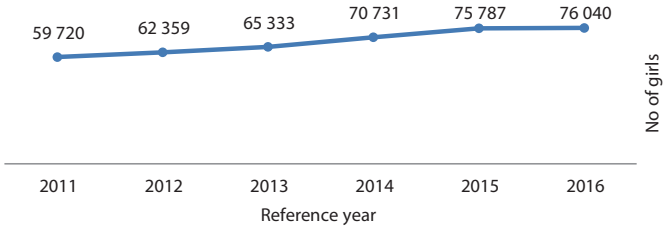
Information on the region of origin of the girls (or their mothers) living in Italy is unavailable. Thus, for countries with a lower prevalence rate, the risk of bias is high when applying the national prevalence rate of female genital mutilation to the migrant population living in Italy.

Table 6.1. Age and generation distribution of the female migrant population (aged 0–18) in Italy originating from FGM-practising countries (2011 and 2016)

	TOTAL	First generation	Second generation	TOTAL (%)	First generation (%)	Second generation (%)	TOTAL generation (%)
2011							
TOTAL 0–18	**59 720**	**20 662**	**39 058**	**100**	**35**	**65**	**100**
0–9	42 220	8 330	33 890	71	20	80	100
10–18	17 500	12 332	5 168	29	70	30	100
2016							
TOTAL 0–18	**76 040**	**19 109**	**56 931**	**100**	**25**	**75**	**100**
0–9	45 532	6 900	38 632	60	15	85	100
10–18	30 508	12 209	18 299	40	40	60	100

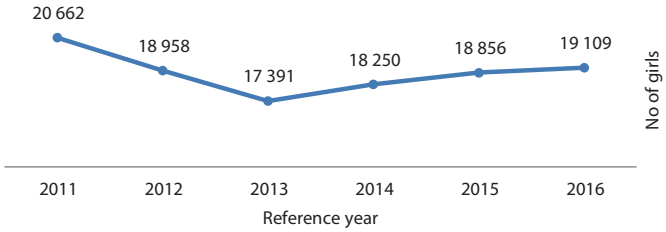
Source: Eurostat and municipal population registers.

Figure 6.1. Total number of girls (aged 0–18) from FGM-practising countries living in Italy (2011–2016)



Source: Eurostat and municipal population registers.

Figure 6.2. Total number of first-generation girls (aged 0–18) from FGM-practising countries living in Italy (2011–2016)

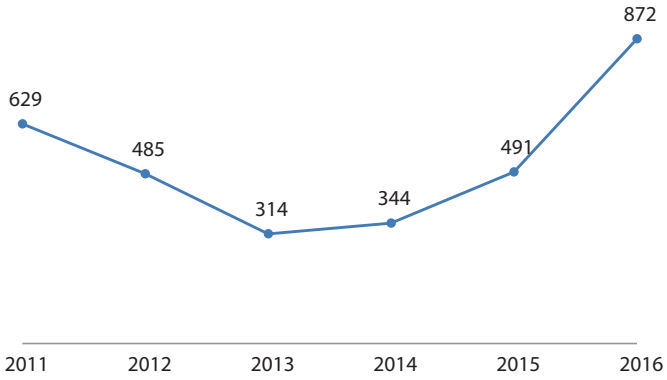


Source: Eurostat.

Asylum seekers

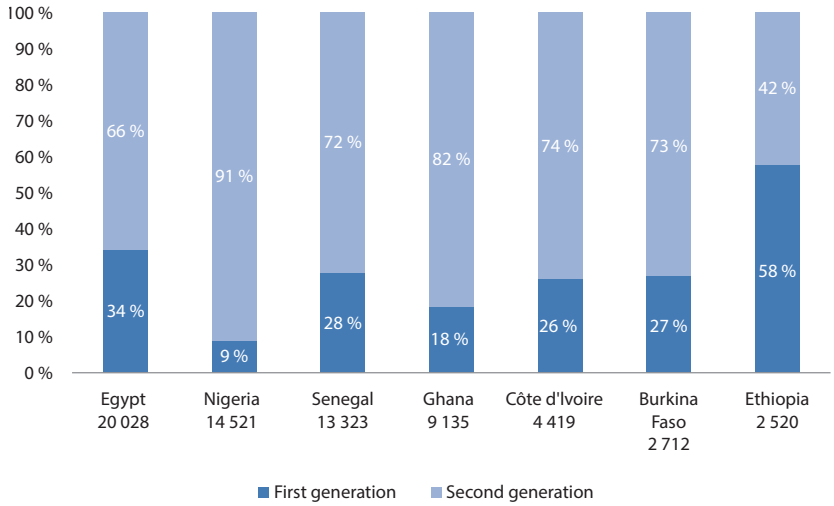
Over the period 2011–2016, after a fall in the first 2 years, there was a rise from 2013 in the number of female asylum seekers from FGM-practising countries in Italy, reaching a peak of 872 in 2016. In particular, there was an increase in the number of asylum seekers among girls

Figure 6.4. Number of asylum-seeking girls (aged 0–18) from FGM-practising countries living in Italy (2011–2016)



Source: Istat.

Figure 6.3. Number of girls (aged 0–18) living in Italy by most represented FGM-practising countries of origin (2016)



Source: Eurostat and municipal population registers.

aged 0–18 coming from Nigeria, while the number of asylum seekers originating from the remaining six countries — presented in Figure 6.2 — was stable and quite low, except for a significant increase for Côte d'Ivoire between 2015 and 2016.

For the latest available year, 2016, there were 872 asylum-seeking girls (aged 0–18) from FGM-practising countries. Out of these 872 girls, approximately 88 % (772) were asylum-seeking girls aged 0–18 from the seven most represented countries. Within this group of 772 girls, 68 % (524) were aged 10–18 and 66 % (506) came from Nigeria.

The other most represented countries of female asylum seekers in Italy were: Côte d'Ivoire, Somalia, Cameroon, Eritrea, Gambia and Iraq. Three out of these seven (Nigeria, Côte d'Ivoire and Cameroon) are also among the countries that make up the highest number of regular female migrants in Italy (originating from the 30 FGM-practising countries).

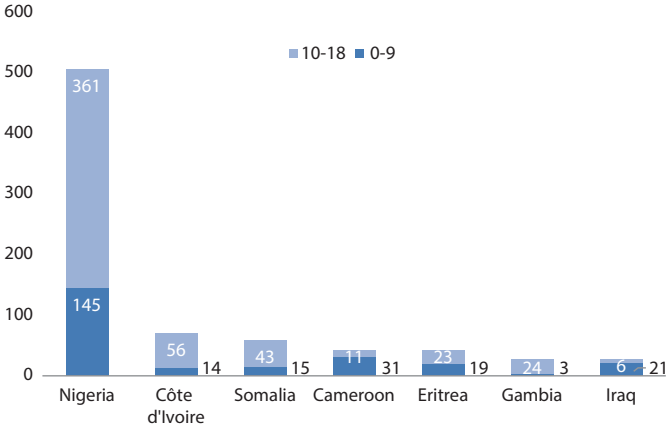
Data on the number of **FGM-related asylum applications** received and granted since 2011 is not available in Italy.

Other records collecting information on female genital mutilation in Italy

Migration patterns

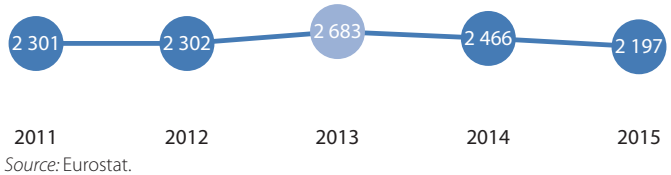
The total of female immigrants (inflows) and emigrants (outflows) originating from the 30 FGM-practising countries are relatively constant over the period 2011–2015. Inflows stand at about 2 500 girls per year; outflows are between 131 and 207 per year. A slight increase in outflows was recorded in 2014 and 2015, with a consequent slight decrease of net migration. Data stems from the registration for immigration in the Italian municipal population registers, provided by Eurostat. Inflows and outflows data was collected based on the country of birth of migrants. This data is not used in the estimates of girls at risk of female genital mutilation as it is a 'flow' variable rather than a 'stock' variable.

Figure 6.5. Number of asylum-seeking girls (aged 0–18) living in Italy by 10-year age group and most represented countries of origin (2016)



Source: Istat.

Figure 6.6. Net female immigrants (inflows) to Italy originating from the 30 FGM-practising countries (aged 0–19, first generation) (2011–2015)



Source: Eurostat.

Irregular migration

No official information is available on irregular migrants from the National Statistical Institute (Istat) for the period 2011–2016.

6.2. Summary of findings from focus group discussions organised in Italy

Four focus group discussions were held In Italy in September and October 2017. Discussions were held with first-generation Egyptian women, second-generation young women of mixed backgrounds, first- and second-generation Egyptian men and Nigerian women combining first-generation and recent migrants ([44]). The contributions from Egyptians offered the perspective of Italy's biggest community with girls at risk of female genital mutilation. The viewpoints of Nigerians reflected the country of origin of a high number of girls at risk of female genital mutilation, as well as of most asylum seekers from FGM-practising countries.

Table 6.2 summarises the demographic information about the participants of each group.

Identity and attitudes about the importance of female genital mutilation

The participants in the focus group discussions said the main aim of the practice is related to **controlling women's sexuality**. According to the Egyptian women and men, cutting allowed for the adoption of more virtuous and approved behaviour. Sexual control was also central in the narrative of the Nigerian women, for whom the practice remains important, even if there have been relevant changes in the type of genital modification undertaken. More broadly, young women of the second generation saw female genital mutilation as a question of gender and power between women and men, in which the role of women is defined by a patriarchal society.

Egyptian women and men generally agreed that the practice is **more linked to tradition than to religion**, even if those who were still practising it perceived female genital mutilation as a religious obligation. The young women of mixed backgrounds saw female genital mutilation as a traditional and cultural element of the countries of origin of their relatives, which was not relevant to their identity as Italians. Egyptian men were clearly divided into those in favour of and those against the practice, but both of these groups felt that the decision affects their personal identity as men and their self-representation. Those in favour tended to underline the religious values involved in practising female genital mutilation (although the religious argument was controversial among participants). However, according to the Egyptian women, the

([44]) In addition to a small focus group discussion, two semi-structured interviews were held with two second-generation young women. This was done to increase the input from the second generation in the study, given the difficulties in encouraging the second generation to participate in a group discussion.

Table 6.2. Overview of focus group discussions and sociodemographic profile of participants in Italy

Key characteristics of focus groups	Older women	Younger women	Men	Hard-to-reach/recent migrants
No. of participants	8	4	8	6
Countries of origin represented ([45])	Egypt	3 participants have both parents from, respectively: Ethiopia, Nigeria, Eritrea; 1 participant has an Egyptian father and a Moroccan mother	Egypt	Nigeria
Age range	Over 25	18–27	25–60	23–49
Generation (first/second)	First	Second	First and second	First and second
Average residence (number of months) and previous residence in other countries	17 years of residence in Italy	21 years of residence in Italy	13 years of residence in Italy	11 years of residence in Italy
No of second-generation participants who have lived in their parents' country of birth	0	1	1	0
Civil status of participants	9 married	Single	6 married	3 married
Number of participants with/without children	9 with children	0 with children	5 with children	5 with children
Religion	Muslim	2 Christian/2 not religious	Muslim	Christian
Ethnic groups (if available)	n/a	n/a	n/a	Urhobo, Edo-Bini, Igbo
Level of education	Secondary education	Secondary education Higher education	Secondary education Higher education	No formal education Higher education
(For first generation): shortest and longest amount of time residing in Italy	Shortest: 1 year Longest: 26 years	n/a (second generation)	Shortest: 6 years Longest: 27 years	Shortest: 1 year Longest: 21 years
(For first generation): shortest and longest amount of time residing in another EU Member State	n/a	n/a	n/a	n/a
Date of session	26 September 2017	29 November 2017	20 September 2017	2 October 2017

position adopted by religious groups has highlighted that religion has nothing to do with the practice of female genital mutilation, which has likely led to a decrease in the number of girls undergoing the practice. According to these women, a third 'modern' and aesthetic justification for female genital mutilation also arises nowadays.

Egyptian women and men felt that an uncircumcised girl could still get **married** without problems. For men, the encounter with the host society played a role in changing some opinions, but it did so selectively: virginity was still important, but female genital mutilation could be left behind (this was valid for those who were against female genital mutilation). To Nigerian women, it seemed that the practice was not a precondition for marriage and that it depended on the man. However, for first-generation women (both Egyptian and Nigerian), migration and the encounter with the host society did not play a role in the decision to cut (or not) their daughters, and more broadly in their overall awareness about gender-based violence, women's rights or women's empowerment.

All Egyptian participants agreed that families in Egypt can exert **social pressure** and exercise influence on an individual's decision to cut a girl, occupying an important and critical role. As a point of disagreement, the men declared that they were the only people with the power to decide about their daughters, whereas women stressed the importance that grandmothers still have in the decision-making process. The older generation and less educated people were said to confer much more importance on female genital mutilation than younger generations and educated people.

Among the participants who were against the practice, in the focus group discussions, a woman's freedom of choice, self-determination and rights were used as an argument only by the second generation. On the contrary, Egyptian men insisted that they had a determining role in breaking the practice, through their **decisions** regarding their daughters, sisters or nieces.

The Nigerian women (first and second generation) had low awareness of female genital mutilation as a form of violence against women. They did not challenge the practice in itself and the reasons behind it, but instead disapproved of the traditional procedure that is used to perform female genital mutilation, which is considered 'bloody', painful, dangerous and cruel. Indeed, according to these women's narratives, the traditional cut has been now abandoned and replaced by a milder and **so-called modern form of modification**. This consists in a massage with hot water and lotion aimed at reducing the size of the clitoris and preventing its growth. The containment of the clitoris has become, in this way, an element of pride among Nigerian women, who felt different from non-circumcised women and from women adopting 'bloody' and 'disgusting' practices. Nevertheless, the role of the clitoris in affecting the sexual desire of women and their ability to enjoy sex was controversial.

([45]) This is the country of birth of first-generation migrants (FGM-practising countries), or the country of birth of the parents of second-generation migrants (FGM-practising countries). Here, someone is second generation if that person was not born in an FGM-practising country but has at least one parent born in an FGM-practising country.

Perceptions about the risk of the practice in the host country and beyond

Overall, the Egyptian women agreed that the practice in their country of origin is still **widespread**, but much less so than in the past. They also felt it is much more common in rural areas, where people are less educated. This change is perceived to have happened in the last 20 years. Today, many people in Egypt, like in Italy, were said to recognise the need to abandon the practice. The Egyptian men clearly stated that female genital mutilation is not practised in Italy and in other European countries: they stated that they had never heard about female genital mutilation in Italy, where, they underlined, it is forbidden by law. At the same time, they referred to the fact that, in Egypt, the practice is widespread, despite the prohibition by law since 2013.

The **medicalisation** of the procedure, although known to be forbidden in Egypt and in the European Union, was seen to make female genital mutilation acceptable in certain cases, as it was perceived as more hygienic and less painful and dangerous for the girl. It was reported as the current way to practise female genital mutilation in Egypt (where it is practised), even among the migrant communities returning to Egypt.

The Nigerian women reported that, generally speaking, the traditional practice of female genital mutilation has now been abandoned in Italy, as it has been in their country of origin (where it has been replaced with the more 'modern' massage for clitoris containment). They believed that female cutting is not practised in Europe and it is legally forbidden. This was something they knew regardless of the number of years they had been in Italy. They were not aware of how widespread the practice was outside their country of origin or in other communities, and they were not aware of other forms of female genital mutilation such as infibulation (FGM type III) and, in this regard, they commonly expressed disapproval and disgust.

Key risk factors for female genital mutilation

Most of the Egyptian women (first generation) agreed that the practice should no longer be imposed on young girls, as it is a form of injustice and cruelty. They all stated that their daughters were not cut. The Egyptian men (first and second generation) were less united in their views and were clearly divided into those in favour of and those against the practice. However, both women and men in favour of female genital mutilation saw the advice of a medical doctor as a critical factor in deciding whether or not to cut their daughters, regardless of the traditional, religious and/or aesthetic motivation behind the practice. In both groups, some participants reported that they would take their daughters to Egypt to visit a doctor (or several for 'second' opinions) to evaluate whether the cut was needed or not. Among women, the issue in this case was the young women's free choice. Even among women who reported that they would take their daughter to a doctor for an assessment, there was no agreement on whether the practice should be imposed on the daughter. Among the men in favour of female genital mutilation, it was thought that the decision had to be taken by the father. It would in any case be a doctor who performed the surgery (in Egypt). According to the Egyptian women, not all professionals agreed to do it, but some, if paid well, were willing to satisfy the parents' wishes.

When asked, first-generation women refused to involve their daughters in the focus group discussion with second-generation young women, stating that their daughters knew nothing about female genital mutilation and that sufficient information was collected in their meeting. This could raise questions as to the veracity of some of the information collected during the focus group discussions, in particular regarding the assertion that none of the daughters of the respondents had been cut.

According to the analysis of both focus group discussions with Egyptians it seems that in the Egyptian community, **returning to the country of origin** can be an indicator of risk of female genital mutilation for girls living in Europe.

Nigerian women claimed not to have had their daughters cut but instead to have replaced the cut with a milder form aimed at reducing the size of the clitoris. This recent genital modification significantly restricted the perception of practising female genital mutilation, as the women felt it was far removed from the practice carried out long ago, although the reasons for the practice remain unchanged. It seemed that the key persons involved in the decision-making process were the mother and grandmother, even in Nigeria.

6.3. Estimating the number of girls at risk of female genital mutilation in Italy

First, this section presents the estimates of the number of girls at risk of female genital mutilation within the regular migrant population; then the estimates for asylum-seeking girls are presented. The estimates are first presented according to the **original methodology** (EIGE, 2015a) and then the **refined methodology** is applied following the improvements as outlined in Chapter 2 of this report. The estimates according to the refined methodology present the final outcomes of the numbers of girls at risk of female genital mutilation in Italy.

Resident population

With regard to the low and high-risk scenarios, the number of girls (aged 0–18) at risk of female genital mutilation in Italy varied between 2 953 and 11 675 in 2011 and 2 499 and 11 515 in 2016. 2015 saw a peak in the high-risk scenario compared to the other years. In all of these years, the majority of girls at risk were younger than 10.

Births for 2016 are not available, so the number of second-generation girls is underestimated for 2016. This lack of data biases only the high-risk scenario estimate. That is why the number of girls at risk in 2016 is less than the number at risk in 2015. Births are available only as far back as 1999, meaning that, for estimations from 2013 to 2015, data on older girls (i.e. born before 1999) is missing. For the years 2011 and 2012, data on births does not allow for an estimation of second-generation girls aged 14 in 2011 and 2012, which was the median age for cutting in some countries of origin.

When applying the **refined methodological approach** ([46]) as described in Chapter 2 of this report, an increased number and proportion of girls at risk of female genital mutilation can be observed in Italy for the reference year 2011 (year of the European population and housing census) and 2016 (the latest available year). By considering half of the second-generation still at risk of female genital mutilation in the low-risk scenario, the expansion of this generation over recent years is more realistically taken into account in the estimation.

([46]) Three adaptations are applied: (1) a more robust calculation of the median age of cutting and an increase of the median age by its standard deviation; (2) adding girls who have reached the median age of cutting into the calculation and (3) considering half of the second generation still at risk of female genital mutilation in the low-risk scenario.

Table 6.3. Estimated number of girls (aged 0–18) at risk of female genital mutilation living in Italy (2011–2016)

	Resident population					
	HIGH-RISK SCENARIO			LOW-RISK SCENARIO		
	TOTAL at risk	First generation	Second generation	TOTAL at risk	First generation	Second generation
2011: TOTAL (0–18)	**11 675**	**2 953**	**8 722**	**2 953**	**2 953**	**0**
0–9	11 633	2 936	8 697	2 936	2 936	0
10–18	42	17	25	17	17	0
2012: TOTAL (0–18)	**11 778**	**2 663**	**9 115**	**2 663**	**2 663**	**0**
0–9	11 732	2 648	9 084	2 648	2 648	0
10–18	46	15	31	15	15	0
2013: TOTAL (0–18)	**11 855**	**2 320**	**9 535**	**2 320**	**2 320**	**0**
0–9	11 814	2 307	9 507	2 307	2 307	0
10–18	40	13	27	13	13	0
2014: TOTAL (0–18)	**12 416**	**2 472**	**9 944**	**2 472**	**2 472**	**0**
0–9	12 371	2 456	9 915	2 456	2 456	0
10–18	45	16	29	16	16	0
2015: TOTAL (0–18)	**12 778**	**2 538**	**10 240**	**2 538**	**2 538**	**0**
0–9	12 733	2 524	10 209	2 524	2 524	0
10–18	45	14	31	14	14	0
2016: TOTAL (0–18)	**11 515**	**2 499**	**9 016**	**2 499**	**2 499**	**0**
0–9	11 467	2 485	8 982	2 485	2 485	0
10–18	48	14	34	14	14	0

Source: Present study.

Table 6.4. Final estimated number of girls (aged 0–18) at risk of female genital mutilation living in Italy according to the refined methodological approach (2011 and 2016)

TOTAL	LOW-RISK SCENARIO Proportion of girls at risk		HIGH-RISK SCENARIO Proportion of girls at risk		LOW-RISK SCENARIO No of girls at risk		HIGH-RISK SCENARIO No of girls at risk	
	Original	Refined	Original	Refined	Original	Refined	Original	Refined
2011								
59 720	5 %	**18 %**	20 %	**27 %**	2 953	**10 541**	11 675	**16 392**
2016								
76 040	3 %	**15 %**	15 %	**24 %**	2 499	**11 382**	11 515	**18 339**

Source: Present study.

The largest share of girls who were at risk in 2016 originate from Egypt. Smaller groups of girls at risk originate from Senegal, Nigeria, Burkina Faso, Côte d'Ivoire, Ethiopia and Guinea. Figure 6.7 shows the top seven countries of origin (first and second generation) of female migrants aged 0–18 residing in Italy in 2016.

Table 6.5 summarises the results of the female genital mutilation risk estimations for both the high and low-risk scenarios. In the high-risk scenario both first- and second-generation girls are considered at risk of female genital mutilation, while the low-risk scenario considers the first generation and half of the second generation still at risk of female genital mutilation.

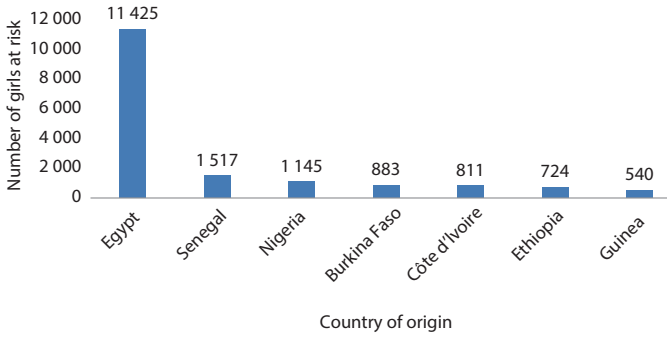
Asylum seekers

Following a decline from 2011 levels, since 2013 there has been an increase in the number of asylum-seeking girls (aged 0–18) from FGM-practising countries. The highest proportion of asylum-seeking girls at risk peaked at 22 % in 2012, reaching its lowest levels in 2015 (8 %) and 2016 (6 %).

If we apply the **refined methodological approach** ([47]) as described in Chapter 2 of this report, an increased number and proportion of asylum-seeking girls at risk of female genital mutilation can be observed in Italy in 2011 (the year of the European population and housing census) and 2016 (the latest available year).

In 2016, Nigeria was the main country of origin for asylum-seeking girls at risk in Italy, followed by Somalia, Eritrea and Mali. The rest of the FGM-practising countries accounted for fewer asylum-seeking girls at risk.

Figure 6.7. Estimated number of girls (aged 0–18) at risk of female genital mutilation living in Italy by most represented countries of origin (2016)



Source: Present study.

Table 6.5. Female genital mutilation risk in Italy in 2016 (latest available year)

High-risk scenario	In 2016, a total number of 76 040 girls aged 0–18 from FGM risk countries (born in the country of origin or Italy) were residing in Italy, of which 18 339 were likely to be at risk of female genital mutilation. **Proportionally, 24 % of girls aged 0–18 originating from FGM risk countries (either born in the country of origin or in Italy) were at risk of female genital mutilation.**
Low-risk scenario	In 2016, a total number of 76 040 girls aged 0–18 from FGM risk countries (born in the country of origin or Italy) were residing in Italy, of which 11 382 were likely to be at risk of female genital mutilation. **Proportionally, 15 % of girls aged 0–18 originating from FGM risk countries (either born in the country of origin or in Italy) were at risk of female genital mutilation.**

Table 6.6. Estimated number of asylum-seeking girls (aged 0–18) at risk of female genital mutilation living in Italy (2011–2016)

	Total number of girls (aged 0–18) from FGM-practising countries	Total number at risk	Proportion of girls at risk
2011	629	95	15 %
2012	485	108	22 %
2013	314	54	17 %
2014	344	64	19 %
2015	491	38	8 %
2016	872	52	6 %

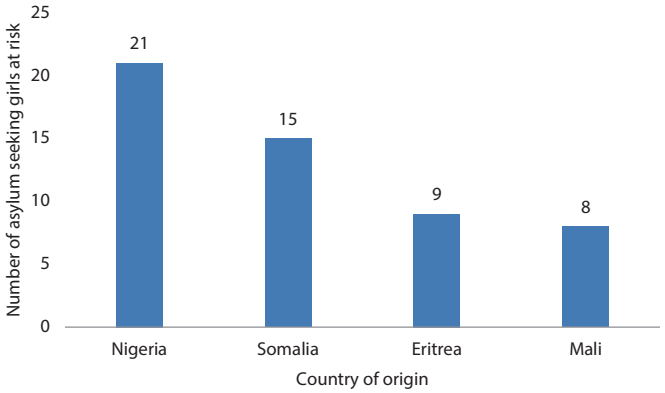
Source: Present study.

Table 6.7. Final estimated number of asylum-seeking girls (aged 0–18) at risk of female genital mutilation living in Italy according to the refined methodological approach (2011 and 2016)

TOTAL	HIGH-RISK SCENARIO Proportion of girls at risk		HIGH-RISK SCENARIO No of girls at risk	
	Original	Refined	Original	Refined
2011				
629	15 %	22 %	95	139
2016				
872	6 %	**9 %**	52	**80**

Source: Present study.

Figure 6.8. Estimated number of asylum-seeking girls (aged 0–18) at risk of female genital mutilation living in Italy by most represented countries of origin (2016) ([48])



Source: Present study.

([47]) Three adaptations are applied: (1) a more robust calculation of the median age of cutting and an increase of the median age by its standard deviation; (2) adding girls who have reached the median age of cutting into the calculation and (3) considering half of the second generation still at risk of female genital mutilation in the low-risk scenario.

([48]) The figure is based on the high-risk scenario data.

6.4. Main findings in Italy

In 2016, a total number of 76 040 girls aged 0–18 originating from FGM-practising countries (born in the country of origin or in Italy) were residing in Italy, of which **15 % to 24 % were at risk** of female genital mutilation.

Looking at **trends over time**, there has been an overall increase in the number of girls at risk since 2011, reaching 18 339 girls in 2016. The proportion of first- and second-generation girls at risk has remained fairly stable, with the latter often exceeding the former by far.

Between 2011 and 2016, the total number of female migrants originating from FGM-practising countries increased by 27 %, from 59 720 to 76 040. The second generation makes up the majority of the population, and the proportion has increased over time. Of girls aged 0–9, 85 % were second generation, 5 percentage points higher than in 2011. The proportion of girls aged 10–18 who were second generation doubled to 60 % in 2016, suggesting a growing second generation within FGM-affected communities.

The largest **communities** which migrant girls residing in Italy originate from are, in descending order, Egypt, Nigeria, Senegal and Ghana. These are not necessarily the communities from which the highest numbers of girls at risk originate, which are, in descending order, Egypt, Senegal, Nigeria and Burkina Faso.

The focus group discussions offered the perspectives of women and men originating from Egypt and Nigeria. The latter being also the country of most asylum seekers from FGM-practising countries. There was a consensus over the fact that female genital mutilation is not occurring in Italy or in Europe more broadly. It appears that among Nigerian women, some alternatives to female genital mutilation may be emerging, such as massage techniques to reduce the growth of the clitoris. This reflects the fact that, while some communities may be moving towards the abandonment of female genital mutilation, this does not always mean that their desire to protect female purity and control women's sexual urges has disappeared.

Egyptian men were relatively split in their views about female genital mutilation, with some seeing 'pros' in the practice. Among the Egyptians, the medicalisation of the procedure, although known to be forbidden in Egypt and in the EU, was seen to make cutting acceptable in certain cases, as it was perceived to be more hygienic and less painful and dangerous for the girl. Both women and men in favour of female genital mutilation saw the advice of the medical doctor as a critical factor in deciding whether or not to cut their daughters, regardless of the traditional, religious and/or aesthetic motivation behind the practice. However, many men noted the benefits of having an uncut partner, who is likely to be more sexually active, and all men stressed that female genital mutilation is forbidden by law in Italy.

Indeed, the focus group discussion results suggest that **awareness of legislation** in migrant communities is high. Despite the high level of awareness, those in favour of the practice tend to take their daughter to their country of origin to have female genital mutilation performed by a doctor. Further cooperation with countries of origin on awareness-raising, women's empowerment, and the implementation of laws is needed. Following the results, attention must also be paid to increasing awareness of prevention initiatives and campaigns, particularly among migrant communities, thereby acknowledging the heterogeneous needs of affected communities and second generations.

There is a need for **multi-sectoral services and coordination** among local authorities. This would foster a better homogeneity of services at national level and continuity of care provided to women and girls. The results from the focus group discussions show that the target population does not know that specific services are available to women and girls affected by female genital mutilation, at least in their region.

Most participants in the focus group discussions said that one of the **primary reasons for practising** female genital mutilation was the perception that it controls women's sexual desires. The Egyptian women and men generally agreed that female genital mutilation is a tradition, and not a religious practice. The views of the younger, second-generation participants were noticeably different, attributing female genital mutilation to living in a patriarchal society, and not as something connected to their 'afro-Italian' identity.

To **tackle female genital mutilation in Italy**, a specific law has been in place since 2006 and the principle of extraterritoriality is applied, criminalising the practice even when committed abroad. General child protection provisions can be applied in cases of female genital mutilation and parents can be held accountable if female genital mutilation is performed on their child. Less is known about the enforcement of the legal provisions as no data is available and no official monitoring systems of judicial investigations or prosecutions have been established. In September 2017, the Gender Equality Department of the Italian Central Government launched a call for the development of training guidelines for professionals and the dissemination of information on FGM, to facilitate identification and referral processes. These will include indicators and tools to support professionals. It will also establish protocols to protect the victim. Furthermore, policies combating female genital mutilation, mostly focusing on health, are included in Italy's latest national action plan on violence against women (2017–2020).

The impact of **migration flows** to the European Union has been visible and challenging in Italy in recent years. With regard to the available data on net inflows of female immigrants (aged 0–19) from FGM-practising countries, a peak was observed in 2013 (2 683), slightly decreasing to 2 197 in 2015. There were 872 asylum-seeking girls (aged 0–18) from FGM-practising countries in 2016, of which 506 came from Nigeria.

Looking at **asylum seekers,** a total number of 872 girls were residing in Italy in 2016, of which 9 % were at risk of female genital mutilation. Female genital mutilation can be incorporated through general asylum provisions in Italy, as girls who have undergone or are at risk of FGM, are recognised as a vulnerable group. If an asylum seeker is known to be a victim of female genital mutilation then special care is granted. However, information is not available on the number of FGM-related asylum applications received and granted. There is a need for gender-sensitive asylum procedures and improved training of personnel working in asylum and reception centres.

7. Female genital mutilation risk estimation in Cyprus

7. Female genital mutilation risk estimation in Cyprus

This section presents the estimated number of girls at risk of female genital mutilation living in Cyprus. Firstly, the female migrant population originating from FGM-practising countries is described. The study population includes the number of girls aged 0–18 living in Cyprus in 2011 (the year of the European population and housing census) who come from FGM-practising countries (first generation) or were born to a mother who originates from a country where female genital mutilation is documented (second generation). Secondly, a summary of the findings from the focus group discussions organised in Cyprus is provided. Finally, the data is processed to determine the high and low boundaries of the interval for female genital mutilation risk estimation.

7.1. Female migrant population aged 0–18 originating from FGM-practising countries

Data on the female migrant population, disaggregated by age, generation, country of origin (birth) and age of arrival, is available in Cyprus for 2011. The **data source** is data on foreign-born girls from the Statistical Service of Cyprus (Cystat) and data from the European population and housing census (Eurostat).

To further **improve** the availability and comparability of data on the female migrant population in Cyprus, the following actions are recommended:

- collect data on the entire female migrant population for the additional 2012–2016 data, not only on those with a residence permit;
- provide for the necessary generational breakdowns in the data on migrants with a residence permit to identify first and second generations;
- consider the availability of data on female live births to mothers originating from FGM-practising countries;
- collect data on total immigrants (inflows) and emigrants (outflows) from FGM-practising countries (aged 0–18);
- provide information on the number of FGM-related asylum applications received and granted;
- collect detailed data and metadata on irregular/undocumented migration;
- collect data on asylum seekers, disaggregated by sex, age and country of birth.

Resident population

In Cyprus, there were 758 girls (aged 0–18) originating from FGM-practising countries within the female migrant resident population in 2011. This includes both first- and second-generation migrants and the data is disaggregated by 1-year age breakdowns. Of these, 428 (56 %) were first generation and 330 were second generation (44 %). Of the total number of girls aged 0–18, more than half (62 %, 467) were aged 0–9 and 38 % (291) were aged 10–18. Of the girls aged 0–9, 60 % are second generation, which falls to 17 % for those aged 10–18.

The available data on the foreign-born female population is disaggregated by first and second generation, but with age breakdowns (1-year intervals) only available for the total. In order to estimate the age distribution of the first and second generation for the 2011 data, it was necessary to use the age structure of the data on the foreign-born population, available from the 2011 census.

The countries of origin of the largest number of first-generation and second-generation female migrants (aged 0–18) in 2011 were, in descending order: Iraq, Egypt, Sudan, Cameroon, Nigeria, Ethiopia and Kenya. With respect to the total number of first-generation female migrants in Cyprus in 2011 aged 0–18, there were 319 female migrants from Iraq, 56 from Egypt, 10 from Sudan, 10 from Cameroon, 12 from Nigeria, 2 from Ethiopia and 3 from Kenya. The total numbers of second-generation female migrants aged 0–18 in 2011 were as follows: 133 from Iraq, 80 from Egypt, 41 from Sudan, 18 from Cameroon, 13 from Nigeria, 15 from Ethiopia and 11 from Kenya. Apart from Iraq, the number of girls in the second generation consistently outnumbered those in the first generation for these seven countries.

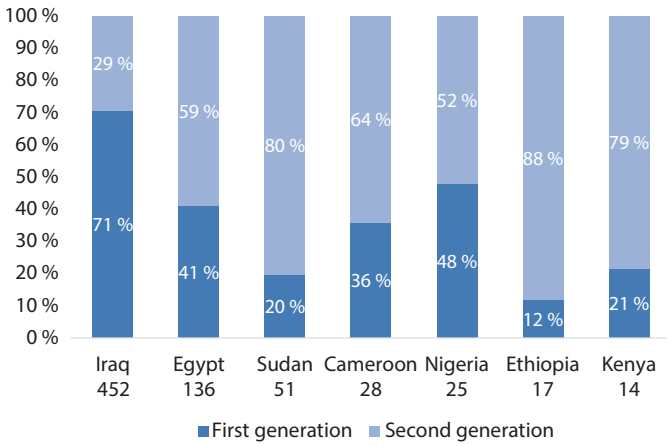
More recent data from the Ministry of the Interior is also available for 2012–2016 and considers the number of female migrants from FGM-practising countries who hold residence permits. There are limits to the comparability of this data to the 2011 data. The 2011 data includes foreign-born migrants and gives a truer picture of the overall migrant population, whereas the 2012–2016

Table 7.1. Age and generation distribution of the female migrant population (aged 0–18) in Cyprus originating from FGM-practising countries (2011) ([49])

	TOTAL	First generation	Second generation	TOTAL (%)	First generation (%)	Second generation (%)	TOTAL generation (%)
0–9	467	187	280	62	40	60	100
10–18	291	241	50	38	83	17	100
TOTAL	758	428	330	100	56	44	100

Source: Cystat.

Figure 7.1. Number of girls (aged 0–18) living in Cyprus by generation and most represented countries of origin (2011)



Source: Cystat.

data excludes any migrants who do not require residence permits to live in Cyprus (such as persons who have gained Cypriot citizenship). Furthermore, the 2012–2016 data is not available with disaggregation by generation, meaning it was necessary to approximate the generation breakdown using patterns observed for 2011.

This data shows that in 2016, there were a total of 184 female permit-holders in Cyprus from FGM-practising countries, of whom 54 % (99) were first generation. Whilst on first sight this appears to be a large reduction since 2011 (758 female migrants aged 0–18 from FGM-practising countries), it is important to note the limitations of this data as explained above. The data provided in the Table 7.2 is indicative and was not used in the final risk estimations.

Data on the number of **FGM-related asylum applications** received and granted since 2011 is not available in Cyprus.

Other records collecting information on female genital mutilation in Cyprus

Migration patterns

The Statistical Service of Cyprus and the Civil Registry and Migration Department of the Ministry of the Interior do not collect data on total immigrants (inflows) and emigrants (outflows) from FGM-practising countries (aged 0–18). It was also not possible to identify relevant data collected by non-governmental organisations.

Irregular migration

The Statistical Service of Cyprus and the Civil Registry and Migration Department of the Ministry of the Interior do not collect data on irregular migration. Civil society organisations do not hold this information either, although the police does collect data on migrants overstaying their permits. In January 2018, the Cypriot police (Statistics and Cartography Office) provided data on the number of identified irregular female migrants aged 0–19 from FGM-practising countries in 2017. The total number of girls was 63, of which 50 were Somali nationals and the remainder were from Iraq (7), Egypt (3) and Cameroon (3). This data was not used in the estimates of the number of girls at risk of female genital mutilation, as it was not provided with detailed metadata.

Asylum seekers

Data on the number of asylum seekers, provided by the Asylum Service of the Ministry of the Interior and organisations working with asylum seekers, in Cyprus is not available with simultaneous disaggregation by country of origin, sex and age.

With regards to data on FGM-related asylum applications, unofficial data received for 2017 counts six female FGM-related applications received, of which three were granted, from Somalian girls aged 0–19 during this period. This data could not be used in the risk estimations for the asylum-seeking population in Cyprus.

The database of the top 10 nationalities maintained by the Office of the United Nations High Commissioner for Refugees in Cyprus shows that in 2011, 2012 and 2013, persons from Iraq and Egypt submitted the largest percentage of applications for asylum out of all FGM-practising countries. In 2014–2015, the largest percentage of asylum applications were filed by Egyptians and Nigerians. The remaining countries recorded in the top 10 list are not FGM-practising; no data can be provided on other FGM-practising countries. In some of the tables compiled by the Asylum Service, the number of applications for asylum does not correlate to the number of persons being grouped into the one application. It is therefore not possible to ascertain accurately whether one application includes just one applicant or her/his entire family.

([49]) Country of origin defined by country of birth.

Table 7.2. Age and generation distribution of the female permit-holders (aged 0–18) in Cyprus originating from FGM-practising countries (2016)

	TOTAL	First generation	Second generation	TOTAL (%)	First generation (%)	Second generation (%)	TOTAL generation (%)
0–9	84	55	29	46	65	35	100
10–18	100	44	56	54	44	56	100
TOTAL	184	99	85	100	54	46	100

Source: Civil Registry and Migration Department of the Ministry of the Interior, Cyprus.

7.2 Summary of findings from focus group discussions organised in Cyprus

Four focus groups were held in Cyprus in September 2017. Discussions were held with older and younger first-generation Somali women; first-generation Somali men of mixed ages; and recent migrants from mixed backgrounds. It was not possible to recruit second-generation women from FGM-practising countries who were over 18, as there are fewer residing in Cyprus. All participants in Cyprus had gone through the asylum system — either as applicants, as having been granted a status of international protection, or as rejected applicants awaiting the outcome of an appeal. The latter was only the case with a few men, as, at the time of the focus groups and interviews, Cyprus implemented a policy of granting protection to all women who had been subjected to female genital mutilation. This policy ended in late 2017 and women who had been subjected to female genital mutilation were thereafter no longer automatically granted asylum on that ground. Even where a status is granted to women, this status does not include the right to travel to their countries of origin and therefore the option of returning for a holiday to have their daughters cut is not available to them.

Table 7.3 presents an overview of the profile of the participants in the four focus group discussions.

Identity and attitudes about the importance of female genital mutilation

From the narrative of the participants of all ages and from all countries, it was clear that female genital mutilation, although seen as undesirable and negative, was at the same time perceived as normal **standard practice** that no one escapes from. All the participants agreed that it was **not part of their communal identity** and that nothing would be lost if female genital mutilation was eradicated. Some of the Somali men reported that eradicating female genital mutilation would be a progression, rather than a loss. The older women made clear that health and personal welfare were more important than tradition and that the problems generated by female genital mutilation did not justify any communal beliefs about tradition.

There was consensus that girls who have not been cut would be unable to marry in the country of origin, where they would be shunned, avoided and insulted as promiscuous. In Nigeria, where the type of cutting reported by the participants was a milder form of female genital mutilation (pricking of the flesh), the community would expect an additional, 'fuller' female genital mutilation procedure to 'vet' a woman for marriage. In the focus group with the men, some of the participants initially expressed, albeit shyly, the view that uncut women were unclean; however, the negative reaction from the rest of the participants was strong and this view did not surface again. The younger and more educated men participants were adamantly against female genital mutilation, claiming they would not marry a girl who has been cut because of the health complications that they must deal with, but primarily because women who have been cut have no sexual pleasure. Contrary to popular belief in their communities, the young Somali men believed it was up to the woman to make the choice to remain faithful without having been cut. The men admitted, however, that their own negative perceptions of female genital mutilation had not yet had an impact on the practice in Somalia and on the perceptions of the older generation, as the **social pressure** to maintain tradition continues to be strong.

Except for Gambia and Ethiopia, the passage of time did not seem to have affected communal perceptions about the necessity to perform female genital mutilation for a girl to be accepted and to marry; only the type of cutting has evolved and only in the urban centres. The moral significance of female genital mutilation appears to have shifted from being a sign of **religion to tradition**; this appeared strongly in the narrative of the participants from Somalia, where religious leaders reportedly have taken an open stand against female genital mutilation, clarifying that Islam not only does not condone it but, in fact, prohibits it. The women participants from countries other than Somalia (Côte d'Ivoire, Ethiopia, Nigeria) said the justification for the practice has not changed over the years and that men always believed the reason to be religion, in contrast with the women who always believed it is tradition. A discussion about the origins of the practice revealed that nobody was exactly sure how it started. There was consensus, however, that neither religion nor tradition could legitimise female genital mutilation in the eyes of the victims.

A participant from Gambia described a rather different situation: it is a common belief in Gambia that if a girl is not cut, then 'she will have a lot of feelings for a man'; however, it is possible for an uncut woman to get married and some have done so. Gambia is the only country among those researched in Cyprus where female genital mutilation was banned, with a law adopted in 2015, and where there is a grassroots anti-female-genital-mutilation movement.

There did not seem to be a definitive answer to the question as to who makes the **decision** to perform female genital mutilation on a girl. In some countries (Côte d'Ivoire, Ethiopia) it was stated that the men have the final say although it is the women who are more in

Table 7.3. Overview of focus group discussions and sociodemographic profile of participants in Cyprus

Key characteristics of focus groups	Older women	Younger women	Men	Hard-to-reach/recent migrant women
Number of participants	7	14	7	5
Countries of origin represented ([50])	Somalia	Somalia	Somalia	Somalia, Ethiopia, Nigeria, Côte d'Ivoire, Gambia
Age range	Over 25	18–25	25–60	18–36
Generation (first/second)	First	First	First	First
Average residence (number of months) and previous residence in other countries	Not provided No previous residence in another EU Member State	Just under 1 year (estimate) No previous residence in another EU Member State	18 months (estimate) No previous residence in another EU Member State	5 years (estimate) No previous residence in another EU Member State One lived in the United Arab Emirates for 10 years
Number of second-generation participants who have lived in their parents' country of birth	n/a	n/a	n/a	n/a
Civil status of participants	Not provided	Married (4) Unmarried (9) Divorced (1)	Married (4) Unmarried (3)	Unmarried (4) Divorced (1)
Number of participants with/without children	All participants had children	11 had no children Three had children	Three had children	Two had no children Three had children
Religion	Muslim	Muslim	Muslim	Muslim and Christian
Ethnic groups (if available)	The Somalis present stated that there are no different ethnicities	The Somalis present stated that there are no different ethnicities	The Somalis present stated that there are no different ethnicities	The Nigerian participant was a member of the Benin ethnic group The Ivorian participant was a member of the Dioula ethnic group The Ethiopian participant was a member of the Oromo ethnic group The Gambian participant was a member of the Mandinka ethnic group
Level of education	No formal education (2) Primary education (1) Secondary education (4)	No formal education (8) Primary education (1) Secondary education (5)	No formal education (1) Primary education (2) Secondary education (2) Higher education (2)	Primary education (2) Secondary education (3)
(For first generation): shortest and longest amount of time residing in Cyprus	Not provided	Shortest: 5 months Longest: 2 years	Shortest: 1 year Longest: 2 years and 3 months	Shortest: 3 months Longest: 11 years
(For first generation): shortest and longest amount of time residing in another EU Member State	n/a	n/a	n/a	n/a
Date of session	7 September 2017	8 September 2017	12 September 2017	28 September 2017

favour, as they are more prone to traditional values and believe they have a duty to safeguard their daughters' future. The grandparents and extended family also have a key role in the decision. In the focus group with the men, the participants said that the decision was made by the men in the family; in the focus group with older women, the participants said the decision was made by the women; in the focus group with the younger women, the participants said the decision was made by both parents. The picture emerging from the participants' narrative was that performing female genital mutilation was the norm, much like a default position that is not necessarily preceded by active decision-making.

Regarding the **impact of the migration** experience, for the African diaspora living in the EU, there does not appear to be any pressure to perform female genital mutilation. However, this does not mean that they have altogether stopped practising female genital mutilation, but rather that those who do practise it, do so out of a personal conviction rather than because of community pressure. There is also

([50]) This is the country of birth of first-generation migrants (FGM-practising countries), or the country of birth of the parents of second-generation migrants (FGM-practising countries). Here, someone is second generation if that person was not born in an FGM-practising country but has at least one parent born in an FGM-practising country.

no particular profile associated with persons who decide to cut their daughter.

According to the participants of the first two focus groups, Somali women living in Europe can marry (in Europe) even if uncut. This tallies with the reporting by some of the Somali men, who stated that they would not want to marry a woman who has been cut. The finding was confirmed by the younger women, who reported that Somali men in the EU and in Somalia would prefer to marry an uncut girl; however, men in Somalia would face great difficulty both in finding and in living with an uncut girl, because of community pressure and hostility.

The Somali women reported that the uncut married women from their communities who return to Somalia for a short visit with their husband do not face community resentment or pressure. It emerged from the participants' narrative that female genital mutilation is closely intertwined with notions of preserving a woman's virginity for marriage and, therefore, once a woman is married her sexuality is less of an issue for the community. Somalis living in Europe are reported to have abandoned the practice to a large extent and only a few return in order to have female genital mutilation performed on their young girls. Participants reported that an estimated 50 % of Somalis living in the EU have abandoned female genital mutilation. The men participants reported that among the first generation of migrants living in the EU, all the women have been cut, while among the second generation, around half of them have been cut. The migration experience had a strong impact on their perceptions and roles, as some of the participants themselves, including the women, reported having been adamantly in favour of female genital mutilation before they migrated to Europe. Some of the men reported that their perceptions about female genital mutilation changed after they migrated to Europe because awareness campaigns there made them see a problem they had not recognised in the past.

Perceptions about the risk of the practice in the host country and beyond

The participants were not aware of the extent of the practice in other communities living either in Europe or in other African countries. Some of the women in the mixed focus group discussions reported having no contact with other members of their communities in Cyprus as there were very few of them (Côte d'Ivoire, Gambia); they were also unaware of the practices of their compatriots or other African communities in other parts of the EU.

Among participants from Somalia, there was consensus that female genital mutilation was practised by everybody in all parts of the country without exception. What differed was the type of procedure performed: a less severe form of female genital mutilation was practised in the urban areas, with cutting of only part of genitalia without stitching, while in the countryside the more severe form is still practised, involving complete removal of genitalia and stitching.

The Somali women, older and younger, expressed the conviction that female genital mutilation was no longer practised in Egypt because of a new law that rendered it illegal. At the same time, however, the participants were adamant that even if the law were to change in Somalia, rendering female genital mutilation unlawful, this would not impact the practice. The reasons for that are because tradition is stronger than the law and because political leaders and policymakers are all men from FGM-practising communities with a strong belief in female genital mutilation. Younger women reported that the adoption of legislation in Somalia against female genital mutilation would not yield results because there is a wider state of lawlessness. The Somali men reported that in Somalia 'tradition is the rule of law'.

None of the participants knew what to do or where to turn in Cyprus if they knew that a girl would be going back to get cut, and few reported being prepared to go to the police with such information. The discussion in the focus group with the men revealed a certain hesitation in reporting other members of their community to the police and a preference to do so anonymously. The policy followed in other EU countries of monitoring the exit and re-entry of families from FGM-affected countries — to investigate if female genital mutilation was performed during their visit to the country of origin — was commented upon in a very positive light.

Awareness and services

The focus group discussions identified several **gaps in health provision**. Asylum-claiming women are obliged to undergo a medical examination to prove their claim that they have been cut. The doctor performing the examination is not necessarily a woman nor is that doctor necessarily trained in the different types of female genital mutilation. If an examination is necessary at all, this should be done only in the context of a general health screening test. Most women participants reported that health practitioners had demonstrated insensitive behaviour when treating FGM-affected women in labour or in relation to other health issues. This reveals training and policy gaps in dealing with female genital mutilation at the level of healthcare. While all women in the focus groups stated that they were in need of counselling and support, they did not know where to turn for help with mental health issues or for dealing with the health complications and marital tensions resulting from female genital mutilation. Of all focus group participants, only one had heard of reconstructive surgery; all, however, expressed a keen interest to find out about it.

None of the participants were aware of where to turn to for **social assistance**. Some non-governmental organisations provide help to individuals with access to welfare and housing; however, assistance is limited and covers mainly persons in reception facilities or unaccompanied minors in shelters.

Only a few of the participants had heard about anti-FGM **awareness campaigns**, but all participants were aware that female genital mutilation is illegal in Europe. Asylum seekers and refugees living in the community rather than in reception facilities are harder to reach in terms of services from non-governmental organisations. Only a few participants were aware of the different types of female genital mutilation as defined by the World Health Organisation, but were aware of the different methods used in rural and urban settings.

Key risk factors for female genital mutilation

There was consensus from all participants that when an uncut young girl **returns to the country of origin for a holiday** there will be immense pressure from the community on the parents to perform female genital mutilation; however, if the stay is short term then the pressure is manageable. In the case of Côte d'Ivoire and Nigeria (but not in Ethiopia), it is possible that the grandmothers may perform female genital mutilation on girls when a family living in Europe returns to the country of origin for a holiday, without the parents' permission or knowledge, by pretending that they are taking the girl for a walk. The general perception of the participants was that, among the African diaspora in Europe, there are not many who would take their daughters back to their countries of origin to be cut. In Ethiopia, there is a considerable financial cost involved because the community

expects a ceremonial party and many Ethiopians living in Europe are unable/unwilling to undertake this cost.

In the case of Cyprus, the option of returning to the country of origin for a holiday is available only to those who are granted Cypriot nationality; persons with international protection will lose their status if they travel to their countries of origin. To estimate the risk of female genital mutilation being performed during a short visit to the country of origin, it would be necessary to examine the number of persons from practising countries who have received Cypriot nationality rather than the entire population of persons from practising communities living in Cyprus.

As a rule, female genital mutilation is not performed in hospitals in the practising countries but only by old women in rural areas. As society is gradually modernised, the new generation is more educated and less interested in taking up such an occupation, thus eventually leading to the demise of the profession. Education in the FGM-practising countries was identified as key to tackling female genital mutilation. Some of the men participants had a clear preference for the more drastic methods of police arrests and criminal prosecutions — possibly out of anger and frustration and a need to see quick results, rather than a belief that these measures would be more effective.

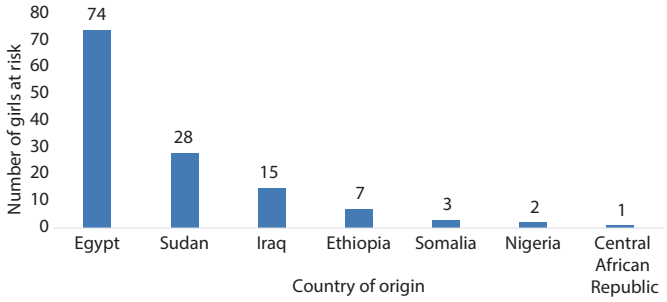
7.3. Estimation of the number of girls at risk of female genital mutilation in Cyprus

First, this section presents the estimates of the number of girls at risk of female genital mutilation within the regular migrant population; then the estimates for asylum-seeking girls are presented. The estimates are first presented according to the **original methodology** (EIGE, 2015a) and then the **refined methodology** is applied following the improvements outlined in Chapter 2 of this report. The estimates according to the refined methodology present the final outcomes of the number of girls at risk of female genital mutilation in Cyprus.

Resident population

With regard to the low- and high-risk scenarios, the number of girls (aged 0–18) at risk of female genital mutilation in Cyprus varied between 29 and 102 in 2011. All those at risk were younger than

Figure 7.2. Estimated number of girls (aged 0–18) at risk of female genital mutilation living in Cyprus by generation and most represented countries of origin (2011)



Source: Present study.

Table 7.4. Estimated number of girls (aged 0–18) at risk of female genital mutilation living in Cyprus (2011)

	Resident population					
	HIGH-RISK SCENARIO			LOW-RISK SCENARIO		
	TOTAL at risk	First generation	Second generation	TOTAL at risk	First generation	Second generation
2011: TOTAL (0–18)	**102**	**29**	**73**	**29**	**29**	
0–9	102	29	73	29	29	0
10–18	0	0	0	0	0	0

Source: Present study.

Table 7.5. Final estimated number of girls (aged 0–18) at risk of female genital mutilation living in Cyprus according to the refined methodological approach (2011)

TOTAL	LOW-RISK SCENARIO Proportion of girls at risk		HIGH-RISK SCENARIO Proportion of girls at risk		LOW-RISK SCENARIO No of girls at risk		HIGH-RISK SCENARIO No of girls at risk	
	Original	Refined	Original	Refined	Original	Refined	Original	Refined
2011								
758	4 %	**12 %**	13 %	**17 %**	29	**88**	102	**132**

Source: Present study.

Table 7.6. Female genital mutilation risk in Cyprus in 2011 (latest available year)

High-risk scenario	In 2011, a total number of 758 girls aged 0–18 from FGM risk countries were residing in Cyprus, of which 132 were likely to be at risk of female genital mutilation. **Proportionally, 17 % of girls aged 0–18 from FGM risk countries (either born in the country of origin or in Cyprus) were at risk of female genital mutilation.**
Low-risk scenario	In 2011, a total number of 758 girls aged 0–18 from FGM risk countries were residing in Cyprus, of which 88 were likely to be at risk of female genital mutilation. **Proportionally, 12 % of girls aged 0–18 from FGM risk countries (either born in the country of origin or in Cyprus) were at risk of female genital mutilation.**

10 years old. When considering only those girls aged between 0 and 9, between 6 % and 22 % were at risk in 2011.

When applying the **refined methodological approach** ([51]) as described in Chapter 2 of this report, an increased number and proportion of girls at risk of female genital mutilation can be observed in Cyprus for 2011.

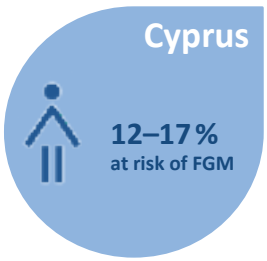
The seven most represented countries of origin for girls (aged 0–18) who were at risk of female genital mutilation in Cyprus in 2011 are presented in Figure 7.2. Egypt is the most common country of origin, followed by Sudan, Iraq, Ethiopia, Somalia, Nigeria and the Central African Republic.

Table 7.4 summarises the results of the female genital mutilation risk estimations for both the high and low-risk scenarios. In the high-risk scenario, both first- and second-generation girls are considered at risk of female genital mutilation, while the low-risk scenario considers the first generation and half of the second generation still at risk of female genital mutilation.

Asylum seekers

There is no available data for calculating the number and proportion of **asylum-seeking girls** from FGM-practising countries who are at risk of female genital mutilation in Cyprus.

7.4. Main findings in Cyprus



In 2011 a total of 758 girls aged 0–18 originating from FGM-practising countries were residing in Cyprus, of which an estimated **12 % to 17 % were at risk** of female genital mutilation.

It is challenging to assess **trends over time** as the 2011 data is not directly comparable to data partly available for the later years 2012–2016. It is therefore recommended to start collecting aggregated data on the female migrant population with and without residence permits in the future.

The largest **communities** in Cyprus originate from Iraq, followed by Egypt, Sudan and Cameroon. Looking at the girls at risk of female genital mutilation, the countries of origin are, in descending order: Egypt, Sudan, Iraq and Ethiopia. When designing targeted policies in Cyprus it is important to take this reality into consideration.

It has been very challenging to reach out to these communities and invite them to participate in the focus group discussions. Participants recruited had all gone through the asylum system — either as applicants, as having been granted a status of international protection, or as rejected applicants awaiting the outcome of an appeal.

Looking at the outcomes of the focus group discussions, participants had strong feelings against female genital mutilation. The practice was described as a widespread and common tradition, particularly in the countryside, but nevertheless an undesirable and objectionable practice that must be stopped. Female genital mutilation was not seen as based on religion. Expectations around marriage and fear of rejection from the community emerged as the **key encouraging factors** for parents to allow the cutting of their daughters. However, both of these considerations lost their significance for the African diaspora in Europe, who appear to have largely abandoned the practice. Key incentives for the African diaspora in Europe when it comes to **abandoning female genital mutilation** are the loss of sexual pleasure for both women and men, the health complications, FGM-related marital problems, information campaigns and the laws in the EU prohibiting female genital mutilation. Community pressure to get girls cut when they **return to the country of origin** can be significant, but it was described as 'bearable' if the visit was brief.

Cyprus has not witnessed a sharp increase in the **inflow of migrants** and refugees in recent years, unlike some other EU countries; however, there has been an increase in the number of unaccompanied children from Somalia who initially arrived in Cyprus with a view to travelling elsewhere ([52]). More recently, however, because of the manner in which the Dublin III regulation (Regulation No 604/2013) is being implemented, these children have remained in Cyprus. The Somali community of Cyprus is therefore growing and unless both women and men are educated on their rights, this may lead to an increased risk of female genital mutilation. The migration of girls from FGM-practising communities to Cyprus appears to be a fairly recent phenomenon. The travel restrictions imposed on persons in the asylum system may mean that travelling to the country of origin is less of a risk. However, it may be an issue to consider for the next generation of migrants whose parents originate from FGM-practising countries. Education, awareness-raising on rights and integration are key to protecting girls and women who may potentially be at risk.

To tackle female genital mutilation in Cyprus, the practice has been criminalised since 2003, punishable with up to 5 years' imprisonment, and the principle of extraterritoriality is applied, making

([51]) Three adaptations are applied: (1) a more robust calculation of the median age of cutting and an increase of the median age by its standard deviation; (2) adding girls who have reached the median age of cutting into the calculation and (3) considering half of the second generation still at risk of female genital mutilation in the low-risk scenario.

([52]) Interview with representative of the Office of the United Nations High Commissioner for Refugees, Cyprus, 18 October 2017.

prosecution for crimes committed abroad possible. However, there has been no data on FGM-related prosecutions so far. The Istanbul Convention was ratified in July 2017 and legislation is being drafted to bring national legislation in line with the convention. General child protection provisions can be used in cases of female genital mutilation and parents can be held accountable if female genital mutilation is performed on their child. Specific legal provisions or guidelines on reporting cases of female genital mutilation are not yet in place, and specific policies, services and training on combating female genital mutilation are still to be designed.

Female genital mutilation can be incorporated in Cyprus' general legal **provisions on asylum** and until 2017, there was a policy in place for granting international protection to all women who could prove they had undergone female genital mutilation. This policy was terminated in late 2017, leaving a number of women and girls who arrived to Cyprus with the hope of receiving international protection in limbo. Gender-sensitive asylum procedures are in place to the extent that women are interviewed by women, they are offered interviews separately from men, there is a choice of interpreters and if they produce a medical certificate that they have been subjected to female genital mutilation, they will be granted international protection. In general, there is no mechanism in place to ensure systematic identification and to address of the needs of vulnerable asylum seekers.

8. Female genital mutilation risk estimation in Malta

8. Female genital mutilation risk estimation in Malta

This section presents the estimated number of girls at risk of female genital mutilation living in Malta. Firstly, the female migrant population originating from FGM-practising countries is described. The study population includes the number of girls aged 0–18 living in Malta in 2011 who come from FGM-practising countries (first generation) or were born to a mother who originates from a country where female genital mutilation is documented (second generation). The resident population is separated from asylum seekers, as the push factors for migration are different when compared to resident migrants (EIGE, 2015a, p. 79). Secondly, a summary of the findings from the focus group discussions organised in Malta is provided. Finally, the data is processed to determine the high and low boundaries of the interval of female genital mutilation risk estimation.

8.1. Female migrant population aged 0–18 originating from FGM-practising countries

Data on the female migrant population is available in Malta for 2011 (the year of the European population and housing census). The **data sources** used were the following:

- 2011: census data for the first generation ([53]) (National Statistics Office Malta) and live-birth data for the second generation (National Statistics Office Malta);
- data on asylum seekers for 2011–2016 from the Office of the Refugee Commissioner Malta.

To further **improve** the availability and comparability of data on the female migrant population in Malta, the following actions are recommended:

- provide data on live births — for the second generation — disaggregated by 1-year intervals instead of age brackets;
- provide data on asylum-seeking girls aged 18;
- collect data on irregular/undocumented migration.

Resident population

In Malta, there were 485 girls (aged 0–18) originating from FGM-practising countries within the female **migrant resident population** in 2011. Slightly over half (59 %) were second generation. The vast majority of the female migrant resident population (87 %, 423) were younger than 10 years old; most of these girls under 10 years old (61 %, 257) were second generation. With regard to the age range 10–18, the split between first and second generation was relatively even (53 % versus 47 %).

In 2011, the largest number of girls from FGM-practising countries originated, in descending order, from: Somalia, Ethiopia, Eritrea, Nigeria, Egypt, Sudan and Iraq. Other than for Ethiopia, a majority of the female migrants from these communities were second generation.

Table 8.1. Age and generation distribution of the female migrant population (aged 0–18) in Malta originating from FGM-practising countries (2011) ([54])

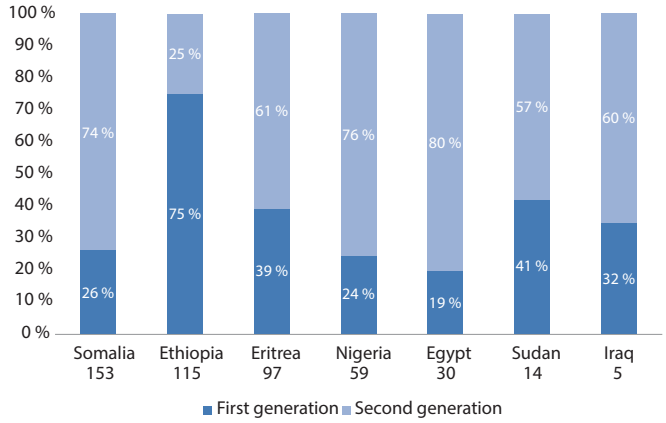
	TOTAL	First generation	Second generation	TOTAL (%)	First generation (%)	Second generation (%)	TOTAL generation (%)
0–9	423	166	257	87	39	61	100
10–18	62	33	29	13	53	47	100
TOTAL	**485**	**199**	**286**	**100**	**41**	**59**	**100**

Source: National Statistics Office Malta.

([53]) Place of birth is defined as the place of usual residence of the mother at the time of the birth, or, if not available, as the place in which the birth took place.

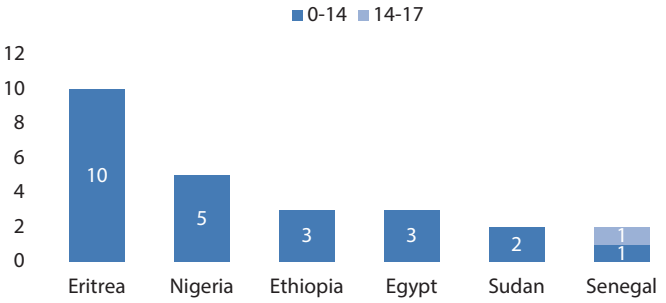
([54]) The number of girls in the age range 10–18 has been estimated and the hypothesis of uniform distribution was applied to estimate births by single years.

Figure 8.1. Number of girls (aged 0–18) living in Malta by most represented countries of origin (2011)



Source: National Statistics Office Malta.

Figure 8.2. Number of asylum-seeking girls (aged 0–17) living in Malta by broad age groupings (2016) ([55])



Source: Office of the Refugee Commissioner Malta.

Information on the region of origin of the girls (or their mothers) living in Malta is unavailable. Thus, for countries with a lower prevalence rate, the risk of bias can be high when applying the national prevalence rate of female genital mutilation to the migrant population living in Malta.

Asylum seekers

In Malta, there were 28 **asylum-seeking girls** (aged 0–17) from FGM-practising countries in 2016. Of these, most (25) were asylum-seeking girls from seven countries, as presented in Figure 8.2. Within this group, 96 % (24) were 0–14 and 40 % (10) came from Eritrea, compared to five from Nigeria, three from Ethiopia and Egypt respectively, and two from Senegal and Sudan respectively. Most of these countries are the same as those making up the highest number of first-generation regular migrants. The exception is Senegal, which does not feature in the list of regular migrants.

The number of asylum seekers in 2016 is low compared to previous years (with the exception of 2014, when there were the same number). In this instance, in 2013 (the peak year), there were 64 asylum seekers from the 30 FGM-practising countries being studied, with the majority (47) from Somalia, and the next greatest number (5) from Nigeria. For most years (2011–2016), the number of asylum seekers aged 0–14 is higher than for girls aged 14–17, apart from in 2013.

Data is not available for the number of **FGM-related asylum applications** received and granted in Malta since 2011 for girls from FGM-practising countries.

Other records collecting information on female genital mutilation in Malta

Migration patterns

According to the 2011 census (National Statistics Office Malta), the total number of (first-generation) female immigrants aged 0–19 arriving in Malta after residing in one of the FGM-practising countries is estimated at 34. Importantly, this figure is approximate and may underestimate the total inflow of female immigrants. Due to confidentiality rules, data was suppressed when there were fewer than three female immigrants originating from an FGM-practising country, and therefore this calculation assumes that only one immigrant arrived in Malta from these countries in 2011. This data is not used in in the estimates of girls at risk of female genital mutilation as it is a 'flow' variable rather than a 'stock' variable. Data on the total outflows of emigrants originating from FGM-practising countries in 2011 is not available, and therefore it is not possible to calculate net inflows.

Irregular migration

Data on the number of irregular female migrants aged 0–18 arriving in Malta by boat from FGM-practising countries is available from the Immigration and Security Division of the Police Department for 2011–2016, though no data is available for 2015. Since 2011, there have been 172 female irregular migrants aged 0–18 arriving in Malta by boat, although numbers have significantly decreased since 2013, when there were 58 illegal female immigrants aged 0–18 arriving by boat, with 46 from Somalia alone. Most recently, in 2016, there were only four recorded female immigrants in this age group arriving from Somalia, Sudan and Iraq.

This data is not available by age of arrival or by generation and does not take into account third-country nationals found to be illegally present in Malta and arriving by other transport methods. Furthermore, migrants' nationality is self-reported upon arrival, which means that there is no single definition of 'country of origin': this can be country of birth, previous country of residence or country in which citizenship is held. Although this data offers useful information, it could not be used in the estimates of girls at risk of female genital mutilation.

Hospital records

The Obstetrics and Gynaecology Department of the Migrant Health Unit records the number of mothers who come from FGM-practising countries who give birth at one hospital. Anecdotal evidence suggests that no female genital mutilation cases have been identified to date in this hospital. It was not possible to use this partial data in the estimations of the number of girls at risk of female genital mutilation because it gives a limited picture and concerns direct estimations.

([55]) Countries of origin are defined by countries of citizenship rather than countries of birth.

8.2. Summary of findings from focus group discussions organised in Malta

Four focus group sessions were held in Malta between September 2017 and January 2018. Two discussions were held with Nigerians (one with women, one with men) and two discussions were held with Egyptian women participants over and under the age of 25 respectively. It proved difficult to engage with other migrant communities of a larger size, although the perspectives of these groups would have been valuable as they accounted for two of the largest countries of origin for young female asylum seekers in Malta, in 2016.

In both Nigerian sessions, the participants were all from a Christian community and were already acquainted with one another. Most of the Nigerian women came from the Nigerian Delta State and had children; most of the men came from the north or northwest of Nigeria and were relatively highly educated. In the focus group discussion with second-generation migrants, the two Egyptian women both arrived in Malta when they were under 5 years of age and both were from the north of Egypt. In the second focus group discussion with the Egyptian community of women the participants had different religions, with the majority being Muslim and two being Coptic. All the participants were married and most had children. Table 8.2 presents an overview of the profiles of the participants in the four focus group discussions.

Identity and attitudes about the importance of female genital mutilation

The **Nigerian** women and men participants were aware of the practice in their country and the majority were against it. They did not attach importance to the practice of female genital mutilation and all emphasised that, with time, this practice is being eradicated. Participants did, however, highlight that there are some rural communities that still practise female genital mutilation, while explaining the need to educate these areas.

The **Egyptian** participants had different religious backgrounds. Those that were of Coptic faith stated that although the practice exists among that religious group, it is rare. Among the Muslim participants, the view was different. Some participants claimed that the practice emanates from the Quran, while others stated that the practice is a cultural one and that no one should interfere in the practice. They all agreed that the practice is performed by a qualified doctor and ultimately it is the doctor who decides whether their daughters are to be cut or otherwise. The second-generation Egyptian participants, who were Muslim, explained that their religion is divided, with some supporting the practice and others campaigning against it. They highlighted, however, that female genital mutilation is still being performed illegally in some parts of the country, particularly those in the desert and in the south.

The participants, having mostly been in Malta or in other EU Member States for a number of years, all emphasised that female genital mutilation is not part of their identity and so they do not experience any feeling of loss. Although all participants agreed that the practice is being eradicated, they explained that this was mostly a result of the **health risks and deaths** that were a consequence of cutting. None of the participants stated that women's empowerment is affecting the abandonment of the practice.

With regard to **men's changing attitudes** about the practice, the Nigerian women participants agreed that this would help a great deal since Nigeria is a 'fathers' land', with men having the ultimate say. The Nigerian men agreed and said that their attitude is important for the same reason; ultimately, they are also affected by the practice because the woman is someone's daughter, someone's sister or someone's wife. Some participants expressed that some men would view the practice positively since it contains a woman's sexual urges, while others think about it negatively since the affected woman would not have any feelings.

Most Nigerian participants agreed that female genital mutilation would not affect a woman's **ability to marry** or her social status. Some, however, emphasised that for certain families this could still be an important criterion since a cut woman is seen as pure. Most of the older Egyptian participants also felt that female genital mutilation does not affect a woman's ability to marry, while maintaining that the practice is part of tradition, and thus it is normally expected and practised. The participants also disagreed on whether this practice affects their identity, with one participant emphasising that this is her culture and her identity and that it cannot be changed.

The perception of the practice was very similar across all four focus group discussions. All participants claimed that the practice was performed to keep a woman **pure and controlled**. The women participants, both Egyptian and Nigerian, agreed that this ultimately does not work as they are aware of cases where women have been in adulterous relationships or have had multiple partners. They therefore felt that, regardless of whether a woman has been cut or otherwise, this does not in any way prevent her from having multiple partners. The men were of a similar opinion. All Nigerian participants agreed that the practice causes serious harm to the women and girls; however, among the Egyptian participants, some argued that the practice is part of their cultural heritage.

All older Egyptian participants agreed that their **relationships with family members** in the country of origin would not be affected since no one speaks about the practice. The family would not even ask whether circumcision had been performed on their daughters. All the Nigerian participants stated that since this practice has been eradicated, it does not affect their relationships with the family. However, some participants explained that although this is the case, they are still worried about what their family would say if they were to find out that their daughters were not cut.

Perceptions about the risk of the practice in the host country and beyond

Most participants explained that **western societies and values** are affecting their sense of identity. The majority also believed that institutions should not get involved.

The Nigerian participants explained that female genital mutilation is no longer being practised in Nigeria, except for some rural areas, while also explaining that they do not know of any cases in Malta. One participant believed, however, that there is a possibility that it is being performed in Europe upon payment. The Egyptian participants agreed that female genital mutilation is not performed in Europe, although one expressed doubt and said that it happens in Germany.

Key risk factors for female genital mutilation

The Nigerian participants explained that the main factor that can **contribute to reducing** female genital mutilation is creating awareness and educating people. They all agreed that although campaigns

Table 8.2. Overview of focus group discussions and sociodemographic profile of participants in Malta

Key characteristics of focus groups	Older women	Younger women	Men	Hard-to-reach/recent migrants
Number of participants	6	2	5	5
Countries of origin represented ([56])	Nigeria	Egypt	Nigeria	Egypt
Age range	31–34	1–25	38–55	29–36
Generation (first/second)	First	Second	First	First
Average residence (number of months) and previous residence in other countries	7 years The majority have never lived in other EU Member States	3.5 years The participants have lived only in their country of origin and never lived in other EU Member States	9 years and 7 months. The majority have never lived in other EU Member States	6 years and 9 months. The majority have never lived in other EU Member States
Number of second-generation participants who have lived in their parents' country of birth	n/a	Both participants lived in their parents' country of birth until the ages of three and four respectively	n/a	n/a
Civil status of participants	Five out of six participants were married	Married (2)	Married (5)	Married (5)
Number of participants with/without children	4 with children 1 expecting first child 1 without children	All participants had children	3 with children 2 without children	4 with children 1 expecting first child
Religion	Christian	Muslim	Christian (4) Urhobo religion (1)	Muslim (3) Christian (2)
Ethnic groups (if available)	One participant belonged to the Esan ethnic group	n/a	n/a	n/a
Level of education	Secondary education (3) Senior school (1) No formal education (1)	Secondary education (1) Higher education (1)	Secondary education (1) High level of education (4)	Secondary education (1) High level of education (4)
(For first generation): shortest and longest amount of time residing in Malta	Shortest: 4 years Longest: 11 years	n/a	Shortest: 1 month Longest: 20 years	Shortest: 9 months Longest: 14 years
(For first generation): shortest and longest amount of time residing in another EU Member State	n/a	n/a	The shortest and longest amount of time is 27 years	The shortest and longest amount of time is 4 years
Date of session	22 September 2017	12 January 2018	23 September 2017	25 September 2017

are making a great deal of difference, more needs to be done. The men participants pointed out that there must be awareness of the approach that needs to be taken, since this is ultimately a tradition and people should not be blamed for practising it. The women participants in particular explained that men need to be more aware of the subject, given that they are the ultimate decision-makers. The men participants explained that there is a need to focus on educating high-profile people in the village, who can influence others. They also highlighted the importance of sharing information between local and European civil society organisations.

The majority of older Egyptian participants were in favour of the practice and were **not willing to discuss factors** which would either reduce or increase the risk of girls undergoing female genital mutilation. They were mostly unaware of such factors since they held that the topic of female genital mutilation was not discussed in an open manner. They did, however, agree that it is up to the mother or the parents to initiate the discussion on female genital mutilation, and that the final decision would be left to the husband. On this point, the second-generation Egyptian participants agreed and said that it is either the father or the mother's father who would take the final decisions. The older Egyptian participants who were against the practice believed that there should be more education. Most participants agreed that awareness campaigns are having an effect on the abandonment of the practice. On the other hand, the second-generation participants both disagreed with the practice and believed that more information should be made available, mainly through an institution

([56]) This is the country of birth of first-generation migrants (FGM-practising countries), or the country of birth of the parents of second-generation migrants (FGM-practising countries). Here, someone is second generation if that person was not born in an FGM-practising country but has at least one parent born in an FGM-practising country.

that would help girls who are about to experience or who have already undergone female genital mutilation.

8.3. Estimating the number of girls at risk of female genital mutilation in Malta

First, this section presents the estimates of the number of girls at risk of female genital mutilation within the regular migrant population; then the estimates for asylum-seeking girls are presented. The estimates are first presented according to the **original methodology** (EIGE, 2015a) and then the **refined methodology** is applied following the improvements outlined in Chapter 2 of this report. The estimates according to the refined methodology present the final outcome of the number of girls at risk of female genital mutilation in Malta.

Resident population

With regard to the low and high-risk scenarios, the number of girls (aged 0–18) at risk of female genital mutilation in Malta varied between 47 and 183 in 2011, all of whom are aged under 10. Most girls at risk were drawn from the second generation.

It should be noted that live-birth data to calculate the second generation was provided only in grouped age brackets and, therefore, births by single years were estimated. Furthermore, in order to calculate the number of girls below the median age for cutting, it was necessary to assume a uniform distribution of girls across the ages of each bracket.

When applying the **refined methodological approach** ([57]) as described in Chapter 2 of this report, an increased number and proportion of girls at risk of female genital mutilation can be observed in Malta for the reference year 2011 (year of the European population and housing census).

Figure 8.3 shows the top seven countries, by total number of girls at risk of female genital mutilation (first and second generation) aged 0–18, residing in Malta in 2011. Somalia is the most commonly occurring country of origin, followed by Eritrea, Ethiopia, Egypt, Sudan, Nigeria and Sierra Leone.

Table 8.5 summarises the results of the female genital mutilation risk estimations for both the high- and low-risk scenarios. In the high-risk scenario, both first- and second-generation girls are considered at risk of female genital mutilation, while the low-risk scenario considers the first generation and half of the second generation still at risk of female genital mutilation

Asylum seekers

With regard to only the high-risk scenario, the number of asylum-seeking girls aged 0–18 at risk of female genital mutilation varied between eight in 2011, 12 in 2012, seven in 2013, three in 2014,

Table 8.3. Estimated number of girls (aged 0–18) at risk of female genital mutilation living in Malta (2011)

	Resident population					
	HIGH-RISK SCENARIO			LOW-RISK SCENARIO		
	TOTAL at risk	First generation	Second generation	TOTAL at risk	First generation	Second generation
2011: TOTAL (0–18)	183	47	136	47	47	0
0–9	183	47	136	47	47	0
10–18	0	0	0	0	0	0

Source: Present study.

Table 8.4. Final estimated number of girls (aged 0–18) at risk of female genital mutilation living in Malta according to the refined methodological approach (2011)

TOTAL	LOW-RISK SCENARIO Proportion of girls at risk		HIGH-RISK SCENARIO Proportion of girls at risk		LOW-RISK SCENARIO No of girls at risk		HIGH-RISK SCENARIO No of girls at risk	
	Original	Refined	Original	Refined	Original	Refined	Original	Refined
2011								
485	10 %	**39 %**	38 %	**57 %**	47	**189**	183	**279**

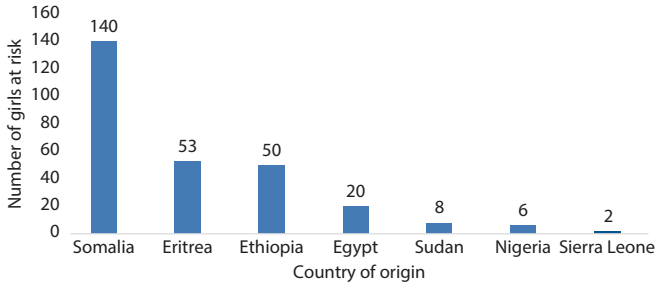
Source: Present study.

([57]) Three adaptations are applied: (1) a more robust calculation of the median age of cutting and an increase of the median age by its standard deviation; (2) adding girls who have reached the median age of cutting into the calculation and (3) considering half of the second generation still at risk of female genital mutilation in the low-risk scenario.

18 in 2015 and five in 2016. When looking at the proportion of **asylum-seeking** girls at risk of female genital mutilation, we observe a low (11 %) in 2013 and 2014, before a peak in 2015 (38 %) and then a fall in 2016 (14 %).

If we apply the **refined methodological approach** ([58]) as described in Chapter 2 of this report, an increased number and proportion of asylum-seeking girls at risk of female genital mutilation can be observed in Malta for 2011 and 2016 (the latest available year).

Figure 8.3. Estimated number of girls (aged 0–18) at risk of female genital mutilation living in Malta by most represented countries of origin (2011)



Source: Present study.

Table 8.5. Female genital mutilation risk in Malta in 2011 (latest available year)

High-risk scenario	In 2011, a total number of 485 girls aged 0–18 from FGM risk countries were residing in Malta, of which 279 were likely to be at risk of female genital mutilation. **This means 57 % of girls aged 0–18 from FGM risk countries (either born in the country of origin or in Malta) were at risk of female genital mutilation.**
Low-risk scenario	In 2011, a total number of 485 girls aged 0–18 from female genital mutilation risk countries were residing in Malta, of which 189 were likely to be at risk of female genital mutilation. **This means 39 % of girls aged 0–18 from FGM risk countries (either born in the country of origin or in Malta) were at risk of female genital mutilation.**

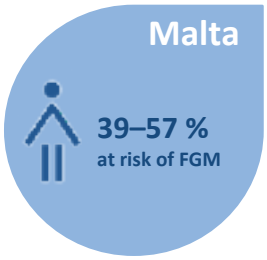
Table 8.6. Estimated number of asylum-seeking girls (aged 0–17) at risk of female genital mutilation living in Malta (2011–2016)

	Total number of girls (aged 0–17) from FGM-practising countries	Total number at risk	Proportion of girls at risk
2011	53	8	15 %
2012	39	12	31 %
2013	64	7	11 %
2014	28	3	11 %
2015	47	18	38 %
2016	28	5	14 %

Source: Present study.

The three top countries of origin for asylum-seeking girls at risk of female genital mutilation (in the latest available year, 2016) are Eritrea, Egypt and Sudan.

8.4. Main findings in Malta



In 2011, a total number of 486 girls aged 0–18 originating from FGM-practising countries were residing in Malta, of which an **estimated 39 % to 57 % were at risk** of female genital mutilation.

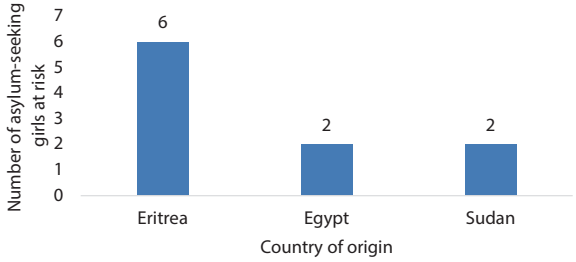
For the resident migrant population it is not yet feasible to assess **trends over time** as data is only available for

Table 8.7. Final estimated number of asylum-seeking girls (aged 0–17) at risk of female genital mutilation living in Malta according to the refined methodological approach (2011 and 2016)

TOTAL	HIGH-RISK SCENARIO Proportion of girls at risk		HIGH-RISK SCENARIO No of girls at risk	
	Original	Refined	Original	Refined
2011				
53	15 %	**32 %**	8	**17**
2016				
28	14 %	**46 %**	5	**13**

Source: Present study.

Figure 8.4. Estimated number of asylum-seeking girls (aged 0–18) at risk of female genital mutilation living in Malta by most represented countries of origin (2016) ([59])



Source: Present study.

([58]) Three adaptations are applied: (1) a more robust calculation of the median age of cutting and an increase of the median age by its standard deviation; (2) adding girls who have reached the median age of cutting into the calculation and (3) considering half of the second generation still at risk of female genital mutilation in the low-risk scenario.

([59]) The figure is based on the high-risk scenario data.

2011. It is therefore recommended to further improve data availability and start collecting aggregated data on the female migrant population for later years as well as beyond the census.

The largest **communities** from FGM-practising countries in Malta come, in descending order, from Somalia, Ethiopia, Eritrea and Nigeria, while girls at risk come in descending order from Somalia, Eritrea, Ethiopia and Egypt. When designing targeted policies in Malta, it is important to take this reality into consideration.

It proved difficult to engage with communities and invite them to participate in the focus group discussions, as most were reluctant to talk openly about female genital mutilation. Participants originating from Nigeria and Egypt were recruited, representing two of the largest countries of origin for young female asylum seekers in Malta in 2016. The majority of the Nigerian participants were against the practice, stating that female genital mutilation is declining in Nigeria due to campaigns and knowledge of the health risks for women. Generational differences emerged between the Egyptian participants, with all second-generation younger girls against female genital mutilation. In contrast, older Muslim Egyptians were largely pro-FGM, and saw it as a cultural practice to be sustained, arguing that it emanates from the Quran. Increased time spent in Malta led many Nigerians to stress that female genital mutilation is not part of their identity as they have been influenced by western values. Neither Nigerian nor Egyptian participants believed that female genital mutilation was occurring in Malta, or Europe more broadly, except for one participant who suggested that the practice may be happening in Germany. Some focus group participants linked the motivation for female genital mutilation to ensuring women's purity and sexual control, despite many acknowledging that there is no truth in these suggestions.

To **tackle female genital mutilation in Malta**, a specific legal provision criminalises the practice and those failing to wilfully avert the authorities. The principle of extraterritoriality is applied, allowing for prosecution for female genital mutilation even when committed abroad. The legal framework was strengthened by the transposition of the Istanbul Convention in April 2018, which entered into force in Malta in November 2014, having been ratified in July 2014. General child protection provisions can be used in cases of female genital mutilation and parents can be held accountable if the practice is performed on their child. A specific legal provision on reporting cases of female genital mutilation is in place, as well as guidelines for professionals. Specific integral policies combating the practice are still to be designed, but initiatives have been taken on discussing the topic at reception centres and sporadic training. A research study resulted in the dissemination of information packages on the topic (National Commission for the Promotion of Equality, 2015).

Most participants in the focus group discussions expressed the need for more **education and awareness-raising** on female genital mutilation. In fact, participants were not aware of any campaigns, with most not even knowing that female genital mutilation is a crime in Malta. The need for counselling services for women and girls who have undergone the practice was highlighted as well.

Looking at available data on **migration patterns** in Malta, the 2011 census data indicates a net inflow of 34 female immigrants (aged 0–19) arriving in Malta from an FGM-practising country. Numbers of irregular migrants arriving by boat significantly decreased between 2011 and 2016, and since 2011 there have been 172 female irregular migrants aged 0–18 arriving by boat.

There were a total of 28 **asylum-seeking girls** in Malta in 2016, of which **46 % were at risk** of female genital mutilation. Compared to 2011, higher proportions of girls were at risk, but lower actual numbers.

General asylum law in Malta can be applied to grant asylum to women and girls who have undergone female genital mutilation or who are in danger of being subjected to it. However, no information is available on the number of FGM-related applications received and granted and a focus on the prevention of female genital mutilation through the asylum system, such as gender-specific asylum procedures, is to be implemented.

9. Comparative analysis on the risk of female genital mutilation

9. Comparative analysis on the risk of female genital mutilation

9.1. Comparing the findings among the six Member States of the study

This chapter summarises the main findings of the quantitative and qualitative research in the six Member States — Belgium, Greece, France, Italy, Cyprus and Malta — where the methodology for estimating the risk of female genital mutilation was applied.

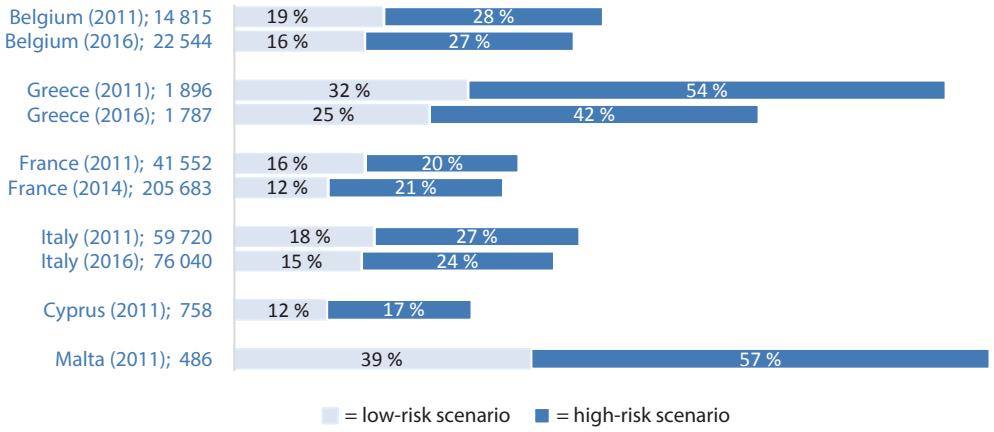
Female genital mutilation affects all six Member States

The findings in the Member State chapters of this report show how female genital mutilation is a problem affecting all six. Applying the same methodology to estimate the risk of female genital mutilation in Belgium, Greece, France, Italy, Cyprus and Malta results in a set of comparable data across different countries, adding evidence-based information to the picture of female genital mutilation in the European Union. Comparisons of the findings should be made with caution and the number of girls at risk of female genital mutilation varies between Member States due to, inter alia, the size of the migrant population from FGM-practising countries, the level of prevalence of female genital mutilation within the dominant countries of origin and the available data in each Member State.

To increase the overall comparability of the findings, data was collected for the reference year 2011 (the year of the European population and housing census collected by Eurostat) and for the latest available year. All countries could provide the necessary data for 2011 and, in addition, data was collected for the latest available years in France (2014) and Belgium, Greece and Italy (2016). The latter sets of data are less comparable due to differences in the availability and collection of data to calculate the number of first- and second-generation female resident migrants in the countries. This data provides useful indicative insights on the trends of female genital mutilation risk in a given country over the years.

In 2011, the **size of the female migrant population** from FGM-practising countries differed substantially across the six Member States, ranging from 486 in Malta to 59 720 in Italy. In Malta and Greece, the smallest overall populations from FGM-practising countries and the highest proportion of girls at risk were observed. However, the Greek data on second-generation girls captures only those with a residence

Figure 9.1. Estimated proportion of girls (aged 0–18) in the resident migrant population at risk of female genital mutilation (in 2011 and latest available year)



Source: Present study.

permit as data on girls without a residence permit is unavailable, and is therefore a significant underestimation of the total number.

The countries with the lowest proportions of girls at risk in 2011 were Cyprus and France. However, France and Italy have the greatest number of girls at risk in 2011. This demonstrates the importance of **considering both the number and the proportion** of girls at risk when interpreting risk estimations. Proportions alone do not reflect the scale of policy intervention necessary to reach out to all girls at risk in a given country. Furthermore, the fact that community size does not automatically correspond to a greater number of girls at risk reflects that there is no straightforward relationship between migration and risk of female genital mutilation. Low prevalence in certain countries of origin means that some of the biggest migrant communities in specific Member States are not among the main countries of origin for girls at risk. For example, in Belgium (2016), the seven largest groups of female migrants (aged 0–18) from FGM-practising countries were, in descending order, from Guinea, Cameroon, Iraq, Ghana, Nigeria, Somalia and Togo. However, the seven most represented countries of origin of girls at risk in this year (according to the high-risk scenario estimates) were, in descending order, Guinea, Somalia, Egypt, Sierra Leone, Côte d'Ivoire, Nigeria and Djibouti. Policy interventions are most effective if they reach out to the communities most affected by female genital mutilation, and this cannot be judged purely by the number of girls aged 18 and under.

The differences between the low- and high-risk scenarios are variable across the six Member States for 2011, and range from a difference of nearly 22 percentage points in Greece in 2011 to a difference of 4 percentage points for France in 2011. This range is generally a good indicator of the difference in size between the first and second generations in a country in a given year.

Table 9.1. Estimated number of girls (aged 0–18) in the resident migrant population at risk of female genital mutilation (2011 and latest available year)

	Total population of girls (aged 0–18) from FGM-practising countries	LOW-RISK SCENARIO No of girls at risk (%)	HIGH-RISK SCENARIO No of girls at risk (%)
Belgium (2011)	14 815	2 762 (19 %)	4 124 (28 %)
Greece (2011)	1 896	615 (32 %)	1 020 (54 %)
France (2011)	41 552	6 473 (16 %)	8 444 (20 %)
Italy (2011)	59 720	10 541 (18 %)	16 392 (27 %)
Cyprus (2011)	758	88 (12 %)	132 (17 %)
Malta (2011)	486	189 (39 %)	279 (57 %)
Belgium (2016)	22 544	3 579 (16 %)	6 122 (27 %)
Greece (2016)	1 787	453 (25 %)	748 (42 %)
France (2014)	205 683	24 660 (12 %)	44 106 (21 %)
Italy (2016)	76 040	11 382 (15 %)	18 339 (24 %)

Source: EIGE.

Trends over time in Belgium, Greece, France and Italy

When comparing trends over time in Belgium, France and Italy, it can be observed that proportions of risk have decreased for both scenarios (only in the high-risk scenario in France is a slight increase from 20 % to 21 % observed), but the number of girls at risk have increased. However, comparisons need to be made carefully, as data for 2014 and 2016 on second-generation girls is incomplete in Belgium and Italy, which creates bias in the high-risk scenario. The case of Greece is specific as, for the available reference years, only data on the female migrants with a residence permit is available, leading to a significant underestimation of the number of girls at risk of female genital mutilation in the country. A fall in the number of girls at risk was observed from 2011 to 2016, in contrast to the other Member States. In the low-risk scenario there was a decrease from 615 girls at risk to 453 girls, which translates into a decrease from 32 % to 25 %. For the high-risk scenario, a decrease in the number of girls at risk of female genital mutilation was recorded, from 1 020 in 2011 to 748 in 2016. This trend translates, in percentage terms, to a fall from 54 % of girls at risk of female genital mutilation out of the total population of girls from FGM-practising countries in 2011, to 42 % in 2016.

Overall, across the four Member States where data is available for more than 1 year, a decrease in the percentage of girls at risk of female genital mutilation since 2011 can be observed. However, this does not, de facto, mean a decrease in the number of girls at risk, as shown in Belgium, Italy and France. This trend relates to the expanding second generation within these Member States. Greece, unlike the other three Member States, experienced a fall in the number of girls at risk relating, inter alia, to the decrease in the total female migrant population (with residence permits) aged 0–18 living in Greece. However, it is not possible to form a picture of the size of the migrant population *without* residence permits in Greece, many of whom are likely to be second-generation girls within the 'at risk' age category.

Impact of the refined methodology

As described in Chapter 2 of this report, the methodology to estimate the number of girls at risk of female genital mutilation has been refined to further enhance its overall soundness. Four main adaptations in the approach used to estimate the risk of female genital mutilation were applied and proposed for future estimations: (1) a more robust calculation of the median age of cutting and an increase of the median age by its standard deviation; (2) adding girls who have reached the median age of cutting into the calculation (3) considering half of the second generation still at risk of female genital mutilation in the low-risk scenario and (4) harmonising the age groups for asylum seekers with the age groups for the migrant population. These adaptations follow the quantitative and qualitative results of this study.

If we compare the findings of the **original methodology** (EIGE, 2015a) and the **refined methodology** used in this report, higher numbers and proportions of girls at risk of female genital mutilation are observed with the refined methodology, both for resident migrant girls and for asylum-seeking girls. This is the result of a more robust calculation of the median age of female genital mutilation and the inclusion of girls who have reached the median age of female genital mutilation in the calculations. Including girls of the median age is in line with the assumption that, in a migratory context, the age of female genital mutilation is likely to be higher than in the country of origin and the practice is more related to an opportunity to get it done than linked to a certain age.

Furthermore, including a part of the second generation still at risk of female genital mutilation in the low-risk scenario is a more valid

option than excluding them from this scenario altogether. From the qualitative research conducted in the report it was concluded that second-generation girls are still to be considered at risk, given that migration mitigates risk, but does not remove it entirely. Travelling to the country of origin is a major risk factor due to traditions and social pressure from family and community members. A direct result of including half of the second generation at risk of female genital mutilation in the low-risk scenario is that the expanding numbers of second-generation girls in some countries (Belgium, France and Italy in particular) are taken into account in the risk estimation in a more realistic way. In the long term it would be preferable to measure the impact of migration through indicators capturing levels of integration among migrants of countries where female genital mutilation is practised. This would allow for more information on how migration and acculturation affect migrants living in the European Union.

Finally, the **refined methodology** harmonised the broad age formats generally provided for asylum seekers with the age structure observed for the regular migrant population of foreign-born girls of the same nationality, to enhance comparability. In the long term, it is recommended that data collection systems disaggregate data on asylum seekers by detailed 1-year intervals, to avoid the need for this assumption and enable more accurate estimations.

Communities present in several Member States

When comparing the most represented countries of origin of girls at risk of female genital mutilation in each of the six Member States, certain overlaps can be identified. In particular, Egypt, Nigeria and Ethiopia are the three countries which are identified in between four to six Member States, while Somalia, Guinea, Sierra Leone, Côte d'Ivoire, Djibouti and Sudan are identified in three Member States. Egypt is the most represented country of origin (present in all six Member States) and is in the top four most represented countries in each Member State (highest in Greece and Cyprus). However, the estimations for the number of girls at risk of female genital mutilation from Egypt vary depending on the Member State.

Information on communities present in several Member States can usefully inform policy design and implementation, when it comes to, for example, adopting the most appropriate messages for engaging with affected communities. In this sense, it is valuable to collect reliable and comparable data regularly and over time. This information, however, needs to be interpreted correctly and carefully to ensure stigmatisation and counterproductive policy is avoided.

Challenges in data collection

Collecting quantitative data is challenging, with some data being unavailable or only partly available. Across all Member States, the necessary disaggregated data, inter alia by generation, is only available upon request. Other data allowing for better calculations is not available, such as data on the region of origin of migrants, on ethnicity, data by father's country of origin or official data on irregular migrants. Other datasets are available in some Member States but not in others, for example inflows and outflows of migrants or the number of FGM-related asylum applications received and granted. Furthermore, differences in the terminologies used to define 'migrants' among Member States hamper comparable data collection.

Reliable and complete data on second-generation migrants is missing because information on individuals' parents' countries of birth is not routinely collected. This can create bias or underestimation, especially in the estimation of the high-risk scenario. In each country, because of the lack of data, the estimations are calculated by utilising a number of expedients that can allow for more precise calculations. For example, in Greece, the second generation is estimated as a fraction of the total residence permit-holders and does not include girls that do not have

Table 9.2. Estimated number and proportion of girls (aged 0–18) in the resident migrant population at risk of female genital mutilation (2011 and latest available year) comparing the original methodology (EIGE 2015a) and the refined methodology used in this report

	Total population of girls (aged 0–18) from FGM-practising countries	LOW-RISK SCENARIO No of girls at risk (%)		HIGH-RISK SCENARIO No of girls at risk (%)	
		Original methodology	Refined methodology	Original methodology	Refined methodology
Belgium (2011)	14 815	1 100 (7 %)	2 762 (19 %)	3400 (23 %)	4 124 (28 %)
Greece (2011)	1 896	161 (8 %)	615 (32 %)	817 (43 %)	1 020 (54 %)
France (2011)	41 552	1 936 (5 %)	6 473 (16 %)	5875 (14 %)	8 444 (20 %)
Italy (2011)	59 720	2 953 (5 %)	10 541 (18 %)	11 675 (20 %)	16 392 (27 %)
Cyprus (2011)	758	29 (4 %)	88 (12 %)	102 (13 %)	132 (17 %)
Malta (2011)	486	47 (10 %)	189 (39 %)	183 (38 %)	279 (57 %)
Belgium (2016)	22 544	597 (3 %)	3 579 (16 %)	4 618 (20 %)	6 122 (27 %)
Greece (2016)	1 787	92 (5 %)	453 (25 %)	454 (25 %)	748 (42 %)
France (2014)	205 683	2 266 (1 %)	24 660 (12 %)	23 885 (12 %)	44 106 (21 %)
Italy (2016)	76 040	2 499 (3 %)	11 382 (15 %)	11 515 (15 %)	18 339 (24 %)

Source: Present study.

Table 9.3. Estimated number and proportion of girls in the asylum-seeking population at risk of female genital mutilation (2011, 2012 and latest available year) comparing the original methodology (EIGE, 2015a) and the refined methodology used in this report ([60])

	Total population of girls (aged 0–18) from FGM-practising countries	HIGH-RISK SCENARIO No of girls at risk (%)	
		Original methodology	Refined methodology
Belgium (2012)	627	215 (34 %)	255 (41 %)
Greece (2011)	10	0 (0 %)	0 (0 %)
France (2011)	1 131	521 (46 %)	632 (56 %)
Italy (2011)	629	95 (15 %)	139 (22 %)
Malta (2011)	53	8 (15 %)	17 (32 %)
Belgium (2016)	969	173 (18 %)	219 (23 %)
France (2016)	1 283	324 (25 %)	421 (33 %)
Greece (2016)	1 123	33 (3 %)	51 (5 %)
Italy (2016)	872	52 (6 %)	80 (9 %)
Malta (2016)	28	5 (14 %)	13 (46 %)

Source: Present study.

or need residence permits (potentially leading to underestimation). In Malta, second-generation data was calculated using information on the number of live births to resident as well as non-resident mothers. However, data was only provided in grouped age brackets, and therefore it was necessary to apply a hypothesis of uniform distribution in order to estimate births by single years.

Collecting qualitative data through focus group discussions is equally challenging, and the recruitment of participants from different communities is a time-consuming process. In Italy, Cyprus and Malta it was difficult to recruit second-generation girls aged 18 and over. Furthermore, engaging 'hard-to-reach' and newer migrants in all Member States called for targeted recruitment through key community contact persons. In several Member States, reluctance among participants to openly discuss female genital mutilation hampered the recruitment process. Peer pressure observed among participants was avoided as much as possible through the valuable contributions of cultural mediators.

Attitudes towards female genital mutilation are changing

In all six Member States, participants in the focus group discussions confirmed that attitudes towards the practice are changing among migrants living in the EU as well as in their country of origin. Somali women and men said that 'less severe' forms of female genital mutilation were practised, particularly among younger generations. Egyptian men explained that the practice used to have religious justifications but nowadays it is perceived as being linked to aesthetics and purity. Nigerian women and men stated that there was no longer a need to perform the practice as the mentality was changing because people travel and discover the ways of life in societies where female genital mutilation is not common. They said that the practice was gradually starting to be perceived as 'outdated'. Sudanese women in Greece said it used to be shameful not to perform female genital mutilation 5 years ago but that times are changing. Malian women and men in France also distinguished between expectations back in the country of origin in contrast to France, where the practice entails serious legal consequences. These findings are in line with previous research showing that migration has an impact on women and men's attitudes towards female genital mutilation (EIGE, 2015a; Gele et al., 2012; Johnsdotter et al., 2009; Morison et al., 2004; Wahlberg et al., 2017). Furthermore, some evidence suggests that the longer migrants stay in EU, the less likely they are to want to continue with the practice (Gele et al., 2012; Johnsdotter et al., 2009; Morison et al., 2004).

On the other hand, a shift towards 'less severe' forms of female genital mutilation or performance by medical staff, often referred to as the 'medicalisation' of the practices, might change the way the practices evolve, but still poses serious threats to the health of women and girls and does not challenge the underlying misbeliefs about women's sexuality and their traditional role in society.

Attitudes and factors that seem to encourage female genital mutilation

Various factors, beliefs and attitudes that may motivate women and men to have their daughters cut or prevent them from doing so emerged in the focus group discussions, affecting different communities to varying extents.

Traditions and cultural beliefs

Overall, the results revealed that, more than a religious requirement, female genital mutilation is rooted in traditions and cultural beliefs. These beliefs are deeply embedded in certain practising societies and communities. However, some participants in the focus group discussions referred to the practice as required by the Prophet Muhammad.

Social pressure and expectations for marriage

The social expectation to be circumcised for marriage was expressed among all communities, but with varying degrees of importance. Somalis, Sudanese, Guineans and Malians stated that in their countries of origin the social expectation was that girls should be cut before marriage. Egyptians and Nigerians, however, stated that in their countries of origin the decision to cut was an individual one and not particularly linked to pressure from the family or society.

In Cyprus, first-generation women and men participants from Somalia reported that, particularly in rural areas of Somalia, it was impossible for a girl to marry if she had not undergone female genital mutilation. In terms of unmarried Somali girls who have grown up in Europe returning to Somalia for marriage, it was suggested that it was impossible for them to get married if they were not circumcised. In Belgium, on the other hand, Somali women and men from the first generation expressed a more nuanced position; while acknowledging the social pressure, they differentiated between types of cutting in rural areas or cities. The expectation to marry a woman who has undergone female

([60]) Belgium, France and Italy cover girls aged 0–18 and Greece and Malta cover girls aged 0–17. No data available for Cyprus.

genital mutilation — particularly type III — appears to be weakening. A similar view was expressed by Somali women of the first generation in Greece, who agreed that it was mostly older people that still cut girls.

Malian men participants in France suggested that in rural Mali, an uncut girl could not get married as she was considered impure. In a key difference to the men, second-generation girls of Malian origin did not perceive the practice to be an important factor for marriage in France. The mentality was different; the husband would find out if a girl was cut after marriage. This reflects a disjuncture between the views of different sexes and generations in the same community, but also a difference in expectations depending on whether the discussion concerns marriage in France or in Mali. Older female Sudanese participants (aged 38 and over) from the first generation spoke of various cases of uncut girls being returned to their parents after the wedding night, saying that they were not accepted until they had undergone female genital mutilation (type III).

Nigerian women and men living in Malta and in Italy did not perceive female genital mutilation as an important criterion for marriage. Although in both countries Nigerians mentioned that the practice controls women's sexuality and faithfulness, women and men said that the practice was disappearing in Nigeria as society was changing. Similarly, despite the high prevalence of female genital mutilation in Egypt, respondents in Greece, Italy and Malta stated that the practice was not a specific request upon marriage, nor was there any social pressure among members of the community or among in-laws to ensure that the bride had undergone the practice. Second-generation women from Guinea in Belgium rejected female genital mutilation but agreed that virginity was extremely important for the honour of the family and the respectability and reputation of the girl. In France, first-generation Guineans also emphasised the importance of virginity upon marriage. Second-generation young women in Italy had more distant perspectives on female genital mutilation and expectations for marriage, as if this was not a criterion that personally concerned them.

Gendered views on women's sexuality

Across all six EU Member States, the belief that it controls women's sexuality was mentioned as an important factor in practising female genital mutilation. This was expressed in different ways: Somali women in Cyprus said that uncut women were promiscuous and their virginity could not be guaranteed. Although, generally, many participants were against the practice and accepted its abandonment, they expressed their concern about girls' control of desire, discipline and education. Second-generation Guineans in Belgium confirmed these findings regarding control of sexuality, stating that female genital mutilation is performed to reduce women's pleasure. However, they were not sure whether women's pleasure is actually reduced through the practice or whether this was an erroneous belief.

Purity and aesthetics

Older first-generation Egyptian and Nigerian women in Italy spoke of the aesthetics of the female genitals, stating that this was the major motivation for the practice. Egyptian women in Italy unanimously stated that it is necessary to take one's daughter to the family doctor; if the doctor thinks that 'the part' does not grow 'out of the body' too much, from the labia, then the young woman can avoid circumcision. Without going into as much detail, the same need for the doctor's evaluation was stated among Egyptians in Malta. Middle-Eastern men (Egypt and Syria) in Greece also suggested that it was important to observe the development of the girl to evaluate whether she needed to be cut.

In Belgium, Somali older women explained that one of the words referring to the practice — halalese, meaning purification — is an expression that is clearly linked to Islamic practice. In France, Malian men also mentioned that uncut women are less clean than cut women. Egyptian men in Italy emphasised that female cutting, like male circumcision, was an act of purification in their Islamic practice. However, there was a general consensus that it was up to the doctors who perform the cutting to ensure purity. This 'medicalisation' of female genital mutilation could be observed as a way of accepting the practice.

Attitudes and factors that seem to discourage female genital mutilation

Negative health consequences

Participants talked of negative health consequences, both physically and psychologically, in different ways as an aspect of discontinuation of female genital mutilation. Some spoke from personal experience and some did so in a more abstract way, pointing to campaigns that emphasised these negative consequences, which they themselves had not experienced but knew about.

In terms of consequences on the sexual health of women, in all countries participants said that the disadvantage of the practice was that women lose sensation during intercourse. In Malta, Nigerian men (first generation) did not mention any sexual problems related to the practice and some Nigerian women said that they had no sexual problems; others complained of loss of feeling. Somali women in Belgium, Cyprus and Greece said that they suffered from lack of 'feeling' during intercourse and that it was painful. Somali men also demonstrated that they were affected by the negative consequences for women's sexual health. Malians put more emphasis on the psychological consequences linked to sexuality. The second-generation young women said that sexual intercourse is performed among girls that have been cut as a form of rebellion against the values of sexual control among members of their community. A Malian woman who had gone through reconstructive surgery expressed the need for psychological follow-up as many women are ashamed. As there is a great taboo around women experiencing pleasure, few Malians openly admit to experiencing sexual problems.

Laws and campaigns against female genital mutilation

Laws against female genital mutilation in the EU are strongly discouraging towards the practice and people feared the consequences of the law more than the consequences of not practising female genital mutilation, particularly in France.

In all six Member States, participants were generally aware that in their EU Member State of residence, female genital mutilation was illegal, except for some Somali men in Belgium. Particularly in France, participants were very afraid of the law and fearful of their daughters being cut against their will when they returned to the country of origin. Among communities where there is less awareness of the law and the consequences of female genital mutilation, research participants were more open to the option of returning to the country of origin for the practice. Iraqis were not aware of the law in Belgium but knew that female genital mutilation was illegal in some countries outside of Iraq. As for Guineans in France, some had never heard of the practice

being performed in France because of fear of the law; others said that regardless of the law Guineans continued to practise female genital mutilation. Egyptians and Sudanese in Greece were also aware of the law but mentioned that this was why some people returned to the country of origin to have the practice performed. Nigerians and Egyptians in Malta and Italy also showed awareness of the law. However, whereas Nigerians showed no interest in continuing with female genital mutilation, for Egyptians returning to the country of origin to have the practice done was not ruled out as an option.

The degree of exposure to awareness-raising campaigns against female genital mutilation varied between countries. In Malta, Nigerian and Egyptian participants said that they had received information only in their countries of origin on television and through non-governmental organisations. In Cyprus, the participants said that they had been informed at the asylum centre. In Belgium, some Somali men had not received any kind of information whereas others were well informed via non-governmental organisations and asylum centres. In Greece, Somalis felt that there were not enough campaigns. The Sudanese in Greece said that, in Sudan, some women took to the streets to demonstrate against female genital mutilation. Egyptians were shocked by this idea and said that it is a private issue and that people would never take it to the public by demonstrating on the streets. These participants did not speak of campaigns in Greece. In France, the Malian participants were also aware of campaigns. Iraqis were not aware of any campaigns in Belgium or elsewhere. Guinean women in France had not seen any campaigns in France but had knowledge of awareness-raising efforts in Guinea.

These results show that the degree of awareness of campaigns varies greatly across study countries. Although there is awareness among women and men participants that female genital mutilation is illegal in the EU, some do not feel as threatened by the law and perceive returning to the country of origin as an option to have the practice performed. Not all were aware of the principle of extraterritoriality whereby individuals can still be prosecuted even if female genital mutilation happens abroad. It would be valuable to raise awareness of the extraterritoriality principle in national legislation.

In places like France, where the law is enforced and surveillance is in place, the legislation has a strongly discouraging effect on attitudes towards the practice. When communities are not very aware of the legislation and no law enforcement or surveillance is in place in their country of residence, they do not feel threatened by the law.

Stigmatisation, especially when accessing health and asylum services

Stigmatisation frustrated and deterred women from many communities from desiring the practice for their own daughters. First-generation Malian and Somali women in France and Cyprus complained extensively about being made uncomfortable due to the fact they were circumcised. In France, women felt that they were being treated differently because people knew that most Malians practise female genital mutilation. It made them feel as if they had no desire or sexual sensation and as if they were not 'complete women'.

Medical examinations were perceived as humiliating, if the medical staff reacted with shock or had never seen it before. In Cyprus, older and younger women (both first generation) also told of embarrassing encounters with medical staff reacting inappropriately during examinations. As part of the asylum procedure, women were also asked if they had undergone female genital mutilation and this was verified upon medical examination. These procedures made women feel uncomfortable and they felt like they were 'different from western women'.

Second-generation girls from Mali and Senegal residing in France did not think that stigmatisation was an issue for them; they thought that women who had been cut perhaps felt different to uncut women, but that they would hide it. In Belgium, second-generation Guinean women expressed concern about experiencing stigma in their social circles; they said they never spoke to non-Guinean friends about the practice because they feared that people would not want to see them anymore and would make comments about their country and people.

Women's accounts regarding stigmatisation show that their psychosocial well-being in some Member States is affected by healthcare professionals' limited experience with FGM-affected women, limited sensitivity when addressing the practice and limited awareness of the sociocultural complexity of female genital mutilation, as well as the perpetuation of stigmatising messages that the practice is 'backward' and 'barbaric'.

Men from Somalia in Belgium and Cyprus expressed no awareness of women being stigmatised in any way. Nigerian and Egyptian women and men in Italy and Malta were not aware of any kind of stigma due to the practice in Europe or for uncircumcised women when returning to the country of origin. Men's lack of awareness of women's sense of being stigmatised as 'mutilated' points to limited communication between women and men about the practice. Previous studies have shown that women and men are very uncomfortable talking to each other about female genital mutilation (see, for example, Kaplan et al., 2013; O'Neill et al., 2017), which may explain why women do not share their psychosocial issues with their partners and acquaintances.

Somali and Sudanese women in Greece expressed the lack of medical care and services for women with female genital mutilation. Various participants said that they had heard of reconstructive surgery and would like to have it done. In Cyprus, none of the Somali participants had heard of reconstructive surgery but they were keen to find out more about it.

Risk of female genital mutilation in EU and when returning

None of the participants admitted to knowing about the practice being performed in their immediate surroundings. However, there might have been respondent bias and social desirability bias and respondents may have feared consequences. Numerous participants seemed to suggest that it was easier to return to the country of origin to perform the practice rather than trying to have it performed in the EU because it was illegal. Except for France, discussions around facing legal consequences upon their return were limited. This may be due to the fact that, in Belgium, Greece, Italy, Cyprus and Malta, prosecutions for practising female genital mutilation are rare and, therefore, migrants simply do not know what will happen to people who arrange for their daughters to be cut.

Somali migrants in Belgium and Cyprus, as well as Malian participants in France, suggested that the risk of being cut upon return to the country of origin could not be ruled out as it was common practice there. Many participants said that their own families/communities were still practising and described the social pressure and negative reputation that uncut women have in those

communities. For instance, various second-generation Guinean girls in Belgium described how older women enquired about whether they were cut when they visited their relatives in Guinea during the holidays. Some parents feared leaving their daughters alone with their relatives in rural Guinea and preferred to stay in Conakry. The participants said that many people told them to say that they had gone through the practice if enquiries were made. Although the girls clearly indicated that there was a risk, they did not seem to be afraid or discouraged from returning to the country of origin for a visit. Somalis in Greece also suggested that it was more common to have girls cut back in the country of origin than in the EU — although the law deterred many people as it was seen as too risky to have it done. The Sudanese and Egyptian participants in Greece suggested that people who wanted the practice performed on their daughters returned to the country of origin. Nigerians and Egyptians in Italy and Malta did not perceive there to be a particular risk upon return, because the performance of the practice was the decision of the parents only — the wider community would not get involved. However, if someone felt that it was important to perform the practice — either upon the husband's request or a doctor's recommendation — then it would be performed.

9.2. Comparing the findings with similar research in the EU

This section compares the main findings of the quantitative and qualitative research in the six Member States of this report — Belgium, Greece, France, Italy, Cyprus and Malta — to the results of EIGE's similar analysis in Ireland, Portugal and Sweden (EIGE, 2015) and other Member States where comparable research was conducted.

Table 9.4. Estimated number and proportion of girls at risk in Ireland, Portugal and Sweden (EIGE, 2015a) as compared to Belgium, Greece, France, Italy, Cyprus and Malta (present study) for the reference year 2011 and according to the original methodology (EIGE, 2015b)

	Total population of girls (aged 0–18) from FGM-practising countries	LOW-RISK SCENARIO: Number of girls at risk (%)	HIGH-RISK SCENARIO: Number of girls at risk (%)
Ireland (2011)	14 577	158 (1 %)	1 632 (11 %)
Portugal (2011)	5 835	269 (5 %)	1 365 (23 %)
Sweden (2011)	59 409	2 016 (3 %)	11 145 (19 %)
Belgium (2011)	14 815	1 100 (7 %)	3 400 (23 %)
Greece (2011)	1 896	161 (8 %)	817 (43 %)
France (2011)	41 552	1 936 (5 %)	5 875 (14 %)
Italy (2011)	59 720	2 953 (5 %)	11 675 (20 %)
Cyprus (2011)	758	29 (4 %)	102 (13 %)
Malta (2011)	486	47 (10 %)	183 (38 %)

Source: EIGE.

Ireland, Portugal and Sweden

The findings are directly comparable when using the **original methodology** (EIGE, 2015) for the reference year of 2011 to estimate the number of girls at risk of female genital mutilation in these nine countries. The results show similar levels of risk of female genital mutilation among migrant girls living in these countries. Challenges surrounding data collection were very similar in both studies, showing that improving data collection processes takes time.

Similarities can be found among the most represented countries of origin of girls at risk. Egypt, Eritrea, Guinea, Iraq, Nigeria, Senegal, Somalia and Sudan are countries that are represented at different levels across the data of the nine Member States.

Both studies found that people find it difficult to speak about female genital mutilation across gender and generations, because of the taboo. As in Ireland, Portugal and Sweden, awareness of the law, knowledge about health consequences and traditional requirements of female genital mutilation were expressed among communities in Belgium, Greece, France, Italy, Cyprus and Malta. However, it seemed that the degree of importance of these attitude-changing determinants varied, with fear of the law being more outspoken in the latter study. Furthermore, there are indications in the present study that most participants in Belgium, Greece, France, Italy, Cyprus and Malta took for granted that female genital mutilation was not a religious requirement.

The research in Ireland, Portugal and Sweden suggested, in line with previous research (Kaplan, 2013; O'Neill et al., 2017), that women are the main decision-makers regarding the performance of the practice. However, when men do get involved, their decision dominates over women's wishes. The current study collected several testimonies, on the one hand, where men requested their future brides to undergo female genital mutilation, and on the other hand, where young men rejected the practice and preferred their wives not to be cut. These are powerful messages, as research shows that social pressure about marriage and virginity affects the continuation or abandonment of the practice.

Germany

The German study (Integra, 2017) is indirectly comparable with the results of the present report as it provides two sets of data: one in line with EIGE's original methodology (EIGE, 2015b) and one adapted methodology where the researchers assumed that adding the median age of female genital mutilation to the calculation would underestimate the total numbers of girls at risk, and therefore the median age was excluded. This assumption was a result of the research findings were it was concluded that the age of female genital mutilation in the countries of origin is generally lower than the age of female genital mutilation in Germany. Both sets of estimations are presented in Table 9.5.

The findings in Germany show similar levels and numbers of girls at risk as compared to the research conducted by EIGE (2015a and present study). The German research applied a mixed-methods approach by combining quantitative research with the qualitative methodology of interviews within migrant communities. The latter is different from the focus group discussions in EIGE's studies (2015a and present study) but this does not hamper comparability, as several qualitative methods can be used to capture the impact of migration on female genital mutilation in the EU (EIGE, 2015b, p. 14). The German study interviewed a total of 52 women and the findings showed that there

Table 9.5. Estimated number and proportion of girls at risk in Germany (Integra, 2017) for the reference year 2015 and according to their adapted methodology and EIGE's original methodology (EIGE, 2015b)

	Total population of girls (aged 0–18) from FGM-practising countries	LOW-RISK SCENARIO: Number of girls at risk (%)	HIGH-RISK SCENARIO: Number of girls at risk (%)
Germany (2015) Adapted methodology	25 325	1 558 (6 %)	5 684 (22 %)
Germany (2015) EIGE's methodology	19 630	1 558 (8 %)	4 189 (21 %)

were very different attitudes and behaviours regarding general topics (e.g. education, childbearing) and the practice of female genital mutilation between women and girls who had been residing in Germany for less than 4 years and those who had been residing there for more than 4 years.

9.3. Concluding remarks

Collecting comparable data on the number of girls at risk of female genital mutilation is a challenging undertaking and results should be presented and interpreted with caution and sensitivity. By developing the methodology, presenting results from different Member States and offering guidance on how to conduct research on the risk of female genital mutilation, EIGE is helping Member States to research the phenomenon in their country. This will further complete the picture of the risk of female genital mutilation in the European Union and present evidence-based, comparable information for policymakers at EU and Member State level.

Estimating the risk of female genital mutilation is a dynamic process and the methodology to do so is evolving. Innovative research in the field, new patterns of migration and data collection systems, among others, all influence the way risk of female genital mutilation is most accurately estimated, according to the available resources. Consequently, EIGE has further developed its risk-estimation methodology to match this reality, without changing the core principles. The findings are presented in this section following the original and refined methodology. It is, however, recommended for future risk estimations of female genital mutilation in Member States to build upon the refined methodology as developed and presented in Chapter 2 of this report.

10. Recommendations for the European Union

10. Recommendations for the European Union

- ✓ **Ratify the Istanbul Convention.** As the European Union has signed the Council of Europe Convention on preventing and combating violence against women and domestic violence, its ratification will guarantee its full implementation in all of the EU Member States, including those which have not yet ratified the convention. It is recommended for the European Union to ratify the Istanbul Convention, as it is a legally binding instrument dedicated to combating violence against women, including female genital mutilation. The Istanbul Convention calls for a broad implementation of the extraterritoriality principle, the adoption of gender-sensitive asylum provisions and reception procedures and the collection of comparable and disaggregated data on female genital mutilation.
- ✓ **A gender-sensitive Common European Asylum System.** Standards for the equal treatment of asylum seekers across the EU are established through the CEAS. However, harmonising the way gender-based asylum claims are dealt with can be improved (European Parliament, 2012). It is recommended to further enhance gender equality in the European Union asylum process and to take gender-related aspects into account in any future CEAS legislation, as this will allow for cases of female genital mutilation to be handled carefully and appropriately. The adoption of EU-wide guidelines should further harmonise gender-sensitive asylum procedures across the EU. Such guidelines, including early warning systems, should include procedures to be followed by frontline officials at border agencies, reception centres and health services.
- ✓ **External action to prevent female genital mutilation.** The EU's external action addresses the prevention of female genital mutilation through strategic planning and targeted funding under several programmes. It is recommended for prevention actions to include the 30 countries where female genital mutilation has been documented, but also to consider affected communities in the Middle East and Asia. Returning to the country of origin is a serious indicator of risk of female genital mutilation for girls in the EU. It is therefore important to support actions that specifically target this risk, both in the country of origin and the country of destination. When carrying out awareness-raising campaigns in FGM-practising countries, there is a strong need to change attitudes in rural areas, as highlighted by the focus group discussions in this report. It is recommended to set up cooperation with different actors involved: the United Nations, EU bodies, civil society organisations and local community actors (schools and community and religious leaders). The messages conveyed must be adapted to suit their target groups, focusing on health consequences and the normalisation of not being circumcised.
- ✓ **Incentives through EU integration strategies.** The findings from the focus group discussions in this report reveal the positive impact of successful integration on the abandonment of female genital mutilation. Host country societies and values are affecting the sense of identity of migrant communities, an important factor in preventing the risk of female genital mutilation. It is recommended for EU strategies that focus on the integration of third-country nationals to take into account this dimension and to explicitly provide for incentives to tackle the risk of female genital mutilation through integration policies.

11. Recommendations for Member States

11. Recommendations for Member States

11.1. Protect girls at risk and prosecute those responsible for their crimes

- ✓ **Make the law specific and complete.** All Member States have criminalised female genital mutilation and the more specific the legislation is, the better victims are protected. For example, general provisions on forms of bodily harm can make it unclear whether all types of female genital mutilation are covered by the law. It is therefore recommended to adopt a specific and detailed legal provision on female genital mutilation. Member States are recommended to apply the provision as outlined in the Victims' Rights Directive in order to protect (potential) victims of female genital mutilation to the largest extent possible. Furthermore, the inclusion of specific provisions on female genital mutilation in national legislation on professional secrecy and child protection will allow for a legal framework on reporting, early identification and protection.
- ✓ **Apply gender-sensitive asylum provisions.** Member States have adopted asylum law that either specifically mentions female genital mutilation or relies upon more general asylum law to incorporate female genital mutilation, often included as a vulnerability. Generally, acknowledging gender-based persecution improves the experience for the applicant as it prompts additional measures and strengthens asylum claims. The transposition of the CEAS has not automatically meant that harmonised gender-sensitive asylum systems have been put in place. It is recommended for Member States to make sure asylum applications on the grounds of female genital mutilation are introduced accordingly. This includes protecting victims at entry points and in the reception system, gender-sensitive risk assessment upon arrival (including medical examination), and onward specialised referral and care. To support Member States in meeting their requirements under the CEAS in this regard, the European Asylum Support Office has developed an online 'Tool for the identification of persons with special needs' (EASO, 2016). Furthermore, Member States are called to respond to migratory flows and ensure gender-sensitive asylum provisions are maintained if fast-track border procedures for arrivals are put in place.
- ✓ **Prosecute crimes committed abroad.** The principle of extraterritoriality makes female genital mutilation punishable even if committed outside the country. It is recommended that Belgium, which has not yet adopted it, add this principle to its legislation in order to prohibit submitting a girl to the practice in another country, regardless of whether it is legal or illegal in that country. Furthermore, the Istanbul Convention calls for the application of the extraterritoriality principle to citizens, residents and non-residents (Council of Europe, 2011: Article 441.e) and it is recommended for all Member States to implement the principle as broadly as possible to protect girls at risk.
- ✓ **Close the gap between laws and prosecution.** Prosecution of cases of female genital mutilation is relatively low compared to the estimated numbers of women and girls who have undergone the practice or who are at risk in the European Union. Legislation on female genital mutilation is considered to be ineffective unless it leads to prosecution and repercussions for the perpetrators. Law enforcement is important, as a strong legal framework was identified as a major discouraging factor in the focus group discussions of this study. Female genital mutilation is extremely underreported due to several factors, including the taboo surrounding it, the attached cultural value in some affected communities, and the fact that victims are mostly underage girls who may not be aware of their rights, while perpetrators are often close family or community members. Member States are encouraged to strengthen the prosecution of cases of female genital mutilation and monitor them systematically through the police and justice sectors. It is recommended to raise awareness about disclosure among FGM-practising communities, to train actors involved in law enforcement and sensitise them about the phenomenon of female genital mutilation and to put in place reporting mechanisms that are safe, confidential, accessible, and include shelter for those fearing repercussions. Following the example of 'female genital mutilation protection orders (FGMPOs)' in the United Kingdom, Member States are encouraged to offer legal means to protect and safeguard victims and potential victims.
- ✓ **Monitor the impact of legislation and policy.** Evaluation of the implementation of legislation will provide information

about the effectiveness of the institutional response and allow for trends to be identified. It is recommended for Member States to collect and publish:

- the number of court cases related to female genital mutilation;
- the number of prosecutions and their outcome;
- the number of women and girls recognised as refugees on the grounds of female genital mutilation.

11.2. Set up policies and services that support victims and those at risk

✓ **Adopt a national prevention strategy.** Female genital mutilation is best addressed in a comprehensive and multidisciplinary way. A national strategy or action plan can establish official mechanisms for coordination and effective multi-year planning to prevent female genital mutilation. It is recommended that Member States adopt a national action plan on combating female genital mutilation or include the topic extensively in a broader plan on gender-based violence. All relevant stakeholders should be involved in this process to address female genital mutilation in a multidisciplinary way: relevant health, education and migration institutions, civil society organisations, migrant representatives and professionals from a range of sectors. Adequate human and financial resources should be allocated and evaluation provided for. Currently, policies to address female genital mutilation appear to occur predominantly in the health and education sectors, but it is also important to take action within other relevant sectors, such as the asylum, police and justice sectors, and to involve women and men from affected communities.

✓ **Create and implement policies with communities.** Involving FGM-affected communities and civil society organisations is critical to designing and shaping effective policies to match the needs of the primary beneficiaries, as well as to highlighting possible shortcomings in existing interventions. Moreover, affected communities and civil society organisations should work together throughout the implementation of such policies, to ensure better outreach. FGM-affected communities can be actors, not only beneficiaries of the change. When reaching out to the communities involved it is important to acknowledge the heterogeneity within these communities and to adopt targeted strategies to widen the approach.

✓ **Provide multidisciplinary support services.** Member States are called upon to establish minimum standards on the rights, support and protection of victims of crimes, even when committed abroad, and to instigate criminal proceedings in the EU as outlined in the Victims' Rights Directive. Services should be made available to women and girls who have undergone female genital mutilation, as well as women and girls at risk and their families. The uptake of available services for female genital mutilation victims is limited and barriers exist for the target groups in terms of language and the specificity of the service provided. Member States are encouraged to increase access to multidisciplinary services — including general practitioners, gynaecologists, midwives, sexologists, psychologists, cultural mediators and interpreters — offering care and assistance. These services should be promoted through awareness-raising campaigns for both professionals and beneficiaries, including through asylum reception centres. An adequate referral system is needed for women and girls to get the care they need.

✓ **Support specialised organisations and projects.** In several Member States, specific civil society organisations and specialised projects are key to combating female genital mutilation. It is recommended for Member States to support civil society and allocate sufficient funding to cover their important work and actions. Furthermore, successful projects should not end at the pilot stage but instead continue or be incorporated into existing practices. Innovative initiatives should be encouraged and supported through open calls for funding.

11.3. Prevent and raise awareness among general and targeted audiences

✓ **Define female genital mutilation as a form of gender-based violence.** In line with the Istanbul Convention, Member States are encouraged to define female genital mutilation as a severe form of gender-based violence, rooted in women's unequal status in society, directly affecting girls' and women's health. It appears that affected communities, even when they are against the practice, do not automatically challenge the reasons for the practice, but focus on its negative health consequences. Although focusing on the health impacts does affect change, it does not tackle the root causes of violence. By defining it as a form of gender-based violence, it can be tackled as such and enable the abandonment of female genital mutilation in the long term.

✓ **Make the law heard.** The results of the focus group discussions in this report identified awareness of the law as an important deterrent factor for practising female genital mutilation. On the other hand, not all aspects of the legal framework (for example, the possibility of being prosecuted for a crime committed abroad or the fact that all types of female genital mutilation are illegal) or the laws in place in the country of origin, are known among communities. Member States are encouraged to raise awareness about the criminalisation of female genital mutilation through the set-up of targeted and ongoing campaigns and the production and dissemination of informative tools accessible in different languages, both offline and online. Trained professionals across the health, asylum, education and justice sectors have an equally important role in informing about the legal framework in place.

✓ **Strengthen professionals' capacities.** Knowledge on gender-based violence in general and female genital mutilation can be improved among all staff working with girls at risk and with those who underwent the practice. For example professionals in education, health, social and asylum services. Member States are encouraged to coordinate specialised training (provided by institutions or recognised services) in a systematic and sustainable way, ensuring they reach the relevant audience. Training should include technical and legal knowledge about female genital mutilation and ensure gender-sensitivity and multicultural understanding. Moreover, specialised knowledge can already be obtained during qualification, when included in the curricula of different professions, for example gynaecology and midwifery. It

is recommended for Member States to adopt guidelines for the relevant professionals on the early identification of victims of female genital mutilation and other harmful practices. Such guidelines would help professionals to identify early warning signs and to foster a consistent approach to safeguarding, reporting and referring.

- ✓ **Prevent through education.** The educational system can raise awareness and promote knowledge on female genital mutilation among children and their families. It is important for these initiatives to be respectful and avoid stigmatisation. Teachers and medical school staff can be involved in prevention, both on an educational and safeguarding level. For this, it is important that educational staff receive appropriate training and initiatives, such as workshops with specialised organisations or change agents from affected communities.
- ✓ **Raise awareness about the negative health consequences.** The focus group discussions in this study identified negative health implications as another factor that effectively discourages female genital mutilation. It is recommended to highlight the multiple physical and psychological negative health consequences of female genital mutilation in prevention messages. It is effective to build awareness-raising campaigns and information materials on female genital mutilation around health implications, targeted at women and men.
- ✓ **Tackle misbeliefs about religious requirements.** Female genital mutilation is not rooted in religion, but in cultural and traditional beliefs, as confirmed in the focus group discussions for this study. Tackling the misbelief that female genital mutilation is a religious requirement is a strong deterrent factor among communities involved. It is recommended to further build effective awareness-raising around this reality.
- ✓ **Create safe spaces for open discussions.** Talking openly and in a group about female genital mutilation is not common within affected communities. For example, it was difficult to recruit participants for the focus group discussions because of a reluctance to discuss the topic, which is still seen as a taboo. It is important to create an enabling context to raise awareness about and discuss female genital mutilation with and among communities involved. It is recommended to introduce the topic by addressing broader subjects around health and/or gender-related matters to create trust and assure confidentiality. Furthermore, it is important to take into account cultural differences and engage mediators and translators.
- ✓ **Build bridges with the country of origin.** Communities living in the EU often maintain strong ties with their country of origin. To decrease the risk of female genital mutilation when returning, it is important to educate and raise awareness in both the Member States and FGM-practising countries. The aim is to reduce potential tension and social pressure. This can be achieved by increasing the level and variety of communication between affected migrant communities and countries of origin, facilitated by the work of international institutions, civil society organisations and online communication tools. Communication streams should be strategically tailored to meet the needs and views of different communities and generations. Specific attention should be paid to rural areas, where female genital mutilation appears to be more common and more severe.
- ✓ **Engage men for change.** Increasing men's knowledge of female genital mutilation is important as they can often have an authoritative role within communities. The focus group discussions in this study found that men appear to be changing their views on the practice more slowly than women. It is recommended that awareness-raising initiatives targeting men focus on the health consequences and stigma surrounding the practice. Furthermore, Member States should invest in creating more dialogue about the practice among men and between men and their partners and family. The idea that female genital mutilation is a private matter must be challenged, through campaigns targeting men or by creating spaces for men to be educated on female genital mutilation, such as discussion groups set up by civil society organisations. Member States are encouraged to engage ambassadors from migrant communities to join the White Ribbon Campaign and speak out against female genital mutilation.
- ✓ **Engage community leaders.** It is recommended to engage community and religious leaders as well as members of, and activists from, migrant communities to prevent and raise awareness about female genital mutilation. Involvement of these agents for change can effectively garner attention in the public sphere and give credibility to campaigns and messages against the practice.
- ✓ **Use the right communication channels.** Nowadays, information and messages are disseminated through online media platforms and social media. It is recommended that campaigning take place both online and offline. Information should be powerful and wide-reaching, understandable and easily accessible. Using different online platforms to raise awareness about the practice, its consequences, available services and referral mechanisms for victims and girls at risk is effective. Information should be made available in different languages. Messages by health professionals and information on the negative aspects of female genital mutilation broadcast by African television channels are often more readily received by affected communities. The good practice of the series *C'est la vie* (That's life) in Senegal and French-speaking west Africa should serve as inspiration.

11.4. Improve data collection and increase knowledge

- ✓ **Undertake regular risk estimations.** Member States are encouraged to adopt EIGE's refined mixed-method approach to estimate the risk of female genital mutilation in their country as outlined in this report. This will allow for in-depth information on the number of girls at risk in the country and for data to be compared among Member States. Both national and EU policy would greatly benefit from this harmonised approach and it would facilitate evidence-based policymaking on a large scale.
- ✓ **Improve the availability of quantitative data.** To estimate the number of girls at risk of female genital mutilation in a certain Member State, a set of underlying data is necessary. This includes data on resident migrants, but also on asylum seekers and irregular/undocumented migrants. Member States are

encouraged to harmonise terminology on migrants in line with Eurostat and this report, and to collect data disaggregated by sex, country and region of birth, generation (first or second, based on country of birth), mother's and father's country of birth, 1-year age intervals, age upon arrival and years since migration. The following indicators are proposed to collect data on the female migrant population:

- the number of female resident migrants (aged 0–18) from FGM-practising countries;
- the number of female asylum seekers from FGM-practising countries;
- female live births to mothers from FGM-practising countries.

Information broken down by region of origin is currently not available, however this would be very valuable, as the risk and prevalence of female genital mutilation can be extremely variable within an FGM-practising country depending on the region of origin. Furthermore, it is recommended for Member States to collect data on irregular/undocumented migrants and to add this information to the calculations. In addition, health and other services (e.g. child protection services) should ideally collect information about girls and women who have undergone female genital mutilation, namely their age and the age at which the practice was performed.

✓ **Consider less well-known populations.** There is evidence that female genital mutilation takes place in countries other than those recognised by the World Health Organisation (EIGE, 2015a). It is important to conduct research and consider the needs of less well-known populations affected by female genital mutilation, as they are less recognised by social, legal and health services. In order to offer support to all women affected by female genital mutilation, more research is needed on the situations of women and girls from the Middle East and Asia.

11.5. Strengthen cooperation and partnerships

✓ **Allow for cross-border cooperation.** Women and girls at risk of female genital mutilation and their families may use unmonitored borders to travel through transit countries within the EU as a means of going to the country of origin to engage in female genital mutilation. Greater data-sharing between Member States in the context of female genital mutilation can contribute to the development of a framework to better identify and prevent female genital mutilation. Collaboration with FGM-practising countries of origin is equally recommended to introduce monitoring around departures and arrivals, and re-entries to and from FGM-practising countries, by families with young girls. Cooperation at airports and border controls can support the prevention of female genital mutilation among families returning to the countries of origin. These preventive actions can take the form of awareness-raising about the extraterritoriality of the law upon departure and the signing of documents by parents to state they will not have their daughters cut while visiting the country of origin. Appropriate and sensitive training of border control staff is recommended to protect the privacy of people involved and to avoid stigmatisation and discriminatory profiling.

✓ **Share best practices.** The findings in this report show that many professionals in different sectors (asylum offices, reception centres, hospitals, civil society organisations, migrant organisations) come across the problem of female genital mutilation. There is a need for experience-sharing and networking in order to cooperate and better respond to the needs of women and girls who either underwent female genital mutilation or who are at risk. It is recommended to develop and sustain platforms for professionals and experts dealing with gender-based violence and female genital mutilation to set up effective cooperation and referral.

12. Conclusion

12. Conclusion

Female genital mutilation is a harmful practice deeply affecting the lives of women and girls living in the European Union today. The findings in this report show that a significant number of girls are at risk of female genital mutilation. There are up to 6 122 girls at risk in Belgium, 748 in Greece, 44 106 in France, 18 339 in Italy, 132 in Cyprus and 279 in Malta. These results complement EIGE's previous risk estimations of female genital mutilation in Ireland, Portugal and Sweden. Data and information on how and why female genital mutilation affects girls and women in the European Union are essential in providing policymakers with the evidence they need to design effective prevention measures.

In recent years, the legal framework against female genital mutilation in the EU Member States has been strengthened. This is partly due to the introduction of the Istanbul Convention, which recognises female genital mutilation as a form of violence against women in the European Union. EU Member States have adopted prevention and protection policies to various extents. The majority focus mainly on health and awareness-raising activities, but others have implemented extensive actions.

The results of this study show that strong laws and anti-FGM campaigns are powerful deterrent factors when it comes to female genital mutilation. However, laws will remain ineffective if not enforced. Law enforcement is essential so that those responsible for the crime, committed either in the EU or abroad, can be prosecuted. The risk of young girls being cut while visiting their parents' country of origin appears to be high due to social pressure and expectations for marriage from family members and communities abroad.

Push factors for performing female genital mutilation include traditional views on women's sexuality, purity and aesthetics. The results also revealed that more than a religious requirement, female genital mutilation is rooted in traditions and cultural beliefs. Discouraging factors include laws and campaigns, awareness about negative health consequences and the reality of being stigmatised. These reasons are helping to change attitudes towards female genital mutilation in the EU, especially among young women from second and third generations, who feel less tied to the practice and have stronger opinions against it.

The involvement of FGM-practising communities is essential to ensure the success of efforts to end the practice. The idea that female genital mutilation is a private matter leads to a reluctance to discuss it, which hampers prevention. A grass-roots approach, recognising the differences between communities and the sensitive nature of the topic, will enable changes through engagement, education and awareness.

In the EU today, women from FGM-practising countries are continuing to seek asylum. In Belgium, Greece, France, Malta and Italy, the total number of asylum-seeking girls in 2016 reached 4 275, with levels of risk between 5 % in Greece and 46 % in Malta. It is important that professionals (for example, immigration officers, health practitioners and teachers) who are in contact with female asylum seekers from these countries are properly trained to notice and assess the potential risk of female genital mutilation. The recent changes to the CEAS place greater emphasis on gender-sensitive asylum procedures, so that women and girls making asylum claims on the grounds of female genital mutilation feel safe. The degree to which these provisions are implemented in practice differs among Member States and depends on the resources available to deal with the pressure of ongoing migratory flows.

The population of female migrants originating from FGM-practising countries is expanding, due to a growing number of second-generation girls born in several of the EU countries included in this study. Although the percentages of risk of female genital mutilation are decreasing, the absolute number of girls at risk is on the rise.

When it comes to female genital mutilation, the principle of due diligence, as articulated in the Istanbul Convention, is critical to further prevent, investigate, punish and provide reparation for acts of violence.

EIGE's approach combining quantitative and qualitative research to estimate the risk of female genital mutilation offers new and comparable data, as well as in-depth information on the realities of the practice in the European Union. With this report, EIGE contributes to reaching the European Commission's priority goal to eliminate female genital mutilation. This knowledge will help inform policy interventions to reach out to all girls at risk across the EU. Member States are encouraged to conduct similar research to increase the total number of available datasets on girls at risk of female genital mutilation in order to better target girls' and women's needs and protect their health and well-being.

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Annexes

Annexes

Annex 1: Glossary

Female genital mutilation

Female genital mutilation comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. The World Health Organisation has developed a classification to distinguish between four types of female genital mutilation:

- **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.

This study distinguishes between types of female genital mutilation only when it is necessary to reflect important differences between the traditions and customs of certain communities. In general, the types are grouped together under the umbrella term 'female genital mutilation'.

Terms commonly used to describe female genital mutilation or its types

- Bolokoli: Malian (Mende) expression for FGM.
- Clitoridectomy: normally refers to FGM type I.
- Excision: normally refers to FGM type II.
- Halalese: Somali expression for FGM, emphasising the purifying aspect.
- Hitan: Egyptian expression for FGM, mostly types I, II and IV.
- Infibulation: normally refers to FGM type III.
- Pharaonic circumcision: expression for FGM type III.
- Suningol: Fulani expression for FGM, meaning 'doing the sunna'.
- Sunna: refers to FGM type I or II.

Asylum seeker (or asylum applicant)

According to Eurostat, an asylum seeker is an asylum applicant awaiting a decision on an application for international protection, granting or refusing a refugee status or another form of international protection. An asylum applicant refers to a person having submitted an application for international protection or having been included in such application as a family member during the reference period. 'Application for international protection' means an application for international protection, as defined in Article 2(h) of Directive 2011/95/EU, i.e. a request by a third-country national or a stateless person for protection from a Member State, who can be understood to seek refugee status or subsidiary protection status, and who does not explicitly request another kind of protection, outside the scope of the directive, which can be applied for separately.

Country of birth

According to Regulation (EC) No 862/2007, 'country of birth' means the country of residence (in its current borders, if the information is available) of the mother at the time of the birth or, if not available, the country (in its current borders, if the information is available) in which the birth took place.

Country of destination

This is the EU Member State where a person originating from a country where female genital mutilation is commonly practised decides to establish her or his residence, or where she or he has asked for international protection.

Country of origin

Unless otherwise stated, this covers an individual's country of birth or the country of birth of their parents. In this study, the countries of origin of the migrant population are FGM-practising countries (see definition below).

Emigrants

Emigrants (outflows) are people leaving the country where they usually reside and effectively taking up residence in another country. An

individual is a long-term emigrant if that person leaves their country of previous usual residence for a period of 12 months or more (1998 United Nations recommendations on the statistics of international migration (Revision 1), Eurostat).

FGM-affected communities

Refers to migrant communities who originate from an FGM-practising country.

Female genital mutilation risk estimation in an EU Member State

The number of girls (either born in an FGM-practising country or whose mothers were born in an FGM-practising country) living in a Member State who might be at risk of female genital mutilation, expressed as a proportion of the total number of girls living in an EU Member State who originate from, or are born to a mother from, FGM-practising countries ([61]).

FGM-practising countries

Refers to 30 countries where female genital mutilation has been documented through national surveys: Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Côte d'Ivoire, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Ghana, Guinea-Bissau, Guinea, Indonesia, Iraq, Kenya, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Somalia, Sudan, Togo, Uganda, Tanzania, Yemen.

FGM prevalence in an EU Member State

The proportion of girls and women who have undergone a form of female genital mutilation out of all girls and women who are currently residing in a Member State and who either originate from, or have mothers who originate from, countries where FGM is commonly practised.

FGM-related asylum applications

The number of applications made for international protection (and/or subsidiary protection) which have been officially classified as relating to female genital mutilation in a given year. Note that national governments may use different classification systems and it is not normally possible to distinguish between an asylum application that relates to a female asylum seeker's protection against the risk of female genital mutilation and one that relates to a female asylum seeker's protection due to having already experienced female genital mutilation.

First-generation migrant

First-generation migrants cover those who were born in an FGM-practising country to one or more parents who were also born in these countries, and who have established usual residence in an EU Member State.

Foreign-born

According to Eurostat, 'foreign-born' persons are those born outside of their current usual residence, regardless of their citizenship (Eurostat).

Immigrants

Immigrants (inflows) are people arriving or returning from abroad to take up residence in a country for 12 months or more, having previously been resident elsewhere (1998 United Nations recommendations on the statistics of international migration (Revision 1), Eurostat).

Irregular migrants

This refers to someone who does not fulfil, or no longer fulfils, the legal conditions for stay or residence in a country. In practice, national authorities are not normally able to track all individuals who are in this situation.

Live births

Live births are the births of children who are breathing or showing evidence of life, i.e. beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles, regardless of gestational age (Eurostat).

Migrant population

In this study, the migrant population covers both those who were born in an FGM-practising country to one or more parents who were also born in that country and who have established usual residence in an EU Member State (first generation); and those who were not born in an FGM-practising country, but who have at least one parent who was born in an FGM-practising country, and who are usually resident in an EU Member State (second generation).

Refugee

A refugee is considered a third-country national who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, political opinion or membership of a particular social group, is outside the country of nationality and is unable or, owing to this fear, unwilling to avail herself or himself of the protection of that country; or a stateless person, who, being outside of the country of former habitual residence for the same reasons as mentioned above, is unable or, owing to this fear, unwilling to return to it, and to whom Article 12 of Council Directive 2004/83/EC does not apply (Council Directive 2004/83/EC).

Second-generation migrant

In this study, a second-generation migrant means a person who was not born in an FGM-practising country, but who has at least one parent who was born in an FGM-practising country, and who is usually resident in an EU Member State.

Usual residence

According to Regulation (EU) No 1260/2013, 'usual residence' means the place where a person normally spends the daily period of rest, regardless of temporary absences for purposes of recreation, holidays, visits to friends and relatives, business, medical treatment or religious pilgrimage. The following persons alone shall be considered to be usual residents of a specific geographical area: (i) those who have lived in their place of usual residence for a continuous period of at least 12 months before the reference time; or (ii) those who arrived in their place of usual residence during the 12 months before the reference time with the intention of staying there for at least 1 year. Where the circumstances described in point (i) or (ii) cannot be established, 'usual

([61]) EIGE (2015), *Estimation of girls at risk of female genital mutilation in the European Union — Step-by-Step Guide*, p. 28. The definitions of 'prevalence' and 'risk' have been slightly shortened but express the same elements.

residence' can be taken to mean the place of legal or registered residence, except for the purposes of Article 4.

Usually resident population

According to Regulation (EU) No 1260/2013, the 'usually resident population' covers all persons having their usual residence in a Member State at the reference time.

Year of arrival

The year of arrival is the calendar year in which a person most recently established usual residence in the country. The year of the most recent arrival in the country shall be reported rather than the year of first arrival ([62]).

([62]) See http://eur-lex.europa.eu/legal-content/EN/TXT/%20HTML/?uri=CELEX:32009R1201&qid=1430139096139&from=EN%0D

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Annex 3: Prevalence rate and median age of FGM in countries of origin

Country	Year of most recent report		Age range of FGM prevalence rate		Prevalence rate by region (%)		Median age of FGM
	Survey	Year	Girls and women aged 15–19 (%)	Girls and women aged 15–49 (%)	Lowest	Highest	
Benin	MICS	2014	2.4	9.2	0.2	37.6	9
Burkina Faso	DHS	2010	57.7	76	55	90	4
Cameroon	DHS	2004	0.4	1	0	5	9
Central African Republic	MICS	2010	17.9	24	3	77	14
Chad	MICS	2014–15	31.8	38.4	0.7	96.1	9
Côte d'Ivoire	DHS	2011–12	31.3	38	12	80	4
Djibouti	MICS	2006	89.5	93	93	95	9
Egypt	DHS	2015	69.6	87.2	74.5	92.1	10
Eritrea	DHS	2010	68.8	83	71.2	95.9	0 (**)
Ethiopia	DHS	2016	47.1	65.2	24.2	98.5	4
Gambia	DHS	2013	76.3	74.9	47.4	96.7	4
Ghana	MICS	2011	1.5	4	0	41	9
Guinea	DHS	2012	94	97	89	100	9
Guinea-Bissau	MICS	2014	41.9	44.9	4.5	96.3	9
Indonesia	DHS	2012	49 (*)	n/a	n/a	n/a	0 (**)
Iraq	DHS	2011	4.9	8	0	58	9
Kenya	DHS	2014	11.4	21	0.8	97.5	14
Liberia	DHS	2013	31.1	49.8	5.4	73	14
Mali	DHS	2012–13	90.3	91	88	95	4
Mauritania	MICS	2011	65.9	69	20	99	4
Niger	DHS	2012	1.4	2	0	9	4
Nigeria	DHS	2013	15.3	25	3	49	4
Senegal	DHS	2015	22.2	24.2	6.9	76.9	4
Sierra Leone	MICS	2013	74.3	89.6	83.4	97.1	14
Somalia	MICS	2006	96.7	98	94	99	9
Sudan	MICS	2014	81.7	86.6	45.4	97.7	9
Togo	DHS	2013–14	1.8	4.7	0.4	17.4	9
Uganda	DHS	2011	1	1	0	5	7
Tanzania	DHS	2015–16	4.7	10	0	57.7	8
Yemen	DHS	2013	16.4	19	0	85	0 (**)

(*) Population aged 0–11
(**) Cutting occurs within the first months or weeks of life

Annex 4: Data tables on the female migrant population at risk

Belgium, 2016: female migrant population from FGM-practising countries (aged 0–18)

Country of origin	Total number of girls in Belgium from this country of origin	No of girls under the median age of cutting / No of girls that have reached the median age plus std. deviation						National prevalence rate for the 15–19 age group	No of girls at risk			
		First generation		Second generation		Total			Min.		Max.	
		O.M.	R.M.	O.M.	R.M.	O.M.	R.M.		O.M.	R.M.	O.M.	R.M.
Benin	216	8	21	141	170	149	191	2.4	0	3	4	5
Burkina Faso	242	1	17	74	144	75	161	57.7	1	52	43	93
Cameroon	3 210	101	243	2 079	2 462	2 180	2 705	0.4	0	6	9	11
Central African Republic	56	8	8	34	38	42	46	17.9	2	4	8	8
Chad	115	4	7	68	90	72	97	31.8	1	16	23	31
Côte d'Ivoire	865	1	43	275	599	276	642	31.3	0	107	86	201
Djibouti	242	17	28	130	150	147	178	89.5	15	92	132	159
Egypt	591	55	71	367	446	422	517	69.6	38	204	294	360
Eritrea	161	0	28	0	76	0	104	68.8	0	45	0	72
Ethiopia	334	6	18	114	254	120	272	47.1	3	68	57	128
Gambia	136	1	4	38	83	39	87	76.3	1	35	30	66
Ghana	2 293	69	50	1 346	1 230	1 415	1 280	1.5	1	10	21	19
Guinea	3 836	400	674	2 284	2 618	2 684	3 292	94	376	1 864	2 523	3 094
Guinea-Bissau	23	3	4	13	16	16	20	41.9	1	5	7	8
Indonesia	294	0	4	0	84	0	88	49	0	23	0	43
Iraq	2 525	448	692	1 153	1 291	1 601	1 983	4.9	22	66	78	97
Kenya	256	14	24	189	207	203	231	11.4	2	15	23	26
Liberia	174	9	11	123	127	132	138	31.1	3	23	41	43
Mali	189	2	6	61	109	63	115	90.3	2	54	57	104
Mauritania	288	4	11	64	109	68	120	65.9	3	43	45	79
Niger	642	2	10	153	329	155	339	1.4	0	2	2	5
Nigeria	1 873	1	12	581	1 060	582	1 072	15.3	0	83	89	164
Senegal	883	11	32	267	495	278	527	22.2	2	62	62	117
Sierra Leone	373	12	39	280	319	292	358	74.3	9	148	217	266
Somalia	1 189	111	165	555	617	666	782	96.7	107	458	644	756
Sudan	222	9	16	122	158	131	174	81.7	7	78	107	142
Togo	964	35	101	577	788	612	889	1.8	1	9	11	16
Uganda	164	9	11	80	91	89	102	1	0	0	1	1
Tanzania	141	5	15	79	106	84	121	4.7	0	3	4	6
Yemen	47	0	0	0	13	0	13	16.4	0	1	0	2
TOTAL	22 544	1 346	2 365	11 247	14 279	12 593	16 644		597	3 579	4 618	6 122

O.M. — Original methodology (according to EIGE, 2015b); R.M. — Refined Methodology (according to the present study).

Belgium, 2011: female migrant population from FGM-practising countries (aged 0–18)

Country of origin	Total number of girls in Belgium from this country of origin	No of girls under the median age of cutting / No of girls that have reached the median age plus std. deviation						National prevalence rate for the 15–19 age group	No of girls at risk			
		First generation		Second generation		Total			Min.		Max.	
		O.M.	R.M.	O.M.	R.M.	O.M.	R.M.		O.M.	R.M.	O.M.	R.M.
Benin	136	34	40	78	86	112	126	2.4	1	2	3	3
Burkina Faso	144	16	24	56	88	72	112	57.7	9	39	42	65
Cameroon	2 242	570	716	1 131	1 263	1 701	1 979	0.4	2	6	7	8
Central African Republic	40	10	10	30	30	40	40	17.9	2	5	7	7
Chad	86	12	17	47	62	59	79	31.8	4	15	19	25
Côte d'Ivoire	613	88	176	199	341	287	517	31.3	28	108	90	162
Djibouti	142	35	40	73	74	108	114	89.5	31	69	97	102
Egypt	385	83	103	246	274	329	377	69.6	58	167	229	262
Eritrea	41	0	8	0	11	0	19	68.8	0	10	0	13
Ethiopia	239	28	46	84	141	112	187	47.1	13	55	53	88
Gambia	80	4	7	37	60	41	67	76.3	3	28	31	51
Ghana	1 534	206	191	970	902	1 176	1 093	1.5	3	10	18	16
Guinea	2 364	702	841	1 125	1 208	1 827	2 049	94	660	1 359	1 717	1 926
Guinea-Bissau	16	1	3	8	9	9	12	41.9	0	3	4	5
Indonesia	196	0	12	0	79	0	91	49	0	25	0	45
Iraq	1 276	394	494	498	557	892	1 051	4.9	19	38	44	51
Kenya	195	45	60	123	123	168	183	11.4	5	14	20	21
Liberia	176	60	65	103	103	163	168	31.1	19	36	51	52
Mali	122	8	12	46	71	54	83	90.3	7	43	49	75
Mauritania	250	36	51	59	84	95	135	65.9	24	62	63	89
Niger	556	68	105	167	250	235	355	1.4	1	3	3	5
Nigeria	1 389	132	230	429	774	561	1 004	15.3	20	94	86	154
Senegal	542	28	64	206	329	234	393	22.2	6	51	52	87
Sierra Leone	309	80	102	201	201	281	303	74.3	59	151	209	225
Somalia	575	86	103	303	351	389	454	96.7	83	270	376	439
Sudan	176	48	56	94	102	142	158	81.7	39	88	116	129
Togo	797	185	280	406	478	591	758	1.8	3	9	11	14
Uganda	68	12	13	29	32	41	45	1	0	0	0	0
Tanzania	91	18	31	41	60	59	91	4.7	1	2	3	4
Yemen	35	0	3	0	6	0	9	16.4	0	0	0	1
TOTAL	14 815	2 989	3 903	6 789	8 149	9 778	12 052		1 100	2 762	3 400	4 124

O.M. — Original methodology (according to EIGE, 2015b); R.M. — Refined Methodology (according to the present study).

Greece, 2016: female migrant population from FGM-practising countries (aged 0–18)

Country of origin	Total number of girls in Greece from this country of origin	No of girls under the median age of cutting / No of girls that have reached the median age plus std. deviation						National prevalence rate for the 15–19 age group	No of girls at risk			
		First generation		Second generation		Total			Min.		Max.	
		O.M.	R.M.	O.M.	R.M.	O.M.	R.M.		O.M.	R.M.	O.M.	R.M.
Benin	1	0	1	0	0	0	1	2.4	0	0	0	0
Burkina Faso	0	0	0	0	0	0	0	57.7	0	0	0	0
Cameroon	5	2	3	0	0	2	3	0.4	0	0	0	0
Central African Republic	0	0	0	0	0	0	0	17.9	0	0	0	0
Chad	0	0	0	0	0	0	0	31.8	0	0	0	0
Côte d'Ivoire	1	0	1	0	0	0	1	31.3	0	0	0	0
Djibouti	0	0	0	0	0	0	0	89.5	0	0	0	0
Egypt	1 266	113	181	506	812	619	993	69.6	78	409	431	691
Eritrea	4	0	1	0	0	0	1	68.8	0	1	0	1
Ethiopia	64	6	28	3	16	9	44	47.1	3	17	4	21
Gambia	1	0	0	0	0	0	0	76.3	0	0	0	0
Ghana	62	4	4	24	19	28	23	1.5	0	0	0	0
Guinea	4	1	2	0	1	1	3	94	1	2	1	3
Guinea-Bissau	0	0	0	0	0	0	0	41.9	0	0	0	0
Indonesia	16	0	2	0	0	0	2	49	0	1	0	1
Iraq	92	36	53	0	0	36	53	4.9	2	3	2	3
Kenya	37	28	33	0	0	28	33	11.4	4	4	4	4
Liberia	0	0	0	0	0	0	0	31.1	0	0	0	0
Mali	0	0	0	0	0	0	0	90.3	0	0	0	0
Mauritania	0	0	0	0	0	0	0	65.9	0	0	0	0
Niger	0	0	0	0	0	0	0	1.4	0	0	0	0
Nigeria	188	12	38	8	28	20	66	15.3	2	8	3	10
Senegal	2	0	1	0	0	0	1	22.2	0	0	0	0
Sierra Leone	9	1	2	5	7	7	9	74.3	1	4	5	7
Somalia	0	0	0	0	0	0	0	96.7	0	0	0	0
Sudan	16	2	3	3	5	5	8	81.7	1	4	4	7
Togo	0	0	0	0	0	0	0	1.8	0	0	0	0
Uganda	6	2	2	0	0	2	2	1	0	0	0	0
Tanzania	11	2	4	2	4	3	9	4.7	0	0	0	0
Yemen	2	0	0	0	0	0	0	16.4	0	0	0	0
TOTAL	1 787	206	359	552	893	759	1 252		92	453	454	748

O.M. — Original methodology (according to EIGE, 2015b); R.M. — Refined Methodology (according to the present study).

Greece, 2011: female migrant population from FGM-practising countries (aged 0–18)

Country of origin	Total number of girls in Greece from this country of origin	No of girls under the median age of cutting / No of girls that have reached the median plus std. deviation						National prevalence rate for the 15–19 age group	No of girls at risk			
		First generation		Second generation		Total			Min.		Max.	
		O.M.	R.M.	O.M.	R.M.	O.M.	R.M.		O.M.	R.M.	O.M.	R.M.
Benin	0	0	0	0	0	0	0	2.4	0	0	0	0
Burkina Faso	0	0	0	0	0	0	0	57.7	0	0	0	0
Cameroon	7	4	5	0	0	4	5	0.4	0	0	0	0
Central African Republic	0	0	0	0	0	0	0	17.9	0	0	0	0
Chad	1	1	1	0	0	1	1	31.8	0	0	0	0
Côte d'Ivoire	0	0	0	0	0	0	0	31.3	0	0	0	0
Djibouti	0	0	0	0	0	0	0	89.5	0	0	0	0
Egypt	1 520	203	248	915	1 115	1 118	1 364	69.6	142	561	778	949
Eritrea	5	0	2	0	0	0	2	68.8	0	2	0	2
Ethiopia	65	15	33	8	19	23	51	47.1	7	19	11	24
Gambia	2	0	1	0	0	0	1	76.3	0	1	0	1
Ghana	44	5	4	28	24	33	29	1.5	0	0	0	0
Guinea	3	2	2	1	1	3	3	94	2	2	2	3
Guinea-Bissau	0	0	0	0	0	0	0	41.9	0	0	0	0
Indonesia	13	0	4	0	1	0	5	49	0	2	0	2
Iraq	60	28	39	0	0	28	39	4.9	1	2	1	2
Kenya	17	13	15	0	0	13	15	11.4	1	2	1	2
Liberia	0	0	0	0	0	0	0	31.1	0	0	0	0
Mali	0	0	0	0	0	0	0	90.3	0	0	0	0
Mauritania	0	0	0	0	0	0	0	65.9	0	0	0	0
Niger	2	0	1	0	0	0	1	1.4	0	0	0	0
Nigeria	106	15	30	11	22	26	53	15.3	2	7	4	8
Senegal	1	1	1	0	0	1	1	22.2	0	0	0	0
Sierra Leone	15	1	2	7	11	8	14	74.3	1	6	6	10
Somalia	0	0	0	0	0	0	0	96.7	0	0	0	0
Sudan	25	6	7	11	13	18	21	81.7	5	11	14	17
Togo	0	0	0	0	0	0	0	1.8	0	0	0	0
Uganda	4	2	3	0	0	2	3	1	0	0	0	0
Tanzania	7	1	2	1	2	1	5	4.7	0	0	0	0
Yemen	0	0	0	0	0	0	0	16.4	0	0	0	0
TOTAL	1 896	297	401	981	1 209	1 278	1 610		161	615	817	1 020

O.M. — Original methodology (according to EIGE, 2015b); R.M. — Refined Methodology (according to the present study).

France, 2014: female migrant population from FGM-practising countries (aged 0–18)

Country of origin	Total number of girls in France from this country of origin	No of girls under the median age of cutting / No of girls that have reached the median age plus std. deviation						National prevalence rate for the 15–19 age group	No of girls at risk			
		First generation		Second generation		Total			Min.		Max.	
		O.M.	R.M.	O.M.	R.M.	O.M.	R.M.		O.M.	R.M.	O.M.	R.M.
Benin	6 683	254	569	2 956	4 460	3 210	5 029	2.4	6	68	77	121
Burkina Faso	2 701	104	341	440	1 005	544	1 346	57.7	60	487	314	777
Cameroon	28 264	1 015	2 427	12 900	17 685	13 915	20 112	0.4	4	45	56	80
Central African Republic	6 323	682	912	3 941	4 391	4 623	5 303	17.9	122	556	828	949
Chad	2 442	78	234	1 051	1 537	1 129	1 771	31.8	25	318	359	563
Côte d'Ivoire	35 042	308	1 952	6 432	18 890	6 740	20 842	31.3	96	3 567	2 110	6 524
Djibouti	2 575	180	245	955	1 182	1 135	1 427	89.5	161	748	1 016	1 277
Egypt	7 459	528	804	3 390	4 790	3 918	5 594	69.6	367	2 227	2 727	3 893
Eritrea	208	0	26	0	82	0	108	68.8	0	46	0	74
Ethiopia	3 263	436	1 386	12	452	448	1 838	47.1	205	759	211	866
Gambia	1 076	4	19	216	514	220	533	76.3	3	210	168	407
Ghana	1 824	36	31	856	756	892	787	1.5	1	6	13	12
Guinea	12 844	441	875	5 967	8 200	6 408	9 075	94	415	4 677	6 024	8 531
Guinea-Bissau	1 524	53	158	579	982	632	1 140	41.9	22	272	265	478
Indonesia	1 326	0	60	0	220	0	280	49	0	83	0	137
Iraq	1 807	118	209	762	957	880	1 166	4.9	6	33	43	57
Kenya	562	104	135	358	391	462	526	11.4	12	37	53	60
Liberia	268	6	8	206	216	212	224	31.1	2	36	66	70
Mali	31 309	412	1 087	5 804	12 464	6 216	13 551	90.3	372	6 609	5 613	12 237
Mauritania	6 466	80	178	1 324	2 336	1 404	2 514	65.9	53	887	925	1 657
Niger	1 641	36	83	324	660	360	743	1.4	1	6	5	10
Nigeria	3 261	116	282	872	1 593	988	1 875	15.3	18	165	151	287
Senegal	36 964	608	1 433	7 036	14 627	7 644	16 060	22.2	135	1 942	1 697	3 565
Sierra Leone	572	34	60	423	489	457	549	74.3	25	227	340	408
Somalia	753	56	90	334	375	390	465	96.7	54	268	377	450
Sudan	855	116	159	351	446	467	605	81.7	95	312	382	494
Togo	7 218	318	814	3 144	5 414	3 462	6 228	1.8	6	64	62	112
Uganda	128	3	3	32	41	35	44	1	0	0	0	0
Tanzania	183	3	12	67	147	70	159	4.7	0	4	3	7
Yemen	142	0	3	0	18	0	21	16.4	0	1	0	3
TOTAL	205 683	6 129	14 595	60 732	105 320	66 861	119 915		2 266	24 660	23 885	44 106

O.M. — Original methodology (according to EIGE, 2015b); R.M. — Refined Methodology (according to the present study).

France, 2011: female migrant population from FGM-practising countries (aged 0–18)

Country of origin	Total number of girls in France from this country of origin	No of girls under the median age of cutting / No of girls that have reached the median age plus std. deviation						National prevalence rate for the 15–19 age group	No of girls at risk			
		First generation		Second generation		Total			Min.		Max.	
		O.M.	R.M.	O.M.	R.M.	O.M.	R.M.		O.M.	R.M.	O.M.	R.M.
Benin	1 116	228	512	234	234	462	746	2.4	5	15	11	18
Burkina Faso	881	100	333	119	119	219	452	57.7	58	226	126	261
Cameroon	7 418	1 043	2 487	1 568	1 568	2 611	4 055	0.4	4	13	10	16
Central African Republic	1 543	676	904	264	264	940	1 168	17.9	121	186	168	209
Chad	452	67	203	104	104	171	307	31.8	21	82	54	98
Côte d'Ivoire	7 072	288	1 821	1 620	1 620	1 908	3 441	31.3	90	824	597	1 077
Djibouti	769	212	287	64	64	276	351	89.5	190	286	247	314
Egypt	1 107	437	665	189	189	626	854	69.6	304	529	436	594
Eritrea	60	0	7	23	23	23	30	68.8	0	13	16	21
Ethiopia	2 269	440	1 396	103	103	543	1 499	47.1	207	682	256	706
Gambia	125	4	17	53	53	57	70	76.3	3	33	43	53
Ghana	380	51	44	120	120	171	164	1.5	1	2	3	2
Guinea	2 226	303	599	859	859	1 162	1 458	94	285	967	1 092	1 371
Guinea-Bissau	218	33	94	68	68	101	162	41.9	14	53	42	68
Indonesia	401	0	64	71	71	71	135	49	0	48	35	66
Iraq	402	67	123	95	95	162	218	4.9	3	8	8	11
Kenya	208	112	143	45	45	157	188	11.4	13	19	18	21
Liberia	39	16	16	15	15	31	31	31.1	5	7	10	10
Mali	4 564	352	927	1 504	1 504	1 856	2 431	90.3	318	1 516	1 676	2 195
Mauritania	985	72	164	279	279	351	443	65.9	47	200	231	292
Niger	383	40	89	98	98	138	187	1.4	1	2	2	3
Nigeria	695	68	167	318	318	386	485	15.3	10	50	59	74
Senegal	6 217	536	1 260	1 764	1 764	2 300	3 024	22.2	119	476	511	671
Sierra Leone	88	28	50	33	33	61	83	74.3	21	49	45	62
Somalia	206	39	62	34	34	73	96	96.7	38	76	71	93
Sudan	181	64	88	51	51	115	139	81.7	52	93	94	114
Togo	1 410	318	812	274	274	592	1 086	1.8	6	17	11	20
Uganda	37	4	4	10	10	14	14	1	0	0	0	0
Tanzania	22	2	7	12	12	14	19	4.7	0	0	1	1
Yemen	78	0	3	14	14	14	17	16.4	0	1	2	3
TOTAL	41 552	5 600	13 348	10 005	10 005	15 605	23 353		1 936	6 473	5 875	8 444

O.M. — Original methodology (according to EIGE, 2015b); R.M. — Refined Methodology (according to the present study).

Italy, 2016: female migrant population from FGM-practising countries (aged 0–18)

Country of origin	Total number of girls in Italy from this country of origin	No of girls under the median age of cutting / No of girls that have reached the median age plus std. deviation						National prevalence rate for the 15–19 age group	No of girls at risk			
		First generation		Second generation		Total			Min.		Max.	
		O.M.	R.M.	O.M.	R.M.	O.M.	R.M.		O.M.	R.M.	O.M.	R.M.
Benin	529	27	66	219	356	246	422	2.4	1	6	6	10
Burkina Faso	2 712	30	186	524	1 344	554	1 530	57.7	17	495	319	883
Cameroon	2 128	109	221	1 109	1420	1 218	1 641	0.4	0	4	5	7
Central African Republic	50	9	10	30	34	39	44	17.9	2	5	7	8
Chad	72	5	13	28	40	33	53	31.8	2	10	10	17
Côte d'Ivoire	4 419	28	238	697	2 353	725	2 591	31.3	9	443	227	811
Djibouti	36	0	0	16	20	16	20	89.5	0	9	14	18
Egypt	20 028	3 131	4 845	8 978	11 570	12 109	1 6415	69.6	2 179	7 398	8 428	11 425
Eritrea	956	0	33	0	216	0	249	68.8	0	97	0	171
Ethiopia	2 520	182	750	237	788	419	1 538	47.1	86	539	198	724
Gambia	179	4	15	30	80	34	95	76.3	3	42	26	72
Ghana	9 135	305	249	4 231	3 681	4 536	3 930	1.5	5	32	68	59
Guinea	769	41	80	352	494	393	574	94	38	307	369	540
Guinea-Bissau	127	12	28	42	71	54	99	41.9	5	27	22	41
Indonesia	343	0	17	0	51	0	68	49	0	20	0	33
Iraq	322	29	51	110	121	139	172	4.9	1	5	7	8
Kenya	589	180	228	285	318	465	546	11.4	21	44	53	62
Liberia	123	7	8	93	95	100	103	31.1	3	17	31	32
Mali	378	17	36	78	147	95	183	90.3	15	99	86	165
Mauritania	186	2	4	16	38	18	42	65.9	1	16	12	28
Niger	238	1	1	33	76	34	77	1.4	0	1	0	1
Nigeria	14 521	81	232	3 078	7 249	3 159	7 481	15.3	12	590	483	1 145
Senegal	13 323	282	941	2 635	5 893	2 917	6 834	22.2	63	863	647	1 517
Sierra Leone	209	13	26	151	179	164	205	74.3	9	86	122	153
Somalia	721	8	15	227	227	235	242	96.7	8	125	227	234
Sudan	308	21	30	147	161	168	191	81.7	17	90	137	156
Togo	835	61	185	407	555	468	740	1.8	1	8	8	13
Uganda	101	7	8	27	35	34	43	1	0	0	0	0
Tanzania	127	13	32	44	78	57	110	4.7	1	4	3	5
Yemen	54	0	0	0	4	0	4	16.4	0	0	0	1
TOTAL	76 040	4 604	8 548	23 824	37 694	28 428	46 242		2 499	11 382	11 515	18 339

O.M. — Original methodology (according to EIGE, 2015b); R.M. — Refined Methodology (according to the present study).

Italy, 2011: female migrant population from FGM-practising countries (aged 0–18)

Country of origin	Total number of girls in Italy from this country of origin	No of girls under the median age of cutting / No of girls that have reached the median age plus std. deviation						National prevalence rate for the 15–19 age group	No of girls at risk			
		First generation		Second generation		Total			Min.		Max.	
		O.M.	R.M.	O.M.	R.M.	O.M.	R.M.		O.M.	R.M.	O.M.	R.M.
Benin	481	43	97	267	315	310	412	2.4	1	6	7	10
Burkina Faso	2 165	112	302	634	1 060	746	1 362	57.7	65	480	430	786
Cameroon	1 566	124	226	864	1 010	988	1 236	0.4	0	3	4	5
Central African Republic	36	6	7	28	28	34	35	17.9	1	4	6	6
Chad	55	9	15	22	33	31	48	31.8	3	10	10	15
Côte d'Ivoire	4 001	67	386	967	2105	1 034	2 491	31.3	21	450	324	780
Djibouti	31	0	0	18	22	18	22	89.5	0	10	16	20
Egypt	15 352	3 439	4 741	7 898	9 092	11 337	13 833	69.6	2 394	6 463	7 891	9 627
Eritrea	918	0	48	0	392	0	440	68.8	0	168	0	302
Ethiopia	2 248	294	888	323	671	617	1 559	47.1	138	576	290	734
Gambia	133	8	18	39	76	47	94	76.3	6	43	36	72
Ghana	7 762	501	418	4 173	3 916	4 674	4 334	1.5	8	35	70	65
Guinea	626	48	94	336	404	384	498	94	45	279	361	468
Guinea-Bissau	126	23	40	50	66	73	106	41.9	10	31	31	44
Indonesia	301	0	13	0	59	0	72	49	0	20	0	35
Iraq	352	70	103	128	135	198	238	4.9	3	8	10	12
Kenya	480	162	216	223	223	385	439	11.4	18	38	44	50
Liberia	110	15	16	81	81	96	97	31.1	4	18	30	30
Mali	274	21	33	69	136	90	169	90.3	19	90	81	152
Mauritania	166	4	5	31	61	35	66	65.9	3	23	23	43
Niger	201	0	3	41	121	41	124	1.4	0	1	1	2
Nigeria	10 788	118	289	4 127	7 159	4 245	7 448	15.3	18	592	650	1 140
Senegal	9 499	537	1 209	3 058	4 962	3 595	6 171	22.2	119	819	798	1 370
Sierra Leone	180	23	51	120	120	143	171	74.3	17	83	106	127
Somalia	716	33	47	291	291	324	338	96.7	32	187	314	327
Sudan	259	31	43	131	145	162	188	81.7	25	94	132	154
Togo	616	97	206	292	341	389	547	1.8	2	7	7	10
Uganda	100	9	11	30	32	39	43	1	0	0	0	0
Tanzania	123	16	41	45	62	61	103	4.7	1	3	3	5
Yemen	54	0	3	0	6	0	9	16.4	0	0	0	1
TOTAL	59 720	5 809	9 570	24 286	33 124	30 095	42 694		2 953	10 541	11 675	16 392

O.M. — Original methodology (according to EIGE, 2015b); R.M. — Refined Methodology (according to the present study).

Cyprus, 2011: female migrant population from FGM-practising countries (aged 0–18)

Country of origin	Total number of girls in Cyprus from this country of origin	No of girls under the median age of cutting / No of girls that have reached the median age plus std. deviation						National prevalence rate for the 15–19 age group	No of girls at risk			
		First generation		Second generation		Total			Min.		Max.	
		O.M.	R.M.	O.M.	R.M.	O.M.	R.M.		O.M.	R.M.	O.M.	R.M.
Benin	0	0	0	0	0	0	0	2.4	0	0	0	0
Burkina Faso	0	0	0	0	0	0	0	57.7	0	0	0	0
Cameroon	28	2	4	16	18	18	22	0.4	0	0	0	0
Central African Republic	6	2	3	2	3	4	6	17.9	0	1	1	1
Chad	1	0	1	0	0	0	1	31.8	0	0	0	0
Côte d'Ivoire	0	0	0	0	0	0	0	31.3	0	0	0	0
Djibouti	0	0	0	0	0	0	0	89.5	0	0	0	0
Egypt	136	30	42	56	64	86	106	69.6	21	51	60	74
Eritrea	1	0	0	0	0	0	0	68.8	0	0	0	0
Ethiopia	17	0	2	8	12	8	14	47.1	0	4	4	7
Gambia	0	0	0	0	0	0	0	76.3	0	0	0	0
Ghana	10	2	2	4	4	6	6	1.5	0	0	0	0
Guinea	0	0	0	0	0	0	0	94	0	0	0	0
Guinea-Bissau	0	0	0	0	0	0	0	41.9	0	0	0	0
Indonesia	3	0	0	0	0	0	0	49	0	0	0	0
Iraq	452	114	182	124	130	238	312	4.9	6	12	12	15
Kenya	14	0	2	9	11	9	13	11.4	0	1	1	1
Liberia	1	0	0	1	1	1	1	31.1	0	0	0	0
Mali	0	0	0	0	0	0	0	90.3	0	0	0	0
Mauritania	0	0	0	0	0	0	0	65.9	0	0	0	0
Niger	1	0	0	0	1	0	1	1.4	0	0	0	0
Nigeria	25	0	0	4	10	4	10	15.3	0	1	1	2
Senegal	0	0	0	0	0	0	0	22.2	0	0	0	0
Sierra Leone	2	1	1	1	1	2	2	74.3	1	1	1	1
Somalia	3	1	2	1	1	2	3	96.7	1	2	2	3
Sudan	51	0	2	25	32	25	34	81.7	0	15	20	28
Togo	0	0	0	0	0	0	0	1.8	0	0	0	0
Uganda	1	0	0	0	0	0	0	1	0	0	0	0
Tanzania	4	0	0	1	4	1	4	4.7	0	0	0	0
Yemen	2	0	0	0	0	0	0	16.4	0	0	0	0
TOTAL	758	152	243	252	292	404	535		29	88	102	132

O.M. — Original methodology (according to EIGE, 2015b); R.M. — Refined Methodology (according to the present study).

Malta, 2011: female migrant population from FGM-practising countries (aged 0–18)

Country of origin	Total number of girls in Malta from this country of origin	No of girls under the median age of cutting / No of girls that have reached the median age plus std. deviation						National prevalence rate for the 15–19 age group	No of girls at risk			
		First generation		Second generation		Total			Min.		Max.	
		O.M.	R.M.	O.M.	R.M.	O.M.	R.M.		O.M.	R.M.	O.M.	R.M.
Benin	0	0	0	0	0	0	0	2.4	0	0	0	0
Burkina Faso	0	0	0	0	0	0	0	57.7	0	0	0	0
Cameroon	2	1	1	0	0	1	1	0.4	0	0	0	0
Central African Republic	0	0	0	0	0	0	0	17.9	0	0	0	0
Chad	1	0	0	0	0	0	0	31.8	0	0	0	0
Côte d'Ivoire	0	0	0	0	0	0	0	31.3	0	0	0	0
Djibouti	0	0	0	0	0	0	0	89.5	0	0	0	0
Egypt	30	3	5	19	24	22	29	69.6	2	11	15	20
Eritrea	97	0	30	0	47	0	77	68.8	0	36	0	53
Ethiopia	115	20	78	17	29	37	107	47.1	9	44	17	50
Gambia	0	0	0	0	0	0	0	76.3	0	0	0	0
Ghana	3	1	1	1	1	2	2	1.5	0	0	0	0
Guinea	0	0	0	0	0	0	0	94	0	0	0	0
Guinea-Bissau	0	0	0	0	0	0	0	41.9	0	0	0	0
Indonesia	3	0	0	0	0	0	0	49	0	0	0	0
Iraq	5	0	0	0	0	0	0	4.9	0	0	0	0
Kenya	0	0	0	0	0	0	0	11.4	0	0	0	0
Liberia	0	0	0	0	0	0	0	31.1	0	0	0	0
Mali	0	0	0	0	0	0	0	90.3	0	0	0	0
Mauritania	0	0	0	0	0	0	0	65.9	0	0	0	0
Niger	0	0	0	0	0	0	0	1.4	0	0	0	0
Nigeria	59	9	12	19	30	28	42	15.3	1	4	4	6
Senegal	0	0	0	0	0	0	0	22.2	0	0	0	0
Sierra Leone	3	0	0	3	3	3	3	74.3	0	1	2	2
Somalia	153	33	33	110	112	143	145	96.7	32	86	138	140
Sudan	14	4	4	5	5	9	9	81.7	3	6	7	8
Togo	0	0	0	0	0	0	0	1.8	0	0	0	0
Uganda	0	0	0	0	0	0	0	1	0	0	0	0
Tanzania	1	1	1	0	0	1	1	4.7	0	0	0	0
Yemen	0	0	0	0	0	0	0	16.4	0	0	0	0
TOTAL	486	71	164	174	251	245	415		47	189	183	279

O.M. — Original methodology (according to EIGE, 2015b); R.M. — Refined Methodology (according to the present study).

Annex 5: Data tables on the female asylum-seeking population at risk

Belgium, 2016: overview of the female asylum-seeking population from FGM-practising countries (aged 0–19)

Country of origin	Total number of girls in Belgium from this country of origin	No of girls under the median age of cutting (O.M.)	No of girls that have reached the median age plus std. deviation (R.M.)	National prevalence rate in the 15–19 age group	No of girls at risk	
					O.M.	R.M.
Benin	5	5	5	2.4	0	0
Burkina Faso	10	4	9	57.7	2	5
Cameroon	16	13	15	0.4	0	0
Central African Republic	0	0	0	17.9	0	0
Chad	5	5	5	31.8	2	2
Côte d'Ivoire	26	14	22	31.3	4	7
Djibouti	9	3	3	89.5	3	3
Egypt	7	6	7	69.6	4	5
Eritrea	29	0	10	68.8	0	7
Ethiopia	0	0	0	47.1	0	0
Gambia	0	0	0	76.3	0	0
Ghana	1	0	0	1.5	0	0
Guinea	142	83	92	94	78	86
Guinea-Bissau	0	0	0	41.9	0	0
Indonesia	0	0	0	49 (*)	0	0
Iraq	505	304	374	4.9	15	18
Kenya	2	2	2	11.4	0	0
Liberia	0	0	0	31.1	0	0
Mali	8	2	3	90.3	2	3
Mauritania	17	5	8	65.9	3	5
Niger	9	3	4	1.4	0	0
Nigeria	30	10	19	15.3	2	3
Senegal	16	6	15	22.2	1	3
Sierra Leone	0	0	0	74.3	0	0
Somalia	110	51	65	96.7	49	63
Sudan	14	10	11	81.7	8	9
Togo	4	2	3	1.8	0	0
Uganda	0	0	0	1	0	0
Tanzania	0	0	0	4.7	0	0
Yemen	4	0	0	16.4	0	0
TOTAL	969	528	672		173	219

O.M. — Original methodology (according to EIGE, 2015b); R.M. — Refined Methodology (according to the present study).

(*) Population aged 0–11.

Greece, 2016: overview of the female asylum-seeking population from FGM-practising countries (aged 0–17)

Country of origin	Total number of girls in Greece from this country of origin	No of girls under the median age of cutting (O.M.)	No of girls that have reached the median age plus std. deviation (R.M.)	National prevalence rate in the 15–19 age group	No of girls at risk	
					O.M.	R.M.
Benin	0	0	0	2.4	0	0
Burkina Faso	0	0	0	57.7	0	0
Cameroon	7	2	4	0.4	0	0
Central African Republic	0	0	0	17.9	0	0
Chad	0	0	0	31.8	0	0
Côte d'Ivoire	1	0	1	31.3	0	0
Djibouti	0	0	0	89.5	0	0
Egypt	7	3	5	69.6	2	3
Eritrea	24	0	5	68.8	0	3
Ethiopia	3	0	0	47.1	0	0
Gambia	2	0	0	76.3	0	0
Ghana	2	1	1	1.5	0	0
Guinea	0	0	0	94	0	0
Guinea-Bissau	0	0	0	41.9	0	0
Indonesia	2	0	0	49 (*)	0	0
Iraq	1 032	464	670	4.9	23	33
Kenya	0	0	0	11.4	0	0
Liberia	0	0	0	31.1	0	0
Mali	1	0	0	90.3	0	0
Mauritania	1	0	0	65.9	0	0
Niger	1	0	0	1.4	0	0
Nigeria	6	1	2	15.3	0	0
Senegal	1	0	1	22.2	0	0
Sierra Leone	1	1	1	74.3	1	1
Somalia	14	6	8	96.7	6	8
Sudan	3	2	2	81.7	1	2
Togo	0	0	0	1.8	0	0
Uganda	2	0	0	1	0	0
Tanzania	0	0	2	4.7	0	0
Yemen	13	0	4	16.4	0	1
TOTAL	1 123	480	706		33	51

O.M. — Original methodology (according to EIGE, 2015b); R.M. — Refined Methodology (according to the present study).

(*) Population aged 0–11.

France, 2016: overview of the female asylum-seeking population from FGM-practising countries (aged 0–18)

Country of origin	Total number of girls in France from this country of origin	No of girls under the median age of cutting (O.M.)	No of girls that have reached the median age plus std. deviation (R.M.)	National prevalence rate in the 15–19 age group	No of girls at risk	
					O.M.	R.M.
Benin	2	2	2	2.4	0	0
Burkina Faso	7	3	4	57.7	2	2
Cameroon	20	18	20	0.4	0	0
Central African Republic	70	58	63	17.9	10	11
Chad	43	34	41	31.8	11	13
Côte d'Ivoire	63	37	49	31.3	12	15
Djibouti	4	2	3	89.5	2	3
Egypt	14	11	12	69.6	8	8
Eritrea	58	0	40	68.8	0	28
Ethiopia	15	9	12	47.1	4	6
Gambia	7	7	7	76.3	5	5
Ghana	1	1	1	1.5	0	0
Guinea	156	124	147	94	117	138
Guinea-Bissau	2	2	2	41.9	1	1
Indonesia	0	0	0	49 (*)	0	0
Iraq	420	252	349	4.9	12	17
Kenya	4	3	3	11.4	0	0
Liberia	0	0	0	31.1	0	0
Mali	60	44	53	90.3	40	48
Mauritania	23	13	16	65.9	9	11
Niger	5	0	4	1.4	0	0
Nigeria	116	59	91	15.3	9	14
Senegal	36	24	29	22.2	5	6
Sierra Leone	3	3	3	74.3	2	2
Somalia	51	25	30	96.7	24	29
Sudan	90	63	76	81.7	51	62
Togo	3	1	3	1.8	0	0
Uganda	0	0	0	1	0	0
Tanzania	0	0	0	4.7	0	0
Yemen	10	0	2	16.4	0	0
TOTAL	1 283	795	1 062		324	421

O.M. — Original methodology (according to EIGE, 2015b); R.M. — Refined Methodology (according to the present study).

(*) Population aged 0–11.

Italy, 2016: overview of the female asylum-seeking population from FGM-practising countries (aged 0–19)

Country of origin	Total number of girls in Italy from this country of origin	No of girls under the median age of cutting (O.M.)	No of girls that have reached the median age plus std. deviation (R.M.)	National prevalence rate in the 15–19 age group	No of girls at risk	
					O.M.	R.M.
Benin	0	0	0	2.4	0	0
Burkina Faso	2	1	1	57.7	0	1
Cameroon	42	31	32	0.4	0	0
Central African Republic	0	0	0	17.9	0	0
Chad	3	1	3	31.8	0	1
Côte d'Ivoire	70	8	14	31.3	3	5
Djibouti	0	0	0	89.5	0	0
Egypt	4	2	3	69.6	1	2
Eritrea	42	0	13	68.8	0	9
Ethiopia	8	2	3	47.1	1	1
Gambia	27	2	3	76.3	2	2
Ghana	12	7	7	1.5	0	0
Guinea	13	3	4	94	2	4
Guinea-Bissau	2	0	0	41.9	0	0
Indonesia	0	0	0	49 (*)	0	0
Iraq	27	19	23	4.9	1	1
Kenya	2	2	2	11.4	0	0
Liberia	2	0	0	31.1	0	0
Mali	17	5	8	90.3	4	8
Mauritania	0	0	0	65.9	0	0
Niger	2	0	0	1.4	0	0
Nigeria	506	105	139	15.3	16	21
Senegal	12	5	6	22.2	1	1
Sierra Leone	8	6	8	74.3	4	6
Somalia	58	14	15	96.7	14	15
Sudan	6	4	4	81.7	3	3
Togo	3	0	2	1.8	0	0
Uganda	0	0	0	1	0	0
Tanzania	0	0	0	4.7	0	0
Yemen	4	0	0	16.4	0	0
TOTAL	872	216	290		52	80

O.M. — Original methodology (according to EIGE, 2015b); R.M. — Refined Methodology (according to the present study).

(*) Population aged 0–11.

Malta, 2016: overview of the female asylum-seeking population from FGM-practising countries (aged 0–17)

Country of origin	Total number of girls in Malta from this country of origin	No of girls under the median age of cutting (O.M.)	No of girls that have reached the median age plus std. deviation (R.M.)	National prevalence rate in the 15–19 age group	No of girls at risk	
					O.M.	R.M.
Benin	0	0	0	2.4	0	0
Burkina Faso	0	0	0	57.7	0	0
Cameroon	0	0	0	0.4	0	0
Central African Republic	0	0	0	17.9	0	0
Chad	0	0	0	31.8	0	0
Côte d'Ivoire	1	0	1	31.3	0	0
Djibouti	0	0	0	89.5	0	0
Egypt	3	2	3	69.6	1	2
Eritrea	10	0	8	68.8	0	6
Ethiopia	3	1	3	47.1	0	1
Gambia	0	0	0	76.3	0	0
Ghana	0	0	0	1.5	0	0
Guinea	0	0	0	94	0	0
Guinea-Bissau	0	0	0	41.9	0	0
Indonesia	0	0	0	49 (*)	0	0
Iraq	0	0	0	4.9	0	0
Kenya	0	0	0	11.4	0	0
Liberia	1	1	1	31.1	0	0
Mali	0	0	0	90.3	0	0
Mauritania	0	0	0	65.9	0	0
Niger	0	0	0	1.4	0	0
Nigeria	5	4	5	15.3	1	1
Senegal	2	0	1	22.2	0	0
Sierra Leone	0	0	0	74.3	0	0
Somalia	1	1	1	96.7	1	1
Sudan	2	2	2	81.7	1	2
Togo	0	0	0	1.8	0	0
Uganda	0	0	0	1	0	0
Tanzania	0	0	0	4.7	0	0
Yemen	0	0	0	16.4	0	0
TOTAL	28	10	25		5	13

O.M. — Original methodology (according to EIGE, 2015b); R.M. — Refined Methodology (according to the present study).

(*) Population aged 0–1

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