

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

**Report**



The European Institute for Gender Equality (EIGE) is an autonomous body of the European Union, established to contribute to and strengthen the promotion of gender equality, including gender mainstreaming in all EU policies and the resulting national policies, and the fight against discrimination based on sex, as well as to raise EU citizens' awareness of gender equality.

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PDF	MH0215093ENN	10.2839/394412	978-92-9218-652-4
Paper	MH0215093ENC	10.2839/574638	978-92-9218-654-8

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# Acknowledgements

This report is based on the study on the estimation on the number of girls at risk of female genital mutilation in selected EU Member States. It was commissioned by the European Institute for Gender Equality (EIGE) in 2014 and was carried out by Yellow Window. The researchers involved were: Lut Mergaert, Catarina Arnaut, Marja Exterkate, Siobán O'Brien Green, Sofia Strid and Els Leye. The researchers were supported by Elise Johansen, Fadela Novak and Philippa Candler, as advisors to this study.

The work on this report was coordinated by Jurgita Pečiūrienė (EIGE). Other colleagues involved from the Institute : Ligia Nobrega, Thérèse Murphy, An Cuypers, Janine Levine and Anne Wiegmann.

This report is accompanied by more publications related to EIGE's work on combating female genital mutilation. More information and these resources can be found at: <http://eige.europa.eu/content/female-genital-mutilation>

The European Institute for Gender Equality would like to thank Eurostat and the Gender Equality Unit at DG Justice, as well as the following people for their involvement in the study:

Experts consulted		
Armelle Andro	Sara Johnsdotter	Diane Nurse
Malin Arhne	Adriana Kaplan	Marika Podda Connor
Philippa Candler	Päivikki Koponen	Fabienne Richard
Dalila Cerejo	Katharina Kunze	Lisa Vicente
Dominique Dubourg	Inger-Lise Lien	Andrea Vonkeman
Patrizia Farina	Christine Loudes	Kerstin Westgren
Katie Furniss	Alison MacFarlane	Paul Stanley Yoder
Elise Johansen	Fadela Novak	

The research team would like to thank the women and men who participated in the focus group discussions organised in Ireland, Portugal and Sweden, as well as the following organisations, officials and individuals, without whom this study would not have been possible to carry out.

## Ireland

United Youth of Ireland (Nobuhle Nokuthula Ncube and Ifrah Ahmed); Sickie Cell Society Ireland (Esther Owuta-Pepple Onolememen); Dun Laoghaire Refugee Project (Rita Canavan); Chinenye Anameje; National Social Inclusion Office, Health Service Executive (Diane Nurse); Census Enquiries Section, Central Statistics Office (Olive Pluck); and Cosc – The National Office for the Prevention of Domestic, Sexual and Gender-based Violence, Department of Justice and Equality (Philip McCormack).

## Portugal

Mariama Djaló, Wilson Cá, Aguienso – Associação Guineense de Solidariedade Social (Fernando Cá, Ana Correia, Graciete Leal Borges and Vânia Cunha), Associação de Melhoramentos e Recreativo do Talude, Associação para o Planeamento da Família (Miguel Feio and Diana Lopes), Directorate-General of Health (Lisa Vicente), and Health Data Platform of the Shared Services of the Ministry of Health (Diogo Reis, Paulo Sá, Marta Canas e Sousa, Arlete Monteiro, Vitor Matias and Henrique Martins).

## Sweden

Africa's Horn Kultur Center (Lul Osmal), Ideellt Utvecklingscentrum, Competencia (Mohamed Isse Ismail and Jocke Kollgård), Länsstyrelsen (Maria Hagberg) and UN Women – Örebro.

# Foreword

Gender equality is one of the founding values of the European Union; it dates back to the inclusion of the principle of equal pay in the 1957 Treaty of Rome. Since then, the EU's gender equality policy has expanded considerably, with areas outside of the employment sector gaining large-scale attention. Violence against women – one of the areas of concern of the Beijing Platform for Action (Area D) – is one of the most pervasive gender-based inequalities, with its entire dimension difficult to measure. Physical, sexual and psychological violence occurring in the family, sexual harassment, stalking, and female genital mutilation deny women's dignity and constitute only some examples of the human rights violations that a great number of women face.

Female genital mutilation (FGM) is a violent form of subordination of women and girls that stands in gross contradiction to principles of gender equality. Following a request from the European Commission, the European Institute for Gender Equality (EIGE) collected and processed first EU-wide data and information on the prevalence of female genital mutilation and then examined national FGM prevention approaches and finally published all the data in the report in 2013. This follow-up study proposing a methodology for the estimation of the number of girls at risk of female genital mutilation in the EU Member States was carried out in 2014. The countries chosen for pilot-testing the methodology were Ireland, Portugal and Sweden.

This report analyses current legal and policy frameworks in the EU Member States, existing approaches to national FGM risk estimations in the EU and their methodological background. It presents quantitative and qualitative data analysis, including that of various focus groups, and carries out a comparative analysis of the selected Member States. The research highlights that strategies preventing female genital mutilation in the EU are effective and their success depends on cooperation between governments and the communities involved.

The findings show that the female genital mutilation risk varies between the Member States according to the total number of first generation migrants originating from a country with high FGM prevalence. Methodology and indicators developed within the present study on FGM risk measurements give a better understanding of this harmful practice. Despite the



difficulty to estimate exact numbers of girls at risk of female genital mutilation, the effectiveness of continuous prevention efforts and cooperation between concerned communities and regulatory bodies have been identified as influential factors.

The report presents recommendations to the Member States on FGM risk assessment and policy development, including the adoption of the Istanbul Convention and effective implementation of the Victim's Rights Directive in national legal frameworks.

On behalf of the European Institute for Gender Equality, I would like to thank the experts and institutions involved in this study for their dedication in tackling the gender-based human rights violation that female genital mutilation is, and their contribution to achieving gender equality.

Virginija Langbakk  
Director

The European Institute for Gender Equality (EIGE)

# Abbreviations

Country abbreviations	
<b>AT</b>	Austria
<b>BE</b>	Belgium
<b>BG</b>	Bulgaria
<b>CY</b>	Cyprus
<b>CZ</b>	Czech Republic
<b>DE</b>	Germany
<b>DK</b>	Denmark
<b>EE</b>	Estonia
<b>EL</b>	Greece
<b>ES</b>	Spain
<b>FI</b>	Finland
<b>FR</b>	France
<b>HR</b>	Croatia
<b>HU</b>	Hungary
<b>IE</b>	Ireland
<b>IT</b>	Italy
<b>LT</b>	Lithuania
<b>LU</b>	Luxembourg
<b>LV</b>	Latvia
<b>MT</b>	Malta
<b>NL</b>	Netherlands
<b>PL</b>	Poland
<b>PT</b>	Portugal
<b>RO</b>	Romania
<b>SE</b>	Sweden
<b>SI</b>	Slovenia
<b>SK</b>	Slovakia
<b>UK</b>	United Kingdom
<b>EU-28</b>	European Union

Frequently used abbreviations	
<b>DHS</b>	Demographic and Health Surveys
<b>EC</b>	European Commission
<b>EIGE</b>	European Institute for Gender Equality
<b>EU</b>	European Union
<b>FGM</b>	Female genital mutilation
<b>MICS</b>	Multiple Indicator Cluster Survey
<b>UNHCR</b>	United Nations High Commissioner for Refugees
<b>UNICEF</b>	United Nations Children's Fund
<b>WHO</b>	World Health Organization

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# Executive summary



# Executive summary

## 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 (WHO, 2008). The practices are sometimes referred to as 'cutting' or 'cutting and sewing'. This publication, however, advocates the use of the term female genital mutilation to emphasize the violating nature of the procedures.

The European Commission (EC) is committed to contribute to the elimination of this phenomenon. In 2013, the European Institute for Gender Equality (EIGE) published a study mapping the current situation and trends of female genital mutilation in the EU-28 Member States. The same year, the European Commission issued a Communication 'Towards the elimination of female genital mutilation' (COM(2013) 833 final). The latter defined as one of its objectives the better understanding of this harmful practice in the EU.

In this Communication, EIGE was asked *'to develop a common methodology and indicators to measure the prevalence of FGM, to estimate the number of women and girls at risk of being mutilated and the number of women affected by FGM in the EU'*. The present study constitutes EIGE's contribution to this end. It aims to build upon and further develop research efforts to estimate the risk of female genital mutilation in the EU. Greater accuracy with respect to estimating FGM risk is important for informing appropriate policy measures for targeted prevention in the EU.

The study ran between June and December 2014. A methodology to estimate FGM risk in the EU was developed and

pilot-tested in Ireland, Portugal and Sweden. The methodological approach includes a quantitative and a qualitative component. This mixed-method approach has proven to be valid and sound. It is valid because it has allowed making a risk analysis for all three countries; it is sound because combining quantitative and qualitative methods provides a more accurate and comprehensive picture than what could be obtained through quantitative or qualitative analysis alone. Despite the methodological progress made in this field, estimating FGM risk remains affected by many uncertainties and the results of the study need to be interpreted with much caution.

## FGM policy and legal frameworks: current state-of-the-art

Efforts to improve the legal and policy frameworks in the EU can be noticed since EIGE's study on 'Female Genital Mutilation in the European Union and Croatia' was published in 2013. A growing number of EU Member States is addressing female genital mutilation in their legislation and policies.

The legal framework concerning female genital mutilation considers the criminal law, provisions for child protection, international protection and professional secrecy.

By July 2014, 13 EU Member States had an FGM-specific criminal law in force: Austria, Belgium, Croatia, Cyprus, Denmark, Germany, Ireland, Italy, Malta, the Netherlands, Spain, Sweden and the UK.



Despite the fact that there are no FGM-specific child protection provisions in any EU Member State, general provisions can be used in cases of female genital mutilation.

With regard to international protection provisions, the 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 (excluding Denmark, Ireland and the UK). Hungary, Portugal and Spain have integrated specific provisions referring to female genital mutilation into their national legislation.

Where professional secrecy provisions are concerned, only Belgium and Sweden have a specific legal provision with regard to reporting cases of performed or planned female genital mutilation. General professional secrecy provisions can be applied to report cases of female genital mutilation or to protect girls at risk of female genital mutilation in all other EU Member States.

As regards the policy framework, Finland, Italy and Portugal are implementing specific national action plans to combat female genital mutilation. Other countries (Belgium, Croatia, France, Spain, Slovakia and the UK) include FGM-related measures in other national strategies. Policies have also been put in place in specific sectors, such as health-care, child protection and criminal police.

## The pilot countries

The main objective of the present study was to give an estimation of the number of girls living in three EU Member States who were at risk of being mutilated. More specifically, this study strove to: analyse and assess the methodological options for FGM risk estimation described and applied in the existing literature and studies; and propose methodologies which can be used to estimate the number of girls at risk of female genital mutilation in the EU Member States.

The study took place between June and December 2014 and comprised four main stages:

1. Mapping recent developments in the 28 EU Member States regarding the legal and policy frameworks and efforts to measure female genital mutilation at national level;
2. Identification and review of existing studies on FGM risk estimation in order to define a methodological approach to estimate the number of girls at risk of undergoing female genital mutilation living in EU Member States;

3. Carrying out a pilot study in three Member States in order to estimate the number of girls at risk of being mutilated in the EU;
4. Development of methodological recommendations for risk estimation of female genital mutilation in all EU Member States.

The proposed methodological approach to estimate the number of girls at risk of undergoing female genital mutilation in the EU builds upon existing knowledge and benefited from the expertise of a diverse range of stakeholders who were involved in different phases of the study.

## FGM risk estimations in the EU

By July 2014, only five EU Member States had estimated FGM risk for their country: Belgium, Germany, Italy, the Netherlands, and the UK. The most recent FGM risk estimations took place between 2007 and 2014. Only Belgium has repeated its risk (and prevalence) estimates over time and the two most recent estimates used the same methodology which allows for assessing trends.

All studies followed a quantitative approach to estimate FGM risk, with the exception of the Dutch study which also included a qualitative component to assess the influence of migration on female genital mutilation behaviour change.

The extrapolation-of-FGM-practising-countries-prevalence-data-method (applying the age cohort 15-49(!)) was used in FGM risk estimations. The age cohorts considered to be 'at risk' vary considerably. Only the Dutch study used the median age of female genital mutilation (as customary in the country of origin) as a variable to obtain more accurate estimates.

A combination of several datasets (from different sources of information) was used in most studies in order to obtain a more accurate estimate. Depending on the study, the data collected included figures for female migrants (first and second generation), and for female asylum seekers. None of the studies included data on female irregular migrants. The lack of ethnicity information on migrants in EU countries remains an issue for all the studies. Considering that female genital mutilation is practised by particular ethnic groups, data on ethnicity would assist in improving FGM risk (and prevalence) estimations (if data collected correspond to the ethnic groups as identified in the reports of Demographic and Health Surveys and/or Multiple In-

indicator Cluster Surveys reports). In order to overcome this limitation, the Dutch study used places of birth of female migrants and regrouped them into regions within the country of origin to obtain more accurate FGM risk estimations (applying regional instead of national FGM prevalence rates which are detailed in the reports of Demographic and Health Surveys and/or Multiple Indicator Cluster Surveys).

## A methodological approach to estimate FGM risk in the EU

For the purposes of this study, FGM 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.

A methodological approach was designed based on the existing knowledge and pilot-tested in Ireland, Portugal and Sweden. This approach was reviewed and validated by a number of experts involved in different phases of the research. The methodology includes a quantitative and a qualitative component.

### Quantitative component

Data had to be collected for those countries where female genital mutilation is documented (i.e. countries of origin) and for EU Member States (i.e. countries of destination).

National (and regional) FGM prevalence rates and age of FGM had to be collated for the countries where female genital mutilation is commonly practised. These figures can be collected through the Demographic and Health Surveys (DHS) published by ICF International and from Multiple Indicator Cluster Surveys (MICS) published by UNICEF and should refer to the 15-19 age cohort (i.e. the group of youngest adults considered to be in 'final cut status', being either cut or not at risk of female genital mutilation anymore) as they will yield a more accurate FGM risk estimation.

Data needed to be collected about the female migrant population residing in an EU Member State, including residents, asylum seekers, refugees and irregular migrants. These data are not accessible in open sources and are not gathered by the same institution. In order to have compa-

table figures across the three countries, the reference year used for all data collected was 2011 as an EU-wide census was conducted that year.

### Qualitative component

In order to assess the influence of migration and acculturation on attitudes and behaviours towards female genital mutilation, a qualitative component was included in the methodology to estimate FGM risk. It comprised focus group discussions. Separate group discussions were organised with women and with men in cities with a high concentration of migrants originating from countries where female genital mutilation is documented: Dublin (Ireland), Lisbon (Portugal) and Örebro (Sweden).

### Estimating FGM risk

The so-called 'extrapolation-of-FGM-practising-countries-prevalence-data-method' is used to calculate FGM risk. In practical terms, the national female genital mutilation prevalence rate of the age cohort 15-19 is multiplied by the total number of girls coming from, or born to a mother originating from, a particular country where female genital mutilation is commonly practised. In order to avoid overestimations, the median age of female genital mutilation (the customary age of cutting in the country of origin) represents an important variable in estimating FGM risk. In other words, those girls whose age is above the median age of female genital mutilation were excluded from the calculation.

In order to obtain more accurate estimates, the following calculation step takes into consideration the migration and acculturation impact factor assessed through the qualitative research. The migration and acculturation impact factor is represented as a binary variable expressed as '0' or '1', in which '0' signifies migration does not influence attitudes and behaviours towards female genital mutilation, while '1' suggests that there is such an influence of migration regarding subjecting girls to female genital mutilation to the extent that the level of risk is reduced to zero. Further research on the influence of migration towards female genital mutilation will ideally provide more refined migration and acculturation impact rates (ranging between 0 % and 100 %, possibly related to different population groups) which will enhance the accuracy of future FGM risk estimations.

Two scenarios of FGM risk were defined in order to determine a risk interval estimation. The high and the low risk scenarios described below delimit the boundaries of this interval. The calculations of these scenarios take into con-



sideration the migration and acculturation impact factor explained above.

### **High FGM risk scenario**

The basic premise behind this scenario is that there is no influence of migration whatsoever, and that the number of girls (originating from an FGM risk country and living in an EU country) at risk of female genital mutilation would be 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 yields the 'upper boundary' of at-risk girls.

Thus, for the calculation of the 'at-risk girls' in this scenario, it is assumed that the female migrant population (regardless of their generation) aged under the median age of cutting as per country of origin is at risk of female genital mutilation, according to the FGM prevalence rate for each country of origin. In this scenario, the migration and acculturation impact factor will be 0 ( $m = 0$ ).

### **Low FGM risk scenario**

In this scenario, it is assumed that there is an influence of migration in changing attitudes and behaviours towards cutting girls. In this case, although it is assumed that the second generation girls (i.e. those born in an EU Member State) experience a lower risk of being subjected to female genital mutilation, for calculation purposes, the level of FGM risk for the second generation girls will correspond to zero (which should, however, not be interpreted in the strictest sense that no girl in this group would any longer be at risk of female genital mutilation). On the other hand, first generation girls whose age is lower than the median age of cutting are still considered to be at risk. In this scenario, the migration and acculturation impact factor for the second generation girls will be 1 ( $m = 1$ ). This hypothetical scenario yields the 'lower boundary' of at risk girls.

The assumptions underpinning these scenarios refer primarily to the female migrant resident population. The qualitative findings and information available about female asylum seekers, refugees and irregular migrants did not allow establishing scenarios for these groups. Nonetheless, as acknowledged by the experts consulted in this study, two aspects seem to reduce the level of FGM risk for female asylum seekers (and refugees). Firstly, their international protection claims might be based on the fear of female genital mutilation and, secondly, they are likely

to find themselves in very precarious situations while they wait for the decision regarding their asylum claim, during which period the priority given to female genital mutilation may be low. With regard to female irregular migrants, no assumptions could be made in the absence of data and knowledge about this particular group.

### **Interpreting FGM risk estimations**

The calculations for each scenario are based on a set of assumptions, and need to be interpreted prudently. As mentioned above, the results are expressed in an interval according to the low and high FGM risk scenarios. A percentage interval estimation is calculated over the total study population (first and second generation girls aged 0-18) due to the fact that in a migration context the customary age of female genital mutilation as practised in the country of origin is likely not to be maintained for those girls who are to be cut. It may be the case that girls younger than the median age of FGM (as customary in the country of origin) arrive in the EU already having undergone female genital mutilation, or that teenage girls above this age might still be at risk because, as supported by findings from the focus group discussions, female genital mutilation in a migration context seems to be more dependent on an 'opportunity to cut' rather than on the customary traditions of the countries of origin.

### **Possible indicators of trends in FGM risk**

Considering that the FGM risk estimation refers to data from a certain reference year, an attempt to assess indicators of trends regarding the level of FGM risk in an EU Member State can be relevant for policy-making purposes. Although more qualitative research is needed to give greater insight into the factors that influence the practice of female genital mutilation, it remains crucial to monitor the evolution of these indicators so that policies can be designed in order to target the particular needs of these groups (female migrants, asylum seekers, girls born to parents originating from countries where female genital mutilation is documented, among others). These indicators need to be monitored regularly (e.g. on a yearly basis) so that trends can be assessed. The indicators used to assess trends in the present study refer to female live births and female asylum seekers. However, additional indicators may be considered for assessing trends in future studies, such as the number of female migrants who originate from countries where female genital mutilation is commonly practised and are registered in an EU Member State, and the migration flows of these girls.

## FGM risk estimation in Ireland, Portugal and Sweden

The main objective of the study is to give an estimation of the number of girls living in Ireland, Portugal and Sweden who were at risk of being mutilated. These three Member States were chosen for the pilot study because they fulfil the set of required criteria including: evidence of a significant number of women and girls who were subjected to female genital mutilation or are at risk of being cut; absence of country-wide FGM risk estimations; and the existence of other administrative records that can allow for an enhancement of the FGM risk estimation. Considering the high and low level of FGM risk scenarios, the estimates of girls living in Ireland, Portugal and Sweden at risk of undergoing female genital mutilation are the following:

- *Ireland*: In 2011, a total number of 14 577 girls aged 0-18 originating from FGM risk countries (born in the country of origin or in Ireland) were residing in Ireland, of which 1 to 11 % were likely to be at risk of female genital mutilation.
- *Portugal*: In 2011, a total number of 5 835 girls aged 0-18 originating from FGM risk countries (born in the country of origin or in Portugal) were residing in Portugal, of which 5 to 23 % were likely to be at risk of female genital mutilation.
- *Sweden*: In 2011, a total number of 59 409 girls aged 0-18 originating from FGM risk countries (born in the country of origin or in Sweden) were residing in Sweden, of which 3 to 19 % were likely to be at risk of female genital mutilation.

## Influence of migration and acculturation on attitudes and behaviour towards FGM

According to the focus group discussions carried out in the framework of this study, several determinants related to migration seem to trigger the change of attitudes and behaviours towards female genital mutilation. These include most notably the existence of a legal framework criminalising female genital mutilation, raised awareness about the harmful effects of FGM, reduced social pressure, and increased contact with people from cultures that do not practise FGM. This seems to lead to a lower FGM risk in the countries of the pilot study than in the countries of origin.

## Main conclusions and recommendations

### Complexity of estimating FGM risk

Estimating the number of girls at risk of undergoing female genital mutilation in EU Member States is very complex owing to the intimate nature of the phenomenon, and also due to the unavailability of data that allows for measuring it. The feasibility of calculating the number of girls at risk of female genital mutilation in the EU Member States depends not only on the availability of the necessary quantitative data (that need to be up-to-date, reliable and complete) on the numbers of girls originating from countries where female genital mutilation is commonly practised, but also on insights into how migration and acculturation influence attitudes and behaviours towards cutting girls.

### Improvement of FGM risk estimations

Considering that female genital mutilation prevalence varies significantly between regions in the countries where it is commonly practised, data on the region of origin of the female migrant population (residents, asylum seekers, refugees and irregular migrants) collected in an EU Member State could exponentially enhance the accuracy of FGM risk estimations.

More qualitative research is needed to gather insights about the influence of migration and acculturation on attitudes and behaviours towards female genital mutilation. This research may well allow for a refining of the migration and acculturation impact factor rates, which will allow obtaining more accurate FGM risk estimates.

### FGM risk estimations and policy-making

FGM risk estimations provide information about an interval of girls that are at risk of being cut, which is useful for designing targeted policies to protect girls from being subjected to female genital mutilation. Furthermore, the needs of those girls (and women) living in the EU who already underwent the practice must also be addressed. For that reason, specialised services need to be established or continued in order to professionally address their needs.

### Need for continuation of effective prevention efforts

The findings of the focus group discussions have shown that awareness-raising initiatives and a legal framework



forbidding female genital mutilation seem to effectively prevent the continuation of the practice in EU Member States. The efforts put in motion in EU countries need thus to be maintained in order to influence migrants' attitudes and behaviours towards female genital mutilation. A discontinuation of the actions undertaken by policy-makers, professionals from different sectors, and civil society organisations might cause a reversal of the progress made so far.

### **Allocation of sufficient resources**

Sufficient resources (human and financial) need to be foreseen when designing policies and funding programmes so that prevention actions can be continued, specialised services can be set up and/or maintained, professionals can be trained, and research on female genital mutilation can be undertaken.

### **Cautious interpretation of research results**

Considering the uncertainties and challenges that FGM risk estimations are confronted with, the research results need to be interpreted and communicated with much caution in order to avoid the misuse of data and information, as well as the stigmatisation of migrant communities, to ensure that no 'at-risk' girls are overlooked when prevention and protection initiatives are implemented, and to guarantee that no girls who have been subjected to female genital mutilation are excluded from care provisions. For these reasons, results are expressed in an interval estimation and not by presenting a single figure.





# 1. Introduction



# 1. 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 (WHO, 2008). The European Commission (EC) is committed to contribute to the elimination of this phenomenon. The most recent efforts include EIGE's study to map the current situation and trends of female genital mutilation in the 28 EU Member States, followed by a Communication to the European Parliament and the Council. Both the study and the communication were launched in 2013.

The EC's Communication 'Towards the elimination of female genital mutilation' has defined as one of its objectives the better understanding of this harmful practice in the EU. To achieve this goal, the EC asked the European Institute for Gender Equality (EIGE) *'to develop a common methodology and indicators to measure the prevalence of FGM, to estimate the number of women and girls at risk of being mutilated and the number of women affected by FGM in the EU'*. In order to contribute to the implementation of these actions, EIGE launched the present study whose main objective is to give an estimation of the number of girls living in three EU Member States who were at risk of being mutilated. More specifically, this study strove to:

- Analyse and assess the methodological options for FGM risk estimation described and applied in the existing literature and studies;
- Propose methodologies which can be used to estimate the number of girls at risk of female genital mutilation in the EU MS.

This study comprised four main stages and took place between June and December 2014:

- a) Mapping recent developments in the 28 EU Member States regarding the legal and policy frameworks and efforts to measure female genital mutilation at national level;
- b) Identification and review of existing studies on FGM risk estimation in order to define a methodological approach to estimate the number of girls at risk of undergoing female genital mutilation living in EU Member States;
- c) Carrying out a pilot study in three Member States in order to estimate the number of girls at risk of being mutilated in the EU;
- d) Development of methodological recommendations for risk estimation of female genital mutilation in all EU Member States.

Firstly, this report describes the study and its milestones, and justifies the selection of the EU Member States where the pilot studies were carried out. Secondly, it highlights the recent developments regarding female genital mutilation legislation, policies and research (prevalence and risk) in the EU Member States since February 2012 (i.e. since the end of the data collection done for the previous study). Thirdly, the report describes the methodological approach followed, along with the FGM risk estimations for Ireland, Portugal and Sweden. Based on the lessons learnt from the experiences of the pilot case studies and the feedback received from the consultation process, recommendations are proposed to improve the methodology to estimate FGM risk and to tackle female genital mutilation in the EU Member States.

## 2. Recent developments concerning FGM-related initiatives in the 28 EU Member States



## 2. Recent developments concerning FGM-related initiatives in the 28 EU Member States

Based on the information and data provided by the EU Member States, an overview of the most recent developments relating to the legal and policy frameworks for combatting female genital mutilation, as well as developments on research measuring FGM prevalence and risk in the EU Member States, are described in the sections below.

### 2.1. Legal framework

#### General and specific criminal laws on female genital mutilation

According to the findings presented in EIGE's report about 'Female Genital Mutilation in the European Union and

Croatia' (2013), up to February 2012, eight countries had introduced a specific criminal law to prosecute female genital mutilation, namely Austria, Belgium, Cyprus, Denmark, Italy, Spain, Sweden and the UK.

Since then, Croatia (2013), Ireland (2012), Germany (2013), Malta (2014) and the Netherlands (2013) issued a specific criminal law to criminalise female genital mutilation. France and Spain amended their general criminal law to make a specific reference to female genital mutilation. In 2014, Belgium submitted a bill proposal to amend the current law<sup>(1)</sup>, while in Portugal three bill proposals were presented in the national parliament to introduce a specific criminal law to prosecute female genital mutilation.

**Table 1. EU Member States with a specific criminal law on female genital mutilation**

Periods covered	EU Member States with a specific criminal law on FGM
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)

Up to February 2012, 41 FGM criminal cases had been brought to court in six EU Member States: Denmark (1), France (29), Italy (2), the Netherlands (1), Spain (6) and Sweden (2). Since then, other cases were brought to court in Belgium (number of cases not known), France (1), Italy (2), Spain (4) and the UK (1). As concluded in the above-mentioned report, it is challenging to obtain data on the number of reports of suspected and/or performed female genital mutilation to police, the number of investigations, the outcomes of investigations, and on the number of court cases, as there are hardly any central registration systems to

provide such information. It is therefore important to note that in Croatia, Germany and Spain the national registration systems for monitoring judicial investigations or court cases allow the retrieval of information on FGM investigations and cases. These systems have been created in Croatia and Germany after the legislation came into force in 2013. No criminal cases were brought to court in Croatia or Germany since February 2012. In Spain, six cases were registered in 2012, two cases recorded in 2013 and, up to September 2014, two cases were documented.



**Figure 1. EU Member States with an FGM-specific criminal law (1982 – August 2014)**



### Child protection provisions

General legal provisions regarding child protection exist in all EU Member States and can be used in cases of female

genital mutilation. To date, no FGM-specific child protection laws have been put in place in any EU Member State. Child protection interventions to protect girls from female genital mutilation took place in Belgium, France and Spain (the number of interventions was not disclosed).

### Asylum provisions

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 (excluding Denmark, Ireland and the UK). Only Hungary (Article 60(2)b) within the Act 80 of 2007 (Asylum Act), Portugal (Law No 26/2014) and Spain (Article 40 of Law 2/2014) have integrated specific provisions on international protection and female genital mutilation into their national legislation.

Except for Luxembourg<sup>2</sup>, no EU Member State reported having a registration system in place for monitoring FGM-specific asylum applications. Nonetheless, Belgium, Denmark, France, Germany, Greece, Ireland, Italy, Luxembourg, Romania and Spain informed to have received asylum applications based on female genital mutilation since February 2012. Numbers are only known for Belgium, Cyprus, Italy and Luxembourg though (see Table 2 below).

**Table 2. Asylum applications received and granted in Belgium, Italy and Luxembourg for 2012 and 2013**

Country	FGM-related asylum applications received	FGM-related asylum applications granted
Belgium	1044	402
Greece	10	6 <sup>3</sup>
Italy	Not known	4
Cyprus	Not known	2
Luxembourg	5	5

### Professional secrecy provisions

Although EU Member States' general professional secrecy provisions can be applied to report cases of female genital mutilation or to protect girls at risk of female genital mutilation<sup>4</sup>, only Belgium and Sweden have a specific legal provision with regard to reporting cases of performed or planned female genital mutilation. Since February 2012, no new legal provision or amendments regarding professional secrecy have been issued in the EU Member States. For more information about the general secrecy provisions in place in each country, consult EIGE's report on 'Female Genital Mutilation in the European Union and Croatia' (2013).

## 2.2. Policy framework

While Finland, Italy and Portugal are currently implementing a national action plan to specifically combat female genital mutilation, Belgium, Croatia, France, Slovakia, Spain and the UK have included measures in other national action plans (such as violence against women and human rights) to fight this harmful practice. Ireland is currently drafting a national action plan to fight female genital mutilation. Portugal is the only country in the EU that has renewed its national action plan across the years (2009-2010, 2011-2013 and 2014-2017). Table 3 below provides an overview of these policies.

**Table 3. Specific national action plans for combatting female genital mutilation and other national plans that include specific measures to fight female genital mutilation currently in place in the EU**

Country	National plan	Period covered	Issued by
Belgium	National action plan to combat intimate partner violence and other forms of domestic violence	2010-2014 (updated in 2012-2013)	Inter-ministerial Conference on Integration in Society
Spain	National Strategy for the Eradication of Violence against Women	2013-2016	Ministry of Health, Social Services and Equality – Government Delegation for Gender-based Violence
France	Inter-ministerial plan to fight violence against women	2014-2016	Inter-ministerial Committee on women's rights and on equality between women and men
Croatia	National Programme of Protection and Promotion of Human Rights for the Period	2013-2016	Government of the Republic of Croatia
Italy	Memorandum of Understanding on the criteria for the distribution of resources, the objectives, implementation and monitoring of the intervention system to be developed in order to prevent and combat female genital mutilation	Since 6 December 2012 <sup>5</sup>	Department of Equal Opportunities and Regional Authorities
Portugal	III Programme of Action for the Prevention and Elimination of Female Genital Mutilation	2014-2017	Presidency of the Council of the Ministers
Slovakia	National Action Plan for the Prevention and Elimination of Violence against Women	2014-2019	Government of the Slovakian Republic
Finland	Action Plan for the Prevention of Circumcision of Girls and Women	2012-2016	Ministry of Social Affairs and Health (STM) / National Institute of Health and Welfare (THL)
UK	A Call to End Violence against Women and Girls: Action Plan 2014	2014-2015	Home Office

Portugal and Spain developed FGM-specific health policies to set procedural guidelines for health professionals. While in Portugal the *Guideline for Healthcare Professionals on Female Genital Mutilation* was issued in February 2012, in Spain the *Common Protocol for healthcare procedures on female genital mutilation* will be put in place in 2015. The Portuguese guidelines encourage professionals to register female genital mutilation cases in a medical/hospital records platform. Based on the data collated through this platform, 30 cases were registered by August 2014.

Both countries also created FGM-specific child protection policy instruments. Portugal has recently issued a *procedures manual to actively collaborate in the prevention and elimination of FGM* (2014), targeting the local Commissions for the Protection of Children and Youth at Risk (CPCJ).

Spain has updated its *Basic protocol for intervention against child abuse* in order to include a reference to female genital mutilation (2014).

In 2012, Portugal issued a *procedures guide about FGM for criminal police staff* aiming at providing hints and instructions to police officers in order to better identify (potential) female genital mutilation criminal cases and to properly run the investigation.

The UK updated in 2014 the *Multi-Agency Practice Guidelines* (initially published in 2011). These updated guidelines support and assist frontline professionals, such as teachers, health professionals, police officers and social workers, in safeguarding children and protecting adults from the abuses associated with female genital mutilation.



### 2.3. Estimating FGM prevalence and risk at national level

By February 2012, ten studies had been conducted in six EU Member States that estimated female genital mutilation prevalence and/or risk: Belgium (2), France (1), Germany (1), Ireland (2), Italy (3), and the UK (1). In the meantime, five other studies were concluded and three others initiated.

Hungary and the Netherlands published their researches later in 2012. In 2013, Ireland published its third FGM prevalence estimate and Germany made available its second FGM prevalence and risk research. More recently, in 2014, Belgium published its third FGM prevalence and risk study. Portugal, Sweden and the UK were estimating FGM prevalence and risk at national level at the time this report was compiled. It should also be noted that Scotland was undertaking a prevalence study in 2014.

**Table 4. Research focusing on the estimation of FGM prevalence and/or risk**

Periods covered	Research about FGM prevalence and/or risk in EU Member States
January 1980 – February 2012	BE (2004, 2011), FR (2007), DE (2007), IE (2008, 2011), IT (2007, 2009, 2011), UK (2007)
March 2012 – June 2014	BE (2014), DE (2013), IE (2013), NL (2012), HU (2012)
To be published in 2015	PT, SE, UK

Although the findings of at least two of these researches are not expected to be published until 2015, some information about the methodological approach has been disclosed.

The Portuguese methodology encompasses a quantitative and a qualitative component for estimating FGM prevalence and risk. The quantitative component takes into account figures from the 2011 census about the female migrant population residing in Portugal and DHS and MICS prevalence rates. Other sources might still be considered in order to enhance the estimations. As regards the qualitative component, interviews with health professionals, religious leaders and civil society organisation leaders are being carried out. Women who underwent female genital mutilation, women who are not cut, and men who originate from countries where female genital mutilation is commonly practised are also being interviewed in order to understand their perceptions about the practice. The interviews are intended to provide information regarding the influence of migration on changing attitudes and behaviours towards female genital mutilation.

The Swedish study is estimating both FGM prevalence and risk using a quantitative methodological approach. For estimating FGM prevalence, the team is applying WHO data on prevalence in FGM-practising countries (females aged over 15) to the Swedish national statistics on residence and country-of-birth. Data on girls and women residing in Sweden, and born in a FGM-practising country are available in

Sweden. A decision is to be made regarding the calculation to estimate the number of girls under 15, as there is no reliable data from WHO or practising countries. Regarding FGM risk, the methodology to be used is still to be decided. The large group considered to be at risk refers to daughters of women originating from practising countries. The team is looking at different risk factors and the change of attitudes in the diaspora towards the practice.

An interim report of the study that is being carried out in the UK was made available in July 2014. This study aims at estimating the numbers of women and girls at risk of female genital mutilation living in England and Wales. Demographic data about women born in FGM risk countries<sup>6</sup> and girls born to them were derived from the 2011 census and from birth registration. The methodological approach used in the present study cannot be compared to the previous study conducted in 2007. For instance, white and South Asian women born in FGM-practising countries were excluded from the most recent study population (based on the analysis of individual anonymised census records which supposedly allowed for the production of more reliable estimates) and estimates for women aged 50 and over were included (as they are believed to give a fuller picture given the growing numbers of women in this age group). In addition, the current study will derive estimates for local areas to enable professionals to plan services to support affected women and safeguard their daughters.





# 3. The pilot countries



## 3. The pilot countries

The European Commission's Communication 'Towards the elimination of female genital mutilation' (2013) identifies 13 EU countries where there is evidence about women and girls who have undergone female genital mutilation or who are at risk of being subjected to this harmful practice. According to the European Commission, these countries are: Austria, Belgium, Denmark, Finland, France, Germany, Ireland, Italy, the Netherlands, Portugal, Spain, Sweden and the UK. Among these, Belgium (2014), Germany (2013), Italy (2011), the Netherlands (2013) and the UK (2007) have estimated the number of girls at risk of being subjected to this practice. The UK study was however not country-wide.

The following criteria were decisive for choosing the three Member States where the pilot studies were conducted:

- Evidence of a significant number of women and girls who were subjected to female genital mutilation or are at risk of being cut;
- Absence of country-wide FGM risk estimations;
- Existence of other administrative records that can allow an enhancing of the FGM risk estimation (hospital/medical records, child protection records, asylum records, irregular migrants records);
- Visible efforts in the country to eliminate female genital mutilation supported by governmental initiatives (such as having a national action plan and a specific law to prosecute female genital mutilation).

Based on these criteria, Belgium, Germany, Italy and the Netherlands (coloured in red in the overview table below) were not considered for the pilot study as there were already country-wide FGM risk estimations for these countries. Although the French prevalence study provides

evidence that there is a substantial number of women that have been mutilated, this country was *a priori* excluded (coloured in red in the overview table below) due to its legal and ethical restrictions that make it unconstitutional to gain access to and utilise certain 'sensitive' hard data. Even when such data is released, researchers experience serious difficulties in publishing their findings.

There were four countries matching all criteria, notably Ireland, Portugal, Sweden and the UK. All are presently collecting hospital/medical records. Whereas Ireland, Sweden and the UK already have a specific legal framework to criminalise female genital mutilation, three bills to introduce a specific law in Portugal were presented in the national parliament in 2014. Sweden adopted an FGM national action plan in 2003 and Portugal has continuously renewed its national action plan for combating the practice. The most recent Programme of Action for Preventing and Eliminating Female Genital Mutilation was launched in December 2013, covering the period between 2014 and 2017. In 2014, Portugal, Sweden and the UK were conducting an FGM prevalence and risk study. Only Portugal was considering a mixed methodological approach (i.e. including both a quantitative and a qualitative component). This may allow for a comparison of methodologies used in order to improve FGM risk estimations in the EU.

Taking into consideration that the UK has a very strong regional policy approach which could compromise data collection within the limited timeframe of this particular study, the EU Member States selected to carry out the pilot studies were: Ireland, Portugal and Sweden (coloured in red in the overview table below).



**Table 5. Assessment of criteria for selecting countries to carry out the pilot studies**

	Evidence of FGM <sup>i</sup>		FGM-specific records <sup>i</sup>				Legal and policy support <sup>i</sup>		TOTAL
	Prevalence studies	Absence FGM risk estimations (country-wide)	Hospital or medical records	Child protection records	Asylum and/or irregular migrants records	Police and criminal justice records	Specific law to prosecute FGM	On-going FGM-specific	
<b>Belgium<sup>ii</sup></b>	<b>X</b>		<b>X</b>		<b>X</b>		<b>X</b>		<b>4</b>
Bulgaria		X							1
Czech Republic		X							1
Denmark <sup>ii</sup>		X					X		2
<b>Germany<sup>ii</sup></b>	<b>X</b>					<b>X</b>	<b>X</b>		<b>3</b>
Estonia		X							1
<b>Ireland<sup>ii</sup></b>	<b>X</b>	<b>X</b>	<b>X</b>				<b>X</b>		<b>4</b>
Greece		X							1
Spain		X				X	X		3
<b>France<sup>ii</sup></b>	<b>X</b>	<b>X</b>	<b>X</b>		<b>X</b>				<b>4</b>
Croatia		X				X	X		3
<b>Italy<sup>ii</sup></b>	<b>X</b>				<b>X</b>		<b>X</b>	<b>X</b>	<b>4</b>
Cyprus		X					X		2
Latvia		X							1
Lithuania		X							1
Luxembourg		X			X				2
Hungary	X	X							2
Malta		X							1
<b>Netherlands<sup>ii</sup></b>	<b>X</b>		<b>X</b>	<b>X</b>			<b>X</b>		<b>4</b>
Austria <sup>ii</sup>		X					X		2
Poland		X							1
<b>Portugal<sup>ii</sup></b>		<b>X</b>	<b>X</b>				<b>(X)</b>	<b>X</b>	<b>4</b>
Romania		X							1
Slovenia		X							1
Slovakia		X							1

	Evidence of FGM <sup>i</sup>		FGM-specific records <sup>i</sup>				Legal and policy support <sup>i</sup>		TOTAL
	Prevalence studies	Absence FGM risk estimations (country-wide)	Hospital or medical records	Child protection records	Asylum and/or irregular migrants records	Police and criminal justice records	Specific law to prosecute FGM	On-going FGM-specific	
<b>Finland<sup>ii</sup></b>		X						X	2
<b>Sweden<sup>ii</sup></b>		<b>X</b>	<b>X</b>				<b>X</b>	<b>X</b>	<b>4</b>
<b>United Kingdom<sup>ii</sup></b>	X	X	X				X		4

<sup>i</sup> Source: EIGE (2013). Female genital mutilation in the European Union and Croatia – Report. This information has been complemented by a web-based research.

<sup>ii</sup> Countries where there is evidence about women and girls who have undergone female genital mutilation or who are at risk of being subjected to this harmful practice according to the European Commission's Communication 'Towards the elimination of female genital mutilation' (2013).<sup>ii</sup> Countries where there is evidence about women and girls who have undergone female genital mutilation or who are at risk of being subjected to this harmful practice according to the European Commission's Communication "Towards the elimination of female genital mutilation" (2013).

# 4. Methodological approach to estimate FGM risk



## 4. Methodological approach to estimate FGM risk

This chapter describes the methodological approach tested in the three pilot studies. The definitions of ‘girls at risk’ and ‘FGM risk estimation’ in EU Member States are discussed, and the methodologies used in the most recent FGM risk estimations conducted in EU Member States are examined. This review, together with the feedback obtained from the one-to-one expert consultations, allowed for a fine-tuning of the methodology and a defining of the types of data needed for undertaking an FGM risk estimation.

### 4.1. Overview of existing FGM risk estimations in the EU

#### 4.1.1. Defining girls at risk and FGM risk estimation

The challenges of defining girls at risk of female genital mutilation and estimating their numbers within EU Member States are many and, as shown in Table 6 below, there are relatively few precise definitions emerging from the most recent studies and academic articles on the subject.

**Table 6. Definition of ‘girls at risk’ of most recent FGM risk estimations in the EU**

Country	Most recent FGM risk estimations	Definition of girls at risk (if any)
BE	Study on the prevalence of female genital mutilation and risk for female genital mutilation in Belgium (2014)	The figures presented in this study combine <b>both</b> girls and women at risk living in Belgium (ages from 0 to 50+). Girls at risk are defined as follows: girls that are born in Europe or who have arrived at young age with their parents on the territory run the risk of being cut because the pressure from family and surroundings is big, even in Europe.
DE	Estimations about Female Genital Mutilation in Germany (2013)	Girls under age 15 who have migrated from FGM risk countries, or were born to parents (or one parent) who originate from countries where FGM is documented.
IT	The right to be girls. Dossier on Female Genital Mutilation (2011)	No definition provided.
NL	Female Genital Mutilation in the Netherlands – Prevalence, incidence and determinants (2013)	The number of girls aged 0-15 who have migrated from FGM risk countries, or were born to parents (or one parent) who originate from countries where FGM is documented.



Country	Most recent FGM risk estimations	Definition of girls at risk (if any)
UK	A statistical study to estimate the prevalence of FGM in England and Wales (2007)	'Girls under 15 born in FGM practising countries and now resident in England and Wales. <b>"And"</b> Girls aged under 15 born in England and Wales to women born in FGM practising countries.'

Sources: Please consult the bibliography for full references of these researches.

In UNICEF's report 'Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change' (UNICEF, 2013), the process and challenges of estimating girls at risk of female genital mutilation following migration are presented. Often the number of girls who are at risk of undergoing female genital mutilation in a country (or region or city) following migration is calculated by applying the national FGM prevalence figure for certain age groups (such as ages 15 to 19) from the country of origin of a girl's parent(s) and applying this figure to the number of daughters of migrants resident in their country, region or city of immigration<sup>7</sup>. These estimates are deemed problematic due to a lack of understanding of the effects that migration may have on the continuation of female genital mutilation and due to a lack of inclusion of factors such as ethnicity, level of education, region of residence of parents in country of origin, and differences between first, second and third generation, in calculating possible FGM risk (UNICEF, 2013). In order to build a common understanding that is intended to support the estimation of FGM risk in the EU, a conceptual framework is suggested below.

As proposed in EIGE's report about 'Female Genital Mutilation in the European Union and Croatia' (2013), *girls at risk of FGM are defined as minor girls (most commonly in the age range of 0-18) who come from FGM risk countries, or were born to parents (or one parent) who originate from countries where FGM is practised.*

The age interval to estimate the number of girls at risk of undergoing female genital mutilation in the EU is an important component of this framework. According to the definitions described above, the age of the girls who are considered to be at risk of female genital mutilation range from 0 to 15 and from 0 to 18. The median age of FGM (as customary in the country of origin) and the definition of 'minor' in the EU appear to be two competing factors when it comes to establishing the age interval of girls who might be at risk of being subjected to female genital mutilation.

The definitions discussed above seem to indicate that *all* girls (either in the age range 0-15 or 0-18) who come from FGM risk countries, or were born to parents (or one parent) who

originate from countries where female genital mutilation is commonly practised are *at risk*. This may lead to an erroneous interpretation of the concept of 'girls at risk'. As explained above, the number of girls at risk of female genital mutilation is a result of a series of calculations based on the absolute numbers of girls who live in an EU Member State and who originate from countries where female genital mutilation is commonly practised or whose parents come from these countries. Therefore, the total number of minor girls living in an EU Member State who come from FGM risk countries, or were born to parents (or one parent) who originate from countries where female genital mutilation is documented can only be considered to be *potentially at risk* as no extrapolation or other calculations have been applied to these data.

Based on the arguments presented above, the following definitions underpin the present study:

**Girls potentially at risk** are defined as minor girls (in the age range of 0-18) who come from FGM risk countries, or were born to parents (or one parent) who originate from countries where female genital mutilation is commonly practised.

**FGM 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) 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.

Although the definition of girls potentially at risk refers to girls born to parents or one parent, the sources of data and information to be consulted for collecting data to estimate FGM risk do not contain information regarding the country of birth or related data for the father. For that reason, the definition of FGM risk estimation established for the present study refers to girls born to mothers who originate from FGM risk countries.

While prevalence and risk are often discussed in similar contexts, the distinction between the two must be clear



for the purposes of this study. FGM prevalence in an EU Member State 'refers to the number of women and girls in that country who have undergone female genital mutilation at a certain point in time, expressed as the proportion of the total number of women living in the country and originating from countries where female genital mutilation is practised' (EIGE, 2013). Therefore, prevalence figures relate to women and girls who have in the past undergone female genital mutilation and risk estimations relate to girls under 18 who may in the future undergo female genital mutilation. The present study focuses solely on FGM risk estimation as defined above.

#### 4.1.2. Review of existing methodological approaches for estimating FGM risk in the EU: advantages and disadvantages

By July 2014, only five EU Member States had estimated FGM risk for their country, namely Belgium, Germany, Italy, the Netherlands, and the UK. The following table provides an overview of these studies.

**Table 7. Overview of the most recent FGM risk estimations in EU countries**

Country	Title of most recent FGM risk estimations	Year of publication	No of girls (and women) at risk of FGM
BE	Study on the prevalence of female genital mutilation and risk for female genital mutilation in Belgium	2014	4 084
DE	Estimations about Female Genital Mutilation in Germany	2013	2 500
IT	The right to be girls. Dossier on Female Genital Mutilation	2011	7 727
NL	Female Genital Mutilation in the Netherlands – Prevalence, incidence and determinants	2013	557-3 477
UK	A statistical study to estimate the prevalence of FGM in England and Wales	2007	79 636
UK	Female genital mutilation in England and Wales: Updated statistical estimates of the numbers of affected women living in England and Wales and girls at risk. Interim report on provisional estimates	2014	Not available yet

Sources: Please consult the bibliography for full references of these researches.

A short annotation of each of the above mentioned studies is provided below. Annotations focus on methods used to estimate the risk, the data sources used and the assets and limitations of each of these methods as identified in each study.

### Belgium

As of June 2014, Belgium has published three FGM prevalence and risk estimations (2003<sup>8</sup>, 2008<sup>9</sup>, 2012<sup>10</sup>). The most recent study report dates from 2014 and refers to data from 2012. The main sources of information were the statistical office, the birth registration office, and the foreign affairs

department. These organisations provided data on the female population originating from FGM risk countries living in Belgium. The number of women living in Belgium and originating from countries where female genital mutilation is documented (first generation) and the number of girls born to these mothers (second generation) was assessed. Then, the prevalence per age cohort from country of origin was extrapolated on women and girls living in Belgium. The extrapolation was based on FGM prevalence data of DHS and MICS for the age cohort 15-49 years.

This study defined four age cohorts for at risk populations: aged less than five years, 5-19 years, 20-49 years, over 50 years (see Table 8 below). ONE and K&G<sup>11</sup> provided the



numbers of births disaggregated by sex and age cohorts 0-4, 5-9 and 10-14, for the period 1998-2012, and according to the origin of the mother (FGM risk countries). ADSEI<sup>12</sup> provided the data of the female population by place of birth, current nationality, first registered nationality, year of birth, and the province of residence (in Belgium) on 31 December 2012. The 'Foreign Affairs' Department (Di-

enst Vreemdelingenzaken) provided the number of women requesting asylum in 2012 from FGM risk countries, and the Federal Agency for the Reception of Asylum Seekers (FEDASIL) provided the number of minor girls who received support from this organisation (non-asylum seekers), for the period 1998-2012.

**Table 8. Estimating FGM prevalence and risk in Belgium (2014)**

At risk age cohort	Number	Status	Data source
< 5 years	2 079	At risk	ONE, K&G
5-19 years	1 597	At risk or might already be cut	ONE, K&G for 5-9 yrs ADSEI for 10-19 yrs
20-49 years	368	At risk or are cut	ADSEI
> 50 years	40	Might be cut	ADSEI
<b>TOTAL</b>	<b>4 084</b>	<b>At risk or might be cut</b>	

The limitations of the approach, as mentioned in the Belgian study, relate to the lack of data on undocumented women and on ethnic background (as the practice of female genital mutilation is linked to ethnicity rather than to nationality), and to the incompleteness of certain data sources (K&G and ONE) as original nationality of the mother was sometimes lacking. The report also mentions that the influence of migration or other factors (family, community and the impact of the law) were not assessed.

## Germany

Terre des Femmes, a German civil society organisation working on the issue of female genital mutilation, recently published a calculation of estimated numbers of women and girls affected by female genital mutilation and of girls at risk of female genital mutilation in Germany. The calculations are based on the figures (obtained from the German Statistical Office) of girls and women registered in Germany, having the nationality of one of the 28 considered countries where female genital mutilation is commonly practised (all countries considered by UNICEF, except Yemen). Based on the UNICEF data, the median age of cutting in each country of origin was calculated, and subsequently the 'extrapolation-of-FGM-practising-countries-prevalence-data-method' was applied: 1) on the number of girls below the median age of cutting, and 2) on the number of girls and women above the median age of cutting. By doing so, the estimated numbers of 1) girls and women having undergone female genital mutilation (24 997) and 2) girls at risk of being subjected to female genital mutilation (2 500) were obtained. The pub-

lication emphasises that these figures underestimate the actual numbers for the following reasons: girls and women of African origin who have been naturalised are excluded, as are stateless and undocumented girls and women; only girls and women from African origin are considered, while female genital mutilation is also practised in some Arab and South-East Asian communities. Moreover, while the UNICEF report indicates a downward trend in the practice of female genital mutilation in African countries, such a trend does not necessarily exist amongst diaspora communities who may retain values and traditions from their home countries.

## Italy

The data source of the most recent FGM risk estimation in Italy differs from all the other researches described in this section. Fondazione l'Albero della Vita collected data on the number of students integrated in the Italian school system who originate from countries where female genital mutilation has been documented. The rationale for collecting data from the statistical office of the Ministry of Education, University and Research relates to the fact that schools are attended by almost all children born to migrants in regular and irregular situation due to a policy to stimulate access to education. In total, in the school year of 2010/2011, there were 25 203 girls registered in Italian schools who originated from FGM risk countries. As done in previous Italian prevalence studies, the 'extrapolation--of-FGM-practising-countries-prevalence-data-method' was used, which indicated that 11 038 girls were at risk.

A percentage (30%) referring to the reduction of the practice between mothers and daughters in the countries of origin<sup>13</sup> was then subtracted from the latter result, indicating that 7 727 girls were at risk of undergoing female genital mutilation in Italy.

As a limitation of this research, the authors recognise that only girls that are registered in the Italian school system were considered for the estimation (i.e. those that are still not attending any school and those who stopped studying after concluding the mandatory education (6-16 years old) were not counted).

## The Netherlands

In January 2013, a report on prevalence, incidence and determinants of female genital mutilation in the Netherlands was published. This was the first prevalence and incidence estimation on female genital mutilation in the Netherlands ever performed. In order to make these estimations, a mixed method approach was followed. This mixed approach consisted of a systematic literature review to assess determinants of risk of female genital mutilation in a migration context, focus group discussions to assess the influence of migration on female genital mutilation in the Netherlands, and an estimation of the number of girls at risk of female genital mutilation. The risk estimations were divided into three categories (high, medium and low). The high variant assumes that the practice of female genital mutilation has not changed among migrant populations<sup>14</sup>. The medium risk estimate assumes that female genital mutilation has not changed among the first generation migrants, while female genital mutilation will not happen in the second generation due to behaviour change of the mothers<sup>15</sup>. Finally, the low variant assumes that female genital mutilation has changed in the first generation migrants, and that it will not happen anymore among the second generation as a result of changed behaviour of mothers<sup>16</sup>.

The main sources of information used included DHS and MICS (for FGM prevalence data in countries of origin), female migrant population data in 2012 from FGM-practising countries derived from the Central Statistical Office, data from the Central Office of Asylum for female asylum seekers in 2012, and data about risk of female genital mutilation in girls under the age of 19 with one or two parents from an FGM risk country, derived from Youth Health Care and the Advice and Reporting Centres for Child Abuse and Neglect (AMK). The female migrant population was disaggregated by age, first and second generation, place of birth, and length of stay in the Netherlands. Data about female asylum seekers in reception centres in 2012 was disaggre-

gated by age and country of origin.

Some limitations of the study were acknowledged in the report. First of all, it was mentioned that the literature review might not have provided an exhaustive overview of determinants, risk of female genital mutilation and behaviour change, as only papers on quantitative data on FGM prevalence and incidence, and its determinants, were included. Secondly, the DHS and MICS data that were used do not include FGM data for the female population younger than 15 and older than 49 years. The FGM status in DHS and MICS surveys is self-reported by mothers. Thirdly, the study did not take into account undocumented migrants. The report mentions that risk taxation is done based on prevalence rates that are calculated according to certain criteria and not based on medical check-ups, hence the risk estimation might contain a bias. Furthermore, the study might suffer from under-registration of (risk of) female genital mutilation as national aggregated data on female genital mutilation are not available<sup>17</sup>. Finally, the assessment of the influence of migration, done through the focus groups, was not performed with a representative sample of all migrant groups, and recruitment was biased as the hard-to-reach groups were difficult to include (those not linked to migrant organisations or not involved in the anti-FGM activities).

## United Kingdom

In 2007, FORWARD published a study with FGM prevalence estimates for England and Wales. Previously, some risk estimates were published (see Kwateng-Kluytse, 2004) but they contained some methodological limitations. The methodology used in the 2007 study was the 'extrapolation-of-FGM-practising-countries-prevalence-data-method', and derived numbers of women born in 29 FGM risk countries from the census data, grouped by age cohort. The number of women having undergone female genital mutilation was estimated by multiplying the number of women in each age group from each FGM country by the age-specific FGM prevalence for that country, and then summing these numbers over all the countries. The age-specific FGM prevalence in each country of origin was assumed to represent the proportion of women from that country in that age group who would have undergone female genital mutilation.

Data sources used were DHS, MICS and other ad hoc surveys and estimates for FGM countries of birth; 2001 census data on the number of girls born in FGM countries and under the age of 15 in 2001; and birth registrations from 1993-2004 indicating the number of girls born in England and Wales to mothers born in countries where female genital mutilation is commonly practised.



Limitations mentioned in the study and by Equality Now (2012) include an underestimation in census data (migration increased but is not quantified in census data), a failure to assess the influence of migration, and the omission of data on the second generation. The study is limited to England and Wales (Scotland and Northern Ireland are not included), and does not take into account asylum seekers (data on asylum seekers are not disaggregated by sex) or undocumented migrants.

In 2014, provisional estimates of the number of women having undergone female genital mutilation living in England and Wales were published. Estimates of the number of women giving birth in the UK who have undergone FGM, and the number of girls born to women who have undergone female genital mutilation, were also published (see Macfarlane and Dorkenoo, 2014). Data was derived from the most recent DHS and MICS surveys, as well as 2011 census data of people born in FGM practising countries. The goal was to estimate at national and local authority level<sup>18</sup> the number of women born in FGM risk countries who gave birth in England and Wales. Estimates regarding the number female live births to mothers having undergone female genital mutilation were also made. The final report of these updated estimates is forthcoming (early 2015) and complete information about the FGM risk estimation should be provided.

## Discussion

All studies used the extrapolation-of-FGM-practising-countries-prevalence-data-method (applying the age cohort 15-49<sup>19</sup>). Sources of information for the female migrant population differ between studies. The age cohorts considered to be 'at risk' also vary considerably. For instance, the Belgian risk estimates included women over 19 years of age. Only the Dutch study used the median age of cutting as a variable to obtain more accurate estimates.

Although the UK and Belgian studies acknowledged that the influence of migration needs to be considered in prevalence and risk estimates, only the Dutch study included a qualitative component that attempts to take into consideration the influence of migration on FGM behaviour change. In terms of FGM risk, this influence will only be relevant for girls born in Europe and those who arrived in Europe before being cut.

The lack of ethnicity information on migrants in EU countries, which would help to estimate prevalence more accurately, remains an issue for all the studies discussed above, as no study has taken ethnicity into consideration. Instead, in the Dutch study, places of birth of female migrants were

used and regrouped to regions within the country of origin. FGM prevalence data by region in the country of origin is available in DHS and MICS data.

It should be noted that most of the studies have tried to combine several databases in order to have an accurate estimate, including data on asylum seekers as well as second generation. In the UK, the female asylum seekers were not taken into consideration, as the data are not disaggregated by sex. No study has included the undocumented female migrant population.

Only Belgium has repeated its risk and prevalence estimates over time; the two most recent estimates used the same methodology and allow for assessing a trend.

## The influence of migration

For the present study, a review of recent literature (2012-2014), complementing the knowledge collected through the study 'Female Genital Mutilation in the Netherlands – Prevalence, incidence and determinants' (Exterkate, 2013), has been conducted on the determinants influencing attitudes and behaviours towards female genital mutilation in a migration context, and on the particularities of applying qualitative methods with this specific target group. The elements which are likely to influence attitudes towards (dis)continuing female genital mutilation include:

- **Societal level:** presence of law and non-supportive environment in European country; better social and economic opportunities for girls and women; the empowerment of girls and women; different perceptions of women's role and status in society, and of parental practices.
- **Community level:** less social pressure to perform female genital mutilation; social pressure from the community (Europe and in the country of origin); female genital mutilation as a symbol of the home country.
- **Interpersonal level:** better marriage prospects for uncut girls; different views on female genital mutilation between men and women.
- **Individual level:** increased knowledge/awareness about health, legal, and religious aspects of female genital mutilation.

Specifically, social pressure and the presence of a law prohibiting female genital mutilation were seen as determinants that can influence attitudes and behaviour both positively (to abandon female genital mutilation) and negatively (to continue female genital mutilation or to perform female genital mutilation prior to migration).

## 4.2. Methodology to estimate FGM risk in the EU

The methodological approach implemented in the three selected Member States is described hereafter. The methodology took into consideration the most recent methodological approaches for estimating FGM risk in other EU countries and the input received through one-to-one consultations with experts. As opposed to the majority of the methodological approaches used in other EU FGM risk estimations, the present methodology includes a quantitative and a qualitative component. The insights and knowledge gained through applying the methodology are also shared in this section.

### 4.2.1. Quantitative component

Different types of data are needed to estimate FGM risk, both in countries of origin and in destination countries. These are described below. This section also describes the data processing required for subsequently calculating an FGM risk estimate.

### Countries of origin (29 FGM-practising countries)

#### Data sources and variables collected

Female genital mutilation prevalence in countries of origin has been estimated based on large-scale, national, representative household surveys. National survey data in these countries originate from Demographic and Health Surveys (DHS) published by ICF International<sup>20</sup> and from Multiple Indicator Cluster Surveys (MICS) published by UNICEF<sup>21</sup>. These surveys include modules on female genital mutilation and pose questions that enable a range of inter- and intra-country comparisons to be carried out. They move towards a set of standardised indicators for situation analysis and monitoring progress towards ending female genital mutilation, which enhances the potential for comparison.

For each country the most recently published reports were reviewed (accessed on 21 August 2014) (see Table 7). Although these reports include information on different variables, not all were considered relevant for the present assignment. The variables that were used for estimating FGM risk in the three selected EU Member States are:

#### 1. Prevalence rates for 15-19 age cohort (instead of 15-49 age cohort)

Using national prevalence levels for the age cohort 15-49 to estimate the number of girls at risk overestimates the true risk for girls from those countries where there has been a decline in female genital mutilation prevalence in recent years (most recent FGM prevalence data indicate a decline in the large majority of countries). As suggested by Yoder (2011) and UNICEF (2013), using prevalence figures for women in the 15-19 age cohort (i.e. the group of youngest adults considered to be in 'final cut status', being either cut or not at risk anymore) in the country of origin is believed to yield a more accurate FGM risk estimation.

#### 2. Age of female genital mutilation for women in 15-19 age cohort (instead of 15-49 age cohort)

Among women, data on age of female genital mutilation are likely to be imprecise, as recall bias can be presumed to affect responses from girls and women who underwent female genital mutilation when they were very young. Data on age of FGM are used for women in the youngest age cohort (15-19) (UNICEF, 2013). In the event that data on age of cutting for women in the 15-19 age cohort were not available, age of FGM for women aged 15-49 was used.

Despite the fact that data about *FGM prevalence rates disaggregated by region* are available for all 29 countries where female genital mutilation is commonly practised, these data cannot be used when data on region of origin are not available in the countries of destination. In most countries of origin (20 countries, see Table 9), the variance in FGM prevalence between different geographical regions is 50 % or more. Region of origin can therefore be considered an important determinant for FGM risk estimations. The migrant population residing in an EU Member State may or may not be representative of the population in the country of origin regarding age and region. Exterkate (2013) found in her study that women living in the Netherlands and originating from Ghana come from regions where female genital mutilation is hardly practised (Greater Accra and Ashanti). Therefore, if the national FGM prevalence rate from Ghana is applied to the Dutch Ghanaian female population, the results will be an overestimation of the number of women that underwent female genital mutilation. For Dutch Nigerian women, the opposite was true, as most Dutch Nigerian women originated from regions with higher than national average FGM prevalence. None of the EU Member States where the methodology for the present study was implemented collects information on the region of origin for the migrant population.



Table 9. FGM prevalence rates and median age of FGM in the countries of origin

Country	Year of most recent report		FGM prevalence rate among		FGM prevalence rate by region (%)		Median age of FGM
	(last checked on 21/08/2014)		girls and women aged 15-19 (%)	girls and women aged 15-49 (%)	lowest	highest	
Benin	DHS	2011/12	2	7	0	41	9
Burkina Faso	DHS/MICS	2010	58	76	55	90	4
Cameroon*	DHS	2004	0.4	1	0	5	9
Central African Republic**	MICS	2010	18	24	3	77	14
Chad**	MICS	2010	41	44	2	96	9
Côte d'Ivoire	DHS	2011/12	31	38	12	80	4
Djibouti***	MICS	2006	90	93	93	95	9
Egypt*	DHS	2008	81	91	66	96	10
Eritrea	DHS	2002	78	89	82	98	1
Ethiopia***	DHS	2005	62	74	27	97	4
Gambia**	MICS	2010	77	76	49	99	4
Ghana**	MICS	2011	2	4	0	41	9
Guinea	DHS	2012	94	97	89	100	9
Guinea-Bissau**	MICS	2010	48	50	6	95	9
Iraq**	MICS	2011	5	8	0	58	9
Kenya	DHS	2008/09	15	27	1	98	11
Liberia*****	DHS	2007	52	58	1	87	14
Mali	DHS	2012/13	90	91	88	95	4
Mauritania**	MICS	2011	66	69	20	99	4
Niger	DHS	2012	1	2	0	9	4
Nigeria	DHS	2013	15	25	3	49	4
Senegal	DHS/MICS	2010/11	24	26	1	92	4
Sierra Leone**	MICS	2010/11	70	88	73	96	14
Somalia***	MICS	2006	97	98	94	99	9
Sudan****	UNICEF	2013	84	88	65	99	7
Togo**	MICS	2010	1	4	1	14	14
Uganda*****	DHS	2011	1	1	0	5	7
Tanzania	DHS	2010	7	15	1	59	4
Yemen****	DHS	2013	16	19	0	85	7



Sources: DHS: <http://www.measuredhs.com/Publications/Publications-by-Country.cfm>  
 MICS: [http://www.childinfo.org/mics\\_available.html](http://www.childinfo.org/mics_available.html)  
 UNICEF: FGM/C: A statistical overview and exploration of the dynamics of change UNICEF, New York, 2013.

*Median age of cutting estimated by using data on age of FGM of the 15-19 year age cohort:*

- \* Estimated by using data on age of FGM of the 15-49 year age group.
- \*\* Estimated by using data on age of FGM of the 15-49 year age group from UNICEF 2013 report.
- \*\*\* Estimated by using data on age of FGM of the daughters from UNICEF 2013 report.
- \*\*\*\* Estimated by using the average of median ages from 25 countries with estimated data.
- \*\*\*\*\* Assumption: median age is the same as in Sierra Leone, as these two countries have similar practices of rites of passage and secret societies.

Although *FGM prevalence rates disaggregated by ethnicity* are available for 11 countries of origin, the EU Member States where the pilot studies were carried out do not collect this information for the migrant population because it is forbidden by law (as is the case in Portugal – Law no. 67/98) or have different typologies of ethnicity (e.g. in Ireland, the categories collected in the census are: white – Irish, Irish traveller, any other white background; black or black Irish – African, any other black background; Asian or Asian Irish – Chinese, any other Asian background; other, including mixed background).

*FGM data referring to daughters* (0-14 age cohort) are also available for some countries where female genital mutilation is documented through the national surveys referred to above. However, such prevalence data for girls aged 0 to 14 reflect their current FGM status and do not reflect the final prevalence for this age group. Some daughters who have not undergone female genital mutilation at the time of the survey may not have reached the customary age for cutting and may still be at risk. These data are biased towards earlier ages in the distribution of age at cutting, and therefore, over-represents girls who are cut at a younger age (UNICEF, 2013). For this reason, it was decided not to include FGM prevalence data on 0-14 year old girls.

The following specific calculations were required for the pilot study:

### FGM prevalence for Liberia

In Liberia, female genital mutilation is practised by bush societies or the Sande society, which refer to bush schools for young girls. Because of the secretive nature of the bush society and the sensitivity of direct questions about female genital mutilation, women interviewed in the DHS were asked if they had ever heard of a bush society like the Sande society and, if so, whether they were a member of it. So, for instance, for the age group 15-49, 89 % of women said they had heard of such bush societies. Among those who had heard of bush societies, 66 % said they were members. Assuming that all members are cut, this translates into an FGM prevalence of 58 % (66 % x 89 %) (Liberia DHS, 2007).

### Median age<sup>22</sup> of FGM was estimated (see Table 9) by:

- Using frequency tables of age at FGM of the 15-19 year age cohort by age group between 0 and 15+ (Benin, Burkina Faso, Côte d'Ivoire, Eritrea, Guinea, Kenya, Mali, Niger, Nigeria, Senegal, United Republic of Tanzania).
- Using frequency tables of age at FGM of the 15-49 year age cohort by age group between 0 and 15+ (Cameroon, Egypt, Central African Republic, Chad, Gambia, Ghana, Guinea-Bissau, Iraq, Mauritania, Sierra Leone, Togo).
- Using frequency tables of age at FGM of daughters of the 15-49 year age cohort by age group between 0 and 15+ (Djibouti, Ethiopia, Somalia).
- Applying the average of median ages from 25 countries with estimated data (Sudan, Uganda, Yemen).
- Assuming the median age for Liberia is the same as Sierra Leone, because these two countries have similar practices of rites of passage and secret societies.

No exact age of female genital mutilation is provided in the DHS and MICS reports. The only information available is the percentage of FGM cases disaggregated by age groups (most often 0-4, 5-9, 10-14, 15+, unknown). The median age of cutting was calculated as follows:

- Firstly, the 'unknown' were redistributed over the age categories.
- Secondly, the highest boundary of the age group in which 50 % falls was selected as the median age.

The DHS report for Eritrea, Egypt and Kenya provided more detailed information on age of FGM and, as a result, a more precise median age could be estimated for these three countries.



## Countries of destination (Ireland, Portugal and Sweden)

### Data sources and variables required

Different types of data are needed from the destination country (in this case, in the EU) to estimate FGM risk and these are not necessarily all collected by the same institution. In the particular case of the three EU Member States where the pilot test took place, as data are not accessible in open sources, different organisations had to be contacted to bring together the required data. The reference year for collecting data was 2011 in order to have comparable data from all sources of information. An EU-wide census took place in 2011 which strived for an output harmonisation in order to establish more comparable data between Member States (including migration history). In the 2011 censuses, information on the 'place of birth' (country) of an individual was (to be) collected according to the place of usual residence of the mother at the time of birth, or, if not available, the place where the birth took place. All countries where female genital mutilation is commonly practised are in the list provided in Eurostat's Explanatory Notes on EU legislation on the 2011 Population and Housing Censuses, so data broken down by country of birth is available. Disaggregated information on the 'year of arrival' is also available. The year of arrival corresponds to the calendar year in which a person most recently established usual residence in the EU Member State (not the year of first arrival in the country, or in the EU).

Although the present research focussed on 2011, the evolution of the number of girls at risk has also been considered. More recent data from 2012 and 2013 were requested regarding live births, asylum seekers, refugees, irregular migrants and other FGM-specific administrative records.

Detailed guidelines with information on the specific data and instructions regarding the disaggregation needed were developed and sent to the institutions holding the data. A glossary was included to ensure a uniform data collection over the three pilot countries.

Variables requested per country (Ireland, Portugal and Sweden) were:

- **Female migrant population** aged 0-18 originating from the 29 countries where female genital mutilation is documented (2011)
  - By country of origin, one year age group<sup>23</sup>, first and second generation
  - By regional level, e.g. region, county or city of birth
  - By age of arrival of the first generation (or length of stay)

These data were collected through the national statistical office.

- **Female live births** to mothers originating from the 29 countries where female genital mutilation is documented (2011, 2012 and 2013)
  - By country of origin of mother
  - By regional level, e.g. region, county or city of birth of mother

These data were collected through the Central Birth Registration Offices in Ireland and Portugal, and through the national statistical office in Sweden.

- **Female asylum seekers, female refugees and irregular female migrants** aged 0-18 originating from the 29 countries where female genital mutilation is documented (2011, 2012 and 2013)
  - By country of origin, one year age group, first and second generation
  - By regional level, e.g. region, county or city of birth
  - By age of arrival of the first generation (or length of stay)

In Ireland, these data were collected through the Reception & Integration Agency, the Office of the Refugee Applications Commissioner, and the Irish Naturalisation and Immigration Service. In Portugal, the Border and Immigration Services provided these data. In Sweden, these data were collected through the national statistical office.

- **Other records regarding FGM data**

These records may refer to female genital mutilation or risk of female genital mutilation among girls under the age of 18 with parents originating from an FGM risk country and currently living in Ireland, Portugal and Sweden (2011, 2012 and 2013). These data were collected through different organisations where relevant records were kept. Medical/hospital records on female genital mutilation are kept in all three countries. By December 2014, only Portugal provided these data, which were collected through the Health Data Platform.

As regards data referring to asylum seekers and irregular migrants, Eurostat could have been a possible source of comparable information across EU Member States. However, the level of disaggregation of the Eurostat data does not allow for applying the present methodology. For instance, data is not broken down by one year age groups.

Another problem related to the availability of data for the present study concerns female refugees. These data could not be retrieved in Ireland or Sweden as data on female asylum seekers and refugees cannot be disaggregated from each other.

Table 10 presents country-specific sources and data availability.



Table 10. Data availability in countries of destination (as of 18 November 2014)

Type of data	Ireland	Portugal	Sweden
<b>Female migrant population originating from FGM risk countries</b>	Central Statistics Office (CSO)	Statistics Portugal (INE)	Statistics Sweden (SCB)
2011	available	available	available
by age (0-18) and country	available	available	available
by first and second generation	available	available	available
by regional level	inexistent	inexistent	inexistent
by age of arrival	available	available	available
<b>Live births in EU to FGM originating mothers</b>	National Perinatal Reporting System (ESRI - HPO)	Institute of Registration and Notary Affairs (IRN)	Statistics Sweden (SCB)
2011, 2012, 2013	available (2011, 2012)	available	available
by country of mother	available	available	available
by regional level of country of mother	inexistent	inexistent	inexistent
<b>Asylum seekers</b>	1) Reception & Integration Agency (RIA) 2) Office of the Refugee Applications Commissioner (ORAC)	Immigration and Border Service (SEF)	Statistics Sweden (SCB)
2011, 2012, 2013	available	unknown	available
by age (0-18) and country	available	unknown	available
by first and second generation	only new asylum seekers	unknown	only new asylum seekers
by regional level	inexistent	unknown	inexistent
by age of arrival	available	unknown	available
<b>Refugees</b>	Irish Naturalisation and Immigration Service (INIS)	Immigration and Border Service (SEF)	Statistics Sweden (SCB)
2011, 2012, 2013		unknown	inexistent (data about refugees are included in data on asylum seekers but cannot be separated until the former are registered)
by age (0-18) and country	inexistent (data about refugees cannot be separated from data on asylum seekers)	unknown	
by first and second generation		unknown	
by regional level		unknown	
by age of arrival		unknown	



Type of data	Ireland	Portugal	Sweden
<b>Irregular migrants</b>	Irish Naturalisation Immigration Service (NIS)	Immigration and Border Service (SEF)	n/a
2011, 2012, 2013	available	unknown	
by age (0-18) and country	available, but only by 0-13 and 14-18 and nationality	unknown	data on irregular migrants does not exist
by first and second generation	inexistent	unknown	
by regional level	inexistent	unknown	
<b>Registration- other sources</b>	1) Health Services Ireland (HSE) 2) Office of the Director of Public Prosecutions (DPP) 3) Child and Family Agency TUSLA	Shared Services of the Ministry of Health: 1) Health Data Platform, and 2) Data from the National Programme for Infantile and Juvenile Health (PNSIJ)	National Board of Health and Welfare (medical records); Swedish National Council for Crime Prevention (police/judicial records)
medical/hospital	available, but no data were collated to date	available (from May 2014 onwards)	available, but the existing data in the system is not reliable and, therefore, was not made available
child protection	inexistent	inexistent	inexistent
police/judicial	inexistent	inexistent	available (no records referring to 2011-2013)
asylum	inexistent	although there is no record system, number of cases is known (no records referring to 2011-2013)	inexistent

## Procedural requirements

Some data could only be retrieved upon payment (i.e. data collected through the statistical offices in Portugal and Sweden, and from the birth registration office in Portugal).

Whereas the guidelines for data collection were sent to the concerned institutions by the end of July 2014, the time for obtaining 'ready-to-be-analysed' data varied significantly (i.e. from less than one week to 12 weeks). In certain cases, several exchanges were needed in order to obtain the level of data disaggregation requested. Some of the institutions had to process data in order to meet the requirements for this study (for instance, readily accessible data were broken down in different age groups than those requested).

For certain datasets, specific non-disclosure and confidentiality declarations had to be signed in order to obtain the data. In Ireland, the National Perinatal Reporting System (NPRS) sent the data in a password protected file, which required a signed and returned consent-of-use form prior to password release. Due to the sensitive nature of the data, the Irish statistical office gave permission to only one team member to analyse the data. The communication of the results had to be reviewed before they could be shared with others.

## Data processing

As the data collected came from a wide range of sources, it was not all formatted or presented in the same way. In order to harmonise the data and make it comparable, the data needed to be processed. In general, the steps for processing the data were similar for all three pilot countries:

- a) Translation to English of information provided in datasets (where necessary). This was only done for Portugal as data were provided in Portuguese.
- b) Upon receiving the tables, a quality assessment of the data received was done. This assessment included a check on completeness, consistency, and whether data were in line with the definitions provided in the guidelines.
- c) In the event that clarifications were needed, these were fed back to the national researcher or directly to the supplier of the data.
- d) Harmonising of the layout (e.g. translation and alphabetisation of data), so that the tables for all countries were presented similarly.

## 4.2.2. Qualitative component

In order to assess the influence of migration on the practice of female genital mutilation, the approach included a qualitative component. This element was understood to be crucial for assessing the level of risk in each country. The level of risk may vary from Member State to Member State depending on acculturation and existing initiatives in the country, notably prevention campaigns, knowledge about the law and its enforcement, and length of stay of migrants, among others. Considering the existing FGM risk estimations conducted in EU Member States, only the Dutch study (published in 2013) included a qualitative part to retrieve information on social pressure and risk of female genital mutilation in the country. Learning from this up-to-date experience and from other FGM-related qualitative studies, focus group discussions were organised to gain an understanding of the influence of migration on attitudes, beliefs and behaviours towards female genital mutilation and of the level of risk of female genital mutilation in a migration context in a certain EU Member State.

Three (Ireland, Portugal) to four (Sweden) group discussions were organised per country. The duration of each group discussion varied between 83 and 150 minutes. The focus group discussions took place in Dublin (Ireland), Lisbon (Portugal) and Örebro (Sweden) due to the high concentration of migrants originating from countries where female genital mutilation is documented living in these cities.

Demographic information about the participants was collected through a pre-discussion written questionnaire (in English, Portuguese and Swedish), covering age; country and region of origin of the participant, her/his parents and her/his partner; ethnicity; age of arrival in country of destination; number of daughters and sons; level of education; and resident status. Some participants required assistance from the facilitators or note-takers to fill in this questionnaire.

Participants in every session had different origins. The number of countries of origin to be represented in the groups was envisaged to be limited to three<sup>24</sup>. However, as recruiting participants posed many challenges, in the Irish groups more than three origins were represented, and in Portugal and Sweden only one community was represented. Both women and men of two different generations (first and second generation) were invited to participate in the focus group discussions: one group was planned with first generation females, one group with second generation females (i.e. born in the EU Member State, to parents originating from FGM risk countries) and one group with first and second generation males. In practice, due to difficulties in recruiting second generation migrants,



the female groups in Ireland and Sweden were broken up into older and younger women instead of first and second generation.

Recruitment of participants relied heavily on the assistance provided by civil society organisations working with migrant communities as well as individuals recognised inside the communities. The role of the national researchers in this process consisted mainly of liaising with these actors. The organisation of the focus groups was very demanding and time-consuming. Regular contacts with the recruiters were required and the logistical aspects (e.g. finding a convenient location, organising the catering and payments) had to be arranged. Other recruitment channels (e.g. asylum and refugee centres, local mosques and churches, schools, university students' organisations representing migrant communities) were considered, but could not be used due to the period during which the discussions were organised (i.e. summer months). The 'snowball technique' was also used for the recruitment.

Participants were offered a monetary compensation as recognition of their contribution and to cover their expenses (travel and childcare, if needed).

Based on existing knowledge and research and taking into consideration the goals of the focus group discussions, a discussion guideline was prepared for the discussions. This instrument proved to be very useful to structure the discussions and to cover all aspects on which information was needed. The following topics were addressed through the discussions:

- Friendship and social networks that participants are currently involved in (to understand the degree of acculturation)
- Awareness of the Member State's legal framework
- Current meaning of female genital mutilation (at personal and social level)
- The role/function of female genital mutilation in people's lives (what does it mean 'being cut' versus not being cut)
- Role of women and men in female genital mutilation
- Family members involved in a decision to cut a girl
- Social pressure for subjecting girls to female genital mutilation

- Expectations and attitudes regarding future marriage partner (origin, FGM status and importance of FGM in the family and in the in-law family)
- Determinants for attitudes in favour of or against female genital mutilation
- Level of FGM risk

The facilitation of the focus group discussions was done by the national researchers, with the exception of the male groups, in which a male co-facilitator assisted. Although participants were required to be able to communicate in the official language of Ireland, Portugal and Sweden, co-facilitators able to speak the language of the most represented community in the groups assisted in Portugal and Sweden. In practice, their intervention was hardly required as the participants were able to express themselves in the language of the facilitator. All groups had at least one note-taker. All groups were audio recorded for analytical purposes (e.g. recalling information and/or for clarifying statements on certain aspects). The recordings were destroyed once the analysis was performed and were not shared with EIGE or any other party, in line with guarantees given to the discussion participants.

Special attention was given to ethical issues: a number of experts were invited to review the methodology and procedures; an informed consent form was explained individually to all participants and signed by them (full confidentiality and anonymity according to national legislation and research ethics were guaranteed); confidentiality and non-disclosure issues for the facilitators and note-takers were ensured; and a reporting procedure in case any participant would expressly share her/his intention to cut a girl was foreseen (in accordance with the law, the national researchers would inform the authorities in such an event). A referral pathway was established for each country in order to inform the participants about the legal framework in place and existing dedicated services in the area of health, justice, asylum, immigration, and child protection, among others.

A report per focus group was drafted by the national researchers. Both the recordings and the notes taken proved to be very useful in drafting the main findings and conclusions for the focus groups. Considering the limited resources for the study, the recordings were not fully transcribed.

### 4.2.3. FGM risk estimation

FGM risk is calculated by applying the so-called 'extrapolation-of-FGM-practising-countries-prevalence-data-method'. In practical terms, the national FGM prevalence rate of the age cohort 15-19 is multiplied by the total number of girls coming from, or born to a mother originating from, a particular country where female genital mutilation is commonly practised and whose age is below the median age of cutting (according to the customary age of cutting in the country of origin). The median customary age of FGM represents an important variable in the FGM risk estimation equation as it helps avoid overestimations. The basic FGM risk formula is calculated for each country of origin and is mathematically translated as follows:

$$x_c = a_c \times p_c$$

*In which:*

$x_c$  = number of girls at risk of female genital mutilation originating from a particular country where female genital mutilation is documented and living in an EU Member State

$a_c$  = first and second generation girls (originating from a particular country where female genital mutilation is documented) who, in the reference year (2011 for this study), had not yet 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.

Another relevant aspect to be considered in an FGM risk estimation is the influence of migration towards cutting girls. The 'migration and acculturation<sup>25</sup> impact factor' in this study is a binary variable expressed as 0 or 1, in which 0 signifies migration does not influence attitudes and behaviours towards female genital mutilation, while 1 suggests that there is an influence of migration regarding subjecting girls to female genital

mutilation to the extent that the level of risk is reduced to zero. The influence of migration is assessed through qualitative information (ascertained in this study through focus group discussions and existing knowledge). The influence of migration can be included in the FGM risk calculation as follows:

$$x_c = a_c \times p_c \times (1 - m)$$

*In which:*

$x_c$  = number of girls at risk of female genital mutilation originating from a particular country where female genital mutilation is documented and living in an EU Member State

$a_c$  = first and second generation girls (originating from a particular country where female genital mutilation is documented) who, in the reference year (2011 for this study), had not yet 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 (either 1 or 0)

As the influence of migration may differ from EU Member State to Member State, two different scenarios were considered in order to reflect as accurately as possible the different levels of FGM risk experienced by the first and second generation female resident migrants. These scenarios will define an interval within which FGM risk will be expressed. The scenarios are underpinned by different assumptions and represent a high and a low level of risk of female genital mutilation in a European migration context. Based on the assumptions defined for the present study, the calculation of FGM risk, taking into account an influence of migration, is done for each country where female genital mutilation is documented and is expressed as follows:



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

In which:

$x_c$  = number of girls at risk of female genital mutilation originating from a particular country where female genital mutilation is documented and living in an EU Member State

$a_{c=first}$  = first generation girls (originating from a particular country where female genital mutilation is documented) who, in the reference year (2011 for this study), had not yet 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 female genital mutilation is documented) who, in the reference year (2011 for this study), had not yet 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 (either 0 or 1)

### High FGM risk scenario

The basic premise behind this scenario is that there is no influence of migration whatsoever, and that the number of girls (originating from an FGM risk country and living in an EU country) at risk of female genital mutilation would be 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 would yield the 'upper boundary' of at-risk girls.

Thus, for the calculation of the 'at-risk girls' in this scenario, it is assumed that the female migrant population (regardless of their generation) aged under the median age of FGM that is customary in their country of origin is at risk of female genital mutilation (according to the FGM prevalence rate for each country of origin). In this scenario, the migration and acculturation impact factor will be 0 ( $m = 0$ ).

### Low FGM risk scenario

In this scenario, it is assumed that there is an influence of migration in changing attitudes and behaviours towards cutting girls. In this case, it is assumed that the second generation girls (i.e. those born in an EU Member State) experience a lower risk of being subjected to female genital mutilation. On the other hand, first generation girls whose age is lower than the median age of cutting are still considered to be at risk. In this scenario, the migration and acculturation impact factor will be 1 ( $m = 1$ ). This hypothetical scenario yields the 'lower boundary' of at-risk girls.

Further research into the influence of migration on female genital mutilation will ideally provide more refined migration impact rates (ranging between 0 % and 100 %, possibly related to different population groups and taking into account as many other variables as possible) which will enhance the accuracy of FGM risk estimations.

### Reflection about the level of risk for asylum seekers, refugees and irregular migrants

The quantitative findings and information available on these population groups did not allow for reliable conclusions to be drawn about the level of risk of female genital mutilation. Based on the qualitative findings and as confirmed by the experts consulted, the level of FGM risk might be lower for female asylum seekers (and refugees) as their international protection claims might be based on the fear of female genital mutilation. Furthermore, they are likely to find themselves in very precarious situations while they wait for the decision regarding their asylum claim, during which period the priority given to female genital mutilation may be low. This particular factor may reduce the risk for girls seeking asylum of being subjected to female genital mutilation and requires further analysis and research.

In the absence of data and knowledge about female irregular migrants, no assumptions could be made in relation to female genital mutilation for this population.

### Interpreting and communicating FGM risk estimations

In order to accommodate the uncertainties around the calculation of FGM risk in the EU, the statistical results of the FGM risk estimation are best expressed as an interval estimation (i.e. the number of girls at risk in a given country varies between  $x$  [low scenario] and  $y$  [high scenario]). Absolute numbers are

provided, as well as percentages (i.e. expressed as the percentage of the number of first and second generation girls aged 0-18 with origins in FGM risk countries living in an EU Member State). The calculations of each scenario are based on a set of assumptions, yielding the higher and the lower risk 'boundaries'. However, the assumptions underpinning the scenarios must not be interpreted as absolutely valid in all cases. The percentage interval estimation is calculated over the total study population (first and second generation girls aged 0-18) precisely because the customary age of cutting as practised in the country of origin is likely not to be maintained in a migration context for those girls who are to be cut. Considering that female genital mutilation in a migration context seems to be a matter of opportunity, expressing the results in a percentage interval estimation is relevant for policy-making purposes because attention is given to girls that might be at risk of being cut before or after the customary age of female genital mutilation as practised in the country of origin.

The existing knowledge and the findings of the qualitative research (and, if and when available, other data records such as health/medical or child protection records) can be taken into consideration to ascertain which scenario seems to better represent the influence of migration on subjecting a girl to female genital mutilation in a certain country.

#### 4.2.4. Possible indicators of trends in FGM risk

An attempt to assess indicators of trends regarding the level of FGM risk seems to be pertinent as the calculated FGM risk estimates refer to a certain moment in time, i.e. the day when census data were collected (2011 for the present study). The following indicators were used to assess possible trends:

a) **Female live births:** although the girls born in an EU Member State to mothers originating from FGM risk countries may no longer be at risk of female genital mutilation, the number of annual births was collected to monitor the evolution across years (2011-2013).

b) **Female asylum seekers:** as explained above, despite the fact that the risk of being cut might be lower for female asylum seekers, the information on the annual total number of girls originating from countries where female genital mutilation is documented requesting asylum was collected to follow the evolution across the years (2011-2013).

### 4.3. Critical assessment of the feasibility of estimating FGM risk in EU Member States

Estimating the number of girls at risk of undergoing female genital mutilation in EU Member States is very complex due to the nature of the phenomenon, and also because of the lack of data that allows for measuring it. The feasibility of calculating the number of girls at risk of female genital mutilation in the EU Member States depends not only on the availability of the necessary quantitative data (which must be up-to-date, reliable and complete) on the numbers of girls originating from FGM risk countries, but also on insights into how migration influences the extent to which female genital mutilation continues to be practised. This is why, ideally, a quantitative approach is combined with a qualitative one.

While the former can be considered a matter of administrative accuracy, the latter poses challenges and limitations to the risk calculations that cannot easily be solved. Qualitative research is needed to understand the influence of migration on the practice of female genital mutilation for the different groups concerned. First and second generation girls might experience different levels of risk. The situation might be different also depending on other variables, such as: the length of stay in the EU, knowledge of the legal framework and knowledge about the degree of enforcement of the law, level of education, length of education received in the EU, country / region / ethnic background, size of the community with origins in FGM risk countries living in the EU Member States concerned (as this might determine the level of social pressure), integration in the EU Member State's society and engaging with people from other nationalities (exposure to different cultures), and age of migration, among others. Furthermore, based on the findings from the focus group discussions, there are indications that the median age of cutting as it applies to countries of origin might be irrelevant in a migration context, where 'opportunity' rather than 'customary age' might determine the age at which a girl is cut.





This implies that, while the important variables for calculating FGM risk (and prevalence) are the prevalence rates in the countries of origin and the median age of cutting in the countries of origin, both are likely to change in a migration context. Therefore, calculating risk assuming these variables are static is problematic. Yet, it is the most accurate approach to FGM risk estimations that can currently be applied.

Existing qualitative research into the influence of migration on the practice of female genital mutilation is scarce. The present research did include a qualitative component, but the findings from the focus group discussions (three to four per country) cannot be generalised because of the relatively limited scale of this qualitative research. More qualitative research is needed to better understand to what extent, at what pace, and under which conditions, opinions and attitudes towards female genital mutilation change. Even with better knowledge about these issues, it may remain

difficult to translate this knowledge into quantitative data for the purpose of calculating risk.

Based on what can be learnt from other FGM risk estimation experiences, from consultations with experts, as well as from the experience gained through applying the methodology in three pilot countries, feasible options for calculating FGM risk have been identified. These are presented in the matrix below.

Within the feasible options, a standard approach is presented, along with additional options that add value to the methodological approach. The options that are not (yet) feasible come under two broad categories: those that are unrealistic (because they cannot be put into practice) and those that could be considered at a later stage. The feasible ones were taken into account. The matrix below provides visual explanation of the possibilities at hand.

**Figure 2. Feasibility matrix**

not (yet) feasible	<p><b>Unrealistic options</b></p> <ul style="list-style-type: none"> <li>▪ Collect information about the father's country of origin</li> <li>▪ Collect data about ethnicity</li> <li>▪ Use micro-data from Eurostat about the concerned population living in the EU Member States (because, for example, data is not disaggregated by one year age cohorts)</li> </ul>	<p><b>Options that might be considered later</b></p> <ul style="list-style-type: none"> <li>▪ Use other sources of information if and when they are collected at central level and are easily accessible (e.g. medical/hospital records, child protection records, police and criminal justice records)</li> <li>▪ Collect data about region of origin and use regional FGM prevalence rates (age cohort 15-19)</li> <li>▪ Collect data about female irregular migrants</li> <li>▪ Assess difference in risk between population groups, between girls born to one parent vs. to both parents originating from FGM practising countries, among others.</li> </ul>
	<p><b>Standard options</b></p> <ul style="list-style-type: none"> <li>▪ Use FGM prevalence rates from DHS and MICS</li> <li>▪ Use census data about the female migrant population in a certain EU Member State originating from countries where FGM is commonly practised</li> <li>▪ Apply the 'extrapolation-of-FGM-risk-countries-prevalence-data-method'</li> </ul>	<p><b>Value-added options</b></p> <ul style="list-style-type: none"> <li>▪ Use FGM prevalence rates for women in the 15-19 age cohort in the country of origin</li> <li>▪ Consider the median age of cutting as customary in the country of origin</li> <li>▪ Include a qualitative methodology to assess the influence of migration on attitudes and behaviours towards FGM</li> <li>▪ Use interval estimations to communicate the results</li> <li>▪ Collect data on live births of girls born in the EU Member State to mothers from FGM risk countries and on female asylum seekers, among others, to monitor indicators of trends in FGM risk</li> </ul>

The standard options mentioned above allow estimating FGM risk across EU Member States in order to obtain comparable results. The other options can be considered by taking into account the following aspects:

- **Existence of data:** different types of data might exist in a given country. At a minimum, countries where the pilot studies took place were able to provide data on the female migrant population residing in the country.



- **Availability of data:** data might exist, but may not be available (e.g. data are not centrally collected). If certain types of data were available within the given timeframe and were useful for this study, they were requested and analysed.
- **Legal issues to access data:** certain countries do not allow access to certain types of data.
- **Access to data:** highly bureaucratic processes and procedures for accessing data may hinder progress within the timeframe established for research. Data were requested following the processes and procedures established in a given country. Data about female asylum seekers, refugees and irregular migrants for Portugal were not provided on time and were thus not considered.
- **Timeliness of data:** some data might be more up-to-date than others and differences may exist between countries. Therefore, a common reference year was considered for every country. The reference year was 2011 because it corresponds to the last EU-wide censuses.
- **Costs:** In some cases a fee may apply for accessing datasets.
- **Timeframe:** The period for collecting data needs to be well-planned.

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 making a risk analysis for all three countries. It is sound because combining quantitative and qualitative methods provides a more accurate and comprehensive picture than what could be obtained through quantitative or qualitative analysis alone, as is acknowledged by Albano and Vanmarcke (2014). However, FGM risk estimations remain affected by many uncertainties and this is why estimations need to be interpreted cautiously. Thus, results are expressed in an interval estimation and not by presenting a single figure. The present research has additionally suffered from significant difficulties due to time and budget constraints.

# 5. Female genital mutilation risk estimation in Ireland



## 5. Female genital mutilation risk estimation in Ireland

Following the methodology proposed, the number of girls at risk of female genital mutilation living in Ireland was estimated (according to the high and low risk scenarios as mentioned in section 4.2.3.). Firstly, the female migrant population originating from FGM risk countries is described below. The study population includes the number of girls aged 0-18 living in Ireland in 2011, and who come from FGM risk countries (first generation), or were born to a mother who originates in a country where female genital mutilation is documented (second generation). They are categorised according to resident population, asylum seekers, refugees and irregular migrants. The data in the sections below originate from several sources, which are listed in Table 10 (see page 41, section 4.2.1.). Secondly, a summary of the findings from the focus group discussions organised in Ireland is provided. Finally, the data are processed to determine the high and low boundaries of the interval FGM risk estimation. The level of FGM risk is then discussed based on existing knowledge and findings from the focus group discussions.

### 5.1. Female migrant population aged 0-18 originating from FGM risk countries in 2011

In Ireland, there were 14 577 girls (aged 0 to 18) originating from FGM risk countries within the female migrant resident population in 2011. Of these, 3 105 (21 %) were first generation and 11 472 (79 %) were second generation migrants. These numbers refer to girls who were living with their parents on the census day. The origin of the mother of those girls who did not live with their parent(s) cannot be retrieved. Therefore, the total number of female migrant residents, aged 0-18, originating from countries where female genital mutilation is commonly practised may not correspond exactly to the absolute number of girls who were born in, or born to mothers from, countries where female genital mutilation is documented.

**Table 11. Age distribution of the female resident population (aged 0-18) originating from FGM risk countries in Ireland, 2011**

	TOTAL	First generation	Second generation	TOTAL	First generation	Second generation	TOTAL	First generation	Second generation
0-9	10 750	727	10 023	100 %	7 %	93 %	74 %	23 %	87 %
10-18	3 827	2 378	1 449	100 %	62 %	38 %	26 %	77 %	13 %
0-18	14 577	3 105	11 472	100 %	21 %	79 %	100 %	100 %	100 %

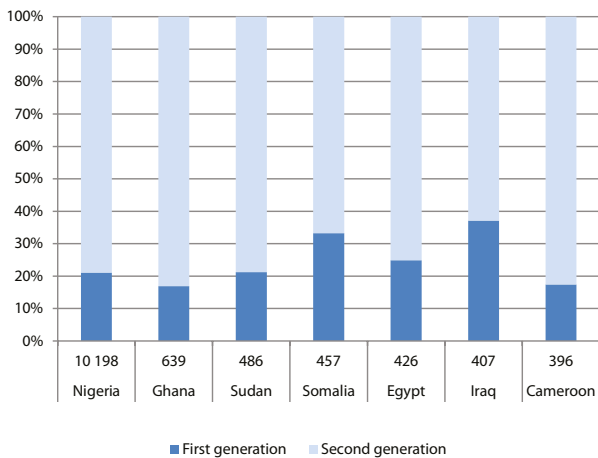
Source: Central Statistics Office Ireland.



As can be seen in Table 11, most of the girls in question were born in Ireland (second generation), and almost three quarters of the girls were below the age of 10. When looking at the first generation, this proportion is much lower: just below one quarter. The second generation is a young population as almost 90 % was below the age of 10.

As regards the origins of the first and second generation girls, 70 % originate from Nigeria and smaller groups from Ghana (4 %), Sudan (3 %), Somalia (3 %), Egypt (3 %), Iraq (3 %), and Cameroon (3 %).

**Figure 3. Number of girls 0-18 living in Ireland, by generation and most represented countries of origin, 2011**



Source: Central Statistics Office Ireland.

According to the DHS and MICS reports (see Table 9), national FGM prevalence rates within the age group 15-19 years in these countries range from very low (Ghana: 2 %), to medium (Nigeria: 15 %), to high (Sudan: 84 %).

Data regarding the age on arrival of the first generation was only available for 40 % (1 213) of the study population. Taking into account the age distribution of the available data, the age on arrival for the remaining 60 % was estimated. Therefore, the data about the date of arrival need to be carefully interpreted. Almost 50 % of the first generation girls who arrived in Ireland in 2011 were at that time younger than five. Fifty-two per cent of the girls from Nigeria who arrived in 2011 were younger than four.

The number of new female asylum seekers aged zero to 18 and originating from the FGM risk countries amounted to 73 in 2011. In the same year, the number of irregular migrants totals to five. The age distribution of the female

asylum seekers is provided in the Table 12 below. Considering that the number of irregular migrants is very low, these were not separated over the age groups in order to ensure that these individuals cannot be identified. Data about female refugees are not available.

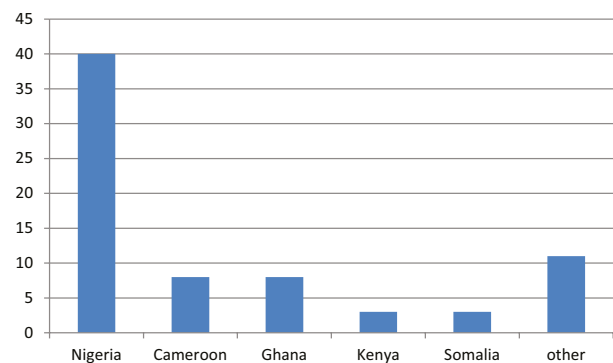
**Table 12. Age distribution of the new female asylum seekers aged 0-18 from FGM risk countries in Ireland, 2011**

	No asylum seekers	% asylum seekers
0-9	66	90 %
10-18	7	10 %
0-18	73	100 %

Source: Reception and Integration Agency.

Of the girls coming from FGM-practising countries requesting asylum, most originate from Nigeria. 85 % of them were younger than four (the median FGM age in Nigeria).

**Figure 4. Number of new female asylum seekers (0-18) in Ireland, by country of origin, 2011**



Source: Reception and Integration Agency.

## Other records collecting information on FGM in Ireland

### Health records

The National Maternal Health Care Record (NMHCR) was introduced in Irish maternity hospital settings in January 2012 with full adoption and use in all settings since September 2012. The NMHCR is used for all women registering for maternity care and includes, for the first time at national level, female genital mutilation as a risk factor on the Record. Although roll-out and use of the Record appears to have occurred across Irish maternity hospitals, data on female genital mutilation are not being (centrally) collated.

In May 2014, the first specialised FGM clinic opened in Dublin. The clinical services are provided by the Irish Family Planning Association, funded by the Health Service Executive (HSE) and informed by the HSE FGM Advisory Group. Extensive planning has gone into the data collection aspect of the clinic services, including tools to gather and record patient knowledge of Irish FGM legislation, number of daughters of patients and their ages, etc. As the clinic was so recently opened at the time of the data collection period for the present study, no data emerging from it could be obtained and examined as numbers of patients were still low. However, this might be an important future source of data relating to female genital mutilation in Ireland.

### Police and judiciary records

Both the Garda Domestic Violence and Sexual Assault Unit and the Garda Racial, Intercultural and Diversity Office were contacted and informed about the study. The timeframe for the current study did not allow for processing of the required An Garda Síochána research application and data processing agreement, therefore Irish police data on female genital mutilation cases (if any) could not be assessed. One issue that emerged during the research process is that female genital mutilation did not have an Irish Crime Classification System (ICCS) code at that time. This is possibly due to the fact that female genital mutilation only became a criminal act in Ireland with the recent FGM legislation in 2012. However, as a result of the lack of a classification code, no cases of female genital mutilation have been recorded by the Crime and Criminal Justice section of the Central Statistics Office.

The Office of the Director of Public Prosecutions (DPP) informed that no cases had come to the attention of the Office of the DPP in relation to female genital mutilation and, as a result, no data were available.

### Child protection records

The new Irish national Child and Family Agency (Tusla), established on 1 January 2014, communicated that no data concerning female genital mutilation were available.

## 5.2. Summary of findings from focus group discussions organised in Ireland

Three focus group discussions took place in Dublin on 9, 16 and 23 August 2014. The participants were recruited via researcher contacts, co-facilitator contacts, CSOs working with migrants and some snowball recruitment. The duration of each of the three discussion groups was between 127 and 146 minutes. In Ireland, due to the relatively recent trend in inward migration, the discussion groups were divided into younger first generation women who migrated to Ireland before 18 years of age, first generation women who migrated as adults to Ireland aged over 18 and the final group was composed of first generation men who arrived in Ireland as adults aged over 18. The 27 group participants came from 11 different African countries with the main populations of interest to the study (migrants from Nigeria and Somalia) represented in two of the groups. The age range of the participants was broad, from 18 to 56, with 10 of the participants having daughters. The groups were a mixture of Christians and Muslims. More than half of the participants had come to Ireland via the asylum seeking process. There were still a number of participants in the asylum process (14), which would impact any possible return trips to their country of origin. Those in the asylum seeking process were living in the Direct Provision system, which is allocated communal housing where meals and a basic weekly living stipend are provided to each person<sup>26</sup>. Some of the older participants were married and living with their spouse in Ireland, but some also had spouses, family and children in their country of origin.

Table 13 summarises the demographic information about the participants of each group.

**Table 13. Demographic information about the participants of the focus group discussions organised in Ireland**

	Younger women	Older women	Men
No. of participants	9	10	8
Age of youngest participant	18	30	25
Age of oldest participant	31	49	56



	Younger women	Older women	Men
Country of origin	Nigeria, Somalia, Sudan	Nigeria, Benin, Sierra Leone, Cameroon, Democratic Republic of the Congo, Congo, Uganda, South Africa, Zimbabwe	Somalia, Nigeria, Benin, Tanzania, Uganda
Ethnic groups	Yoruba and Igbo	Fon, Igbo, Temne, Bakossi, Mushi, Muganda, Bas-Congo and Xhosa	Yoruba, Igbo, Bajuni, Hutu, Lango, Rerhamar and Tumul
Age of arrival at youngest age	5	24	18
Age of arrival at oldest age	29	39	44
No. participants with partner(s)	1	Not available	5
No. participants with daughters	1	4	5
Age of youngest daughter	1	9 months	8 months
Age of oldest daughter	11	22	20
Level of education	Secondary education: 1 Higher Education: 8	Primary education: 1 Secondary education: 2 Higher Education: 7	Secondary education: 2 Higher Education: 7
Resident status	Citizen: 5 Stamp 4 <sup>27</sup> : 2 Seeking asylum: 2	Citizen: 1 Stamp 4: 1 Seeking asylum: 8	Citizen: 2 Stamp 4: 2 Seeking asylum: 4
No. participants that lived in other countries	1	2	3
Countries where participants lived	Ethiopia	Egypt and South Africa	Kenya, Rwanda and UK

Many of the participants had their immediate family with them in Ireland, mostly children and spouses for the older participants, and parents and siblings for the younger participants, with their extended family in their countries of origin. Two of the women had their husbands in other parts of Ireland and the UK and at least one woman had left her children in her country of origin. Many of the participants had family members in other parts of Europe, especially in the UK, but also further afield in the USA.

Very few of the participants had travelled back to their country of origin and only the women who were Irish citizens spoke about being able to do this. In all of the groups, keeping in touch with contacts and friends via social media (such as Facebook) was mentioned. The level of interaction with Irish society varied, with those in the asylum process less likely to interact with Irish people but having a large degree of inter-

action with asylum seekers from other countries living with them in Direct Provision. Living closer to or in Dublin City also seemed to allow for more opportunities to interact with a greater diversity of nationalities. Attending church, mosques or religious services seemed a key opportunity to meet people from all nationalities, including Irish. The younger group participants who had attended second or third level education (college or university) in Ireland had more interaction with Irish people and articulated a better sense of integration in Ireland. Overall, the participants' connections with their communities or ethnic groups from their countries of origin were very strong, but living in Ireland did allow for more exposure to other nationalities and cultures when compared with their home countries.

For most of the participants, especially the men, discussing female genital mutilation was taboo and uncommon. In some

countries, such as Somalia, it was taken for granted that female genital mutilation would happen to all girls at a certain point and as such it was not even discussed. Some of the participants had siblings, cousins, nieces or in one case a spouse who had undergone female genital mutilation and, as a result, they were familiar with the procedure and its consequences. Older sisters were a source of information on female genital mutilation for some of the younger women and two of the women had discussed female genital mutilation with their mothers. For many of the younger women, it was a recent realisation that female genital mutilation happens in countries other than their own country of origin. The internet was a source of information on female genital mutilation for many of the women. The male group asked for clarification from the researcher on whether female genital mutilation was a traditional practice in Ireland. It is likely that some of the female participants had undergone female genital mutilation but this was not asked in the groups. There appeared to be little communication between the sexes on female genital mutilation and one man stated that it was difficult to even bring the topic up with his wife. The only time female genital mutilation appeared to be discussed in Ireland was in relation to maternity care: when women who had undergone female genital mutilation became pregnant, they talked amongst themselves to find out information on which hospital or doctor was best to attend for ante-natal care and the birth.

The status and significance of female genital mutilation varied depending on the country of origin, and in some cases depending on religion. Participants noted that in Somalia and Sierra Leone female genital mutilation is very important and getting married is very difficult for girls who have not undergone female genital mutilation, and girls can be at risk of attack, isolation and stigma if they are not cut. In all countries, female genital mutilation was primarily seen as a way to prevent girls from becoming promiscuous and sexually active prior to marriage. In Uganda, the health risks of female genital mutilation, especially in relation to HIV transmission, were better known and as a result female genital mutilation was starting to be considered old fashioned and the practice is declining. The Somali group participants articulated that female genital mutilation was seen as a way to prevent the rape of girls and women. Some women mentioned families converting to Christianity as a reason for declining female genital mutilation, while other women mentioned that it was not part of Islam, nor a religious requirement, although widely practised by Muslims in Sudan and Somalia. Bride price in relation to female genital mutilation also emerged, with some men referring to women in Nigeria and Tanzania who were not cut commanding a higher bride price. Alternative forms of female genital mutilation were also discussed in the groups and the reasons elaborated for stretching the labia prior to pu-

erty included making birth easier for the mother and making women more sexually appealing for husbands. The pressure to continue the practice of female genital mutilation emerged in all the groups, with grandmothers, mothers-in-law, extended family, neighbours, and the community in the country of origin being identified as the key figures who put pressure on parents to circumcise their daughters.

Mothers were considered the key decision makers on female genital mutilation in a family, while grandmothers, aunts, and mothers-in-law were also very important. Although men were considered by all the groups as the head of the family with a key decision making role, they appeared to have little say with regard to female genital mutilation for their daughters. All the groups agreed that more communication on female genital mutilation was needed between men and women and between mothers and fathers. According to all the groups, men have a role to play in rejecting female genital mutilation for their future wives and daughters and ensuring their safety, and a role to play vis-à-vis speaking out against female genital mutilation, especially as imams, pastors and faith/religious leaders. The female participants also felt it was very important that men were taking part in this research. Marrying into a family that practises female genital mutilation was a concern for the younger female participants; care in choosing a future husband and ensuring that future in-laws were opposed to female genital mutilation was strongly recommended by the young women.

The consequences for a girl or woman undergoing female genital mutilation were overwhelmingly negative according to the groups and mainly related to health repercussions and the impact upon sexuality. The impact of female genital mutilation on a woman's capacity to enjoy sexual relations and to feel sexual pleasure was a substantial issue for all the groups. According to the participants, female genital mutilation was strongly implicated in marriage breakdown in Ireland, and sometimes in country of origin, as a result of lack of mutual sexual pleasure. As a result some husbands were leaving their wives who had undergone female genital mutilation and were seeking new female sexual partners who had not. However, the participants also appeared to have difficulties with the scenario where women who had undergone female genital mutilation were sexually insatiable or seen as unable to control their desires. Nonetheless, the negative impact of female genital mutilation on wife and husband relationships and on marital sexual relations was articulated strongly and given as a reason to abandon the practice. The trauma of a woman finding out in her adult life that she had been subjected to female genital mutilation as a baby was also discussed in the older women's group and this scenario was quite distressing for some of the women.



The consequences of not undergoing female genital mutilation and living in Ireland were all positive according to the groups. This led to better sexual relations and increased feelings of self-confidence, value and dignity. Living in a country where women were not forced to undergo female genital mutilation was considered a privilege by the men's group.

Legislation in relation to female genital mutilation was unclear for many of the group participants. There appeared to be little comprehensive knowledge amongst the groups that female genital mutilation was illegal in Ireland or about the penalties for breaking the law. About four of the participants knew clearly that female genital mutilation was illegal in Ireland and this was through the campaigning work of activist Ifrah Ahmed and United Youth of Ireland. The internet was also mentioned as a source of information on legislation. The Irish FGM legislation is relatively recent and was only enacted in September 2012 and it would appear that there is still much work to be done to reach out to FGM-practising communities to inform them of this legislation. The enforcement of any law on female genital mutilation was also deemed important by the groups, and comparisons were made with Scandinavian countries and their strict interpretation of FGM legislation, to the point where parents are fearful their children will be removed by social workers. All the groups agreed that laws against female genital mutilation were positive, serving as a deterrent to the practice, but stated that they needed to be enforced with severe penalties for breaking the law, and that communities needed to be aware and informed of legislation criminalising female genital mutilation. This applied to legislation in Ireland, as well as in other European countries, and in African countries. Legislation in their countries of origin was queried by the groups demonstrating little knowledge of where female genital mutilation was outlawed. However, the fact that female genital mutilation was now illegal in Ireland seemed to generate closer examination of the practice by some of the group members, and to have led them to question the cultural beliefs and practices in their country of origin.

While anecdotal cases emerged in the groups of girls being taken back from Ireland to countries of origin by their parents for female genital mutilation, no specific scenarios of female genital mutilation being performed in Ireland arose. Participants had met or heard of parents in the Direct Provision system who wanted to cut their daughters, but this appeared to be rare. According to the groups, if parents or families really wanted to practise female genital mutilation, they would travel to their country of origin and possibly not return to Ireland.

The groups agreed that protective factors for girls in relation to female genital mutilation were:

- Travel (to work, study or live) to countries where female genital mutilation was not performed as this allowed for exposure to the fact that not all girls globally are cut, and a chance to re-evaluate long accepted traditional practices such as female genital mutilation, that are considered the norm in the country of origin.
- Education was considered very important in raising individuals' and communities' awareness about the harmful effects of female genital mutilation, especially related to the health repercussions. Less educated areas or regions in countries of origin (mostly rural areas where second level and third level education is not common) were considered more dangerous for girls at risk of female genital mutilation.
- Legislation had a protective factor as parents could tell relatives in the country of origin that if their daughters were cut, the parents would go to prison. However, the groups acknowledged that legislation is not enough as people break laws all the time. Strong anti-FGM legislation with supporting publicity, awareness-raising campaigns, and information dissemination in the country of origin were seen as important by the younger women. The fact that Ireland criminalises female genital mutilation also provoked deeper examination of the practice by group participants, and influenced attitudinal change.
- The work of anti-FGM campaigner Ifrah Ahmed was mentioned in the groups, and her events with a focus on rejecting female genital mutilation and campaigning for the Irish FGM legislation appeared to raise awareness on the issue in Ireland.
- The groups were clear that female genital mutilation was not a religious requirement but they felt this was not necessarily known by others in their communities and countries of origin. They suggested that religious/fair leaders, pastors and imams need to speak out against female genital mutilation and that this would have a strong protective effect.
- Inter-marriage between female genital mutilation practising and non-practising partners (which could be Irish or European, or from the same country of origin but from a different ethnic group) seemed to have a possible protective effect but this would need to be examined more closely as inter-marriage did not seem common among the groups.

Communication between the sexes about female genital mutilation seemed to be very important to reduce or eliminate the practice. Considering that female genital mutilation emerged as a severe problem in marriages, sometimes leading to mar-



riage breakdown due to its impact on sexual enjoyment, more discussion about female genital mutilation could lead to men rejecting it for their future wives and insisting on marrying women who have not been cut. This increased communication would also lead to families where both parents rejected female genital mutilation for their daughters and looked to protect them from it. The internet was discussed in all the groups as a source of information on the harm, severity and impact of female genital mutilation, and in a few cases as a source of information on legislation in relation to female genital mutilation. While the internet does not have a protective effect per se, it does seem to have influenced some group participants to re-examine their prior acceptance of the practice and to now reject it, and influenced participants from countries where FGM type I (i.e. the partial or total removal of the clitoris) is practised to learn about other types of female genital mutilation.

Based on the limited number of group discussions, there appears to be a low risk of girls undergoing female genital mutilation in Ireland. Considering the communal living conditions within the Direct Provision system, with families often sharing rooms for many years, it would be expected that any probable cases of female genital mutilation in Ireland would have been raised by the participants in the discussions or known to the researcher and co-facilitators. The risk of female genital mutilation seemed to emerge only in relation to returning to the country of origin. Grandmothers and in-laws were mentioned by all three groups as being the key risk agents of female genital mutilation. The risk was considered so severe that participants suggested the following to avoid it:

- Not returning to the country of origin with daughters.
- Not leaving daughters alone with any family member in the country of origin.
- Bringing family members to Ireland for visits instead of returning to the country of origin.
- Ensuring prior to marriage that future in-laws in the country of origin did not practise female genital mutilation.

However, it is important to contextualise this fear within the reality that the asylum process in Ireland is lengthy and some group participants had been waiting up to eight years for a decision on their asylum application. During this time, they cannot leave Ireland. Almost all migrants coming to Ireland from countries that practise female genital mutilation are coming via the asylum seeking system. Once they receive leave to remain in Ireland or subsidiary protection or a Stamp 4 they will still not be able to travel to their country of origin if they left it to seek asylum. Even if they receive Irish citizenship and an Irish passport, it is not considered appropriate by the Irish Department of Justice for them to ever return to their country of origin since they fled it as a refugee. Therefore, the risk of female genital mutilation could be greater for second generation girls born in Ireland who have been granted Irish citizenship and who may travel without their parents. Integration, education, living in Ireland and legislation all appear to act as risk reduction factors for female genital mutilation.

## 5.3. Estimating the number of girls at risk of undergoing FGM in Ireland

### 5.3.1. FGM risk estimation in Ireland

Considering the FGM risk scenarios defined above (see section 4.2.3.), in 2011, the number of girls at risk of female genital mutilation varied between 158 and 1 632. In addition, 11 female asylum seekers appear to have been at risk of female genital mutilation in 2011. The table below gives a summary of results.

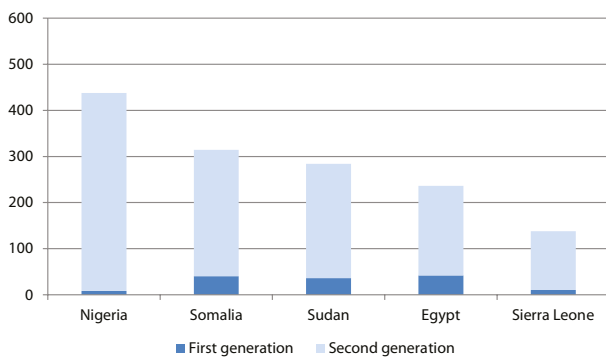


**Table 14. Estimated number of girls (aged 0-18) living in Ireland in 2011 who are at risk of FGM**

	Resident population						Asylum seekers	
	TOTAL	HIGH SCENARIO		TOTAL	LOW SCENARIO		HIGH SCENARIO	LOW SCENARIO
		First generation	Second generation		First generation	Second generation		
0-9	1 565	135	1 429	135	135	0	11	0
10-18	68	22	46	22	22	0	0	0
0-18	1 632	158	1 475	158	158	0	11	0

Source: present study.

**Figure 5. Estimated number of girls (aged 0-18) living in Ireland in 2011 who were at risk of FGM by generation and most represented countries of origin**



Source: present study.

The largest share of girls who were at risk originates in Nigeria (ranging from 9 to 438 girls, corresponding to the low and high scenarios respectively), followed by Somali girls (between 41 and 314 girls, corresponding to the low and high scenarios respectively). Smaller groups of girls at risk originate in Sudan, Egypt and Sierra Leone.

The largest group of new asylum seeking girls who were at risk originated in Nigeria (nearly 50 %).

Table 15 summarises the results of the FGM risk estimations for both the high and low scenarios.

**Table 15. FGM risk in Ireland in 2011: summary of results**

<i>High scenario</i>	In 2011, a total number of 14 577 girls aged 0-18 originating from FGM risk countries (born in the country of origin or in Ireland) were residing in Ireland, of which 1 632 girls were likely to be at risk of female genital mutilation. <b>Proportionally, 11 % of girls aged 0-18 originating from FGM risk countries (born in the country of origin or in Ireland) were at risk of female genital mutilation.</b>
<i>Low scenario</i>	In 2011, a total number of 14 577 girls aged 0-18 originating from FGM risk countries (born in the country of origin or in Ireland) were residing in Ireland, of which 158 girls were likely to be at risk of female genital mutilation. <b>Proportionally, 1 % of girls aged 0-18 originating from FGM risk countries (born in the country of origin or in Ireland) were at risk of female genital mutilation.</b>

The qualitative findings of the Irish pilot study provide relevant insights for ascertaining the scenario that seems to better reflect FGM risk in this EU Member State.

As suggested in the focus group discussions, although the level of awareness about the existence of a specific legal framework forbidding female genital mutilation is low, the institutionalisation of a law seems to be a deterrent to the continuation of the practice in Ireland. The female participants felt that if female genital mutilation were not il-

legal in Ireland, some parents would continue cutting their daughters and possibly bring grandmothers to Ireland to subject the girls to female genital mutilation.

The customary age of cutting appears to be less relevant for migrants living in Ireland as it was said that for cost savings, groups of parents would probably pool money together and fly in a circumciser to get many girls cut at the same time as this would be cheaper than returning to the country of origin. The 'opportunity to cut' might thus be

a more relevant factor determining the practice of female genital mutilation in Ireland.

According to the participants of the focus groups, family and social pressure is quite strong in the migrant communities living in Ireland and in the countries of origin. This pressure was perceived to be more acute when it came from the husband's or the future husband's families. While the female participants felt they could negotiate pressure to cut their daughters in their own families, their future in-laws were considered to be a more serious issue. On the other hand, in general, the female participants felt that girls were safer in Ireland from risk of female genital mutilation.

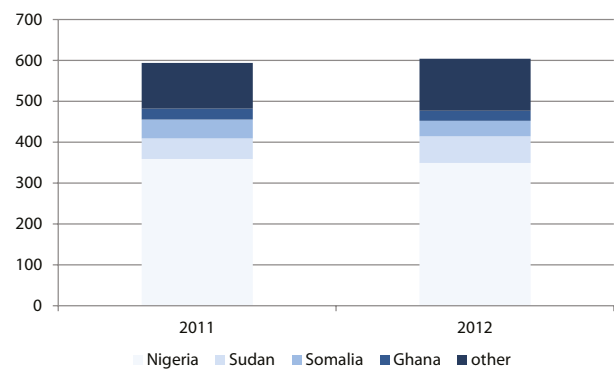
The group discussions allow for the conclusion that integration, education, living in Ireland and the legislation in force play an important role in reducing the risk of female genital mutilation. The level of FGM risk seems to be higher when visiting the country of origin during holidays, particularly to those second generation girls born in Ireland who have been granted Irish citizenship and who may have to travel without their parents.

Attitudes and behaviours towards female genital mutilation seem to have changed after migrating to Ireland. The enabling environment appears to play an important role in this change: female genital mutilation is not a cultural tradition of the country, there is legislation forbidding it and several mechanisms have been put in place to protect girls and to raise awareness about the topic. This might indicate that FGM risk would be rather low in Ireland. The most affected groups in absolute numbers are the communities originating from Nigeria. Although for the calculation of the lower risk scenario it was assumed that only first generation girls were at risk, these findings need to be interpreted with prudence because cases of female genital mutilation may occur in both the first and second generations. Similarly, it is likely not all first generation girls are still cut.

### 5.3.2. Towards monitoring possible trends of FGM risk in Ireland

The number of live births of girls born in Ireland to mothers who originate in FGM-practising countries slightly increased in 2012: from 594 in 2011 to 611 in 2012. The majority of the mothers have Nigerian origin (see figure below).

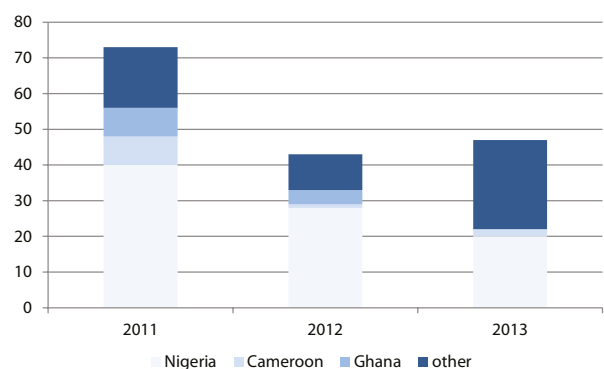
**Figure 6. Number of female live births in Ireland to mothers originating in FGM-practising countries, by country of origin of the mother, 2011, 2012**



Source: National Perinatal Reporting System.

With regard to the female asylum seekers, the number of girls (aged 0-18) originating in FGM risk countries requesting asylum in Ireland has been decreasing over the past three years (2011 to 2013): 73 in 2011, 43 in 2012 and 47 in 2013. Most girls requesting asylum originate in Nigeria. The proportion of girls below the age of four (the median age of FGM in Nigeria) that requested asylum decreased from 85 % in 2011 to 55 % in 2013.

**Figure 7. New female asylum seekers (0-18) in Ireland by country of origin, 2011, 2012, 2013**



Source: Reception and Integration Agency.

With regard to the female irregular migrants that were identified, the number of girls aged zero to 18 years originating in FGM risk countries in Ireland has been increasing from five in 2011, 15 in 2012, to 28 in 2013. They mostly originate in Nigeria and Ghana. Due to the overall low number of identified female irregular migrants this information will not be presented as a graph.

# 6. Female genital mutilation risk estimation in Portugal



## 6. Female genital mutilation risk estimation in Portugal

Following the methodology proposed, the number of girls at risk of female genital mutilation living in Portugal was estimated according to the high and low risk scenarios (as mentioned in section 4.2.3.). Firstly, based on the data collected, the female migrant population originating in FGM risk countries is described below. The study population includes the number of girls in the age range of 0-18 living in Portugal in 2011 who come from FGM risk countries (first generation), or were born to a mother who originates from a country where female genital mutilation is documented (second generation). They are categorised according to resident population, asylum seekers, refugees and irregular migrants. The data in the sections below originate from several sources, which are listed in Table 10 (see page 41, section 4.2.1.). Secondly, a summary of the findings from the focus group discussions organised in Portugal is provided. Finally, the data are processed to determine the high and low boundaries

of the interval FGM risk estimation. The level of FGM risk is then discussed based on existing knowledge and findings from the focus group discussions.

### 6.1. Female migrant population aged 0-18 originating from FGM risk countries in 2011

In Portugal, 5 835 girls (aged 0 to 18) originating from FGM risk countries compose the concerned female migrant resident population in 2011. Of these, 2 198 (38 %) are first generation and 3 637 (62 %) are second generation girls.

**Table 16. Age distribution of the female resident population (aged 0-18) from FGM risk countries in Portugal, 2011**

	TOTAL	First generation	Second generation	TOTAL	First generation	Second generation	TOTAL	First generation	Second generation
0-9	2 907	572	2 335	100 %	20 %	80 %	50 %	26 %	64 %
10-18	2 928	1 626	1 302	100 %	56 %	44 %	50 %	74 %	36 %
0-18	5 835	2 198	3 637	100 %	38 %	62 %	100 %	100 %	100 %

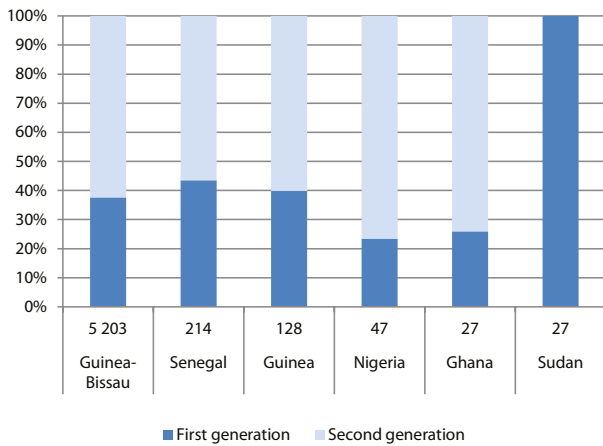
Source: Statistics Portugal.

As shown in the Table 16 above, in 2011, half of the girls were below the age of 10. The second generation is much younger than the first generation: almost two thirds of the girls of the second generation were below the age of 10 in 2011.

As regards the origins of the first and second generation girls, almost 90 % originate from Guinea-Bissau, 4 % from Senegal and 2 % from Guinea. Another 2 % originate from Nigeria, Ghana and Sudan. Within these countries, the percentage of first generation girls ranges between 25 % and 100 % (see graph below).



**Figure 8. Number of girls 0-18 living in Portugal, by generation and most represented countries of origin, 2011**



Source: Statistics Portugal.

According to the DHS and MICS reports (see Table 9), national FGM prevalence rates within the age group 15-19 years in the countries mentioned above range from relatively low (Senegal: 24 %), to medium (Guinea-Bissau: 48 %), to high (Guinea: 94 %).

Almost 50 % of the first generation girls who arrived in Portugal in 2011 were younger than four years old. Keeping in mind that the median age of FGM in Guinea-Bissau (the largest group in Portugal) is nine, these girls may still be at risk of female genital mutilation. In total, 77 % of the girls who arrived in 2011 were younger than nine. Data on female asylum seekers was not available.

## Other records collecting information on FGM in Portugal

### Health records

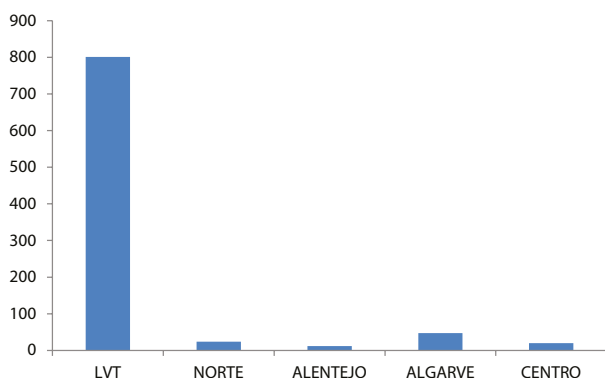
Efforts to register female genital mutilation in the IT software system of the public healthcare facilities in Portugal started as early as 2012, when a guideline about female genital mutilation for health professionals (Directorate-General of Health guideline No. 005/2012) was issued in February of that year. It recommends the identification and guidance by health professionals of girls and women that are at risk or who have been subjected to female genital mutilation. The record system was pilot-tested and health

professionals have been receiving training on recognising, registering and treating the consequences of female genital mutilation in the area of Lisbon and Vale do Tejo where the majority of migrants originating from FGM risk countries is concentrated. The registration of FGM cases/records (excluding FGM risk) at a national level started in 2014. These records can be extracted from the Health Data Platform and include the following information: registration date, healthcare facility where the case was observed/registered, type of female genital mutilation, age of cutting, country of origin of the girl/woman, place where female genital mutilation was performed, situation in which the case was observed/registered (e.g. pregnancy medical consultation, hospitalisation), and the complications experienced by the patients due to female genital mutilation (e.g. psychological, sexual, gynaecological, urogynaecological). According to the data collected up to September 2014 for the purposes of this study, 30 girls/women (aged 15-61) who had undergone female genital mutilation were registered in this data platform, of which four cases refer to girls aged 15-18. The latter originate from Guinea and Guinea-Bissau. These girls were allegedly cut outside Portuguese borders (probably in the countries of origin) and their self-reported age of cut ranges between one and seven. In addition, 10 girls/women aged 15-41 are registered in this platform as having visited the healthcare facilities for a pregnancy medical consultation.

Other efforts to collect medical/hospital records were initiated in 2012 when reviewing the National Programme for Infantile and Juvenile Health (PNSIJ). This Programme was issued in May 2013 and it aims to identify, support and guide children and their families who are victims of ill-treatment and violence, including female genital mutilation (objective 8, Directorate-General of Health guideline No. 010/2013). Health developmental examinations are scheduled for children aged 0-18. The health developmental examinations are established to occur within the following periods: 0-9 months, 1-3 years, 4-9 years, and 10-18 years. A reference to female genital mutilation is foreseen in the programme for each of these groups. Health professionals are recommended to pay specific attention to signs of female genital mutilation in risk families and to register these cases in the IT system. Although there is no particular code to register FGM cases (performed or at risk), these types of observations are to be included in the software module 'Assessment of risk within the family'. For

the purposes of the present study, the IT system referring to the PNSIJ was searched. Since 1 October 2013, when the module 'Assessment of risk within the family' was opened for registrations, no cases of female genital mutilation or FGM risk were identified (last checked on 25 August 2014). This system disaggregates information by countries of origin of the girls examined, by one year age groups, and by the health regions where the health developmental examinations took place. Between 1 October 2013 and 25 August 2014, 904 girls aged 0-18 who originated in FGM risk countries were registered in the IT system referring to the PNSIJ. As shown in the graph below, approximately 89 % of the girls were registered in the health systems of the region of Lisbon and Vale do Tejo (LVT). In Portugal, the majority of the girls examined originate from Guinea-Bissau (approximately 80 %).

**Figure 9. Number of girls aged 0-18 originating from FGM risk countries who were registered in the IT systems referring to PNSIJ between 1 October 2013 and 25 August 2014**



Source: Health Data Platform.

### Asylum records

Although there are no FGM-specific asylum records, information about the number of requests based on the fear of female genital mutilation exist. According to the Immigration and Border Service, three such asylum requests were received in 2011. Since then, no asylum requests based on these grounds have been received.

### Child protection records

Although child protection records were not being collected when the present study took place, the National Commission for the Protection of Children and Young People at Risk (Comissão Nacional para a Proteção de Crianças e Jovens em Risco, CNCPCJ) will be responsible for

collecting these data, if and when such a record system is put in place. According to the current programme of action for the prevention and elimination of female genital mutilation (2014-2017), in 2014, an 'FGM subcategory' will be included under the 'physical abuse category' in CNCPCJ's record system (measure 33). The local Commissions for the Protection of Children and Young People at Risk (CPCJ) will be responsible for identifying FGM cases.

### Police and judiciary records

Police and judiciary FGM data were not recorded in Portugal at the time this research took place.

## 6.2. Summary of findings from focus group discussions organised in Portugal

Three focus group discussions were organised on 24 and 25 August 2014 in Lisbon. All 31 participants originated from Guinea-Bissau<sup>28</sup>, the largest migrant community living in Portugal from an FGM risk country. These are referred to as Guineans hereafter.

The age of the female participants of the first generation ranged between 33 and 59 years old, while in the second generation group the age of the female participants ranged between 18 and 22 years old. In the men's group (all first generation) the age ranged between 18 and 64. The level of education was particularly low in first generation women and men. The groups were a mixture of Christians and Muslims. Participants belonged to different ethnic groups that are Muslim and that practise female genital mutilation. Most first generation men had a partner, and approximately half of the first generation women had a partner (some of the others were widows or divorced). The second generation women did not have partners. Whereas most first generation women were Portuguese citizens, most first generation men had temporary visas. In both first generation groups, a few participants lived in other countries before migrating to Portugal (mostly African countries, in two of which female genital mutilation is commonly practised). All female participants of the first generation and nearly half of the male participants had daughters, whose ages ranged between two and 39. The table below summarises the demographic information about the participants of each group.



**Table 17. Demographic information about the participants of the focus group discussions organised in Portugal**

	First generation women	Second generation women	First generation men
No. participants	13	5	13
Age of youngest participant	33	18	18
Age of oldest participant	59	22	64
Ethnic groups	Cristão de Geba, Balanta, Djacanca, Fula, Manjaco, Mancanha, Papel, Saracolé	Biafada, Saracolé, Fula	Fula, Papel, Mancanha, Mandinga, Biafada
Age of arrival at youngest age	15	n/a	7
Age of arrival at oldest age	49	n/a	39
No. participants with partner(s)	7	n/a	11
No. participants with daughters	13	0	7
Age of youngest daughter	6	n/a	2
Age of oldest daughter	35	n/a	39
Level of education <sup>29</sup>	1 <sup>st</sup> cycle: 3 2 <sup>nd</sup> cycle: 3 3 <sup>rd</sup> cycle: 5 Secondary education: 0 Higher Education: 1	1 <sup>st</sup> cycle: 0 2 <sup>nd</sup> cycle: 0 3 <sup>rd</sup> cycle: 1 Secondary education: 4 Higher Education: 0	Less than 1 <sup>st</sup> cycle: 3 1 <sup>st</sup> cycle: 2 2 <sup>nd</sup> cycle: 1 3 <sup>rd</sup> cycle: 6 Secondary education: 1 Higher Education: 0
Resident status	Citizen: 9 Permanent visa: 2 Temporary visa: 2 Irregular migrant: 0	Citizen: 5 Permanent visa: 0 Temporary visa: 0 Irregular migrant: 0	Citizen: 2 Permanent visa: 2 Temporary visa: 7 Irregular migrant: 2
No. participants that lived in other countries	2	n/a	4
Countries where participants lived	Senegal, Cuba	n/a	Angola, Senegal, Mali, Cape Verde, Spain

Participants of all three groups described having families in Guinea-Bissau, including close relatives like partners, children, and siblings. The majority did not return frequently to their country of origin. Participants also mentioned having relatives residing in Portugal. As regards their social networks, the participants interact with both Guineans and

non-Guineans. Of the non-Guineans, Cape Verdeans and Portuguese were the origins most referred to.

Most participants had heard about female genital mutilation at an early age and had been aware before they migrated that female genital mutilation was not practised in Portugal.



Female genital mutilation is not a topic that is usually spoken about, as confirmed by both women and men, especially not between the older and the younger generation. The latter was confirmed by both generations of women: the first and second generation women avoid discussing this topic with each other, sometimes with the aim of preventing younger women from talking about female genital mutilation with non-Guineans. Female genital mutilation is a subject to be kept secret. Although mothers avoid talking about this topic with their children, at some point the children hear about it on TV or at school. The second generation female participants mentioned that female genital mutilation can be discussed between young people, but that they are not allowed to talk about it with adults. This was said to be the case in both Portugal and Guinea-Bissau.

On the other hand, most female participants mentioned having talked about female genital mutilation with people from different origins to their own on distinct occasions, such as after a TV report was shown on Portuguese television, or at school. Both generations felt the need to either clarify that they were not cut, or to explain that not all female Guineans are cut, and that female genital mutilation is carried out in other countries in Africa as well.

Based on the participants' insights, the main aspects sustaining the practice are related to women's sexuality, purity, and cleanliness, and their subservience to men:

- Girls/women are cut to prevent them engaging in sexual relations and to maintain their virginity until marriage.
- Female genital mutilation is seen as a way of reducing sexual desire in girls/women and girls'/women's pleasure during sexual intercourse, and thus to ensure wives' faithfulness.
- Uncut girls/women are not allowed to share the same bed as their husbands.
- Female genital mutilation is associated with hygiene and purity: girls/women who do not undergo the practice are considered 'dirty'.
- Girls/women who are not cut are not allowed to cook for adults or serve their husbands during Ramadan (because they are considered 'dirty').
- Girls/women that do not undergo female genital mutilation cannot pray in religious spaces or participate in women's or family gatherings/meetings.

Other factors also appear to play a role in the continuation of the practice. Some people, including a few older participants, believe that the Quran makes reference to female genital mutilation. Female participants also reported that, in Guinea-Bissau, being cut is something a girl/woman and

her family can be proud of and can be understood as a 'rite of passage' for girls of a certain age. As pointed out in the male group, a factor that seems to perpetuate the practice is that the circumcisers (called 'fanatecas') depend on the payments of their 'cutting activity' to feed their families. An aspect that appears to have an indirect but strong influence on perpetuating the practice is the general belief in witchcraft. Both generations made reference to particular situations in which people were threatened to be cursed if they would pursue their opposition to female genital mutilation.

The meaning of and importance attached to female genital mutilation seem to be different for older and younger generations, but also for those living in remote villages in Guinea-Bissau, in cities in Guinea-Bissau, and in Portugal. While the elders, particularly those living in rural areas, appear to strongly believe in the need to cut girls and to stick to their cultural traditions, the younger generation living in cities in Guinea-Bissau (especially Bissau) or in Portugal recognises the consequences of this harmful practice and does not attach so much importance to the tradition. There do not seem to be any gender differences regarding these attitudes. The social pressure for subjecting girls to female genital mutilation seems to be lower in Portugal when compared to Guinea-Bissau. As both children and adults in Portugal are aware of the consequences of female genital mutilation and know that it is illegal, parents feel more supported to oppose female genital mutilation and to resist the social pressure to perform it.

The opinions regarding who decides to cut a girl were slightly contradictory. While the first generation women stated that the older female family members make this decision, the second generation women and the men consider the father to be the decision-maker. However, both latter groups agree that female family members hold the power to make the final decision. Several stories were told exemplifying situations where female family members (grandmothers, mothers, or aunts) took the girls to be cut without the fathers' consent.

As for the consequences of not being cut, these strongly differ for those living in the country of origin and those living in Portugal. While in Portugal there do not seem to be any consequences for uncut girls and women, in Guinea-Bissau girls and women that do not undergo the procedure are socially excluded. Both female and male participants reported that girls who are not cut can be called insulting and offensive names, may not be allowed to play with girls who are cut, and can be discriminated against and singled out in other ways as well. This social exclusion seemed to be stronger in the past than nowadays and may currently be more pronounced in rural areas in Guinea-Bissau, as opposed to urban areas.



Whereas in Guinea-Bissau undergoing female genital mutilation is something to be proud of (especially in villages), in Portugal there are women who are ashamed of being cut. The second generation women said that, in Portugal, not being cut is perceived as a privilege, as something positive, and as a matter of good fortune. The first generation women generally agreed that female genital mutilation has no meaning in Portugal. As regards the 'cut status', nothing was explicitly mentioned, but the older men said that as long as a woman is Muslim she does not need to be cut. On the other hand, the younger male participants affirmed they prefer women who are not cut because these women can enjoy sexual intercourse.

In general, participants from both generations seem to be aware of the Portuguese legal framework prohibiting female genital mutilation. The existence of a law was considered to be positive (both in Portugal and in Guinea-Bissau) in terms of reducing the practice.

As pointed out in the focus groups, the abandonment of the practice might be influenced by the existence of a legal framework, by awareness-raising initiatives, and by the effect of living in a country where female genital mutilation is not a cultural tradition.

In general, participants believe that the law diminishes the practice. Nonetheless, reporting family members to authorities poses a moral problem to the male group as they do not feel comfortable with denouncing their own wives, mothers, sisters or grandmothers. One participant confronted the group saying that an example must be set in order to change the practice and the mentalities.

Participants in all groups mentioned that awareness-raising initiatives were taking place via the radio, in schools, and in the national parliament in Guinea-Bissau, particularly in the capital.

Despite the existence of a law criminalising female genital mutilation since 2011 and the awareness-raising actions, the male participants mentioned that female genital mutilation is still currently performed in the villages where the authorities do not act and where there is a lack of knowledge about the consequences of female genital mutilation.

The second generation female participants explained that living in Portugal was advantageous for changing attitudes and behaviours because female genital mutilation is not a Portuguese cultural tradition. The younger male participants confirm this opinion by stating that most girls with Guinean origins born in Portugal are not cut, and they provided examples of families where daughters born in Guinea-Bissau

were cut and of families where daughters born in Portugal were not. Participants of the first generation women group believe that living in Portugal may change women's minds as they see that they do not need to be cut to find a husband. Nonetheless, the younger female generation believe that it can be more difficult to change attitudes and behaviours in Guinea-Bissau because there people grow up with the idea of female genital mutilation throughout their lives and it is commonly accepted without being questioned.

Both female and male participants were generally opposed to female genital mutilation due to its health consequences, particularly the transmission of diseases. The younger generations of women and men said that they would not allow their daughters to be cut. Some female participants of the first generation group also expressed this opinion. Although the older men did not expressly state that they were in favour of the practice, their few cautious comments and their silence may indicate their agreement with milder forms of female genital mutilation. For instance, one of the older men said that the Quran allegedly recommends that a small drop of blood should be dripped.

Most participants agreed that female genital mutilation is not being performed in the communities living in Portugal because it does not have the same meaning as in Guinea-Bissau. However, anecdotal examples about cases of female genital mutilation performed in Portugal or girls that were taken to Guinea-Bissau to undergo the practice were provided in all groups. In the first generation women group it was also mentioned that families planning to migrate might circumcise their daughters before they come to Portugal (no matter how old the girls are). Other anecdotal situations referred to by the participants included: Portuguese women who have Guinean partners being subjected to female genital mutilation, as well as Guinean women choosing to be cut if, in polygamous marriages in Guinea-Bissau, other wives of the same husband are cut.

The feeling of 'safety' and 'protection' from female genital mutilation was mentioned by the second generation women. Participants feel more protected in Portugal than in Guinea-Bissau because female genital mutilation is not a cultural tradition of Portugal and it is illegal there. While in Guinea-Bissau the elders have authority to decide whether and when to cut a girl, in Portugal the participants feel they can say 'no' and escape from being cut.

Based on the three group discussions, it is possible to understand that the risk of undergoing female genital mutilation is reduced in Portugal. The same might be true for Guinean urban areas. However, there seems to be a higher risk for girls of being subjected to female genital mutilation in rural areas in Guinea-Bissau. All three groups agreed on this.

## 6.3. Estimating the number of girls at risk of undergoing FGM in Portugal

### 6.3.1. FGM risk estimation in Portugal

Considering the FGM risk scenarios defined above (see section 4.2.3.), in 2011, the number of girls at risk varied between 269 and 1 096. The table below gives a summary of results.

**Table 18. Estimated number of girls (aged 0-18) living in Portugal in 2011 who are at risk of FGM**

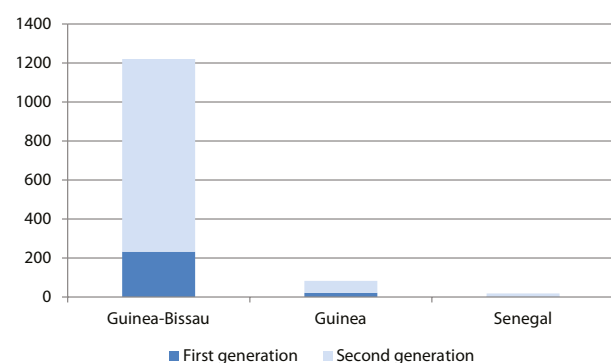
	Resident population						Asylum seekers	
	HIGH SCENARIO			LOW SCENARIO			HIGH SCENARIO	LOW SCENARIO
	TOTAL	First generation	Second generation	TOTAL	First generation	Second generation		
<b>0-9</b>	1 361	267	1 094	267	267	0	n/a	n/a
<b>10-18</b>	4	2	2	2	2	0	n/a	n/a
<b>0-18</b>	<b>1 365</b>	<b>269</b>	<b>1 096</b>	<b>269</b>	<b>269</b>	<b>0</b>	n/a	n/a

Source: present study.

The table above summarises the results of the FGM risk estimations for both the high and low scenarios.

The majority of the girls who are at risk originate in Guinea-Bissau (ranging from 232 to 1 220 girls, corresponding to the low and high scenarios respectively). Smaller groups of girls at risk originate in Guinea and Senegal. The graphs below illustrate the number of girls at risk living in Portugal disaggregated by country of origin and generation.

**Figure 10. Estimated number of girls (aged 0-18) living in Portugal in 2011 who are at risk of FGM by generation and most represented countries of origin**



Source: present study.

**Table 19. FGM risk in Portugal in 2011: summary of results**

<i>High scenario</i>	In 2011, a total number of 5 835 girls aged 0-18 originating from FGM risk countries (born in the country of origin or in Portugal) were residing in Portugal, of which 1 365 girls were likely to be at risk of female genital mutilation. <b>Proportionally, 23 % of girls aged 0-18 originating from FGM risk countries (born in the country of origin or in Portugal) were at risk of female genital mutilation.</b>
<i>Low scenario</i>	In 2011, a total number of 5 835 girls aged 0-18 originating from FGM risk countries (born in the country of origin or in Portugal) were residing in Portugal, of which 269 girls were likely to be at risk of female genital mutilation. <b>Proportionally, 5 % of girls aged 0-18 originating from FGM risk countries (born in the country of origin or in Portugal) were at risk of female genital mutilation.</b>

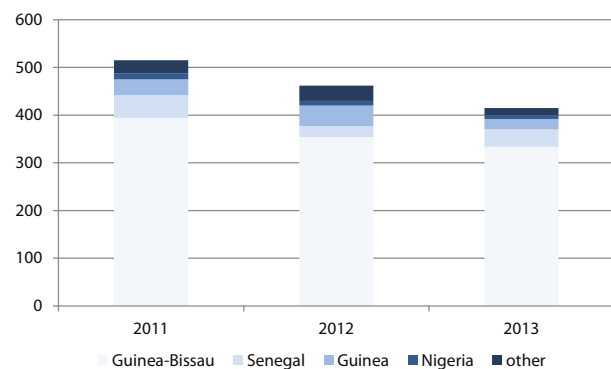
The qualitative findings of the Portuguese pilot study provided relevant insights for ascertaining the scenario that seems to more accurately describe FGM risk in this EU Member State.

As suggested in the focus group discussions, after migrating, people tend to no longer consider it a necessity to subject girls to female genital mutilation. According to the participants, the meaning of female genital mutilation appears to have changed in Portugal. It was stated that most girls born in Portugal were not cut. The social pressure is lower as female genital mutilation is not a cultural tradition of the EU Member State and there is legislation forbidding the practice. As a consequence, participants felt more protected in Portugal than in Guinea-Bissau. Moreover, parents feel more supported to oppose female genital mutilation while living in Portugal. Participants believed that female genital mutilation would be continued in Portugal if there were no legal framework in place prohibiting it. The risk for girls of undergoing female genital mutilation is perceived as higher in Guinea-Bissau (especially in the rural areas) than in Portugal.

Attitudes and behaviours towards female genital mutilation among migrant communities seem to have changed after migrating to Portugal. The discouraging environment appears to play an important role in this change. This indicates that FGM risk is rather low in Portugal. In absolute numbers, the most affected groups are the communities originating in Guinea-Bissau and Guinea. Although for the calculation of the lowest risk scenario it was assumed that only first generation girls are at risk, these findings cannot be generalised. Cases of female genital mutilation may continue to exist in both the first and second generations. Similarly, it is unlikely that all first generation girls continue to be cut.

### 6.3.2. Towards monitoring possible trends of FGM risk in Portugal

Concerning the girls born in Portugal to mothers who originate from FGM-practising countries, the number of live births has been decreasing gradually over recent years: 515 in 2011, 462 in 2012 and 415 in 2013 (see graph below). The majority of the mothers originate from Guinea-Bissau or Senegal.

**Figure 11. Number of female live births in Portugal by country of origin of the mother, 2011, 2012, 2013**

Source: Institute of Registration and Notary Affairs.

As, by December 2014, the data about female asylum seekers had not been provided yet, trends for this group cannot be presented.



# 7. Female genital mutilation risk estimation in Sweden



## 7. Female genital mutilation risk estimation in Sweden

Following the methodology proposed, the number of girls at risk of female genital mutilation living in Sweden was estimated (according to the high and low risk scenarios as mentioned in section 4.2.3.). Firstly, based on the data collected, the female migrant population originating in FGM risk countries is described below. The study population includes the number of girls in the age range 0-18, living in Sweden in 2011 who came from FGM risk countries (first generation), or were born to a mother who originated in a country where female genital mutilation is documented (second generation). They are categorised according to resident population, asylum seekers, refugees, and irregular migrants. The data in the sections below originate from several sources, which are listed in Table 10 (see page 41, section 4.2.1.). Secondly, a summary of the findings from the focus group discussions organised in Sweden is provided. Finally, the data are processed to determine the high and low boundaries of the interval FGM risk estimation.

The level of FGM risk is then discussed, based on existing knowledge and findings from the focus group discussions.

### 7.1. Female migrant population aged 0-18 originating from FGM risk countries in 2011

In Sweden, the migrant resident population counted 59 409 girls (aged 0-18) originating from FGM risk countries in 2011. Of these, 17 014 (29 %) were first generation and 42 395 (71 %) were second generation girls.

**Table 20. Age distribution of the female resident population (aged 0-18) originating from FGM risk countries in Sweden, 2011**

	TOTAL	First generation	Second generation	TOTAL	First generation	Second generation	TOTAL	First generation	Second generation
<b>0-9</b>	34 810	5 315	29 495	100 %	15 %	85 %	59 %	31 %	70 %
<b>10-18</b>	24 599	11 699	12 900	100 %	48 %	52 %	41 %	69 %	30 %
<b>0-18</b>	<b>59 409</b>	<b>17 014</b>	<b>42 395</b>	<b>100 %</b>	<b>29 %</b>	<b>71 %</b>	<b>100 %</b>	<b>100 %</b>	<b>100 %</b>

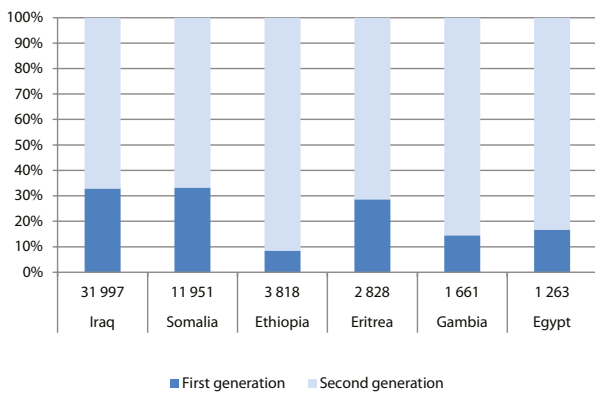
Source: Statistics Sweden.



The table above shows that more than half of the girls were below the age of 10, although of the first generation, only roughly a third were below the age of 10. The second generation was much younger: 70 % were below the age of 10.

As regards the origins of the first and second generation girls, 80 % originate from three countries: Iraq (54 %), Somalia (20 %) and Ethiopia (6 %). Other groups originate from Eritrea (5 %), Gambia (3 %) and Egypt (2 %). Most of these girls were born in Sweden (second generation) (see graph below).

**Figure 12. Number of girls 0-18 living in Sweden, by generation and most represented countries of origin, 2011**



Source: Statistics Sweden.

According to the DHS and MICS reports (see Table 9), national FGM prevalence rates within the age group 15-19 years in these countries range from relatively low (Iraq: 5 %) to medium (Ethiopia: 62 %) to high (Somalia: 97 %).

Almost 50 % of the first generation girls who arrived in Sweden in 2011 were at that time younger than six years of age. Keeping in mind that the median age of female genital mutilation in Iraq and Somalia is nine and four years old in Ethiopia, these girls may still be at risk of female genital mutilation. On average, 70 % of the girls from Iraq and Somalia who arrived in 2011 were younger than nine. Of the Ethiopian girls, 27 % of the arrivals in 2011 were younger than four.

The number of new female asylum seekers originating from the risk countries amount to 863 in 2011. The age distribution of the female asylum seekers is provided in the table below.

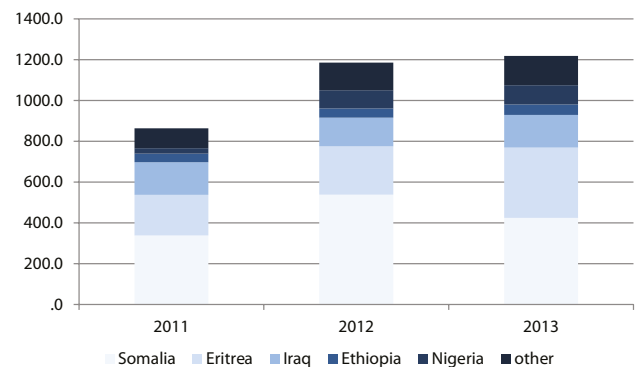
**Table 21. Age distribution of the new female asylum seekers (aged 0-18) from FGM risk countries in Sweden, 2011**

	No asylum seekers	% asylum seekers
0-9	524	61 %
10-18	339	39 %
<b>0-18</b>	<b>863</b>	<b>100 %</b>

Source: Statistics Sweden.

Over this three-year period (2011 to 2013), most girls requesting asylum originated from Somalia, Eritrea and Iraq. More than half of the Iraqi and Somali female asylum seekers were younger than nine (the median FGM age). Almost 20 % of the Eritrean girls were younger than one year old (the median FGM age in Eritrea).

**Figure 13. New female asylum seekers (0-18) in Sweden by country of origin, 2011**



Source: Statistics Sweden.

Refugees are included in the 'asylum seekers' category in Sweden and therefore data on them cannot be extracted separately. Once refugees receive a status, they are registered in the 'population' category.

Data on irregular migrants are not collected in Sweden as these individuals are 'out of the authorities' radar'. According to the Swedish statistical office, in order to meet EU requirements as regards reporting data about the population residing in an EU Member State (including irregular migrants), in 2015 this office will develop a method to estimate the number of irregular migrants in Sweden.

## Other records containing information on FGM in Sweden

### Health records

The National Board of Health and Welfare (NBHW) is in charge of the birth registration office. The Swedish Medical



Birth Register was founded in 1973 and includes data on almost all births (deliveries) in Sweden. It is compulsory for every healthcare provider to report to the register, and the information available is collected from medical records from the prenatal, delivery and neonatal care units. Upon delivery, the status of the genitals of the birth-giving mother is recorded. Even if potentially of poor quality, it is possible to collect and to aggregate national level data. There is a risk of the data being of poor quality because there is no uniform or generally agreed diagnosis code for female genital mutilation, or for the various types of female genital mutilation. Although the data of the Medical Birth Register is generally public, there are some forms of individual level data that are not. Data from NBHW were not made available.

### Police and judiciary records

The Swedish National Council for Crime Prevention (BRÅ)<sup>30</sup>, which is an agency under the Ministry of Justice, is a centre for research and development within the judicial system. BRÅ's primary task is to reduce crime and improve levels of safety in society. It does so by 1) producing data and 2) disseminating knowledge on crime and crime prevention work. BRÅ produces Sweden's official crime statistics, evaluates reforms, conducts research to develop new knowledge, and provides support to local crime prevention work. The results of BRÅ's work are a basis for decision-makers within the judicial system, the Parliament, and the Government. Data on reported crime, number of suspects, and unfinished crimes of female genital mutilation are not recorded individually/specifically in the crime statistics. In the statistics on people recorded for a crime, there is however data on the number of recorded crimes, according to crime code and age (Table 405). Swedish crime statistics are built on administrative data gathered from various authorities within the criminal justice system. These data are only built on empirical knowledge of crimes (many crimes go unreported). Several pitfalls can be identified in the Swedish crime statistics: different codes for recording crimes and different systems of classification are used by different authorities. Nevertheless, for the purpose of this study and according to the crime statistics, no recorded crime based on the law against female genital mutilation in the period 2012-2013 was registered<sup>31</sup>.

### Asylum records

Claims based on female genital mutilation are not traceable in the asylum records.

### Child protection records

Female genital mutilation is not traceable in the child protection records.

## 7.2. Summary of findings from focus group discussions organised in Sweden

Three different focus group discussions were organised on the 21, 22 and 23 August 2014 in Örebro, Sweden. Of the 45 participants, 42 originated from Somalia, one from Iraq, one from Eritrea and one from Ethiopia. The Somali population in Sweden is the migrant group with the highest prevalence of female genital mutilation<sup>32</sup>. The discussions lasted 150-180 minutes. Due to difficulties in recruiting second generation migrants, the female groups were broken up in older and younger women instead of first and second generation.

All participants were either long-term residents, Swedish citizens, or awaited approval of their Swedish citizenship. Most of them spoke Swedish well and were either in education or employed. Some were on parental leave and a few were unemployed. The area in which the participants lived was made up of migrants from various non-EU countries, although it was highly segregated from Swedish society.

The average age of the young women's group was 21, with the youngest being 17 and the oldest 26. They self-identified as practising Muslims. Three were born in Sweden. The majority had migrated to Sweden after the age of cutting (the average age of arrival was 10.6). The youngest migrated at the age of five and the oldest at 17. With the exception of three young women who were born in Sweden, they all came from regions where female genital mutilation is commonly practised. Of the Somali-born young women, all had Somali-born parents. Three were mothers. In general, the level of education was high among the young women. All of the young women were Swedish citizens. Most of the participants had visited their country of origin in the last ten years.

The average age of the older women was 49, with the oldest being 63 and the youngest 39. The average age of arrival in Sweden was 32. The youngest arrived at the age of 19 and the oldest at 53. All participants were born in Somalia, except two women, one of which was born in Ethiopia and one in Iraq. They were all from regions where female genital mutilation is commonly practised. All but one of the Somali women had Somali-born parents. Four of the participants had lived in other countries prior to migrating to Sweden, including Ethiopia, Uganda and Yemen. All but two were mothers. Sixteen had daughters, the youngest of which was one year old and the oldest of which was 33. Most of the women were in paid employment, predominantly working as nurses and personal assistants.



Most of them had some form of post-primary education, i.e. high school, college, or in a few cases, university level.

The average age of the male participants was 42, the youngest being 27 and the oldest 63. They were all born in Somalia. The average age of migration was 35, the youngest being 20 and the oldest 57. None of the participants had lived in any other country prior to migrating to Sweden. All but one had children. Ten of the men had daughters, of which the

youngest was one and the oldest 23. They were all permanent Swedish long-term residents, and some were Swedish citizens. Most male participants said they had attended the equivalent to high school in Somalia. In addition, considering that the Somalian and Swedish education systems are different, the participants had also participated in 'Swedish for Immigrants' or in the 'Municipal Adult Education', which is a Swedish secondary education for adults.

**Table 22. Demographic information about the participants of the focus group discussions organised in Sweden**

	Older women	Younger women	Men
No. of participants	19	13	13
Age of youngest participant	39	17	27
Age of oldest participant	63	26	63
Age of arrival at youngest age	19	5	20
Age of arrival at oldest age	53	17	57
Average age of migration	32	10.6	35
No. participants with children	17	3	12
No. participants with daughters	16	0	10
Age of youngest daughter	1	n/a	1
Age of oldest daughter	33	n/a	23
No. participants with post-compulsory school education	8	13	13 <sup>33</sup>
No. participants that had lived in other countries	4	8	0
Countries where participants lived	Ethiopia, Yemen, Uganda	Ethiopia, Kenya, Egypt	None

Across the three groups, most of the participants attached high importance to family ties. General decisions about life were said to be made within the family and most participants saw the family as the main organising unit to depend on. They distinguished between family in Sweden and family in the country of origin. The young women talked more often about visiting their country of origin than the older women.

Most participants were integrated into Swedish society through employment and/or education, albeit to varying degrees. All of the young women had either grown up within

the Swedish educational system or attended it upon arrival. The majority of the men and older women had participated in some form of schooling in Sweden. They did not have any/much Swedish friends outside of education/work, and were less integrated in social life than in working life. The former predominantly included activities within their ethnic community. Most of the participants socialised with women and men from their country of origin. The older women seemed to be the least integrated in Swedish traditions, norms and culture. The men, and the older women to a lesser extent, were socially active in their own communities. They regularly

met other male, and sometimes female, migrants at one of the two local community centres. The older women, and in particular the men, were quite well connected to international Muslim social networks, both in their country of origin and in other African and European countries.

The participants felt that the importance of FGM was diminishing with time. They talked about it in terms of how it 'used to be' or how it was 'over there'. In their own communities, female genital mutilation is not talked about between individuals, according to any of the three groups, although the older women said that there was a change in behaviour and in the discourse on female genital mutilation; from barely being mentioned, people have started talking about female genital mutilation a little bit. The participants who had visited Somalia two years ago said that there were now advertisements on the radio informing about the health risks of female genital mutilation and stating that religion forbids female genital mutilation. The men said they had never talked about female genital mutilation before. According to all three groups, female genital mutilation is talked about on a more general/public level: it is visible in public discourse. It is not visible or talked about on a personal level as it is considered a private matter. There is a division and tension along the lines of private and public: female genital mutilation is taboo and is considered a private issue, and yet the public discourse is saturated with the issue. This was said to be the case in both Sweden and Somalia.

In the focus groups, female genital mutilation was predominantly talked about as something that was not required by the Quran. This was a recurring theme throughout the discussion and across all groups. The older women said that they were not aware that some women were not cut until they came to Sweden. They did not know that cutting could be a choice. They thought it was obligatory as both a tradition and as required by the Quran. It was agreed across the groups that, in most countries where female genital mutilation is customary, there exists a misconception that religion is the reason it is performed. One woman said that she intended to have her daughter cut when she gave birth in Sweden, but then changed her mind when she realised that it was not required by Islam. Instead, the groups talked about the meaning of female genital mutilation as part of an old tradition which has been around for a long time. The women and the men talked about female genital mutilation as part of a value system. They said that there is, however, a tendency in some traditions to use religion to legitimise cutting. The participants talked about a change in Somalia, where religion is now being used to discourage female genital mutilation. Across all groups, it was mentioned that most people in the country of origin still believe that Islam requires cutting girls, despite information campaigns.

Most participants said that in the country of origin it is considered shameful to not have been cut. A girl/woman would feel shame and would want to hide. There was a general agreement that a girl/woman was not considered pure or clean if she was not cut. The men said that in the country of origin cutting is thought of as necessary in order for girls to both be, and be perceived of, as clean and pure; 'cutting and sewing'<sup>34</sup> make sure that they are pure and virtuous. Tradition requires female genital mutilation to make sure the woman is pure/clean and a virgin; sewing guarantees the latter. The older women expressed the same sentiment by saying that female genital mutilation is seen as a way to make genitals 'clean and beautiful' – the expression 'halal' was used to describe this. The young women said that in the country of origin, an uncut girl would lie and say that she had been cut. Typically, a girl is away from school for about a week when she is cut, and some of the uncut girls said that they had stayed home from school to make it appear as if they had been cut. Girls who have been cut bully uncut girls, and according to the older women, neighbours and friends may bully the uncut daughters and their families in the country of origin. The male participants agreed that in the country of origin, girls who are not cut may get bullied and they may not get married – a recurring theme across all the groups.

Across the groups it was underlined that the social pressure and cultural significance of female genital mutilation in contemporary Somalia is different than in Sweden. The young women described it as different in Sweden, especially for the young migrant girls born in Sweden. For their younger sisters, female genital mutilation is basically not known to be an issue. Female genital mutilation was described as not 'as relevant here as in Somalia', and as not being the norm. The women stated that there were no particular consequences in Sweden if one has not been cut. However, they said that men will only marry a girl who is cut. A major difference cited was that the parents who had migrated to Sweden had been provided with information and had been educated about the risks of female genital mutilation, and the girls thought this had altered their conception of female genital mutilation.

All three groups related cutting to the prospect of marriage. Female genital mutilation was seen as a necessity for marriage in Somalia; cutting and sewing was believed to preserve a girl's virginity before marriage. All three groups said, in one way or another, that female genital mutilation was understood as a way of controlling women's sexuality. Cutting and sewing guarantee women's fidelity. The older women added that because cutting reduces sexual pleasure, they are seen as less likely to want to be unfaithful.



According to the men, there is a social pressure to cut, which is related to marriage, in the country of origin, even if the father would not want to cut his daughters. A man would be ashamed if he married an uncut woman. In the country of origin, to marry is the decision of the man, but the father and relatives give money to the woman's family when they get married. The people who pay discuss whether he should marry the woman in question, but it is his own decision in the end. One younger man said: 'the one I am marrying will have to decide if she is to be cut/ sewn. Not me'. This should be interpreted cautiously; the general impression was not that the girl herself decides, but that her family does.

In relation to marriage, it was described as being less of a problem to be uncut in Sweden than in Somalia. The men said that in Sweden a man can choose if he wants to marry a cut or an uncut woman. This is not the case in Somalia. They also said that, in addition to the normative ideas discouraging marrying an uncut woman, it would be difficult to find an uncut woman in the homeland even if someone wanted to marry one. The men would not choose to marry an uncut woman in the country of origin. In Sweden, all groups agreed that daughters can marry any man of their choice and the family would be happy with her choice. As regards the sons, they can marry an uncut woman if they wish.

Female genital mutilation is considered a cultural tradition which, according to all three groups, is often used as an argument for its continuation. In Somalia, it is also often seen as a prerequisite for being a 'real woman', just like male circumcision is understood as a way to create 'real men'. The men underlined tradition as one of the main reasons for cutting girls: it is the way it has always been done and people believe it is necessary.

There was an agreement among all groups that the meaning of female genital mutilation is changing both in the country of origin and in Sweden: from being seen as a necessity to being understood as something that can be and is questioned. Furthermore, all participants underlined the regional differences in Somalia and pointed out that one cannot talk about it as one homogenous country. Somalia's geographical closeness to different countries and its borders are mentioned. The decision to cut or not cut varies depending on region.

The participants underlined that the family, in contrast to the community, is the main decision-maker when it comes to female genital mutilation, in particular the mother and grandmother: 'The decision lies with the women, the money with the men', a male participant said. Initially, the women talked about how it is the mothers' or possibly the grandmothers' decision to cut their (grand) daughters.

It is 'the women who are stronger than the men' and the women decide to cut. Later on in the discussion, the role of the fathers was mentioned and it became apparent that fathers do influence the decision. On a private level, it is the women's decision, but on a societal and structural level, it is a tradition and practice held up by men as well as by women because of what they believe men require. This was exemplified in the statements of all of the participants, who stated that there is a fear of the girls not getting married if they are not cut. Uncut girls will not become married. It is the mother's job to prepare the daughter for marriage, and having her cut constitutes this preparation. This is the reason that the mothers will have their daughters cut.

The male participants said that fathers had nothing to do with female genital mutilation, but this is questionable for a number of reasons. For one thing, fathers were said to pay the cost of the procedure itself. In addition to this, the reduced marriage prospects a girl may experience if she has not undergone female genital mutilation and the perceived adverse health consequences of not undergoing it are part of a wider social pressure to be cut that both men and women alike contribute to. Therefore, it is difficult to pinpoint exactly who the decision makers are in this regard. In Somalia, mothers deal with having the daughters cut. Many of the men said that they had never met anyone who had not been cut. They believed it to be important that the girl be cut before she reaches puberty, preferably and usually between the ages of five and seven, and never older than 10. If the girl is older than 10, it is regarded as too late because she is nearly ready to get married (although the men later said that girls are ready to marry from 15 onwards). It was mentioned that it is physically better if they are younger at the time of cutting.

While most male participants believed that girls who are not cut would experience health problems, both groups of women believed the opposite: being cut leads to health problems. One man said: 'if she is not cut there will be catastrophic health consequences'. Some of the other participants agreed, and expressed a genuine concern for the girls' health. They believed it was better to cut just to be on the safe side – even if just a little bit. The women, on the other hand, emphasized the severe health problems and the mental and physical pain arising from cutting.

All participants were aware of the existence of a legal framework prohibiting female genital mutilation in Sweden. While the older women were well aware of the specifics of the legislation, the younger women and the men lacked similar levels of knowledge. The three groups attached varying levels of importance to, and perceived impact of, legislation relating to female genital mutilation. The young women assessed the impact and importance as being fairly

low. Instead, religion was referred to as 'the law'. In contrast, the older women regarded the law as a platform for action and considered it an important tool to reduce the practice of female genital mutilation. The men said they respected and even feared the law, but nevertheless questioned its importance when stating that others (not themselves) who were determined to have their daughters cut would find a way. There was a general lack of knowledge about the legal framework in the country of origin across all three groups.

Knowledge was identified as the dominant agent of change in attitudes and behaviours towards female genital mutilation. The knowledge that religion does not require female genital mutilation and the knowledge that there are severe health consequences attached to cutting were mentioned in the three groups. All the female and some male participants generally opposed female genital mutilation due to its 1) health consequences, 2) physical pain, and 3) uncertain grounding in religion.

The younger women stressed information and education as agents of change, especially the knowledge that not only does religion not require cutting but, according to the participants, actively forbids any mutilation or alteration of the human body. Lack of education is, according to the participants, a main reason why girls are being cut. Education can change attitudes. They described female genital mutilation as tradition, not religion. This was repeated on many occasions throughout the discussion. Tradition and norms were named as the two main reasons for having a daughter cut. Parents who lived in Sweden and had received information about the health risks of cutting did not want to subject their daughters to female genital mutilation. The participants said that a well-educated person or a person of high social ranking, particularly those specialising in health and care, can affect other people's attitudes towards female genital mutilation. The community and social pressure were regarded as impacting on the decision to cut/not cut. Moreover, the importance of following the norms of the community, be it in Somalia or Sweden, was apparent.

Based on the information provided by the older female participants, the existence of the Swedish law had an impact on the decision to cut/not cut girls when living in Sweden. When the participants received information about the Swedish law, it functioned as a platform to search for more knowledge. The participants stated that it made them want to understand their religion, and they started asking questions about how a law could forbid what their 'religious law' stipulated. In this sense, the existence of the Swedish law led to an increased knowledge about the lack of a religious requirement. The men argued that it takes time to convince people in the country of

origin not to have their daughters cut, even if respect for the law and fear of punishment are strong determinants against female genital mutilation. The participants believed that the existence of a law does not prevent female genital mutilation everywhere, but it will stop it from happening in Sweden.

The reasons to cut, and the main agents influencing change in attitudes and behaviours towards female genital mutilation, are summarised below.

Reasons to cut and their motivation vary, but include:

- Religion (although underlined as a misconception of what is required)
- Tradition
- The suppression of women's sexuality
- As a rite of passage to adulthood
- The reduction of a woman's sexual drive
- A lowering of the risk of sex before marriage
- Cleanliness and hygiene
- Making sure girls are pure, 'halal'
- Health reasons
- Marriage prospects

The main agents of change were named as:

- Knowledge about the Quran: re-reading the Quran and learning that female genital mutilation is not required by Islam. The imams are mentioned as particularly important agents of change: what they say has the power to change people's attitudes.
- Swedish legislation criminalising travelling to the country of origin
- Education: learning about the negative health consequences of being cut
- Civil society organisations that are working to raise awareness
- The experienced health problems; the participants talk about how their own experiences have made them change their attitudes to female genital mutilation
- Meeting women from other countries who may not have undergone female genital mutilation has increased their knowledge base.

Based on the discussions, the level of risk of being subjected to female genital mutilation is, as perceived by the participants: 1) lower in Sweden than in the country of origin, 2) decreasing in both countries, and 3) changing because of a) education, b) knowledge and c) the existence of the Swedish legal framework. In the country of origin, there seems to be a higher risk of being cut in a rural area than in an urban area. Social pressure is perceived as a risk factor in the country of origin, but not in Sweden.



## 7.3. Estimating the number of girls at risk of undergoing FGM in Sweden

Considering the FGM risk scenarios defined above (see section 4.2.3.), in 2011 the number of girls at risk of female genital mutilation varied between 2 016 and 11 145. In addition, 293 female asylum seekers appear to have been at risk of female genital mutilation in 2011. The table below gives a summary of results.

### 7.3.1. FGM risk estimation in Sweden

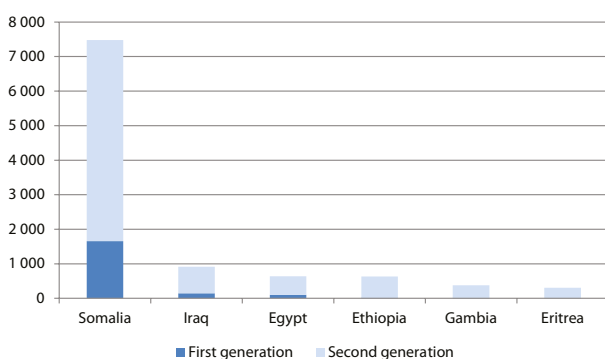
**Table 23. Estimated number of girls (aged 0-18) living in Sweden in 2011 who are at risk of FGM**

	Resident population						Asylum seekers	
	HIGH SCENARIO			LOW SCENARIO			HIGH SCENARIO	LOW SCENARIO
	TOTAL	First generation	Second generation	TOTAL	First generation	Second generation		
<b>0-9</b>	10 460	1 707	8 753	1 707	1 707	0	281	0
<b>10-18</b>	685	309	376	309	309	0	12	0
<b>0-18</b>	<b>11 145</b>	<b>2 016</b>	<b>9 129</b>	<b>2 016</b>	<b>2 016</b>	<b>0</b>	<b>293</b>	<b>0</b>

Source: present study.

The major category of girls who were at risk was made up of girls originating in Somalia (ranging from 1 659 to 7 478 girls, corresponding to the low and high scenarios respectively), followed by Iraqi girls (between 145 and 914 girls, corresponding to the low and high scenarios respectively). Smaller groups of girls at risk originate in Egypt, Ethiopia, Gambia and Eritrea. The graph below illustrates the number of girls at risk living in Sweden disaggregated by country of origin and generation.

**Figure 14. Estimated number of girls (aged 0-18) living in Sweden in 2011 who are at risk of FGM by generation and most represented countries of origin**



Source: present study.

The major category of new asylum seeking girls who were at risk originates from Somalia (well over 200), followed by Eritrea and Egypt.

Table 24 summarises the results of the FGM risk estimations for both the high and low risk scenarios.

The qualitative findings of the Swedish pilot study provide relevant insights for ascertaining the scenario that seems to more accurately reflect FGM risk in this EU Member State.

As suggested in the focus group discussions, the institutionalisation of a legal framework and a rather strong awareness about its existence seem to inhibit FGM-practising communities in Sweden from cutting their girls. Furthermore, it was mentioned that parents would fear that girls would report having been cut in the case that they were subjected to female genital mutilation.

Although participants considered their daughters not to be at risk of being subjected to female genital mutilation when visiting the country of origin, they admitted that there might be a higher risk for girls of being subjected to female genital mutilation when visiting rural areas in the country of origin. Social pressure to cut girls was said to be inexistent in Sweden.

Despite the fact that the female participants of the younger generation did not consider female genital mutilation a cultural norm among migrant communities in Sweden, at the same time, they reported that men from FGM-practising communities still prefer to marry women who are cut.



Attitudes and behaviours towards female genital mutilation seem to have changed following migration to Sweden. The following elements appear to play an important role in this change: female genital mutilation not being a cultural tradition of the country, legislation forbidding it, and mechanisms in place to protect girls and to raise awareness about the topic. This suggests that FGM risk is rather low in Sweden. The most affected groups in absolute numbers

are the communities originating in Somalia, and to a lesser extent, Iraq and Egypt. Although for the lower risk scenario calculation it was assumed that only first generation girls are at risk, these findings need to be interpreted with prudence because cases of female genital mutilation may occur in both the first and second generations. Similarly, it is likely not all first generation girls are still at risk of being cut.

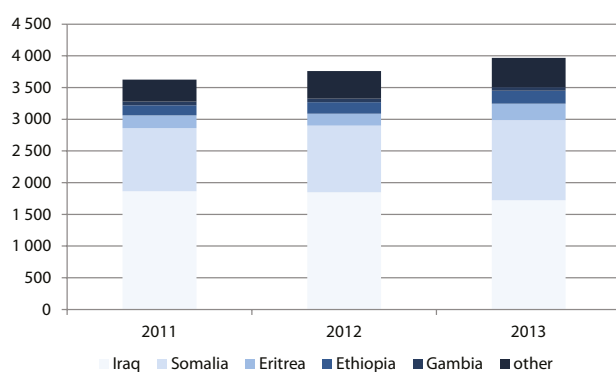
**Table 24. FGM risk in Sweden in 2011: summary of results**

<i>High scenario</i>	In 2011, a total number of 59 409 girls aged 0-18 originating from FGM risk countries (born in the country of origin or in Sweden) were residing in Sweden, of which 11 145 girls were likely to be at risk of female genital mutilation. <b>Proportionally, 19 % of girls aged 0-18 originating from FGM risk countries (born in the country of origin or in Sweden) were at risk of female genital mutilation.</b>
<i>Low scenario</i>	In 2011, a total number of 59 409 girls aged 0-18 originating from FGM risk countries (born in the country of origin or in Sweden) were residing in Sweden, of which 2 016 girls were likely to be at risk of female genital mutilation. <b>Proportionally, 3 % of girls aged 0-18 originating from FGM risk countries (born in the country of origin or in Sweden) were at risk of female genital mutilation.</b>

### 7.3.2. Towards monitoring possible trends of FGM risk in Sweden

The number of live births of girls born in Sweden to mothers who originate from FGM-practising countries has been slightly increasing over the recent years: 3 625 in 2011, 3 760 in 2012 and 3 968 in 2013. The majority of the mothers have Iraqi or Somali origin (see graph below).

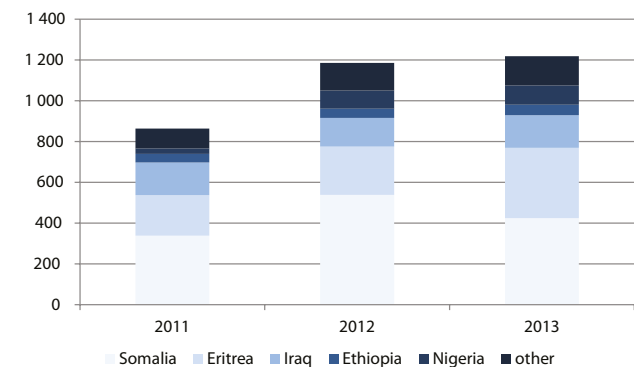
**Figure 15. Number of female live births in Sweden by country of origin of the mother, 2011, 2012, 2013**



Source: Statistics Sweden.

With regard to the female asylum seekers, the number of girls originating from FGM risk countries requesting asylum in Sweden has been increasing over the past three years (2011 to 2013): 863 in 2011, 1 185 in 2012 and 1 218 in 2013. Most girls requesting asylum originate from Somalia, Eritrea and Iraq (see graph below). More than half of the Iraqi and Somali female asylum seekers were younger than nine (the median FGM age), and almost 20 % of the Eritrean girls were less than one year old (the median FGM age in Eritrea).

**Figure 16. New female asylum seekers (0-18) in Sweden by country of origin, 2011, 2012, 2013**



Source: Statistics Sweden.

# 8. Comparative analysis and discussion of findings regarding FGM risk estimation in three selected EU Member States





# 8. Comparative analysis and discussion of findings regarding FGM risk estimation in three selected EU Member States

This chapter summarises the main findings of the research in the three countries where the methodology for estimating the risk of female genital mutilation was tested.

## Collecting quantitative data

With regard to data collection, none of the datasets required for estimating FGM risk were available through the internet in any of the three countries. All datasets had to be requested individually with precise and detailed specifications of the required breakdowns. In Portugal and Sweden, some datasets could only be obtained upon payment of a fee.

None of the countries' information contained data on migrants' region of origin (in the country of origin) or information about migrants' ethnicity. Such information, if it had been available, would have enhanced the accuracy of the risk estimations significantly because the FGM prevalence rates vary widely within the countries of origin.

## Data on female asylum seekers and refugees

According to the findings of the present study, data on female asylum seekers and refugees may be included in census data, which does not allow for estimating FGM risk (and prevalence) separately for these groups. Nonetheless, it was noted that when data can be singled out for female asylum seekers and refugees, FGM risk (and prevalence) should be estimated for each group separately, as the push factors for migration are different when compared to the resident migrants.

## Data on female irregular migrants

A common limitation in FGM risk (and prevalence) researches conducted so far in the EU relates to the exclusion of irregular/undocumented migrants in the estimations. Despite the fact that this study strove to overcome this limitation, data for this group are not generally available. In Ireland, where microdata exist, the numbers are very low. As a result, to ensure anonymity of the individuals in question, the research team could not be provided with data disaggregated by one year age groups, thus making it impossible to calculate FGM risk.

## Interpreting qualitative findings

The *significance* of female genital mutilation appears to be changing in Ireland, Portugal and Sweden, in comparison to the countries where female genital mutilation is commonly practised. Several *determinants* seem to trigger the change of meaning of and attitudes towards female genital mutilation, namely the existence of a legal framework forbidding female genital mutilation, a higher awareness of the consequences of female genital mutilation due to prevention initiatives, a better understanding of religious requirements, decreased social and family pressure, increased levels of empowerment of young people, and contact with other cultures in which female genital mutilation is not a tradition.

Female genital mutilation was said to be a '*taboo*' topic that was not commonly discussed, or spoken about between older and younger generations, and especially not with people who do not belong to FGM-practising communities. However, contradictions were also identified in the participants' discourses. Although participants claim not



to discuss female genital mutilation, they do appear to talk about it among people with the same sex belonging to a certain community and within their own age ranges (men to a lesser extent than women). It was noted that couples do not talk about female genital mutilation and this also appeared to impact the decision about cutting their daughters.

Another apparent contradiction that was identified relates to the *role of women and men* in deciding whether or not girls should be mutilated. Men were said to be the main decision-makers in a household. Nonetheless, when it came to female genital mutilation, women (grandmother, mother, aunt or mother-in-law) were said to be the ones making the decision about cutting girls. At the same time, it was recognised that men also have a role in the decision-making process, directly or indirectly (for example, when refusing to marry an uncut girl). But even when men oppose female genital mutilation and their daughters are not 'supposed' to be cut, it was acknowledged that women make the ultimate decision. There are indications that a decision to cut made by the family without consulting the parents is more likely to occur in, or when visiting, the countries of origin.

Across the three countries of the pilot study, the focus group discussions indicated that *the risk of female genital mutilation* was lower in Ireland, Portugal and Sweden than in the countries of origin. The lower risk seems to be mainly related to the fact that female genital mutilation is not a cultural tradition in these EU countries, but it is also related to the legal and policy frameworks in force. In the countries of origin, the risk is perceived as higher in rural than in urban areas. This is explained by the fact that the cultural norms are stricter and that there is a general lack of education in rural areas. Participants expressed their fear that their daughters would be cut against their will when visiting the country of origin (especially in a rural area). These findings might indicate that the risk of being subjected to female genital mutilation is higher for girls who travel to countries of origin, particularly to rural areas.

The media seem to play a role in disseminating information about female genital mutilation in Portugal and Sweden. Although media help to raise awareness about the harmful tradition, there is also a negative impact of stigmatising migrant communities who originate from FGM risk countries. This impact appeared to be stronger in Sweden than in Portugal.

Despite the fact that some findings from the focus groups discussions apply across the three countries, conclusions need to be drawn with caution. The participants in the

discussions were not representative of the total migrant population originating from FGM-practising countries and living in Ireland, Portugal or Sweden respectively, and the opinions they expressed cannot be generalised. Nevertheless, the focus group discussions proved to be valuable in a mixed-method approach to provide insights regarding the influence of migration on attitudes and behaviours towards female genital mutilation and to ascertain the most plausible level of FGM risk.

## FGM risk estimation

In this study, FGM risk estimation in an EU Member State has been calculated as a proportion of the total number of girls living in an EU country that are either born in (first generation), or born to mothers (second generation) who migrated to Europe from FGM risk countries. Although the definition of girls potentially at risk discussed in section 4.1.1. refers to girls born to parents or one parent, information regarding the country of birth of the father is rarely collected. Therefore, the FGM risk estimation can only rely on data about the mother's origin. Despite considering several types of data, FGM risk estimates cannot be completely accurate due to the private nature and secrecy around this practice and the ethical concerns related to gynaecological check-ups targeting only certain members of a population.

Taking into account the accuracy issues emerging from FGM risk estimations, it was decided to express the results in an interval. The upper and lower boundaries of the interval were determined based on two scenarios of level of risk. The high and the low level of risk scenarios are underpinned by assumptions regarding the study population. The qualitative component improved the understanding of how migration influences attitudes and behaviours towards cutting girls.

Although a mixed-method approach, combining quantitative and qualitative research, helps to avoid under- and over-estimations, the results are to be interpreted with caution. The assumptions that underpin the risk scenarios may not always hold: while the assumptions represent likely scenarios, they cannot be taken as absolute certainties. The information and data currently available do not allow for further refinements in the calculations. As well as conducting more qualitative research, medical/hospital records might also provide additional relevant insights in the future after they have been operational for a longer time.

Based on the focus group discussions organised in Ireland, Portugal and Sweden, the most plausible scenario appears to correspond to a low FGM risk in all countries. Accord-

ing to this scenario, it is assumed that the first generation girls (female migrant residents) are still at risk of being subjected to female genital mutilation. On the other hand, the second generation girls are assumed to be no longer at risk of undergoing female genital mutilation as migration influences the attitudes and behaviours towards the practice. Female asylum seekers can be regarded as being at lower risk as, in many cases, they are likely to find themselves in very precarious situations while they wait for the decision regarding their asylum claim, during which period the priority given to female genital mutilation may be low. Additionally, their international protection claims might be based on the fear of female genital mutilation.

Despite the fact that the level of FGM risk is regarded as low in all three countries, and keeping in mind the risks of drawing conclusions from a relatively small number of focus group discussions, some differences were noticeable between the three pilot countries. For instance, while in Sweden and Portugal the migrant population seemed to be aware of the legislation in force, in Ireland the knowledge about the existence of the law within the migrant communities appeared to be scarcer. Strong legal and policy frameworks have been in place in Sweden since the early 1980s. These appear to have an effect in changing the attitudes and behaviours of migrants. Hence, it can be assumed that the risk is lower in Sweden than in Portugal and Ireland.

### **Towards assessing possible indicators of trends in FGM risk**

Due to the unavailability of comparable recent data across EU Member States about the first and second generation female migrant population originating in countries where female genital mutilation is commonly practised, census data referring to 2011 were, at the time of the study, the most recent and comparable figures available across countries in the EU that could be used to estimate FGM risk. However, it is important to recognise that census data refer to a particular moment in time. Per definition, information about the population residing in a certain country is collected on a 'census day'. In addition, censuses are not conducted on an annual basis due to the amount of data to be collected and the efforts required collecting and analysing them. Other types of data covering complete calendar years which are collected more frequently (on an annual basis) may thus be important to assess trends regarding FGM risk.

Considering potentially useful data for monitoring trends, the following were requested and available in the three countries within the present study, covering 2011, 2012 and 2013: live births and female asylum seekers. Other sets of data might be considered for assessing trends of FGM risk in a country, such as the national population registers. The assessment of trends in FGM risk will specifically refer to a certain EU country and cannot be compared to other countries. Although monitoring indicators of trends in FGM risk (e.g. number of girls born to mothers originating from FGM risk countries) might provide relevant insights for policy-making, these are to be interpreted with prudence.

### **Legal and policy frameworks in Ireland, Portugal and Sweden**

While in Ireland and Sweden there is a specific legal framework criminalising female genital mutilation, in Portugal the practice can be prosecuted as a serious bodily injury. In 2014, the Portuguese national parliament discussed three proposals regarding a specific legislation to prosecute female genital mutilation. The focus group discussions organised in the three EU Member States indicate a general agreement that legislation forbidding female genital mutilation prevents the continuation of the practice (both in the EU countries and in the countries of origin). However, even when participants were aware of the existence of a legal framework prohibiting the practice (even if under the general law, as is the case for Portugal), they lacked knowledge about the particularities of the laws in place.

Portugal is the only country that renewed its national action plan to combat female genital mutilation since 2009. Although at present Ireland and Sweden do not have such a strategic policy document (Ireland is currently developing one), their efforts to prevent, protect and provide services to migrant communities originating from countries where female genital mutilation is documented are visible. Most participants across the three countries where the focus group discussions took place recognised the importance and need to organise awareness-raising initiatives targeting migrant communities in order to inform them about the health consequences of female genital mutilation and the legal framework in place.

Awareness about the existence of a criminal law prohibiting female genital mutilation, as well as prevention initiatives to inform and combat the practice, seem to influence the change of attitudes and behaviour of migrants originating from countries where female genital mutilation is practised.

## 9. Concluding remarks



## 9. Concluding remarks

### Mixed-method approach to estimate FGM risk in the EU

The methodology to estimate FGM risk in the EU developed within the framework of the present study took into account the most recent research focussing on FGM risk estimations conducted in five EU Member States and the feedback of European and international experts in the field that were consulted during the study (i.e. before and after testing the proposed methodology).

The quantitative data used in the FGM risk estimations was derived from the national censuses of the three pilot countries in order to allow comparability of data across countries. The most recent EU-wide census took place in 2011. Hence, this has been the reference year for the present FGM risk estimations. The qualitative component comprised focus group discussions. Separate group discussions were organised with women and with men.

The study has confirmed the importance and the relevance of complementing quantitative research with qualitative research for estimating FGM risk in the EU. The focus group discussions organised within this study provided relevant insights regarding the attitudes and behaviours towards female genital mutilation. However, the findings refer to a limited number of migrants originating from countries where female genital mutilation is commonly practised and, therefore, cannot be generalised. Firm statements cannot be made when it comes to translating findings into a mathematical calculation of FGM risk. There is still insufficient knowledge about how the reality of female genital mutilation within the EU differs from the situation in countries of origin. It should thus be kept in mind that all calculations of FGM risk come with a serious margin of error.

### FGM risk estimation in Ireland, Portugal and Sweden

The methodology developed to estimate FGM risk established two scenarios of level of risk:

1. A *high FGM risk scenario* assumes no effect of migration on the practice of FGM. In this case, it is assumed that the entire female migrant population (both first and second generation) aged under the median age of FGM as per country of origin is at risk of female genital mutilation.
2. A *low FGM risk scenario* assumes that there is an influence of migration on the practice of FGM. In this case, while the first generation girls are still considered to be at risk, it is assumed that the second generation girls (i.e. those born in an EU Member State to a mother originating from a country where FGM is commonly practised) experience a lower risk of being subjected to female genital mutilation.

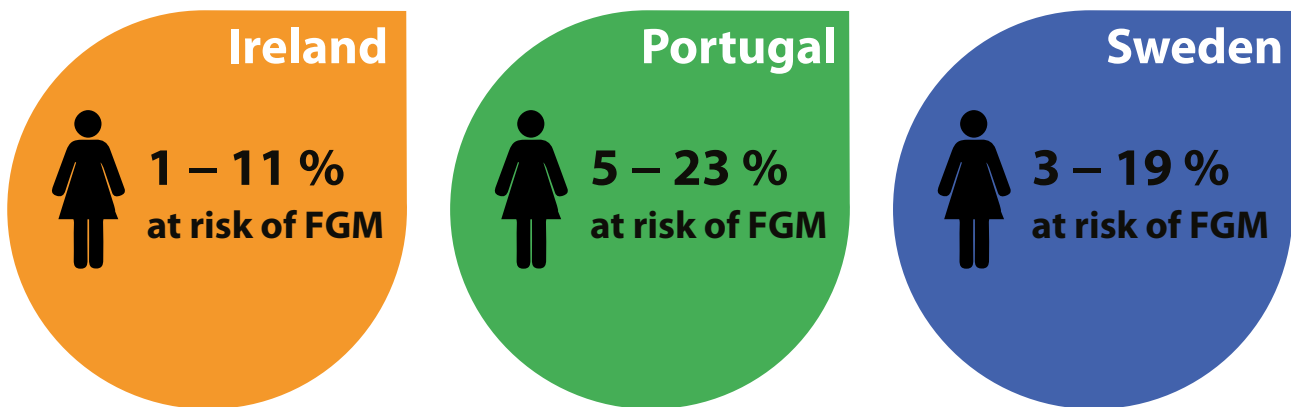
Considering the above mentioned scenarios, the estimates of girls living in Ireland, Portugal and Sweden at risk of undergoing female genital mutilation are as follows:

- *Ireland:* In 2011, a total number of 14 577 girls aged 0-18 originating from FGM risk countries (born in the country of origin or in Ireland) were residing in Ireland, of which 1 % to 11 % of girls were likely to be at risk of female genital mutilation.
- *Portugal:* In 2011, a total number of 5 835 girls aged 0-18 originating from FGM risk countries (born in the country of origin or in Portugal) were residing in Portugal, of which 5 % to 23 % of girls were likely to be at risk of female genital mutilation.

- *Sweden:* In 2011, a total number of 59 409 girls aged 0-18 originating from FGM risk countries (born in the country of origin or in Sweden) were residing in Sweden, of which 3 % to 19 % of girls were likely to be at risk of female genital mutilation.

A visual representation of the percentages of girls at risk of female genital mutilation in 2011 in Ireland, Portugal and Sweden is provided below. The percentages of FGM risk vary between these countries due to the total number of first generation migrants living in each EU Member State, their origins and corresponding FGM prevalence rates in countries of origin.

Figure 17. Percentages of girls (aged 0-18) likely to be at risk of FGM in 2011 in Ireland, Portugal and Sweden



### Prevention efforts are effective and need to be continued

Based on the findings of the focus group discussions, awareness-raising initiatives and the legal framework forbidding female genital mutilation seem to effectively prevent the continuation of the practice in the countries of destination. Therefore, the efforts put in motion in EU Member States need to be maintained in order to influence migrants' attitudes and behaviours towards female genital mutilation. A discontinuation of the actions undertaken by policy-makers, professionals of different sectors and civil society organisations may reverse some of the progress made so far.

### Protecting girls from FGM

Although FGM risk estimations provide information about an interval of girls that are at risk of being cut, risk assessment procedures are crucial for detecting individual cases where risk exists. Good instruments setting up these procedures were created and are in place. These can be used and disseminated on a wider scale. In addition, training of professionals who work with at-risk populations is fundamental (e.g. teachers, doctors, midwives, integration workers). The risk as-

essment tree that was developed in Belgium can serve as an example instrument to support individual risk assessments. More information about the prevention kit can be found at: <http://www.strategiesconcertees-mgf.be/scmgf-15/>.

### Services need to be provided to girls and women who were subjected to FGM

Although this study provides insights regarding an interval estimation of girls living in Ireland, Portugal and Sweden who were likely to be at risk of being subjected to female genital mutilation in 2011, it is relevant to highlight that there are girls (and women) living in the EU who have already undergone the practice and their needs must not be ignored. For that reason, specialised services need to be put in place in order to professionally address the needs of these girls and women.

### Allocation of sufficient resources

In order to ensure the continuation of prevention actions, the establishment of specialised services, the training of professionals, and the conducting of research on the topic, sufficient resources (human and financial) need to be foreseen when designing policies and funding programmes.



# 10. Recommendations for a better estimation of FGM risk in the EU





# 10. Recommendations for a better estimation of FGM risk in the EU

Based on the findings from previous FGM risk estimations in the EU and from the present study, as well as on the feedback received from the experts consulted, recommendations to improve the methodology for estimating the number of girls at risk of being subjected to female genital mutilation are provided below. Detailed recommendations can be found in the step-by-step guide to estimate FGM risk in the EU.

## Mixed-method approach

A methodological approach combining a quantitative and a qualitative component to estimate FGM risk yields more insights than a methodology opting for one or the other approach. The methodology developed within the framework of this study included focus group discussions. Nonetheless, other methods can be considered (alone or in combination), depending on the resources available, the research questions, and the target group(s) envisaged. These may include a systematic review of literature, community-based participatory research, and in-depth interviews, among others.

## Consider other countries of origin where there is evidence about the practice of FGM

There is evidence that female genital mutilation takes place in other countries besides those recognised by WHO. Despite the fact that data sources for South East Asian and Kurdish populations may not be as reliable as MICS or DHS, other existing and on-going studies could be used in order to include these communities in the FGM risk (and prevalence) estimations in the EU.

## Regional data in the country of destination

Information about the regional distribution of the female migrant population in the country of destination could be considered in future FGM risk estimations in EU Member States. Collecting this type of data can be particularly important for the allocation of resources and to design regional policies aimed at preventing girls from being subjected to female genital mutilation and/or addressing the needs of girls (and women) who have undergone female genital mutilation.

## Frequency of FGM risk estimations

FGM risk needs to be estimated regularly so that trends can be assessed. Countries that have a population register can carry out FGM risk (and prevalence) estimations more frequently than those that only have census data (as censuses only take place every 10 years). For the latter, it might be relevant to monitor other indicators (such as live births and asylum seekers records) that may provide hints as regards the evolution of the number of girls originating, or born to parent(s), from FGM risk countries. Despite the disadvantages of using census data, this is as yet the only source of information that ensures comparability of data across EU Member States.

## Caution with interpretation of research results

As acknowledged by all involved in this study, FGM risk estimations need to be interpreted and communicated with much caution in order to avoid the misuse of data and information, as well as the stigmatisation of migrant communities.

# 11. Recommendations for FGM policy-making



# 11. Recommendations for FGM policy-making

Although estimating FGM risk is fraught with challenges, this exercise provides relevant information to EU Member States' policy-makers to prevent female genital mutilation and protect girls from being subjected to the practice. Recommendations for female genital mutilation policy-making are presented below, and are structured along the 'six Ps' holistic approach defined within the framework of ElGE's 'study to map the current situation and trends on Female Genital Mutilation in the European Union and Croatia' conducted in 2012. These recommendations reflect the findings from the study, as well as the main conclusions of the consultation processes organised during the research.

## 11.1. Prevention

Prevention involves measures to promote changes in the social and cultural patterns of behaviour of women and men of all ages. It includes female genital mutilation awareness-raising initiatives, the development of educational materials, and the training of professionals.

The focus group discussions showed that the policies in place to eliminate female genital mutilation seem to be effective and therefore need to be maintained. Many participants highlighted the need for more prevention policies in order to raise awareness about the harmful consequences of the practice, about the legal framework, and in order to demystify its relation to religion.

### **Awareness-raising about and enforcement of the law**

The participants in the focus group discussions confirmed the important deterring effect of having a legal framework in place that criminalises female genital mutilation. At the

same time, more efforts are needed to raise awareness about the existence of the laws in place and what exactly they entail. For example, while knowing that female genital mutilation is forbidden, some may not know that this law may also apply to territories outside the EU countries' territory (for countries where the extra-territoriality principle applies). Similarly, some may not know that the law also prescribes that awareness of a girl being at risk of female genital mutilation needs to be reported to the authorities. Participants highlighted the need for awareness-raising about the legal framework not only within the EU, but also in countries of origin. The knowledge that female genital mutilation is criminalised in the EU triggers interest and enquiries among FGM-practising communities, encourages discussion about the practice, leads to heightened awareness about its harmful effects, and can contribute to questioning the value of this tradition. Furthermore, it lowers the risk for girls when travelling back to their (or their parents') country of origin, because female relatives will be less inclined to subject the girl to female genital mutilation if the parents risk prosecution upon returning to the EU. In this case, prevention work and the enforcement of the law should be conducted jointly.

### **Encourage discussions about FGM**

In all focus group discussions, the participants stated that female genital mutilation is a subject that is not generally talked about in the practising communities. Only some one-to-one discussions about the subject may happen among a mother and her daughter (e.g. about the 'value' of being cut), among young mothers or young mothers-to-be (about medical issues), among sisters or cousins, or within a couple (e.g. when the fact that the woman is cut seriously affects the sexual relationship). Overall, participants stated that even between sexual partners and between parents of a daughter



female genital mutilation is not discussed. In Sweden, there was at the same time some feeling of 'saturation' about the subject in public discourse, as well as of 'stigmatisation' of the practising communities due to this high level of attention (e.g. among medical care providers or within the education system). Nevertheless, the important deterring effect of enhanced knowledge about female genital mutilation through discussions about the subject has been confirmed. The focus group discussions triggered requests for follow-up discussions (notably in Ireland and in Sweden), declarations of interest to participate in further research on the subject, as well as expressions of interest from other people to participate in a focus group discussion about female genital mutilation, indicating that participants had been positive in their feedback about the discussions.

### **Sensitise and encourage men to stand up against FGM**

The focus group discussions indicate that while men generally are the main decision-makers in the family, this does not seem to apply to the decision to cut a girl. Referring to the countries of origin, the decision about female genital mutilation was said to be the women's affair, whereby the mother is primarily the one to decide, while other female relatives, including in-laws, also have a major say. Women were said to perpetuate the practice mainly because of social pressure and because of the shame and stigma that would come from not having their daughter cut. An uncut girl or woman would be regarded by the community (including men) as impure, promiscuous, and unmarriageable. In this way, men indirectly have a role in the perpetuation of female genital mutilation. However, in a migration context, with more knowledge about the harmful effects of female genital mutilation, knowing that female genital mutilation is not a prerequisite for marriage, and that uncut women can better enjoy sex, men start to express their preference to marry an uncut woman. This change in men's attitudes may also be a trigger for an abandonment of the practice.

### **Individual risk assessment**

The importance of individual risk assessments cannot be underestimated. Assessing the risk that a girl might be exposed to because one or both her parents originate from countries where female genital mutilation is practised is crucial for initiating specific prevention and protection actions

## **11.2. Protection**

Protection comprises cooperative actions to protect victims who have undergone female genital mutilation and girls and women at risk of being subjected to it; focussing on the safety and needs of victims is the primary objective. Protection within the EU is firstly achieved by recognising the transnational nature of female genital mutilation and that it mainly occurs outside of the EU. Hence, having protection policies in place within the countries where female genital mutilation mainly occurs is crucial, even though few currently seem to be in place. It also includes reporting the occurrence of female genital mutilation or anticipated acts of female genital mutilation, under appropriate conditions, by any person or professional. Two types of protection are relevant in relation to female genital mutilation: child protection and international or asylum protection. Regarding international protection, special attention is given to the recognition of gender-based violence, and in particular female genital mutilation, as a form of persecution and serious harm requiring protection.

### **Girls travelling to countries of origin**

An important aspect mentioned in the focus group discussions relates to the particular higher FGM risk for girls that travel to the country of origin. The experts consulted acknowledged that efforts should be made to monitor girls who travel to the countries of origin. It could be considered to establish special reporting mechanisms by accessing records of travel permits.

### **EU guidance on integrated Child Protection Systems**

The EU is currently developing a guidance document on child protection (which will be published in March 2015). A reference to female genital mutilation in these guidelines would be important.

## **11.3. Prosecution**

Prosecution covers not only the legal proceedings against those suspected of having subjected a girl or woman to female genital mutilation, but also the related investigative measures and judicial proceedings, including court cases.

### **Call upon the EU Member States to introduce the Istanbul Convention and the Victims' Rights Directive in their national legal frameworks**

As discussed in the consultation meeting organised within the framework of this study, a harmonisation of the EU Member States' legal framework to criminalise female genital mutilation does not seem realistic. In this context, it is important to highlight that other instruments are already in place, namely the Convention on preventing and combating violence against women and domestic violence (Istanbul Convention) and the Victims' Rights Directive. These constitute a robust package to be used by EU Member States. The introduction of the measures foreseen in these documents into the national laws of the EU Member States and the efforts to ensure the enforcement of these measures, are crucial to the combatting of female genital mutilation (as a form of gender-based violence) and to defend victims' rights. In line with the need for enforcing the EU/national legal framework, training judges and other professionals (such as the police and public prosecutors) is an important requirement to ensure its consistent and harmonised implementation.

#### **Law enforcement**

The participants of the focus group discussions emphasised the importance of enforcing the law, and they suggested possible policy measures to accompany the law (e.g. the threat of having the child removed from the family).

## 11.4. Provision of services

Provision of services refers to the services offered to women and girls who have undergone female genital mutilation, as well as to women and girls at risk of female genital mutilation, and their families. It also covers the professionals who perform the activities related to these services (e.g. specialised training) and existing tools (e.g. guidelines, learning materials) to assist them in better addressing the needs of this target group.

#### **Specialised care and services for girls and women having undergone FGM**

Although this study focuses on girls at risk of undergoing female genital mutilation, it is pertinent to point out that there are girls and women living in EU Member States that were already subjected to female genital mutilation. Their particular needs should not be disregarded and special-

ised care and services ought to be put in place and/or continued in cases where these already exist.

## 11.5. Partnership

Partnership relates to the involvement of relevant actors at international, national and regional level including government agencies, CSOs, migrant organisations, community-based organisations, etc., all working in collaboration on concerted actions to combat female genital mutilation.

#### **Need for better coordination of actors involved in the child protection system**

A problem relating to child protection on FGM (risk) cases is the lack of coordination among professionals (notably those active in health and protection services, and in education) and the lack of guidelines. As suggested by the experts consulted, the Belgian tool mentioned above (decision tree for professionals in cases of girls at risk) could be a useful tool for overcoming some of these challenges. It also emerged from the consultation processes that a memorandum of understanding among professionals is needed and that protocols need to be developed, supported by training of professionals. Finally, the experts underlined that a holistic approach is paramount: protection and prosecution should be linked with prevention.

#### **Cross-border cooperation**

Ways of cooperation between EU Member States and countries of origin need to be sought to explore prevention pathways for travelling girls. Diplomatic officers can play an important role in this matter.

## 11.6. Prevalence and risk

Prevalence and risk estimates and (quantitative and qualitative) data collection can contribute to reasoned, comprehensive and coordinated policy-making. Therefore, prevalence and risk estimates, as well as research and administrative records/datasets that allow an understanding of an approximate reality of the phenomenon, are considered in the six Ps approach.

#### **Data collection and record systems**

Although health/medical records seem to be scarce across the EU, different codes to register female genital mutilation



are being used. As a new code for female genital mutilation within ICD10 will be published in January 2015, this may allow for more consistent registration of cases across countries.

## 11.7. Other recommendations

### Research for policy-making

More qualitative research is needed to gather further insights about the influence of migration on attitudes and behaviours towards female genital mutilation, and to learn more from the practising communities themselves about which policy measures are likely to be most effective, and are at the same time regarded as appropriate. The following topics are to be considered:

- a) Most important factors contributing to the abandonment of female genital mutilation in an EU migration context;
- b) Influence of prevention campaigns and/or legal framework in changing attitudes and behaviours towards female genital mutilation;
- c) Role of female genital mutilation in the sense of identity and membership/belonging in the migrant community living in the EU;
- d) Link between female genital mutilation and forced marriages;

- e) Link between female genital mutilation and marriage patterns (mixed couples with migrant and EU background, or with different migrant backgrounds originating from countries where female genital mutilation is practiced, or with a migrant living in the EU and migrant from a country of origin, etc.); and
- f) FGM decision-makers (who decides on cutting, which decision factors are at play for whom, etc.).

Considering that the level of integration of families with origins in countries where female genital mutilation is commonly practised seems to influence the risk of subjecting girls to female genital mutilation (i.e. the higher the level of integration, the lower the risk), more research on integration indicators<sup>35</sup> and how they correlate with FGM risk (and prevalence) in the EU should be considered.

### Disseminating good practices and peer-learning

The existing good practices in EU Member States need to be continuously gathered, well-documented and given visibility so that their learning potential can be shared. Experience exchange meetings could be encouraged at EU level so that professionals working in the field have the opportunity to learn from one another.

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## Annex 1. Glossary

Unless otherwise mentioned, the definitions provided below have been developed by the research team for the purpose of this study.

### **Asylum seeker (or asylum applicant)**

According to Eurostat, an 'asylum applicant' is 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 made 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 this Directive, that can be applied for separately. This definition is intended to refer to all who apply for protection on an individual basis, irrespective of whether they lodge their application on arrival at the airport or land border, or from inside the country, and irrespective of whether they entered the territory legally (e.g. as a tourist) or illegally (see Article 4.1(a) of the Regulation). 'Asylum applicants considered to be unaccompanied minors' means all applicants for international protection who are considered by the national authority to be unaccompanied minors during the reference period and relates to Article 4.3(a) of the Regulation. 'Unaccompanied minor' means minor as defined in Article 2(l) of Directive 2011/95/EU, i.e. a minor who arrives on the territory of the Member States unaccompanied by an adult responsible for him or her whether by law or by the practice of the Member State concerned, and for as long as he or she is not effectively taken into the care of such a person; it includes a minor who is left unaccompanied after he or she has entered the territory of the Member States.

Source: [http://epp.eurostat.ec.europa.eu/statistics\\_explained/index.php/Glossary:Asylum\\_applicant](http://epp.eurostat.ec.europa.eu/statistics_explained/index.php/Glossary:Asylum_applicant)

According to the International Organization for Migration, an 'asylum seeker' is a person who seeks safety from persecution or serious harm in a country other than his or her own and awaits a decision on the application for refugee status under relevant international and national instruments. In case of a negative decision, the person must leave the country and may be expelled, as may any non-national in an irregular or unlawful situation, unless permission to stay is provided on humanitarian or other related grounds.

Source: <http://www.iom.int/cms/en/sites/iom/home/about-migration/key-migration-terms-1.html>

### **Country of birth**

According to the 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, in default, the country (in its current borders, if the information is available) in which the birth took place.

Source: <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2007:199:0023:0029:EN:PDF>

### **Country of origin or FGM risk country**

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

### **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.



## **Female Genital Mutilation (FGM)**

According to the World Health Organisation, female genital mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.

*Source:* <http://www.who.int/mediacentre/factsheets/fs241/en/>

In this report, the terms 'cut' and 'cutting' also refer to female genital mutilation.

### **FGM prevalence in an EU Member State**

FGM prevalence in an EU Member State is defined as the proportion (expressed as a percentage) of girls and women who are currently residing in an EU Member State and originate from or are born to mothers from countries where female genital mutilation is commonly practised, and who have undergone some form of female genital mutilation.

### **FGM risk estimation in an EU Member State**

FGM 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) 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 aged 0-18, living in an EU country who originate from or are born to a mother from FGM risk countries.

### **First generation**

First generation migrants refer to persons who were born in a country where female genital mutilation is commonly practised to one or both parents who were also born in these countries, and established residence in an EU Member State.

### **Foreign-born**

According to Eurostat, 'foreign-born' persons are those whose place of birth (or usual residence of the mother at the time of the birth) is outside the country of his/her usual residence.

*Source:* [http://ec.europa.eu/eurostat/ramon/nomenclatures/index.cfm?TargetUrl=LST\\_NOM\\_DTL\\_GLOSSARY&StrNom=C0DED2&StrLanguageCode=EN](http://ec.europa.eu/eurostat/ramon/nomenclatures/index.cfm?TargetUrl=LST_NOM_DTL_GLOSSARY&StrNom=C0DED2&StrLanguageCode=EN)

### **Girls potentially at risk of female genital mutilation**

Girls potentially at risk of female genital mutilation are defined as minor girls (in the age range of 0-18) who come from FGM risk countries, or were born to parents (or one parent) who originate from countries where female genital mutilation is commonly practised.

### **Immigration**

According to Eurostat, immigration means an action by which a person establishes his or her usual residence in the territory of a country for a period that is, or is expected to be, at least 12 months, having previously been usually resident in another country.

*Source:* [http://ec.europa.eu/eurostat/ramon/nomenclatures/index.cfm?TargetUrl=LST\\_NOM\\_DTL\\_GLOSSARY&StrNom=C0DED2&StrLanguageCode=EN](http://ec.europa.eu/eurostat/ramon/nomenclatures/index.cfm?TargetUrl=LST_NOM_DTL_GLOSSARY&StrNom=C0DED2&StrLanguageCode=EN)

### **Irregular migrant or undocumented migrant or third-country nationals found to be illegally present**

The concept of 'irregular or undocumented migrant' refers to a group of people that do not, or no longer, fulfil the legal conditions for stay or residence in a country. Authorities are not able to track all individuals who are in this situation. Those who are found in this situation, are defined as 'third-country nationals found to be illegally present' in a country. According to the Regulation (EC) No 862/2007, 'third-country nationals found to be illegally present' means third-country

nationals who are officially found to be on the territory of a Member State and who do not fulfil, or no longer fulfil, the conditions for stay or residence in that Member State. For statistical purposes, the term 'irregular migrants' in this report refers to 'third-country nationals found to be illegally present' as identified by official authorities. However, it is recognised that these individuals are a fraction of those who might find themselves in an irregular situation in an EU Member State. *Source:* <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2007:199:0023:0029:EN:PDF>

## Live birth

According to Eurostat, 'live births' refer to births of children that showed any sign of life.

*Source:* [http://ec.europa.eu/eurostat/ramon/nomenclatures/index.cfm?TargetUrl=LST\\_NOM\\_DTL\\_GLOSSARY&StrNom=CODED2&IntCurrentPage=1&StrLanguageCode=EN&RdoSearch=BEGIN&TxtSearch=live%20birth&CboTheme=&IsTer=](http://ec.europa.eu/eurostat/ramon/nomenclatures/index.cfm?TargetUrl=LST_NOM_DTL_GLOSSARY&StrNom=CODED2&IntCurrentPage=1&StrLanguageCode=EN&RdoSearch=BEGIN&TxtSearch=live%20birth&CboTheme=&IsTer=)

## Refugee

According to the Council Directive 2004/83/EC, a 'refugee' means 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 such fear, is unwilling to avail himself or herself 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 such fear, unwilling to return to it, and to whom Article 12 does not apply.

*Source:* <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:32004L0083:EN:HTML>

## Second generation

According to Eurostat, second generation migrants refer to two different groups of immediate descendants of migrants. The first group, with a mixed background, is defined as persons who are native born and who have one foreign-born parent and one native-born parent. The second group, with a foreign background, is defined as persons who are native born with both parents foreign born. In the context of the present study, second generation migrants were born to one parent or both parents who was/were born in a country where female genital mutilation is commonly practised.

*Source:* [http://ec.europa.eu/dgs/home-affairs/what-we-do/networks/european\\_migration\\_network/glossary/index\\_s\\_en.htm](http://ec.europa.eu/dgs/home-affairs/what-we-do/networks/european_migration_network/glossary/index_s_en.htm)

## Usual residence

According to the 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:

- those who have lived in their place of usual residence for a continuous period of at least 12 months before the reference time; or
- 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 one year.

Where the circumstances described in point (i) or (ii) cannot be established, 'usual residence' can be taken to mean the place of legal or registered residence, except for the purposes of Article 4.

*Source:* <http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32013R1260&from=EN>

## Year of arrival

According to Eurostat, the 'year of arrival' to be considered in a census shall be 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 (i.e. the topic 'year of arrival in the country' does not provide information on interrupted stays).

*Source:* <http://eur-lex.europa.eu/legal-content/EN/TXT/HTML/?uri=CELEX:32009R1201&qid=1430139096139&from=EN>

## Annex 2. Study implementation

The process to develop and test a methodological approach to estimate the number of girls at risk of undergoing female genital mutilation in the EU included a review of existing knowledge and a strong empirical component. It also significantly relied on the involvement and consultation of a diverse range of stakeholders throughout different phases of the study. Individual experts (at national, European and international level), civil society organisations and public institutions at national level, the End FGM European Campaign, the European Commission (DG Justice's Gender Equality Unit and Eurostat) and the United Nations High Commissioner for Refugees were engaged in this study in order to share their expertise and/or to assist during the pilot testing phase. A list of all actors involved is provided in Annex 3.

The existing methodological approaches estimating FGM risk in the EU and other existing knowledge were reviewed in June 2014 in order to develop a methodology to be pilot tested in three selected EU Member States. Considering the advantages and challenges of the approaches revised, a methodology was designed. Before testing the proposed methodology, a limited number of experts were consulted individually at the end of June 2014 by e-mail to validate the proposed mixed-method approach. Based on the feedback received from 11 experts (see list in Annex 3), the methodological approach was fine-tuned. The selection of the countries where the approach would be tested was done during this same period against a set of criteria (see Chapter 3).

The pilot studies were carried out between mid-July and mid-October 2014 in Ireland, Portugal and Sweden. During these three months, data were collected, focus group discussions were organised, and all information and data were analysed. One native-speaker national researcher per country was responsible to liaise with national stakeholders, collect the required data and to organise and facilitate the focus group discussions. National stakeholders played an important role during the pilot tests, particularly in providing the data needed and in the organisation of the group discussions.

An expert consultation meeting was held in Vilnius on 30 October 2014 aiming at discussing the main findings of the pilot studies, as well as recommendations to improve the methodology to estimate FGM risk in the EU. Twenty-five experts representing 11 EU Member States were brought together for this purpose (see list of participants in Annex 3). A discussion note constituted the basis for debating the methodological approach tested within the framework of this study. Prior to the meeting, this note was sent to all participants, as well as to the European Commission's Directorate-General for Justice (Gender Equality Unit) and Eurostat, and to researcher Paul Stanley Yoder.

Based on the experience of the study, a step-by-step guide describing a common methodology to estimate FGM risk in the EU has been conceived. This guide is intended to assist EU Member States in estimating the number of girls at risk of female genital mutilation in the EU using a methodological approach that allows comparing results across countries.

In order to update the information collected in the previous study on female genital mutilation in the EU, the national institutional bodies responsible for the development and implementation of policies on female genital mutilation, gender-based violence or gender equality were requested to respond to an online survey. The survey collected information regarding recent developments in legal and policy initiatives for eliminating female genital mutilation, as well as on efforts for measuring the phenomenon in the countries. This online survey was intended to update the information collated in the previous study undertaken in 2012, which mapped the situation and trends of female genital mutilation in the EU. Therefore, the information requested covers the period between February 2012 and June 2014. The survey included closed and open questions and was available in English (see Annex 4). The online survey ran between 18 June and 7 July 2014. The deadline was extended until 12 September 2014 to give more Member States the opportunity to fill in the survey and/or provide more information and data that was not yet available by the first deadline. A helpdesk was available to answer to Member States' queries during the whole period. Follow-up was done by e-mail and phone when needed (e.g. in case of no-reply, incomplete or unclear information). Twenty-six EU Member States responded to the questionnaire. Some information was complemented through a web-based search.

## Annex 3. List of experts consulted

Experts	One-to-one consultations	Consultation meeting	Other consultations
Armelle Andro <i>University of Paris 1 Panthéon Sorbonne, France</i>		x	
Malin Arhne <i>National Board of Health and Welfare, Sweden</i>		x	
Philippa Candler <i>UNHCR</i>	x		x
Dalila Cerejo <i>Nova University of Lisbon, Portugal</i>		x	
Dominique Dubourg <i>Health Observatory in Wallonia, Belgium</i>	x	x	
<i>Unit B1: Methodology and corporate architecture</i> <i>Eurostat</i>			x
Patrizia Farina <i>University of Milan-Bicocca, Italy</i>	x	x	
Katie Furniss <i>Islington Council, UK</i>		x	
Emilie Jarrett <i>DG Justice (Gender Equality Unit)</i>			x
Elise Johansen <i>Norwegian Centre for Violence and Traumatic Stress Studies, Norway</i>	x	x	x
Sara Johnsdotter <i>Malmö University, Sweden</i>	x		
Adriana Kaplan <i>Autonomous University of Barcelona, Spain</i>		x	
Päivikki Koponen <i>National Institute for Health and Welfare, Finland</i>		x	
Katharina Kunze <i>Terre de Femmes, Germany</i>		x	
Inger-Lise Lien <i>Norwegian Centre for Violence and Traumatic Stress Studies, Norway</i>	x	x	
Christine Loudes <i>Amnesty International – EU End FGM campaign</i>	x	x	

Alison Macfarlane <i>University City London, UK</i>	x	x	
Fadela Novak <i>UNHCR</i>	x		x
Diane Nurse <i>Health Service Executive, Ireland</i>		x	
Marika Podda Connor <i>Migrant Health Unit, Malta</i>		x	
Fabienne Richard <i>Institute of Tropical Medicine in Antwerp, Belgium</i>	x	x	
Lisa Vicente <i>Directorate-General of Health, Portugal</i>		x	
Andrea Vonkeman <i>UNHCR</i>		x	
Kerstin Westgren <i>National Board of Health and Welfare, Sweden</i>		x	
Paul Stanley Yoder <i>ICF International, USA</i>	x	x	x

## Annex 4. Questionnaire used in the online survey

### Online survey to map recent developments in EU Member States

Dear Madam or Sir,

In 2012, Yellow Window and the International Centre for Reproductive Health conducted for EIGE a [study to map the current situation and trends of Female Genital Mutilation \(FGM\) in the EU-28 Member States](#). A report with the main findings of this study was published in 2013. Most likely you were contacted by our national researchers to provide information in relation to this study. We are now contacting you again because the European Institute for Gender Equality has commissioned a new study to be undertaken by Yellow Window to develop a methodology to estimate the number of girls at risk of undergoing FGM who are living in EU Member States and to test this methodology in three EU Member States. At the same time, this study also aims to **map and document recent developments in all EU Member States regarding FGM policy and legal frameworks, as well as efforts to measure the phenomenon**. The following questions aim at collecting this information. Please be as precise as possible. In case we need any further clarifications, we will contact you.

Thank you in advance for your cooperation.

Yours sincerely,  
Yellow Window

### General information

*\*Select your country*

[drop-down list with EU Member States]

Austria  
Belgium  
Bulgaria  
Croatia  
Cyprus  
Czech Republic  
Denmark  
Estonia  
Finland  
France  
Germany  
Greece  
Hungary  
Ireland  
Italy  
Latvia  
Lithuania  
Luxemburg  
Malta  
Netherlands  
Poland  
Portugal  
Romania  
Slovakia  
Slovenia  
Spain  
Sweden  
United Kingdom

\*Person responding to this questionnaire (in case we need to contact you to clarify any aspect)

Full name:

Position:

Direct contact (preferably email):

\*1. Identify the main public organisation responsible for implementing FGM policies (or gender-based violence (GBV) in case there are no FGM-specific policies).

- a) In your native language
- b) Provide an (official) English translation
- c) There is no such organisation
- d) There is no FGM/GBV policy

\*2. Select the type of organisation mentioned above:

- a) Equality body (According to Equinet, *equality bodies are independent organisations assisting victims of discrimination, monitoring and reporting on discrimination issues, and promoting equality. They are legally required to promote equality and combat discrimination in relation to one, some, or all of the grounds of discrimination covered by European Union (EU) law – gender, race and ethnicity, age, sexual orientation, religion or belief and disability.*)
- b) Government \_ Ministry
- c) Government \_ Other
- d) National machinery for gender equality (This body specialises in promoting gender equality and on gender matters).
- e) Other. Please specify:

\*3. Key contact point for the policy area of FGM (or GBV)

\*3.1. Name

\*3.2. Position

\*3.3. E-mail contact

## Policy framework

*Definition of policy: a plan or course of action (to be) adopted by a government.*

\*1. Since February 2012, did any new policy addressing FGM enter into force (i.e. a specific FGM policy or a general policy in which FGM is included)?

- a) No
- b) Yes

If yes, please specify:

## Policy 1

- a) Title of policy (in native language)
- b) Title of policy (in English)
- c) FGM policy-specific
  - Yes
  - No
- d) Type of policy
  - Action plan
  - National action plan
  - National policy/strategy
  - Recommendations/Advice/Guidelines
  - Other. Please specify:
- e) Date of entering into force (dd/mm/yyyy)
- f) Institution issuing/adopting the policy
- g) URL
- h) Brief description (no longer than 500 characters)
- i) Budget attached

## Policy 2

1. Title of policy (in native language)
2. Title of policy (in English)
3. FGM policy-specific
  1. Yes
  2. No
4. Type of policy
  1. Action plan
  2. National action plan
  3. National policy/strategy
  4. Recommendations/Advice/Guidelines
  5. Other. Please specify:
5. Date of entering into force (dd/mm/yyyy)
6. Institution issuing/adopting the policy
7. URL
8. Brief description (no longer than 500 characters)
9. Budget attached

## Policy 3

1. Title of policy (in native language)
2. Title of policy (in English)
3. FGM policy-specific
  1. Yes
  2. No
4. Type of policy
  1. Action plan
  2. National action plan
  3. National policy/strategy
  4. Recommendations/Advice/Guidelines
  5. Other. Please specify:
5. Date of entering into force (dd/mm/yyyy)
6. Institution issuing/adopting the policy



7. URL
8. Brief description (no longer than 500 characters)
9. Budget attached

## Legal framework

*Here you can include information on hard and soft laws.*

*While a hard law refers to binding laws that create enforceable obligations and rights, a soft law refers to rules that are neither strictly binding in nature nor completely lacking legal significance.*

### **Criminal law** (pertains to crime and sanctions)

\*1. Since February 2012, did any specific criminal law to prosecute FGM enter into force? (this means that besides the general legal provisions dealing with bodily injury, mutilation and removal of organs or body tissue, which are applicable to the practice of FGM, a FGM-specific law has been issued)

- a) No
- b) Yes

If yes, please specify:

- Title of the law (in native language)
- Title of the law (in English)
- Type
  - a) Law
  - b) Resolution
  - c) Other. Please specify:
- Date of entering into force (dd/mm/yyyy)
- URL
- Brief description (no longer than 500 characters) (please refer to the legal principle of extraterritoriality and principle of double incrimination, identify which forms of FGM are forbidden)

\*2. In case no specific law was issued, was there any amendment to the existing legislation, since February 2012, making a specific reference to FGM?

- c) No
- d) Yes

If yes, please specify:

10. Title of the law (in native language)
11. Title of the law (in English)
12. Type
  1. Law
  2. Resolution
  3. Other. Please specify:
13. Date of entering into force (dd/mm/yyyy)
14. URL
15. Brief description (no longer than 500 characters) (please refer to the legal principle of extraterritoriality and principle of double incrimination, identify which forms of FGM are forbidden)

\*3. Since February 2012, was any criminal case brought to court?

- e) No
- f) Yes

If yes, please specify how many cases were brought to court: \_\_\_\_

\*4. Since February 2012, has any registration system for monitoring judicial investigations or court cases prosecuting FGM been put in place or updated/changed?

- g) No
- h) Yes

If yes, provide a brief description of the system (e.g. how data are collected, how it can be retrieved, who has access to it, number of FGM cases registered so far)

### Child protection provisions

\*1. Since February 2012, did any FGM-specific child protection measure enter into force?

- i) No (general laws regarding child protection can be used in cases of FGM)
- j) Yes

If yes, please specify:

- 16. Title of the law (in native language)
- 17. Title of the law (in English)
- 18. Type
  - 1. Law
  - 2. Resolution
  - 3. Other. Please specify:
- 19. Date of entering into force (dd/mm/yyyy)
- 20. URL
- 21. Brief description (no longer than 500 characters)

\*2. In case no specific law was issued, was there any amendment to the existing legislation, since February 2012, making a specific reference to FGM?

- k) No
- l) Yes

If yes, please specify:

- 22. Title of the law (in native language)
- 23. Title of the law (in English)
- 24. Type
  - 1. Law
  - 2. Resolution
  - 3. Other. Please specify:
- 25. Date of entering into force (dd/mm/yyyy)
- 26. URL
- 27. Brief description (no longer than 500 characters)

\*3. Since February 2012, was there any child protection intervention related to FGM?

- m) No
- n) Yes

If yes, please specify how many interventions have taken place: \_\_\_\_

\*4. Since February 2012, has any registration system for monitoring child protection interventions related to FGM been put in place or updated/changed?

- o) No
- p) Yes

If yes, provide a brief description of the system (e.g. how data are collected, how it can be retrieved, who has access to it)

## Asylum provisions

\*1. Since February 2012, did any FGM-specific international protection legal provision enter into force?

- q) No (legal framework in place can be used to grant international protection in cases of FGM)
- r) Yes

If yes, please specify:

- 28. Title of the law (in native language)
- 29. Title of the law (in English)
- 30. Type
  - 1. Law
  - 2. Resolution
  - 3. Other. Please specify:
- 31. Date of entering into force (dd/mm/yyyy)
- 32. URL
- 33. Brief description (no longer than 500 characters)

\*2. In case no specific law was issued, was there any amendment to the existing legislation, since February 2012, making a specific reference to FGM?

- s) No
- t) Yes

If yes, please specify:

- 34. Title of the law (in native language)
- 35. Title of the law (in English)
- 36. Type
  - 1. Law
  - 2. Resolution
  - 3. Other. Please specify:
- 37. Date of entering into force (dd/mm/yyyy)
- 38. URL
- 39. Brief description (no longer than 500 characters)

\*3. Since February 2012, did your country receive any asylum application based on FGM?

- u) No
- v) Yes

If yes, please specify how many FGM-related asylum applications were received: \_\_\_\_

If yes, please specify how many FGM-related asylum applications are pending: \_\_\_\_

If yes, please specify how many FGM-related asylum applications were granted: \_\_\_\_

\*4. Since February 2012, has any registration system for monitoring FGM-specific asylum applications been put in place or updated/changed?

- w) No
- x) Yes

If yes, provide a brief description of the system (e.g. how data are collected, how it can be retrieved, who has access to it)

## Professional secrecy provisions

\*1. Since February 2012, did any FGM-specific professional secrecy legal provision enter into force?

- y) No (legal framework in place can be used to disclose information on FGM cases)
- z) Yes

If yes, please specify:

- 40. Title of the law (in native language)
- 41. Title of the law (in English)
- 42. Type
  - 1. Law
  - 2. Resolution
  - 3. Other. Please specify:
- 43. Date of entering into force (dd/mm/yyyy)
- 44. URL
- 45. Brief description (no longer than 500 characters) (e.g. specify which professionals are targeted, conditions for disclosing information, specify if there is a right or duty to report, sanctions foreseen in case of non-disclosure)

\*2. In case no specific law was issued, was there any amendment to the existing legislation, since February 2012, making a specific reference to FGM?

- aa) No
- bb) Yes

If yes, please specify:

- 46. Title of the law (in native language)
- 47. Title of the law (in English)
- 48. Type
  - 4. Law
  - 5. Resolution
  - 6. Other. Please specify:
- 49. Date of entering into force (dd/mm/yyyy)
- 50. URL
- 51. Brief description (no longer than 500 characters) (e.g. specify which professionals are targeted, conditions for disclosing information, specify if there is a right or duty to report, sanctions foreseen in case of non-disclosure)

## Estimating FGM

\*1. Since February 2012, have any efforts been made to estimate the prevalence of FGM or the number of girls at risk at national level?

- cc) No
- dd) Yes

If yes, please specify:

### Document 1

- 52. Title of the document reporting the findings (in native language)
- 53. Title of the document reporting the findings (in English)
- 54. Year of publication
- 55. Author(s)
- 56. URL
- 57. Brief description (no longer than 500 characters) (data collection methods, year when data were collected, study population, age groups, prevalence data and risk estimation data, data disaggregated by age, data disaggregated by country of origin, other type of disaggregation, limitations)

## Document 2

58. Title of the document reporting the findings (in native language)
59. Title of the document reporting the findings (in English)
60. Year of publication
61. Author(s)
62. URL
63. Brief description (no longer than 500 characters) (data collection methods, year when data were collected, study population, age groups, prevalence data and risk estimation data, data disaggregated by age, data disaggregated by country of origin, other type of disaggregation, limitations)

# Endnotes

- (1) Currently, Article 409 of the Penal Code criminalises FGM. Perpetrators face three to five years in prison. If the victim is less than 18 years old, punishment for perpetrators extends to imprisonment for five to seven years. If the practice incapacitated the victim, perpetrators face up to ten years of imprisonment. The amendment proposes that Article 409 of the Penal Code also punishes those who encourage or publicise the practice.
- (2) The reasons motivating an asylum request are specified in the form that is required to be filled in.
- (3) The decision regarding one of the applications received is still pending (according to information provided on 7 August 2014).
- (4) Conditions for disclosing information differ across countries, ranging from a suspicion of a pending criminal offence to a crime that is already committed. Depending on the country, information either can or must be disclosed when an under-age child is severely endangered. In this way, general professional secrecy provisions can be applied to report cases of female genital mutilation or to protect girls at risk of female genital mutilation. For more information about professional secrecy provisions and professionals envisaged consult ElGE's report on 'Female Genital Mutilation in the European Union and Croatia' (2013).
- (5) Activities foreseen in this memorandum did not start exactly at the same time. The duration of the activities is 18 months.
- (6) FGM risk countries correspond to those countries where female genital mutilation is documented. A list of these countries is provided in Table 9.
- (7) This approach can be called the 'extrapolation-of-FGM-practising-countries-prevalence-data-method'.
- (8) Leye, E. and Deblonde, J. (2004), *Belgian legislation regarding female genital mutilation and the implementation of the law in Belgium*, The Consultory, Lokeren: International Centre for Reproductive Health No 9.
- (9) Dubourg, D., Richard, F., Leye, E., Ndam, S., Rommens, T., and Maes, S. (2011), "Estimating the number of women with female genital mutilation in Belgium", *Eur J Contracept Reprod Health Care*, Vol. 16, No 4, pp. 248-257.
- (10) FOD Volksgezondheid (Promotor), Dubourg, D., Richard, F. (2014), *Studie over de prevalentie van vrouwelijke genitale verminking en van het risico op vrouwelijke genitale verminking in België*, (update 31 December 2012).
- (11) ONE: Office de la Naissance et de l'Enfance (Office of newborns and children); K&G: Kind en Gezin (Child and Family). ONE and K&G are the departments of the Walloon and Flemish governments respectively, responsible for the wellbeing of young children and their families regarding preventive family support, childcare and adoption.
- (12) ADSEI: Algemene Directie Statistiek en Economische Informatie (General-Directorate for Statistics and Economic Information).
- (13) Although the influence of migration was not assessed in the present study, the authors sustain that the higher the level of integration of a family with origins in FGM risk countries, the higher the probability to abandon the practice. The authors suggest that the level of integration can be measured through the integration of migrants in the labour market, the increase of the level of education of women, the integration of minors in the school system, the access to health and social services, and the participation in the life of the host country.
- (14) This means that all girls of first and second generation aged 0-15 years are at risk according to the practices in the regions of countries of origin, as well as female asylum seekers in reception centres in that age range.
- (15) First generation girls aged 0-15 years and female asylum seekers in reception centres aged 0-15 are at risk according to the practices in the regions or countries of origin.
- (16) First generation girls aged 0-10 years and female asylum seekers in reception centres aged 0-10 are at risk according to the practices in the regions or countries of origin.
- (17) FGM risk is registered at municipal level within the Youth Health Care. Aggregation of data at national level is not possible. Every municipal system needs to be checked manually to obtain these data.
- (18) Data items included (for each year from 2005 to 2012): sex, age in years, country of birth, ethnicity, local authority of residence, age on arrival in UK, year of arrival in the UK, passport held, main language spoken, proficiency in English, religion, highest educational qualification, National Statistics Socio-economic Class, address one year ago, whether they were usually resident in the UK and size of household) and birth registration data.
- (19) No information is provided regarding the FGM prevalence age cohort used for estimating FGM risk in Italy.

- (20) Available here: <http://www.measuredhs.com/Publications/Publications-by-Country.cfm>.
- (21) Available here: [http://www.childinfo.org/mics\\_available.html](http://www.childinfo.org/mics_available.html).
- (22) The age that divides the population at risk of female genital mutilation into two numerically equal groups: half the people are below this age of FGM and half are older than this age of FGM. This age is usually lower than the average age of FGM.
- (23) Collecting data by one year age group is very important to estimate FGM risk as the median age of cutting varies between countries.
- (24) Those FGM risk countries that are highly represented amongst migrants in the respective EU Member State.
- (25) '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 psycho-logy of ethnic groups in the United States*. SAGE. Available at: [http://www.sagepub.com/upm-data/30900\\_Chapter4.pdf](http://www.sagepub.com/upm-data/30900_Chapter4.pdf)).
- (26) Direct provision is a means of meeting the basic needs of food and shelter for asylum seekers directly while their claims for refugee status are being processed rather than through full cash payments. Direct provision commenced on 10 April, 2000 from which time asylum seekers have received full board accommodation and personal allowances of EUR 19.10 per adult and EUR 9.60 per child per week (Source: Reception and Integration Agency, Department of Justice and Equality website, accessed 24 August 2014).
- (27) Stamp 4 status means a person is entitled to live and work in Ireland and is usually given to Convention or Programme refugees or former asylum seekers granted humanitarian leave to remain. It is not easy to travel to and from Ireland on this Stamp, due to visa costs, and unlikely a person who has gone through the asylum process would return to their country of origin on this Stamp (Source: Irish Refugee Council personnel communication 11 September 2014). For more information, check: <http://www.inis.gov.ie/en/INIS/Pages/Stamps>
- (28) According to Guinea-Bissau MICS (2010), the national FGM prevalence rate is 50 % for girls and women aged 15-49.
- (29) The basic and compulsory education comprises three cycles: 1<sup>st</sup> cycle (four years of school), 2<sup>nd</sup> cycle (six years of school) and 3<sup>rd</sup> cycle (nine years of school which corresponds to Lower Secondary Education). The Secondary Education lasts for three years and corresponds to the Upper Secondary Education. The Higher Education includes university and polytechnic education.
- (30) Available here: <http://www.bra.se/bra/bra-in-english/home.html>.
- (31) Data for previous years: <http://www.bra.se/bra/brott-och-statistik/statistik/personer-lagforda-for-brott.html>. Less common crimes against laws like the one prohibiting female genital mutilation are recorded under a 'mutual other category', with the crime code 4013.
- (32) According to Somalia MICS (2006), the national FGM prevalence rate for girls and women aged 15-49 is 98 %.
- (33) This predominantly included SFI – Swedish for immigrants or KomVux – Municipal Adult Education.
- (34) 'Cutting and sewing' refers to FGM type III, i.e. infibulation.
- (35) See, for example, UNHCR's refugee integration indicators: <http://www.refworld.org/docid/522980604.html>.







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Publications Office

PDF	10.2839/394412	978-92-9218-652-4
Paper	10.2839/574638	978-92-9218-654-8