Estimations of the number of girls at risk of female genital mutilation in Belgium, Cyprus, France, Greece, Italy and Malta

2017

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1 Introduction

This study increases the understanding of FGM in Europe by estimating the number of girls at risk of female genital mutilation in six Member States of the European Union: Belgium, Greece, France, Italy, Cyprus and Malta. The study builds upon the methodology developed by the European Institute for Gender Equality (EIGE) to estimate the risk of female genital mutilation, as outlined in detail in EIGE's Step-by-Step Guide[1] (hereafter referred to as 'EIGE's risk estimation methodology). It represents a continuation of EIGE's earlier work, in particular research conducted in 2015 to pilot the risk estimation methodology within three Member States: Ireland, Portugal and Sweden (EIGE, 2015).

The study aims to provide better information on the experiences and potential numbers of girls at risk of female genital mutilation in Europe, as well as to assess the effectiveness of measures to combat this practice.

The data collection period for this study was between August 2017 and January 2018. The research has both a quantitative and a qualitative component. Combining both components provides a more accurate and comprehensive picture than one obtained through quantitative or qualitative analysis alone.

1.1 Methodology – Quantitative component

Adopting EIGE's risk estimation methodology, estimates were calculated for the FGM risk of girls (aged 0-19) in the case study countries. The methodology uses two scenarios to establish a range in the number of girls at risk in a given Member State:

- **High 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 in their country of origin faces the same level of risk of FGM as in their country of origin.
- **Low Scenario** assumes that that migration decreases the risk of FGM. In this case, while first generation girls under the median age of FGM in their country of origin are still considered to face the same risk as in their country of origin, it is assumed that the second generation girls experience no risk of being subjected to FGM.

This methodology to calculate the number of girls at risk of FGM (x) originating from a specific country (c) in a selected EU Member State according to the following formula,

$$x_c = \left(a_{c=first} * p_c * \left(1 - m_{c=first}\right)\right) + \left(a_{c=second} * p_c * \left(1 - m_{c=second}\right)\right)$$

where:

- x_c is the number of girls at risk of FGM originating from a particular country c where FGM has been documented;
- $a_{c=first}$ is the number of first generation girls from country c that are below the national median age of FGM occurrence in country c;
- $a_{c=second}$ is the number of second generation girls from country c that are below the national median age of FGM occurrence in country c;
- p_c is the national prevalence rate of FGM in country of origin c; and
- $m_{c=first}$ is the migration and acculturation factor, which estimates how FGM prevalence differs between first generation migrants and the population of the country of origin c.

[1] http://eige.europa.eu/rdc/eige-publications/step-step-guide-estimation-girls-risk-female-genital-mutilation-european-union

- $m_{c=second}$ is the migration and acculturation factor, which estimates how FGM prevalence differs between second generation migrants and the population of the country of origin *c*.

In the High Scenario, $m_{c=first}$ and $m_{c=second}$ are both assumed to be 0, reflecting the idea that migration does not reduce the FGM risk of either the first or second generation. In the Low Scenario, $m_{c=first}$ is assumed to be 0 but $m_{c=second}$ is assumed to be 1, reflecting the idea that migration does not reduce the FGM risk of the first generation, but that second-generation girls are no longer at risk of FGM.

To carry out this calculation for the six Member States of the study a range of data from both these countries and FGM-practising countries ('countries of origin'). In particular, the main data and metadata were collected on the following indicators.

Destination countries (Belgium, Cyprus, France, Greece, Italy and Malta):

- Female migrant population (aged 0-19) from FGM-practising countries
- Female asylum-seekers from FGM-practising countries
- Female live births to mothers from FGM-practising countries

Country of origin data:

- National FGM prevalence rates for women/girls (aged 15 to 19)
- Regional FGM prevalence rates for women/girls (aged 15 to 19)
- National median age of FGM occurrence

Destination country data were collected disaggregated by: sex, country and region of origin of migrants, exact age and age of arrival of migrants, by generation. In most cases, not all of the requested data were available and a number of 'proxies' were used (such as live births data), as explained in in chapter 8.2.3. The main sources for destination country data were: national statistical institutes, birth registration organisations, Eurostat, and border and immigration agencies.

The main sources for country of origin data were: the Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS), and other national surveys. These sources normally use five-year age groups (0-4, 5-9, 10-14, 15-19) to present data on FGM. For this reason, this study focused on girls aged 0-19, as opposed to girls aged 0-18. This represents a change from EIGE's last round of research on this topic (2015) and at first sight reduces the comparability of the FGM risk estimations. However, to overcome this issue, FGM risk estimates are also given for the 0-18 group, and where available, extra age breakdowns are provided for these categories: 0-9, 10-18, 19.

Data was requested for all available years between (and including) 2011 and 2016. The focus on 2011 was because this was the year of last Europe-wide census, so it represents a year when all Member States can provide data for the FGM risk estimation. It is important for making cross-country comparisons that the years are comparable. In addition, data was requested for more recent years, in order to analyse trends.

1.2 Methodology – Qualitative component

In order to assess the influence of migration and acculturation in the EU on attitudes and behaviours towards FGM, the methodological approach to estimate the number of girls at risk of undergoing FGM includes a qualitative component.

The **qualitative method** (step 8) of focus groups discussions was chosen as the most appropriate to addres the following research questions:

- Explore the influence of migration on attitudes and behaviours towards FGM, and in particular consider how the impact of migration affects [or not] decisions to engage in the practice;

- Discuss strengths and weaknesses of prevention and protection policies and services (health, education, social);
- Identify measures to improve effectiveness of policies and services;
- Discuss levels of awareness of legislation and available services (health, education and social) within communities, and propose measures to increase awareness.

Purposive and snowball sampling techniques was used to select participants.

Different **target groups** (step 9) were defined in order to engage with community members with different backgrounds. The criteria for the target groups were mainly based on the variables age, sex, generation and country of origin. Exclusion criteria for participation were: being below the age of consent (18) and coming from a non-FGM-practising country. For each country, four target groups were predefined:

1. Women aged 25 and over, who may have daughters at risk (first generation)
2. Young women aged 18-25 (second generation)
3. Men aged 25 and over (first and/or second generation)
4. Women from hard-to-reach populations or recent migrant groups (first generation)

Due to the small size of the second-generation population in some Member States, the recruitment criteria for the session with young women was enlarged after recruitment proved to be difficult. Girls who arrived in Europe under the age of 5 were added to the second generation focus group discussion. In cases where this still did not allow for a big enough pool of recruits who were over 18 (Cyprus and Malta), the focus group discussion with young women was held with all first generation women aged 18-25.

The choice of the variable 'country of origin' in each Member State was based on:

i) communities with a high prevalence of FGM in the country of origin (thereby likely to contain a higher number of girls at risk of FGM)

ii) the overall size of the migrant population from FGM-practising countries (with preference given to the biggest communities in a Member State).

In many cases, the community with the biggest population also originated from a country with high FGM prevalence. In cases where this was not true, preference was given to engaging communities with high FGM prevalence in the country of origin, with a smaller overall population. The focus group discussions with recent migrantswere an exception to this rule, as here the objective was to gain information about newer communities where less is known about the practice of FGM. As such, it was more acceptable in these instances to engage communities with a lower level of FGM recorded in the country of origin (such as Iraqi communities).

Communities were combined in the same session when it was judged that this could aide understanding and be done in a way that was both culturally and linguistically sensitive. The choice to mix communities was decided on a case-by-case basis by the staff responsible for the research (national researchers, translators, mediators and the civil society organisations involved).

The identification and **recruitment of participants** (step 10) according to the predefined criteria was facilitated by advertising via different channels in cooperation with local civil society organisations (including charities, migrant networks and others) to engage individuals who may be interested, and word of mouth (snowball recruitment). National research teams experienced challenges when recruiting, further explained in the Chapter 8 of this report.

Table 1.1 Country of origin of the participants of the 24 focus group discussions

EU Member State	Older women[2]	Young women[3]	Men	Hard-to-reach or recent migrants (women)
Belgium	Somali	Guinean	Somali men (first generation)	Iraqi (first generation)
Cyprus	Somali	Somali	Somali (first generation)	Somali, Ethiopian, Nigerian, Ivory Coast, Gambian (first generation)
France	Malian	Malian	Malian (first and second generation)	Guinean (first generation)
Greece	Egyptian and Sudanese	Nigerian and Egyptian	Egyptian, Iraqi[4] (first and second generation)	Somali (first generation)
Italy	Egyptian	Ethiopian, Nigerian, Eritrean, Egyptian	Egyptian (first and second generation)	Nigerian (first and second generation)
Malta	Nigerian	Egyptian	Nigerian (first generation)	Egyptian (first generation)

The research activitites were **planned and prepared** (step 11). Informed consent forms were prepared and signed and ethical approval for the research was obtained. A discussion guide was developed and in-depth training was provided to facilitators, to advise them on the appropriate language and tone to use during the recruitment process and during focus group discussions themselves. Cultural mediators, peer educators and translators played an important role in the delivery of the sessions, building upon established relationships with some participants.

[2] All first-generation.

[3] All either second generation or, in exceptional cases, first generation fulfilling key criteria (see explanation above table).

[4] In addition, a Syrian individual attended, although note that Syria is not officially considered an FGM-practising country at the time of this study.

2 Female genital mutilation risk estimation in Belgium

2.1 Summary of findings from focus group discussions organised in Belgium

2.1.1 Overview of the focus group discussions

Four focus group discussions took place in Belgium in September 2017. Discussions were held with first generation women and men from Somalia, second generation young women from Guinea-Conakry and first-generation female asylum-seekers from Iraq. The countries of origin were chosen according to data[5] of the largest populations from FGM-practising countries living in Belgium (Guinea-Conakry and Somalia) and populations of newly arrived asylum seekers potentially affected by FGM (Iraq).

All participants were Muslim. Most first-generation participants (but no second generation) had partners and children. The table below presents an overview of the profile of participants in the four focus group discussions.

Table 2.1 Socio-demographic information about participants in Belgium

	Focus group discussion 1: Older women	Focus group discussion 2: Younger women	Focus group discussion 3: Men	Focus group discussion 4: Hard-to-reach/recent migrants
Number of participants:	9	5	10	3
Countries of origin represented[6]:	Somalia	Guinea-Conakry	Somalia	Iraq
Sex of participants:	Women	Women	Men	Women
Age range:	26-47	18-20	21-39	25-53
Generation	First	First (arrived at maximum age 5) and Second	First	First
Average residence (number of months) & previous residence in other countries	83 months (7 years), 0 months in other countries	158 months (13 years), 2.8 years in other countries	17.3 months (1.4 years), none had lived in other countries	0.8 months, 4 months in another country
Number of second-generation participants who have lived in their parents' country of birth	n/a	4 (before moving to Europe)	n/a	n/a
Civil status of participants:	5 were divorced, 4 were married	All were unmarried	9 were married, one lack of information	2 were married, 1 was a widow
Number of participants with/without children	All had children (8 had daughters)	None had children	All but one had children (6 had daughters)	All had children (1 had daughters)
Religion:	All Muslim	All Muslim	All Muslim	All Muslim
Ethnic groups (if available):	Asharaf, Haweyé (3), Bide. 4 participants did not answer.	Fulani	*No information.*	*No information.*
Level of education:	No education (1), Primary education (6), Secondary education (2).	Secondary education (3) and University (2).	No (2), Quoranic (3), Secondary (4), University (1)	Primary (1), Secondary/ 1st year University (1)
(For first generation): Shortest and longest amount of time residing in Belgium:	1.5 years – 17 years	3 – 16 years	3 months – 2 years 3 months	1 day – 1.5 months

[5] See section 2.2 and section 2.3 for quantitative data on the characteristics of the migrant population in Belgium.

[6] This is the country of birth of first-generation migrants (FGM-practising countries); country of birth of parents of second-generation migrants (FGM-practising countries). Here, someone is second-generation if he/she is not born in an FGM-practising country but he/she has at least one parent is born in an FGM-practising country.

	Focus group discussion 1: Older women	Focus group discussion 2: Younger women	Focus group discussion 3: Men	Focus group discussion 4: Hard-to-reach/recent migrants
(For first generation): Shortest and longest amount of time residing in other European Member State:	0 – 1 year	0 – 14 years	X	5 days – 1 year
Date of session:	23 September 2017	26 September 2017	16 September 17	28 September 2017

2.1.2 Key findings from the focus group discussions organised in Belgium

Identity and attitudes about the importance of FGM

All Somali, Guinean and Iraqi women, and most Somali men, were personally opposed to all types of FGM. Several Somali women and men were protecting their daughters from FGM. However, some Somali men had ambiguous feelings; a few were opposed to infibulation (FGM Type III) but did not oppose, or were indifferent, vis-à-vis 'sunna' (FGM type I or FGM Type IV ("pricking"). They saw 'sunna' as equivalent to not undergoing FGM, as beneficial for women, required by Islam or a tradition to be respected. Somali and Guinean participants said FGM is a strong traditional practice in their country of origin : "if you touch excision you touch our traditions, and [the community thinks that] you should not touch our traditions" (Somali woman, personally opposed to FGM). Likewise, Iraqi women explained that the practice, as performed at the time of their grand- or great-grand-parents, was a "traditional practice", transmitted between generations. They were unsure whether it was regional or the tradition of specific ethnic groups. According to them, FGM is currently practised by a few communities for whom it is a tradition, but it is also used by armed groups as a means of controlling the population, and as such has no importance for the identity of the communities. Several participants considered FGM to be more important to older generations (women) and in rural sectors. Men said that some men in Somalia now prefer women who had not undergone infibulation.

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

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

Several Somali men and women spoke about strong pressure to have their daughters cut from their families in Somalia, causing tensions with family members. Three men were afraid that their (ex-)wives or the family would force their daughters living in East Africa to undergo FGM. A Somali woman shared the story of her family regularly asking for money to practise FGM on her three daughters living in Somalia. For another woman, her own daughter – who stayed in the country of origin – pressures her into having the younger daughters undergo FGM. When visiting Guinea-Conakry, second-generation Guinean women were sometimes asked by female relatives or community members whether they were cut. Coping strategies include lying about having undergone FGM or mothers not leaving daughters alone with persons they do not trust.

It can be difficult for Guineans and Somalis living in Belgium to discuss FGM with communities living in the country of origin as their peers may have undergone FGM while they have not, or they are seen as

"Europeans". A young Guinean woman explained: "people question what I say [laughing] especially when it comes to that [FGM]".

The reasons underlying the practice of FGM in all countries of origin related to controlling women's sexuality. According to male and female Somalis, infibulation is seen as a guarantee that the girl is a virgin until she gets married. FGM also relates to purity; according to participants, the word used in Iraqi, "*tohor*" means "purity", and in Somali the word for infibulation, is "*halalese*", meaning "purification".

Male participants explained that, in Somalia, difficulties of sexual intercourse with an infibulated woman on the wedding night is proof of the woman's virginity and the man's virility. Nevertheless, results from the focus groups suggest that there is a transition from "pharaonic" (FGM Type III) to "sunna" (FGM Type I or II). This transition started in the 1990s as a result of campaigns and awareness of complications from infibulation. Some Somali men thought that infibulation is mostly practised today in rural areas and that younger men prefer women who are not infibulated because they are considered better sex partners. One man explained that young boys will say: "what will I do with a 'pharaonic' woman, she will make me tired at night". In fact, some men might not even accept to marry a woman who has undergone infibulation.

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

Participants in all focus groups thought that FGM is not practised in their communities in Europe. In Belgium, FGM is not a social norm, it is against the law and in Europe people learn that negative health consequences are linked to FGM. Therefore, whether to have daughters cut was not seen as a relevant issue for women and men whose daughters lived in Europe because, according to the participants, the "mentality" of Somali and Guinean people changes when they live in Europe.

In the Somali and Guinean groups, women, and especially "older women", were seen as the main decision-makers for FGM. Information about consequences of FGM and that it is not a religious requirement was said to be key to abandon the practice. Iraqi women also said that the practice had been abandoned in their communities over time as people were educated.

While Guinean women agreed that excision is traditionally practised to guarantee pre-marital virginity, they did not think that it was a pre-requisite any longer for persons living in Europe. Rather, they stressed the importance of a good education. According to them, a Guinean man living in Belgium would not expect his wife to have undergone FGM. However, pre-marital virginity remains important to the Guinean diaspora.

None of the young women expressed fears or concerns about FGM or difficulties dealing with the expectations of the community regarding the practice.

Key risk factors for FGM

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

In Iraq, the presence of armed forces, such as Daesh, was seen to embody a risk factor for FGM particularly to young unmarried women. However, this differed for Somali women, who argued Daesh were opposed to infibulation in Somalia as it is against Islam. According to participants, since Daesh preaches against FGM, some Somali women keep a negative idea of FGM when they leave the country for Europe. Moreover, Somali women and men argued that since mothers are often aware of the negative health consequences of FGM, they stop practising it once they escape from the pressure of mother-in-laws or grandmothers.

Participants in the three first focus groups were generally aware of the existence of a law against FGM in Belgium. The law was frequently put forward as a reason to abandon the practice when living in Europe, together with the change of mentality. Many Somali participants had received information about FGM

when living in asylum centres or through integration classes. However, three of the Somali men had never been informed of FGM in Belgium, out of which two had been in the country for over two years.

2.2 Female migrant population aged 0-19 originating from FGM-practising countries

Table 2.2 Overview of data availability in Belgium

Type of data	Summary of data availability and sources
Risk estimation	
Sources used in risk estimation	Population Register (Belgium Statistics Office) for data on the first-generation, and the Birth Register (Office de la Naissance et de l'Enfance) for the second-generation data, for the 2012 and 2016 estimates. Census data (Eurostat) for first-generation and Birth Register (Office de la Naissance et de l'Enfance) for the second-generation data 2011.
Data issues:	Combining sources was necessary due to the difficulty of tracing second-generation persons in the Population Register. The Population Register can include some first-generation migrants who have been in the country fo less than 12 months. As live births data for 1997 is not available, estimation data on 19 year olds is missing for 2016, estimation data on those aged 15 and above is missing for 2012. For 2011 estimates, female live births covers only those aged 0-13. For 2012 estimates, female live births covers only those aged 0-14.
Overview data presented on the migrant population	
Female migrant population originating from FGM-practising countries	Population Register (via Belgium Statistics Office) for 2012 and 2016; Eurostat for 2011
Years available	2011, 2012, 2016
By age	0-19: One-year age intervals
By country of origin	Available
By first and second generation	Available, but incomplete. Only possible when second-generation girls are born to mothers without Belgian nationality (see below).
By regional level	Unavailable
By age of arrival	Available
Data issues	Population Register refers to the legal population; excludes irregular migrants/migrants still in the asylum process. Migrants are included as soon as they get their Refugee Grant or other legal resident permit; thus, this population comprises any foreign-born person with a legal permit of residence independently of the length of their stay. There is a problem tracing second generation persons; only the first and second nationality is mentioned in the Population Register. A girl (second generation) born from a mother who became Belgian by naturalisation before the birth of her daughter is not captured. Incomplete second-generation data was supplemented by female live births data (see below).
Female live births in EU to mothers originating from FGM-practising countries	Birth Notification (Avis de Naissance) information collected by the services in charge of Child Health prevention: Office de la Naissance et de l'Enfance for the French part of the country and Kind en Gezin in Flandres. Used to complement data on the second generation.
By country of mother	Available
By regional level of country of mother	Unavailable
By region of birth of the child	Available

Type of data	Summary of data availability and sources
Data issues	Some issues with using live births data to estimate the size of the second generation, as some of the girls may have left the country. Nonetheless, it is closer to the real figures than the missing data from the Population Register. 1997 births not available.
Female asylum seekers	Federal Agency for the reception of asylum seekers in Belgium (FEDASIL) - collect data on all residents of the Reception network, including centres managed by FEDASIL or by the Red Cross, Caritas and other partners.
Years available	2012, 2015, 2016
By age	0-19, with one-year age breakdowns.
By country of origin	Available.
By regional level	Unavailable
By age of arrival	Available
Data issues	A large amount of data was missing for the variable age of arrival. It was sometimes difficult to know if infants were born in Belgium during the asylum process of their mother, or if they were born in a third country.
Female refugees	Unavailable (not possible to distinguish from other migration statistics).
Years available	
By age	
By country of origin	
By first and second generation	
By regional level	
By age of arrival	
Data issues	
Female irregular migrants	Official data unavailable. Unofficial data available from Médecins du Monde on the number of undocumented migrants accessing free healthcare.
Years available	20 September 2016-20 September 2017
By age	0-19.
By country of origin	Available
By first and second generation	Unavailable
By regional level	Unavailable
By age of arrival	Unavailable
Data issues	Detailed metadata not available. Under-estimation, covers only those who seek care from Médecins du Monde.
Official registration – other sources on identified FGM cases	
Medical/hospital	Available.
Child protection	Available
Police/judicial	Available
Asylum	Available: FGM-related international protection. FGM-related asylum applications received and granted in Belgium.
Other	n/a

This section of the Belgium chapter provides data (where available) on four groups: i) the recorded migrant population, who are legally present and 'usually resident' in the Member State; ii) recent immigrants and emigrants to the country; iii) irregular migrants, who do not – or no longer – fulfil the conditions for legal residence in the country; and iv) asylum-seekers, who are legally present but have not found out if their application for international protection was successful. Having an overview of this data is important for understanding potential populations of interest when estimating the number of girls at risk of female genital mutilation. The chapter ends by presenting data on other sources (if any) that are collecting FGM in the country.

2.2.2 Migrant population

In Belgium, there were 15,074 migrant girls (aged 0-19) originating from FGM-practising countries in 2011.Of these, 70% (8,150) were second generation. Of the total number of girls aged 0-19, the majority (78%, 11,721) were aged 0-9 and 21% (3,104) were 10-18; 249 were aged 19 (1%). Of the girls aged 0-9, most were from the second generation. Put simply, girls in the younger age category are much more likely to be from the second generation, whereas the reverse is true for older girls.

Table 2.3 Age distribution of the female migrant population (aged 0-19) originating from FGM-practising countries, in Belgium, 2011

	TOTAL	First generation	Second generation	TOTAL (%)	First generation (%)	Second generation (%)	TOTAL generation (%)
0-9	11,721	3,571	8,150	78%	30%	70%	100%
10-18	3,104	1,995	1,109	21%	64%	36%	100%
19	249	249	0	1%	100%	0%	100%
TOTAL	15,074	5,815	9,259	100%	39%	61%	100%

Notes: The number of second-generation girls is an under-estimation; for the 2011 data, the second generation girls only includes girls 0-13. The incomplete second-generation data was compensated with female live births, by using the Birth Notification (Avis de Naissance) information (sex, place of birth, country of origin of the mother) collected by services in charge of Child Health prevention.

Source: Census data and Office de la Naissance et de l'Enfance.

In Belgium, there were 17,283 migrant girls (aged 0-19) originating from FGM-practising countries in 2012. Of these, 63% (10,811) were second generation. Of the total number of girls aged 0-19, the majority (66%, 11,322) were aged 0-9 and 31% (5,401) were 10-18, leaving only 560 (3%) aged 19. Of the girls aged 0-9, 82% are second generation, which falls to 28% for those aged 10-19. As in 2011, the same pattern holds that younger girls are far more likely to be drawn from the second generation.

Table 2.4 Age distribution of the female migrant population (aged 0-19) originating from FGM-practising countries, in Belgium, 2012

	TOTAL	First generation	Second generation	TOTAL (%)	First generation (%)	Second generation (%)	TOTAL generation (%)
0-9	11,322	2,006	9,316	66%	18%	82%	100%
10-18	5,401	3,906	1,495	31%	72%	28%	100%
19	560	560	0	3%	100%	0%	100%
TOTAL	17,283	6,472	10,811	100%	37%	63%	100%

Notes: The number of second-generation girls is an under-estimation; for the 2012 data, the second generation girls only includes girls 0-14. The incomplete second-generation data was compensated with female live births, by using the Birth Notification (Avis de Naissance) information (sex, place of birth, country of origin of the mother) collected by services in charge of Child Health prevention.

Source: Belgium Statistics, Office de la Naissance et de l'Enfance,and Kind en Gezin.

In Belgium, there were 22,984 migrant girls (aged 0-19) from FGM-practising countries. Of these, 5,140 (22%) were first generation and 17,844 (78%) second generation. In all, 68% of these girls (both generations) are below the age of 10, although a higher proportion of the second-generation are under 10 and indeed the first-generation mostly includes young women aged 10-18. The detailed age disaggregation is available in Annex 1. For more information on the estimation of the number of second-generation girls, see Section 2.2.6 on 'Other records collecting information on FGM in Belgium'.

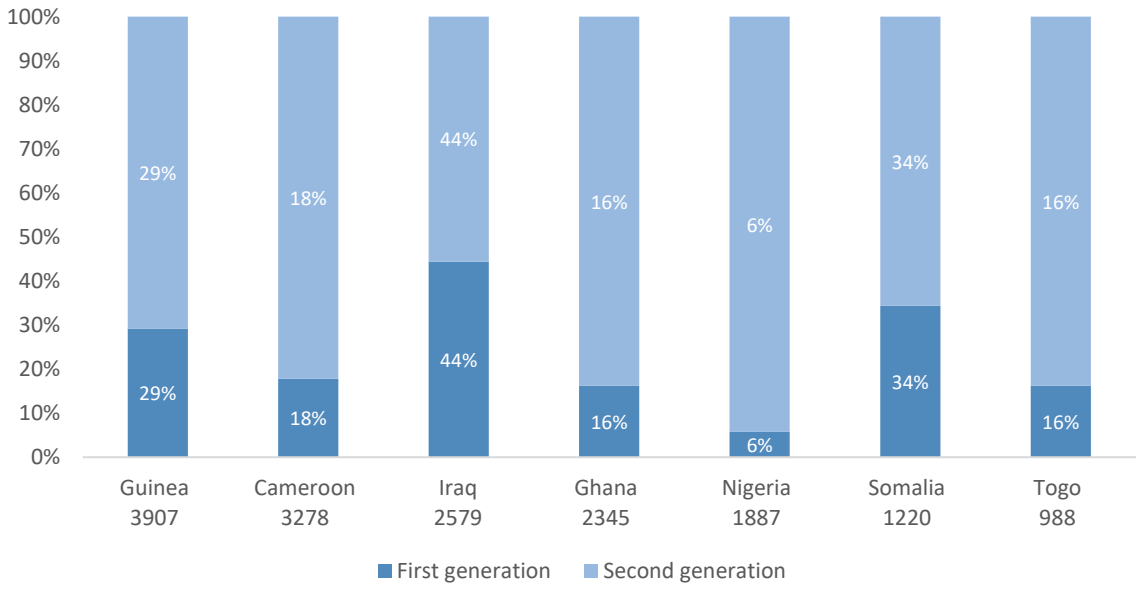
Table 2.5 Age distribution of the female migrant population (aged 0-19) originating from FGM-practising countries, in Belgium, 2016

	TOTAL	First generation	Second generation	TOTAL (%)	First generation (%)	Second generation (%)	TOTAL generation (%)
0-9	15,646	1,770	13,876	68%	11%	89%	100%
10-18	6,898	2,944	3,954	30%	43%	57%	100%
19	440	426	14	2%	97%	3%	100%
TOTAL	22,984	5,140	17,844	100%	22%	78%	100%

Source: Belgium Statistics,Office de la Naissance et de l'Enfance,and Kind en Gezin.

Notes: There is a problem tracing second generation persons using the Population Register. The incomplete second-generation data was compensated with female live births, by using the Birth Notification (Avis de Naissance) information (sex, place of birth, country of origin of the mother) collected by services in charge of Child Health prevention

Figure 2.1 Number of girls (aged 0-19) living in Belgium by generation and seven most represented countries of origin, 2016



Notes: From left to right, these countries are presented in descending order when it comes to the size of the communities (with Guinea Conakry being the highest and Togo being the lowest). However, they are shown on the same scale to enable percentage comparison per generation.

Source: Belgium Statistics, Office de la Naissance et de l'Enfance, and Kind en Gezin

The seven countries most represented in 2016 were Guinea Conakry, Cameroon, Iraq, Ghana, Nigeria, Somalia and Togo (first and second generations girls). Guinea Conakry, Cameroon, Iraq and Ghana represent 50% of the total population of girls (aged 0-19) originating from a FGM-practising country.

Information on the region of origin of the girls (or their mothers) is unavailable. Thus, for countries with a low FGM prevalence, such as Cameroon (1%), Iraq (8%) and Nigeria (25%)[7], the risk of bias is high when applying the national prevalence to the migrant population living in Belgium. Data is also unavailable for the years 2013, 2014 and 2015.

2.2.3 Inflows and outflows

To get a sense of migration patterns over time, it is worthwhile to consider 'inflows' and 'outflows' from FGM-practising countries. The former covers immigrants (inflows): people arriving or returning from abroad to take up residence in a country for 12 months or more, having previously been resident elsewhere. The latter covers people who are leaving the country where they usually reside and effectively taking up residence in another country. An individual is a long-term emigrant if he/she leaves his/her country of previous usual residence for a period of 12 months or more. A positive 'net inflow' indicates that more people are arriving than leaving Belgium, within a given year.

Figure 2.2 Total female immigrants (inflows) and emigrants (outflows) from the 30 FGM-practising countries in Belgium (aged 0-19), 2016

	Year
	2016
Total inflow	1225
Total outflow	54
Net inflow	1171

Source: Belgium Statistics Office.

The net inflow in 2016 was positive (1171). Fifty-four girls (0-19) left the country in 2016. Ideally, one would know their age and country of destination to estimate the risk of being subjected to FGM (in case of return to the country of origin).

2.2.4 Irregular migration

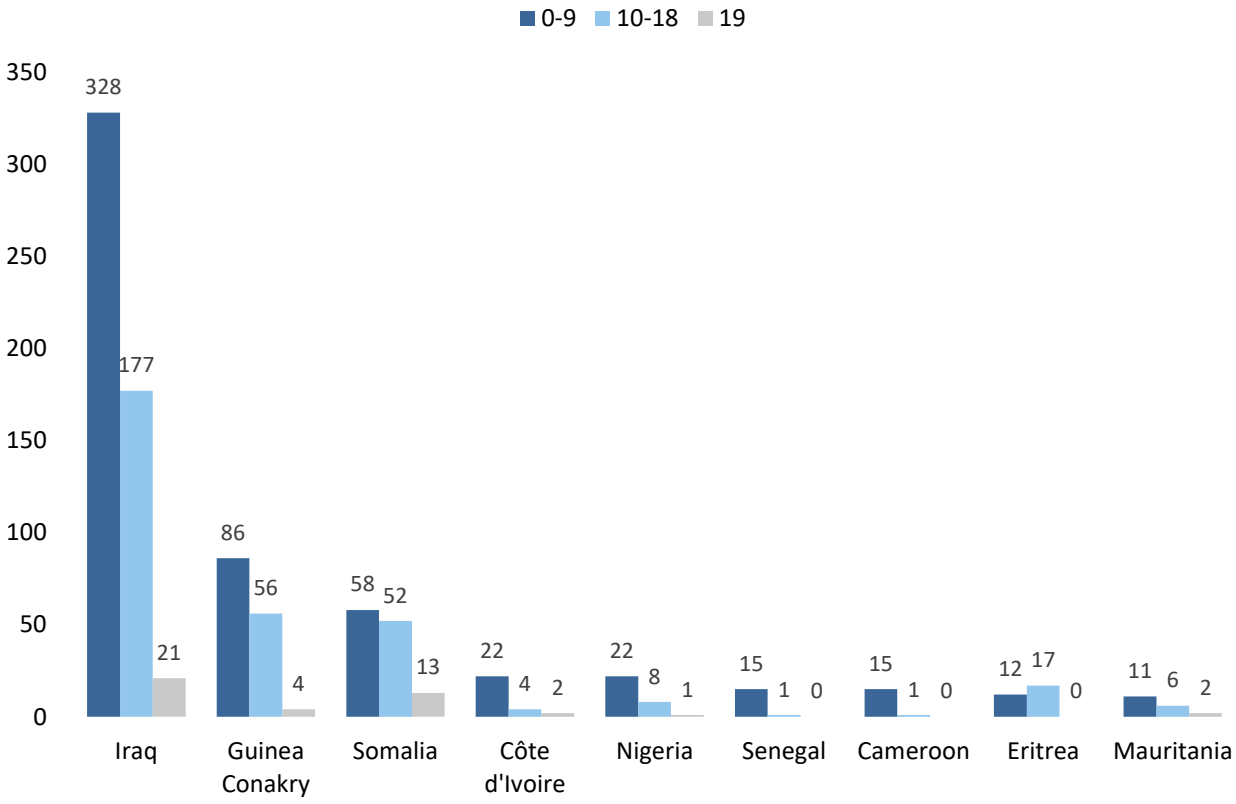
There is no official data available on the number of irregular migrants living in Belgium. Several civil society organisations provide health care or social support to undocumented persons and can provide useful information. To avoid double counting by asking several organisations, the biggest civil society organisation Médecins du Monde has provided data from the 30 FGM-practising countries, as they offer free health care to undocumented migrants at a national level. They found that 38 girls aged 0 to 19, originating from a FGM-practising country, came to seek care to one of their dispensaries (between 20/09/16 and 20/09/17). Twenty-three were from Iraq (60%).

[7] See country of origin data in Table A2.1 in Annex 2 of this report.

2.2.5 Asylum-seekers

FEDASIL is the Federal Agency for the reception of asylum seekers in Belgium. They collect data on all the residents of the reception network (individual and collective centres): FEDASIL centres as well as centres managed by the Red Cross, Caritas and other partners. FEDASIL provides disaggregated data on country of origin, sex, age and age of arrival. However, data on the 'age of arrival' of asylum-seekers is not available for all the asylum seekers and so cannot be used for analysis.

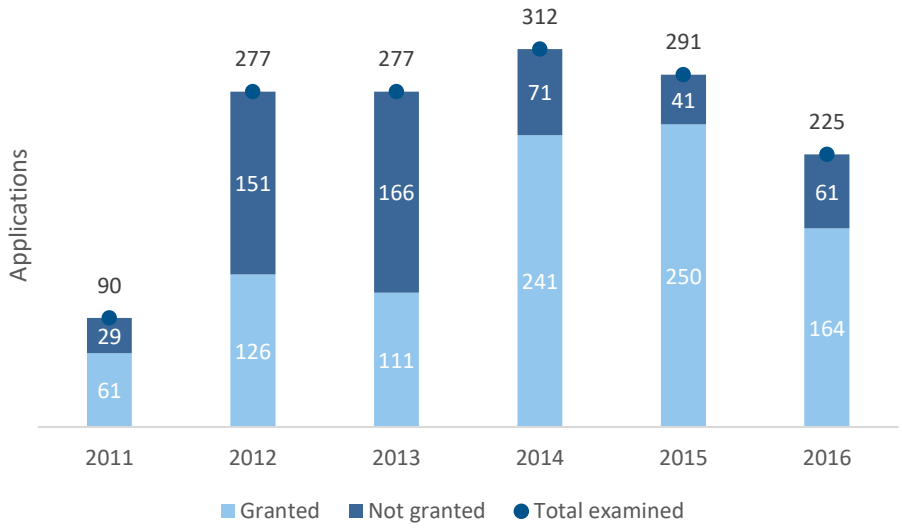
Figure 2.3 Number of asylum-seeking girls (aged 0-19) in Belgium, by age and by most represented countries of origin, 2016



Source: Federal Agency for the reception of asylum seekers (Fedasil), Belgium.

In 2016, the total number of female asylum seekers (aged 0-19) originating from the 30 FGM-practising countries was 1,016 versus 682 in 2012. Three countries, Iraq, Guinea Conakry and Somalia, represent 78% of the total female asylum-seeking population (0-19). Overall, 61% of the asylum-seeking population presented in Figure 2.4 are below the age of 10 and 32% are below age 5. Most asylum-seekers from each of these seven countries are also younger than 10.

Figure 2.4 Examined FGM-related asylum applications in Belgium since 2011 for girls aged 0-18, from the 30 FGM-practising countries, broken down by those that were granted and **not granted**



Notes : 'Examined applications' do not cover all those received: some are not examined because they are not complete or not accepted.

Source: Office of the Commissariat General for Refugees and Stateless persons (CGRS), Belgium

Belgium is one the EU Member States where FGM is recognised as a form of gender-based persecution and child-specific persecution and can be considered as a ground to claim asylum[8]. The Office of the Commissariat General for Refugees and Stateless persons (CGRS) keeps yearly records of the number of applications on the base of FGM which have been examined and for which a decision has been taken: Refugee status or Subsidiary Protection (see Figure 2.4). The number of FGM grants increased progressively from 2011 to 2015, but decreased again in 2016 (from 250 to 164 FGM Grants) for girls aged 0-18. The proportion of granted applications varies every year from 40% to 86% with a trend towards higher percentage in the last years (68% in 2011, 45% in 2012, 40% in 2013, 77% in 2014, 86% in 2015 and 73% in 2016).

On 29 September 2017, there were 1,803 girls from 0 to 10 in Belgium with an international protection on FGM: 1,703 were intact (granted protection against FGM) and 100 had already undergone FGM (grant accepted on grounds of consequences of FGM or risk of re-excision).

Data on FGM grants are not included in the estimates of the number of asylum-seekers at risk (see section 2.3).

2.2.6 Other records collecting information on FGM in Belgium

Hospital records

[8] There is some ambiguity at international level over the status of FGM in refugee law. The 1951 Refugee Convention (UNHCR, 2017) states that individuals are eligible for asylum when they possess a "well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion" (Article 1(2)). This does not explicitly cover gender a grounds for asylum, nor does it directly state that FGM qualifies as persecution. For more on the Belgian situation, see European Commission, Home Affairs. A Common European Asylum System. Luxembourg: Publications of the European Union, 2014. https://ec.europa.eu/home-affairs/sites/homeaffairs/files/e-library/docs/ceas-fact-sheets/ceas_factsheet_en.pdf

FGM appears as a primary or secondary diagnosis in the Summary Hospitalisation Report (Résumé Hospitalier Minimum - RHM) that should be filled for every hospitalisation[9]. The Public Federal Service of Public Health is in charge of analysing the RHM. A pilot project, coordinated by International Center of Reproductive Health, Gent, in 2013, conducted in maternity wards, showed that the percentage of complete data increases after an information session with the maternity staff (ICRH, 2014). The small number of first or second diagnoses of FGM for girls (0-18) who have been hospitalised suggests underreporting and a lack of knowledge by professionals of how to identify FGM amongst children, compared to adult women. Data on hospitalisation was not used in the estimates of girls at risk.

Births Certificates

Most data on population living in Belgium comes from the National Population Register. There is a problem tracing second-generation persons as only the first and second nationality is mentioned in the Register. A girl (second generation) born from a mother who has become Belgian by naturalisation before the birth of her daughter is not captured by the research based on the nationality of the girl (first and second nationality).

To overcome this, data on female live births was added to collect information on the second generation, using the birth certification information (registering country of origin of the mother) collected by the Belgian institutions in charge of child health prevention: 'Office de la Naissance et de l'Enfance' for the French Community and 'Kind en Gezin' for the Flemish Community. Data is available from 1998. The estimation of the second generation using these data is approximate, as the oldest girls may have moved and left the country (54 girls from FGM-practising countries left Belgium in 2016). Nevertheless, it is better to use this source of data for the second generation as one cannot trace them in the Population Register.

Police and judiciary records

Since 2008, Belgian correctional prosecutors encode cases of FGM under the generic code "43 K-Sexual mutilation". According to the database of the College of prosecutors (as of 10 June 2017), 21 cases of FGM have been brought to the correctional courts between 2008 and 2016.

Analysis of the years 2013 to 2016, shows that 10 cases have been classified without further action and 1 had been classed for disposition (reclassified under another number).

The defendants were 7 men and 4 women. Out of the 10 cases classified without further action, 2 were classified for lack of a criminal offence, 4 for insufficient charges, 1 for prescription (termination of prosecution), 1 for incompetence (inadmissibility of prosecution) and 2 for insufficient investigative capacity (source: database of College of Public Prosecutors). To allow for better understanding and apprehension of female genital mutilation and an accurate perception of statistical data on the subject, two separate codes were created in June 2017 with the implementation of the new circular of the Public Prosecutors on FGM (COL 06/2017)[10]: the code 43 K for FGM (section 409 of the penal Code) and the code 43 L for other types of sexual mutilation. Acts of FGM must now be registered in the court system under the code 43K. For the Police services registration system of infractions, the code is 43.

Police and judicial records were not used in the estimates of girls at risk.

[9] The Summary Hospitalisation Report is a mandatory report filled for every hospitalisation and send to the Ministry of Health with some standardised information about the patient characteristics, diagnosis and treatment received. The analysis of these data helps to determine the financial dotation of hospitals, to guide health policies and research. Two medical diagnosis can be mentioned: the primary is the main reason of hospitalisation and the secondary diagnosis is an eventual associated or co-existent pathology.

[10] Ministère Public de la Justice. Circulaire commune du ministre de la justice et du collège des procureurs généraux relative à la politique de recherche et de poursuites en matière de violences liées à l'honneur, mutilations génitales féminines et mariages et cohabitations légales forcés. COL 06/2017.

Child protections records

Girls living in Belgium, including girls born in Belgium, may be at risk of FGM when travelling abroad to the country of origin of their parents where FGM is practised. The specialised civil society organisations (GAMS and INTACT), together with the network "Concerted Strategies against FGM"[11] have developed a protocol for the prevention of FGM for these girls, including a risk scale and a decision-tree informing professionals of the necessary steps to protect at-risk girls/women. Moreover, the NGOs have developed a range of tools to help the professionals with this prevention work, such as the FGM Prevention Kit[12] and the Best Practices Guide[13]. The lead organisations of the Concerted Strategies on FGM have a registration of risk situations that are brought to their attention (19 cases in 2016) but many professionals who have been trained by the organisations use the protocol independently without consulting the organisations. Thus, there is no comprehensive data on the number of risk situations managed by the professionals each year.

Child protection records were not used in the estimates of girls at risk.

2.3 Estimation of the number of girls at risk of FGM in Belgium and possible trends of FGM risk

The following section provides data on the estimated number of girls at risk of FGM in Belgium, following the methodology in EIGE's step-by-step guide. It begins by presenting estimates of the number of girls at risk within the 'regular' migrant population, then presents the estimates for asylum-seeking girls. This is an important difference, as asylum-seekers are not included within the migrant population (unlike, for example, recognised refugees). It is worth remembering that the estimates for asylum-seekers cannot distinguish between a high and low scenario, as technically all asylum-seekers being considered are from the first generation.

For the regular migrant population, the statistics used come from two sources: the Population Register (Belgium Statistics Office) for data on the first-generation, and the Birth Register (Avis de Naissance) for the second-generation data. Combining these two sources was necessary due to the difficulty of tracing second-generation persons in the Population Register.

There are some caveats in the data that first need to be noted. Firstly, there is a discrepancy in the definition of the female migrant population, relative to the official definition in use for the study[14], because some migrants can be in Belgium for less than 12 months and be registered in the National Population Register if their residence permit allows them to be in the country. Furthermore, refugees with a Grant are included in the first generation, but this is not case for asylum seekers, which are kept separate. There is also a lack of data on female babies born from a naturalised migrant mother, as this information is lost in the system. The National Register only covers current and previous nationalities and if a refugee mother has been naturalised, her daughter is registered as Belgian. For this reason, the National Register is only used for first generation, or second generation who are born in another EU country or non-practising country, while the birth registration office data is used for second generation born in Belgium (with Belgian or foreign nationality), as it provides information on the mother's country of origin. Following this approach, data on

[11] This is a network composed of different Belgian stakeholders from the state and the civil society concerned by the issue of FGM. See http://www.strategiesconcertees-mgf.be

[12] http://www.strategiesconcertees-mgf.be/scmgf-15/

[13] http://www.strategiesconcertees-mgf.be/tool/guide-de-bonnes-pratiques/

[14] The migrant population covers both: i) those who were born in an FGM-practising country to one or more parents who were also born in these countries, and who established 'usual residence' in an EU Member State (first generation) and ii) those who were not born in FGM-practising country, but who have at least one parent who was born in an FGM-practising country, and who is 'usually resident' in an EU Member State (second generation). Here, usual residence is linked to at least 12 months' continuous residence in the country; see Glossary for more information.

the second generation has been estimated by adding female live births and females born in another EU country or non-practising country.

Data on female live births is not available prior to 1998, as the recording system at this time had an unreliable database that was difficult to access. As data for 1997 is not available, data on 19 year olds is missing for 2016, data on those aged 15 and above is missing for 2012, data on those aged 14 and above is missing for 2011. Therefore, data on 19 year olds was taken from the National Register. Furthermore, female live births were only available at aggregate level and not broken down by age. The study team therefore assumed the same age structure for data on national born provided by the National Register.

In regards to data from 2012, reliable second generation data is missing. Data is also missing for first generation age 0, as well as first generation data for women and girls from Indonesia.

2.3.1 Estimation of girls at risk within the regular migrant population

In 2016, the number of girls (aged 0-19) at risk of female genital mutilation in Belgium varied between 596 and 4,612. In 2012, the number of girls at risk was estimated to be 523 in the low scenario, demonstrating that this number is estimated to have increased slightly over the years. However, there are issues with the second-generation data for 2012: missing retrospective data on births to have the full range from 0 to 19 years old. This means the high scenario of girls at risk in this year (3,178) is likely to be an under-estimate.

In 2011, between 8.3% and 24% of girls aged 0-19 were at risk; and, in 2016 between 2.6% and 20% of girls aged 0-19 were at risk. Despite the reduction in the proportions at risk, the *number* of second-generation girls at risk has substantially increased (from 2,301 in 2011 to 4,016 in 2016), whereas the number of first-generation girls at risk has decreased (from 1,254 in 2011 to 596 in 2016).

If one restricts the age range to 0-18, in 2016, the number of girls at risk in Belgium varied from 596 to 4612, representing between 3% and 20.5% of girls. In 2011, between 8.5% and 24% of girls aged 0-18 were at risk.

The table below gives a summary of results for 2011, 2012 and 2016. Underlying data for these estimations is available in Annex 2.

Table 2.6 Estimated number of girls (0-19) living in Belgium in 2011,2012 and 2016 who are at risk of FGM

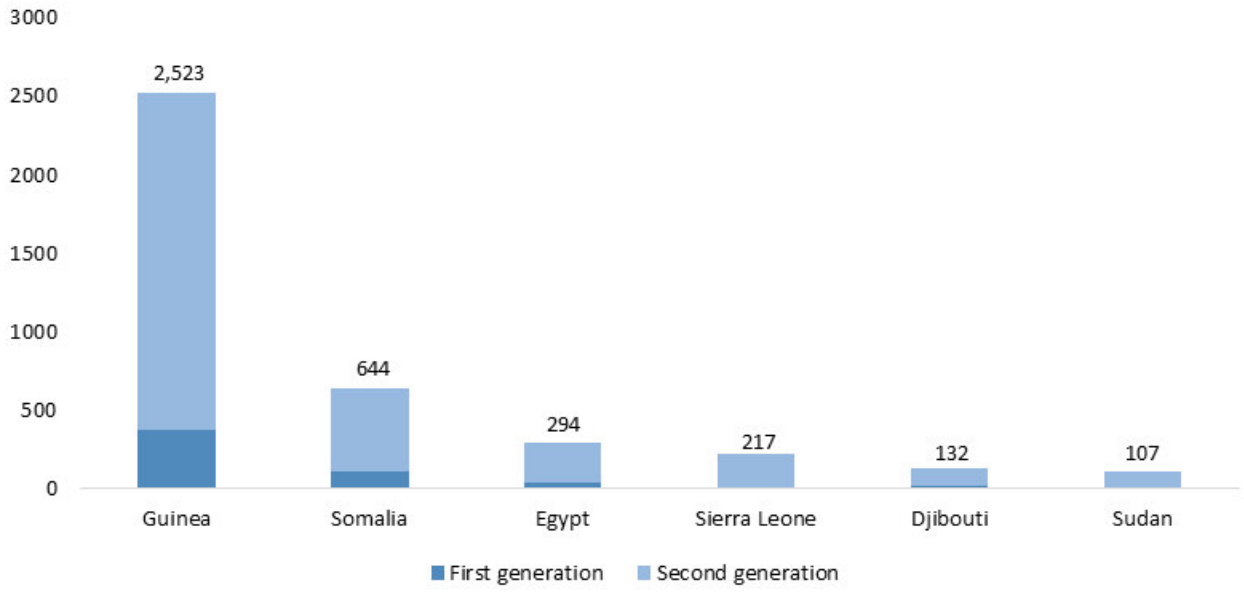
	Female migrant population					
	HIGH SCENARIO			LOW SCENARIO		
	TOTAL at risk	First generation	Second generation	TOTAL at risk	First generation	Second generation
2011 TOTAL (0-19):	**3,555**	**1,254**	**2,301**	**1,254**	**1,254**	**0**
2011 TOTAL (0-18):	**3,555**	**1,254**	**2,301**	**1,254**	**1,254**	**0**
2011: Ages 0-9	3,503	1,240	2,263	1,240	1,240	0
2011: Ages 10-18	52	14	38	14	14	0
2011: Age 19	0	0	0	0	0	0
2012 TOTAL (0-19):	**3178**	**523**	2655	**523**	**523**	**0**
2012 TOTAL (0-18):	**3178**	**523**	2655	**523**	**523**	**0**
2012: Ages 0-9	3114	501	2,613	501	501	0
2012: Ages 10-18	64	22	42	22	22	0
2012: Age 19	0	0	0	0	0	0
2016 TOTAL (0-19)	**4,612**	**596**	**4,016**	**596**	**596**	**0**
2016 TOTAL (0-18)	**4,612**	**596**	**4016**	**596**	**596**	**0**

2016: Ages 0-9	4,533	585	3,948	585	585	0
2016: Ages 10-18	79	11	68	11	11	0
2016: Age 19	0	0	0	0	0	0

Notes: Due to incomplete data on second-generation girls, the 2011 and 2012 estimates in the high scenario are a likely under-estimate. Source: present study

For girls aged 0-9 from FGM-practising countries, in 2011, between 11% and 30% of girls were at risk and between 4% and 29% in 2016. By comparison, relatively low proportions of girls aged 10-18 were at risk in both 2011 and 2016 (approximately 2% or less). There were no girls at risk aged 19 for these years. The total number of girls at risk aged 0-9 showed an increase from 2011 to 2016 in the High Scenario (from 3,503 in 2011 to 4,533 in 2016), as well as those aged 10-18 (from 52 in 2011 to 79 in 2016). In general, the picture is that the proportion of girls at risk is decreasing but that the number is rising, suggesting a rise in the total population of female migrants from FGM-practising countries living in Belgium between 2011 and 2016. This fits with the data given in section 2.2.2, which showed that the number of second-generation female migrants rose from 2011 to 2016.

Figure 2.5 Estimated number of girls (aged 0-19) living in Belgium in 2016 who were at risk of FGM by generation and most represented countries of origin



Notes: Data on second-generation girls aged 19 is taken from national register. Uses High Scenario data.

Source: Present study

In 2016, the largest number of girls who were at risk originate from Guinea: respectively 376 and 2,147 girls from the first and second generations. This is followed by Somalian girls. Smaller groups of girls at risk originate from Egypt, Sierra Leone, Djibouti and Sudan.

The Table summarises the results of the FGM risk estimations for both the high and low scenarios for age group 0-19.

FGM risk in Belgium in 2016: summary of results

High scenario	In 2016, a total number of 22,984 girls aged 0-19 originating from FGM risk countries (born in the country of origin or in Belgium) were residing in Belgium, of which 4,612 girls were likely to be at risk of female genital mutilation. **Proportionally, 20% of girls aged 0-19 originating from FGM risk countries (born in the country of origin or in Belgium) were at risk of female genital mutilation.**
Low scenario	In 2016, a total number of 22,984 girls aged 0-19 originating from FGM risk countries (born in the country of origin or in Belgium) were residing in Belgium, of which 596 girls were likely to be at risk of female genital mutilation. **Proportionally, 2.6% of girls aged 0-19 originating from FGM risk countries (born in the country of origin or in Belgium) were at risk of female genital mutilation.**

2.3.2 Estimation of asylum-seeking girls at risk

Table 2.7 Estimated number of asylum-seeker girls (aged 0-19) at risk of FGM in Belgium in 2012, 2015 and 2016

	Total number of girls (0-19) from FGM-practising countries	Total number at risk	Proportion of girls at risk
2012	682	218	32%
2015	1,035	152	15%
2016	1,016	174	17%

Source: present study

There has been a clear fall in the percentage of girls at risk of FGM since 2011, although the numbers have remained relative similar.

For 2016, the top three countries of origin for asylum-seeking girls who were at risk of FGM were Guinea (78), Somalia (49), Iraq (15) and Sudan (8). The other FGM-practising countries accounted for no more than four asylum-seekers. The patterns of countries is similar for 2012 and 2011.

Underlying data for these estimations is available in Annex 3.

2.4 Effective measures and challenges for tackling FGM in Belgium

FGM has been illegal in Belgium since 2001, according to Article 409 of the Penal Code, which provides for a prison sentence of three to five years for "*all persons participating, facilitating or encouraging all forms of female genital mutilation or any attempt to do so, with or without the consent of the person concerned.*" Since 2010, the Belgian National Action Plan on combating intimate partner violence and other forms of domestic violence has referred to FGM.[15] As of July 2014, encouraging the practice of FGM is punishable with imprisonment, for a period of between eight days and one year. Since 2017 the Belgian Attorneys General and the Ministry of Justice have adopted a new circular on Honour crimes, FGM and forced marriage and cohabitation (COL 06/2017)[16]. Moreover, Belgium has ratified several international conventions relevant to FGM, including the Istanbul Convention (ratified by Belgium in 2016), and several United Nations Conventions[17].

[15] UEFGM Country Focus « Belgium » : https://uefgm.org/index.php/belgium/

[16] http://igvm-iefh.belgium.be/sites/default/files/downloads/col06_2017_col_fr.pdf

[17] The United Nations Convention on the Elimination of All forms of Discrimination against Women of 18th December 1979 (CEDAW), the United Nations Convention on for the Rights of the Child of November 20th 1989 (CRC) as well as the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment of December 10th 1984

Somali women from the focus group were generally positive towards services and information available to women affected by FGM in Belgium. Professionals had been respectful and provided good information. One exception experienced by a Somali woman was lack of knowledge from medical professionals during child birth in another Member State (Sweden). Iraqi women and second-generation Guinean women, who had not undergone FGM, were unaware of specific FGM services. Somali participants and a few of young women knew about the specialised civil society organisation (GAMS Belgium). Having staff members speaking Somali seems particularly positive.

Somali men and women were satisfied with the information they had received about the practice, either in asylum reception centres, integration courses, by a medical doctor, or by a civil society organisation. The results from the focus group discussions suggest that the health sector has been particularly active on the issue of FGM, compared to other sectors. Somali women generally had good experiences of discussing FGM with medical professionals. Half of them said that they preferred to speak about it with female practitioners, but for others this did not matter as long as the person was professional. Although they seem to have spoken about FGM with some medical professionals, most Somali women were unaware of the existence of reconstructive surgery, although this service is available in Belgium through two specialised FGM clinics (in Brussels and in Gent).

There are no general policies on FGM for the educational sector. In fact, results from focus group discussions with young Guinean women, who had all gone to school in Belgium, showed that they had never received any information on FGM from school. Instead, these young women had relied on information tools provided by civil society organisations (a graphic novel on FGM) and the internet for information about FGM. Focus group discussion results suggest that awareness of a law prohibiting FGM in Belgium has a clear positive effect in favour of the abandonment of the practice. Some stakeholders in interviews considered legislation against FGM to be insufficient and stress the importance of awareness-raising and prevention measures. The new Circular (COL 06/2017) will hopefully enable a better identification of FGM cases through training of professionals (police and judges) and clear registration procedures.

Interview results suggest that one of the main challenges when dealing with the issue of FGM in Belgium is the difficulty of getting accurate information about the practice happening. If FGM is practised in Belgium or by parents travelling abroad, it is done in secret as it is a criminal offence in the country. Very few cases have surfaced in the last years; between 2008 and 2016, 21 cases of FGM were registered at the Criminal Court but most were dismissed and none have resulted in a conviction. There is no proof whether it means that the practice is not done in Belgium or whether they are not identified or reported. Another challenge is the lack of systematic information about FGM, together with other information on sexual and reproductive rights and health, to all new migrants. To overcome this, the Federal Agency for Asylum Reception (Fedasil) has supported (in mid-2017) the implementation of a trajectory to help reception centres staff identify and provide adequate care to women with FGM. This task has been delegated to NGOs specialised in FGM Prevention.

Civil society organisations appear to be the main providers of training on FGM for professionals in Belgium who meet girls and women affected by FGM, such as for example social workers, reception centre staff, health professionals, youth educators, legal professionals, etc. Some interviewees in this study stress that funding to civil society organisations is inadequate and that institutional support is needed to meet the training needs of this large number of professionals. Training on FGM should be integrated in the initial training of key professionals. A recent positive example is the integration of four modules on gender based violence, including FGM, in the paramedical, social science and social sectors of six training centres for further education, in Wallonia and Brussels[18].

[18] Press release by Ministry of Health promotion education, youth, women's rights and equality : « 25/11: mesures fortes contre les violences et relance de la campagne de sensibilisation « Le Journal de Marie » qui dure désormais toute l'année », 23/11/2017, available at : http://simonis.cfwb.be/2511-mesures-fortes-contre-les-violences-et-relance-de-la-campagne-de-sensibilisation-le-journal-de-marie-qui-dure-d-sor

Armed conflicts in countries such as Egypt, Somalia, Eritrea, Mali and Iraq may lead to an increase in asylum seekers concerned by FGM from these countries. Awareness-raising and prevention measures are needed and must be adapted to the specific situation of these groups, as well as more 'traditional' groups who experience FGM due to practices prevalent in some parts of their country.

2.5 Conclusions from Belgium

There was an increase in the number of girls living in Belgium originating from FGM-practising countries between 2011 and 2016; increasing from 15,074 in 2011 to 17,283 girls in 2012 to 22,984 in 2016 (aged 0-19). Most of these girls are second generation: indeed, there was an increase in the number and proportion that are second-generation (17,844 or 76%, in 2016 versus 10,881, or 63%, in 2012 and 9,259, or 61%, in 2011). In contrast, the total number of first generation female migrants aged 0-19 from FGM-practising countries fell from 6472 to 5140 between 2012 and 2016. Monitoring trends is possible in Belgium as FGM prevalence studies are done every four years on request of the authorities.

A total of 22,984 girls aged 0-19 from FGM risk countries were residing in Belgium in 2016. Of these, the number of girls at risk of FGM varied between 596 and 4,612, which represents between 2.6% and 20% of the total population. The percentage of girls at risk in the high scenario has decreased since 2011 (from 24% to 20%); however, growth in the total population means over 1,000 more girls are at risk in 2016. This growth relates to an expanding second generation within FGM-affected communities.

From highest to lowest, the seven countries from which the largest number of girls at risk originated (first and second generation) were (in 2016): Guinea-Conakry, Somalia, Egypt, Sierra Leone, Djibouti, Cote d'Ivoire and Sudan. The largest number of girls who were at risk originate from Guinea-Conakry: respectively between 376 and 2,147 girls at risk from the first and second generations.

In Belgium, the communities that engaged in the four focus group discussions were Somali women and men (both first generation); second generation young women from Guinea-Conakry; and female asylum-seekers from Iraq. Significantly, the focus groups comprised members of the two largest populations affected by FGM living in Belgium (communities from Guinea-Conakry and Somalia). All Somali and Guinean women and most men from these communities opposed FGM and viewed the practice as something occurring in their countries of origin, but not in their communities in Europe. Somali participants recounted the social pressures to get daughters cut when they returned to their country of origin, particularly from older women. Iraqi women stated that FGM is practised by armed groups as a means to control the population. The participants came from families where FGM had been practiced by previous generations.

Acquiring new information about the practice, the law and social norms against FGM, are all factors contributing to the FGM being abandoned in Belgium. However, although most men opposed the practice, some men expressed ambigious feelings, and considered that certain types of FGM might be more acceptable than others, reflecting that attitude change may not be occurring at the same rate across different groups in this community (Somalis). This may also be linked to other factors, such as differences relating to to an individual's length of stay, geographical area (urban/rural), as well as a potential shift from infibulation (FGM Type III) to "sunna" (FGM Type I or II).

There have been measures to prevent FGM in Belgium; namely, the practice is illegal (since 2001) and FGM is included in the Belgian National Action Plan on combating intimate partner violence and other forms of domestic violence. Whilst Somali men and women from the focus groups praised the information they had received in asylum reception centres and health practitioners, an interviewed governmental expert called for systematic information on FGM and sexual and reproductive rights to be given to all newly-arriving asylum seekers. Young Guinean women also highlighted the lack of information on FGM in the education sector.

One of the main challenges to preventing FGM in Belgium is the distinct lack of accurate information about the practice; an issue heightened by focus group participants' view that FGM takes place secretly and back in the country of origin. The need for adequate funding for civil society groups and effective training for relevant professionals were also identified by interviewees. Awareness-raising and prevention measures must be adapted to the needs of specific communities, such as recognising that in some cases FGM acts as a weapon for armed forces (as noted by Iraqi women).

3 Female genital mutilation risk estimation in Greece

3.1 Summary of findings from focus group discussions organised in Greece

3.1.1 Overview of the focus group discussions

Four focus group discussions were conducted in Greece from September – November 2017. Discussions were held with: first-generation older women from Egypt and Sudan; second generation women from Nigeria and Egypt (all of whom were brought up in Greece); men from Egypt and Iraq[19]; and women from Somalia. In particular, participants offered the perspective of the community in Greece with the most girls at risk (Egypt) (see section 3.3.1), as well the perspective of countries about which less is known about the practice of FGM (Iraq).

The participants in the discussions had mixed religious backgrounds and residence statuses. All of the second-generation women engaged were childless, whereas generally the older women from Egypt and Sudan, as well as most of the men engaged, had children. The sessions were held in a mixture of languages to match the mixed background of participants (Greek and Arabic for the first focus group discussion; Greek for the second; English and Arabic for the third; and English and Greek for the fourth). The table below presents an overview of the profile of participants in the four focus group discussions.

Table 3.1 Overview of focus group discussions and socio-demographic profile of participants in Greece

Key characteristics of focus groups	Focus group discussion 1: Older women	Focus group discussion 2: Younger women	Focus group discussion 3: Men	Focus group discussion 4: Hard-to-reach/recent migrants
Number of participants:	7	9	7	9
Countries of origin represented[20]:	Egypt and Sudan	Nigeria and Egypt	Egypt, Iraq, Syria[21]	Somalia
Sex of participants:	Women	Women	Men	Women
Age range:	Over 25	18-25	25-60	21-40
Generation (first/second):	First	Second	First and second	First
Average residence (number of years/months) & previous residence in other countries	33 years-10 years	19-20 years	24 months	12 months
Number of second-generation participants who have lived in their parents' country of birth	One from Egypt: came to Greece when she was very young.	None	None	None
Residence status of participants:	Long-term residence permits	Migrants with residence permits as unaraged depended members or students	Migrants with residence permits and 2 asylum seekers (Syrian and Iraqi)	Asylum seekers
Number of participants with/without children	6 with children 1 without children	9 without children	5 with children 2 without children	3 with children 6 without children
Religion:	Muslim and Christian	Christian and Muslim	Muslim and 1 Atheist (Iraqi)	Muslim

[19] A man from Syria also took part, despite being from a non-practising country. He had strong views in favour of FGM and his wife was cut. He could provide a perspective on the possible spread of FGM in new countries.

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

[21] A man from Syria also took part, despite being from a non-practising country. He had strong views in favour of FGM and his wife was cut. He could provide a perspective on the possible spread of FGM in new countries.

Key characteristics of focus groups	Focus group discussion 1: Older women	Focus group discussion 2: Younger women	Focus group discussion 3: Men	Focus group discussion 4: Hard-to-reach/recent migrants
Ethnic groups (if available):			1 Iraqi Kurd	
Level of education:	3 high school/ 1 technical school/3 University	High school University	2 primary school, 3 high school, 1 University	1 no school, 2 primary school, 4 high school, 1 University
(For first generation): Shortest and longest amount of time residing in Greece	10-33	n/a	Shortest: 1 year – Longer: 10 years	6 months-2 years
(For first generation): Shortest and longest amount of time residing in other European Member State:	None resided in another EU country	n/a	None resided in other EU member states	None in other EU member states
Date of session:	10 October 2017	11 November 2017	17 October 2017	13 September 2017

3.1.2 Key findings from the focus group discussions

Identity and attitudes about the importance of FGM

In general, there are significant differences between various communities, but also some similarities, especially between Somali and Sudanese female participants. In Egypt and Sudan, and Nigeria the word most commonly used for FGM is "circumcision", whereas in Somalia, the most common term for FGM is "cutting" (gudnin). Although "circumcision" is also used for males, the word "cutting" refers to females only.

FGM was considered a far more important community issue amongst the Somalian and Sudanese participants than the Egyptian, Iraqi, Nigerian or Syrian ones. The Somalian and Sudanese participants – all women – discussed FGM much more openly and were more outspoken about the implications for the sexual and reproductive health of women and girls than the Egyptian and the Nigerian ones. Although in Egypt FGM is widely practised, the Egyptian focus group participants – both male and female – mostly consider FGM as "private issue" that is not usually debated openly. Egyptian women showed more reluctance and shame to participate in the discussions and expressed their views on sexual and reproductive questions only with reference to friends. The Egyptian male participants were more open about the issue.

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

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

Most of the women that participated in the focus groups considered FGM as a cultural and not a **religious practice**. Some Sudanese and Somali women argued that FGM originates from the ancient Egyptians, the Pharaoh kings and queens, but the Egyptian participants declined this story. Some of them maintained that FGM is practiced only by Muslims in Egypt. There were, however, two women of different ages and nationalities – one 22-year-old Somalian and one 50-year-old Sudanese - who argued that FGM is something that the Prophet Mohamed has dictated when he was asked about female purity. They both argued that this dictation cannot be found in the Koran but in the Hadiths. Although both women expressed their strong objection to the old practices of circumcision, they insinuated that a "lighter" version of FGM may not be harmful for Muslim women and girls. The reaction of the other participants was extremely

negative towards the suggestion that FGM is something that the Muslim religion dictates. It was the same for Egyptian and Iraqi female participants who declined suggestions that FGM is a religious practice.

Women from Egypt, Sudan and Somalia were all very aware of the negative implications of FGM on female sexual and reproductive health. All participants agreed that women who have already undergone FGM, should receive more information and medical assistance on FGM related health problems, plastic surgery and sensation during sex. Second-generation girls from Egypt and Nigeria were aware of the sexual and reproductive health risks of FGM, mostly from documentaries as the issue was not discussed in their families or communities. They argued, however, that they were not under pressure to do FGM, because in their migrant communities protecting girls' chastity was mainly done through religious education and discipline.

Maintaining or abandoning the practice affects the relationships with elderly family members in the country of origin. For example, one participant from Sudan said that younger generations are resisting FGM but grandmothers insist on doing it to their grand-daughters. Another participant explained that in her village the grandmothers take their 5 or 6 year old granddaughters in secret to the local "cutters" and they perform the circumcision against the will of their parents. She was in her village two years ago and she made a complaint to the village leader – a respected male elderly – who told her that there is nothing he can do because older women do it in secret even now that it is illegal.

Moreover, women from Sudan said that older women in villages tempt the girls by giving them presents and beautiful things, "money, gold, nice clothes". This was done more often in the past for both boys and girls, but still today it is occasionally practised by the elderly:

"They dress them in a nice dress with pink lace, nice, and they put a golden pound to stop the bleeding. A pound or a bead is tied on a red ribbon and they put it in their hand. The girls lie on a bed and the guests bring money and put [it] under their pillow. In the past, [...] they slaughtered animals, invited musicians and there was dancing. A feast. The girl is lying down on a bed like sick person, but it is a celebration. They still do it."

In terms of **purity and marriageability**, in the home countries there are still derogatory expressions used to describe women who have not been "cut" or "circumcised" and their daughters as impure. The cultural mediator/translator in the focus group discussion with Somalis explained also that many mothers in Somalia chose FGM for their daughters because it relieves them from the burden of protecting their chastity: "Mothers want their daughters to be cut because if they are not cut they have to forbid them going out alone. They have to follow them everywhere and cover them. [...] In Somalia, mothers cut the girls and then they do not have to worry anymore. In the villages, more than in towns". Also, another Somali participant added: "The women who do the cuttings do not want to stop because it is their job. They do not want it to be illegal".

The views against FGM are **not in most cases linked to women's emancipation**. Women who might be very conservative with regards to women's role in society are mostly against FGM because of the physical pain, suffering and lack of enjoyment of sex that it causes. As on Somali participants said: "I am not well. My body is not well. Allah made 'it' closed, not open [not cut]. Cutting the outside is only tradition, not Islam. I do not like sex. I do not want to have sex with my husband".

Social norms against FGM in Greece, however, tend to affect migrant women more than migrant men. In comparison to Egyptian women, who were all against FGM, some Egyptian men kept a positive view of FGM, even though they had resided in Greece for more than two years. This indicates that attitudes towards FGM may change more rapidly amongst females than amongst males. Factors that contributes to this are the silencing of FGM as a "private" issue and the fact that women who have undergone FGM face the immediate consequences on their bodies and experience the dangerous impact of FGM in their everyday lives, whereas for men, FGM is mostly a question of religious ethics and morality that dictates the protection of women and girls' purity.

However, female participants expressed concerns about the impact of FGM on their marriages. As one participant said, husbands often turn against their wives for not enjoying the sexual act: "My husband gets angry because I do not feel anything and I don't like it. He tells me that he will leave me and go with a woman who is uncut." They all laughed with this phrase and agreed that this happens very often. A second generation Egyptian woman argued that in Egypt the high divorce rate, male adultery and polygamy are all phenomena that are caused by the lack of interest for sex that women who have undergone FGM suffer from. Somali participants were interested to learn wether or not stories about surgical operations that give "a new vagina" and allow women to "feel" were true.

Younger boys who grow up in Greece are, according to both mothers and second generation women from all ethnic groups, against FGM. One Sudanese woman said that her sons watched a documentary on TV about FGM and they were horrified saying "What have they done to you?". Pressure with regards to marriageability, however, is exercised by young men and their families in home countries, especially in Sudan and Somalia. Although both Sudanese and Somali women said that younger generations of men increasingly want their women not to be cut, they had many stories to tell about brides that were sent back because they had not undergone FGM. One Sudanese woman told the story of a girl who was sent back to her father to be circumsized when her husband, who resided in the USA, realized during the wedding night, that she was not circumcised. In most of these stories the girls end up being circumcised, but there is a negotiation between the girls' families and the groom on what type of FGM they will perform, usually arguing for a "lighter" version of FGM.

Another interesting finding from the focus group with men is that Muslim male migrants may be influenced by Muslim cultures other than their own in favour of FGM, i.e. those who come from countries with little or no prevalence of FGM may come to view FGM in a positive light either because they resided in countries or came in regular contact with members of communities, in which FGM is prevalent. For example, a 42-year-old Syrian man was strongly in favour of FGM after getting married to his second wife -a Saudi Arabian. He explained that he preferred his second wife who was circumcised to his first wife who was not because, in his mind, women who undergo FGM give much more pleasure to their husbands and are much more faithful to their marriage. In agreement with a younger Egyptian man, he advocated a conception of FGM as a "protective" measure. According to this view, young girls who are prematurely developed get carried away easily especially when they reside in hot climates. FGM constitutes, from this perspective, an effective method of birth control, which prevents those girls from having sexual intercourse with men at an early age and getting pregnant prematurely.

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

With regards to the **impact of migration on FGM practices** in migrant communities, All the participants – both women and men – said that they think that FGM is not widely practised in the Egyptian, Nigerian, Sudanese, Syrian and Somalian communities in Greece and Europe irrespective of whether they were for or against FGM. They all agreed that there are no "cutters" or "midwives" performing FGM in migrant communities. Second generation participants from Nigeria and Egypt argued that parents in European countries have realized that FGM is harmful for their children while newcomer Somali participants argued that change has to do with coming to contact with Civil Society Organisations.

There were, however, stories about friends and relatives who have taken their children, both male and female, to experience circumcision back home. For example, one Somali female participant, said that her sister, who resides in Germany, did "cutting" to her daughter during a trip back to Somalia. However, she also noted that in Sweden it is illegal to go back to the country of origin to do "cuttings" and families that do it lose their residence permits and are denied the right to re-enter if they do it. The view that there is no evidence that FGM is widely practised in Greece by migrant communities may also be linked to the fact that many second generation children born in Greece have been unable to travel to their parents' country of origin, because they lacked travel documents to enter their country of origin and there was no legal procedure for granting them citizenship until 2016. . Although this was more common in the past, some of

them were concerned, especially Sudanese, Egyptian and Somalis, that older relatives may take the initiative to circumcise girls if they return back home without their parents.

Unlike second generation girls, older female participants from Somalia and Sudan were all aware of the different types of FGM. Older Egyptian participants were mostly aware of the "lighter" version that is practised today, which includes only the cutting of the tip of the vagina (likely equivalent to either FGM Type I or Type IV). One of the participants from Sudan told the group that in the area where she comes from they use the Arabic terms "Pharon", from the Egyptian Pharao dynasty, to describe the complete removal of the vagina including the skin (FGM Type III), involving the stitching together of the labia, with only a small hole left for urinating. She argued that it is pleasing to men because it results in a 'tighter' vagina but causes a lot of pain for women and girls, as well as problems during menstruation and birth., when the stitches are cut. According to most participants, "Pharon" is not a common practice anymore, except in remote villages.

The Somalian and Sudanese women over 30 had mostly undergone "Pharon" when they were young. Some of them reported that they were treated as exceptional cases when thet were first examined by doctors and medical staff in Greece, who were not trained to deal with cases of sexual and reproductive health problems related to FGM. One older Sudanese woman said:

"When I gave birth here in Greece, they brought cameras. They wanted to photograph it because there were students [...] doing their practice. They did not know what it was. Then they brought a doctor from Iraq and he explained everything [...]. I refused [the photos] because I did not like it. We don't do this."

Thes examples indicate the need for training of doctors in Greece to recognize and treat such cases properly. The women in these cases said that they felt intimidated and ashamed. Being objectified by medical professionals in this manner was described as a very negative experience.

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

Some participants – women from Somalia and men from Egypt and Syria- argued that FGM is still practised more in hotter climates than in cold ones. Climate plays an important role in legitimizing FGM and is used to explain why the practice is not necessary in Europe but continues to be necessary in Africa. According to this argument, women and young girls who become more "hot " more inclined to have sex from an early age if they live in hot climates. In this view, girls in warmer places should be protected from having sex and children prematurely.

Key risk factors for FGM

Key factors that increase the risk of girls include the possibility of return to the home country without parental suervision, secrecy about FGM within the households, pressures to conform to stereotypes about purity and chastity in the home country, perceptions about the sexual development of young girls, i.e. that girls who are more sexually "developed"at an early stage may be more at risk, perceptions of secual promiscuity in hotter climatic conditions, ie young girls are considered more prone to premature sexual relations and pregnancy in hotter climates and the lack of campaigns against FGM in Greece and in countries of origin. On the contrary, participants identified as factors that decrease the risks for young girls include travelling home with close parental supervision by parents who are against FGM, discussing FGM and its negative effects on female reproductive and sexual rights openly in households, tackling misconceptions about the climate and sexuality, chastity and purity of female bodies, as well as spreading awareness of the negative effects of 'lighter' forms of FGM (such as FGM Type I), which are considered "safe" by some women and men who against FGM, promoting information that disqualifies claims that FGM is a religious practice that the Prophet has dictated.

3.2 Female migrant population aged 0-19 originating from FGM-practising countries

Table 3.2 Overview of data availability in Greece

Type of data	Greece
Risk estimation	
Sources used in risk estimation	Migrants' with legal residence permits – Eurostat (code: migr_resvas). 2011 census.
Data issues:	The distinction between first and second generation is estimated using the proportion observed for 2011 (census) comparing the proportion of first generation (foreign-born) girls to total residence permits (in the few cases where the foreign born population outnumbers those with residence permits, the proportion of foreign born is considered 100%). Due to the lack of data, the second generation are estimated as a fraction of the total residence permit-holders and does not include girls without residence permits (for example, with an EU father, born to asylum seekers, born to naturalized women or born to undocumented mothers). This means the number of second-generation girls at risk is a likely significant under-estimate. Births data could not be used to estimate the size of the second generation due to missing data for selected years and for selected mothers' country of births. When working with a 5-year age interval, it was necessary to approximate girls of a single age group as one-fifth of the girls in each 5-year interval.
Overview data presented on the migrant population	
Female migrant population originating from FGM-practising countries	Ministry of Migration Policy and Eurostat (code: migr_resvas). Covers data on migrants' with legal residence permits
Years available	2011-2016
By age	0-19, with breakdowns by five-year age groups: 0-4, 5-9, 10-14, 15-19.
By country of origin	Available by citizenship (not country of birth).
By first and second generation	Unavailable (approximation necessary)
By regional level	Unavailable
By age of arrival	Unavailable
Data issues	Small discrepancies in permits data from Ministry of Migration Policy and Eurostat; as Eurostat data is available for a greater number of years, it has been taken as authoritative.
Female live births in EU to mothers originating from FGM-practising countries	Vital and Migration Statistics Section of the Hellenic Statistical Authority (ELSTAT). Sources of information for vital statistics are Administrative records provided by Registries from all around country.
By country of mother	Partially available
By regional level of country of mother	Unavailable.
By region of birth of the child	Unavailable.
Data issues	Earliest available year is 2004. Some countries of origin are missing.
Female asylum seekers	(1) Asylum Service of the Ministry of Migration Policy (2) Eurostat (2011-2012)
Years available	2011-2016
By age	0-17 years, with these breakdowns: 0-13, 14-17
By country of origin	Available

Type of data	Greece
By regional level	Unavailable
By age of arrival	Unavailable
Data issues	Before 2013, data on asylum seekers were collected by the Hellenic Police. Police data for 2011 and 2012 is not accessible, so data from Eurostat Database were used for these years. Eurostat data is broken down by citizenship, not country of birth.
Female refugees	Asylum Service of the Ministry of Migration Policy (IT department): Annual number of positive decisions on applications (asylum status or subsidiary protection) regarding female refugees.
Years available	2013-2016
By age	0-17, with these breakdowns: 0-13, 14-17
By country of origin	Available by citizenship of applicants (not country of birth).
By first and second generation	n/a
By regional level	Unavailable
By age of arrival	Unavailable
Data issues	Before 2013, data on asylum seekers were collected by the Hellenic Police. Police data for 2011 and 2012 is not accessible, so Eurostat data were used for these years.
Female irregular migrants	Unofficial data available from the Hellenic police on annual number of: a) arrested persons (aliens) for illegal entering or staying in Greece by police and port authorities; b) deported irregular (aliens) migrants.
Years available	2011-2015
By age	Unavailable
By country of origin	Available by citizenship (not country of birth).
By first and second generation	Unavailable
By regional level	Unavailable
By age of arrival	Unavailable
Data issues	Not disaggregated by sex. Likely under-estimation; only covers irregular migrants who experience arrests and deportations.
Official registration – other sources on identified FGM cases	
Medical/hospital	Unavailable
Child protection	Unavailable.
Police/judicial	Unavailable.
Asylum	Partially available: The reasons invoked by asylum-seekers. For FGM, the reasons are classified under a wider category related to vulnerable groups
Other	Unofficial: NGO records. Health survey data.

This section of the Greece chapter provides data (where available) on four groups: i) the recorded migrant population, who are legally present and 'usually resident' in the Member State; ii) recent immigrants and emigrants to the country; iii) irregular migrants, who do not – or no longer – fulfil the conditions for legal residence in the country; and iv) asylum-seekers, who are legally present but have not found out if their

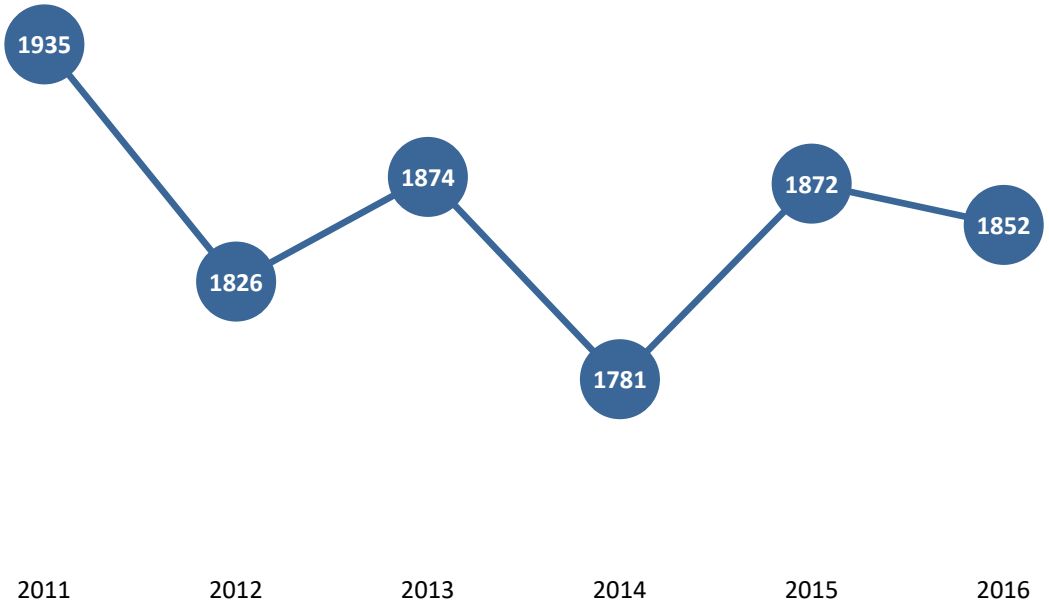
application for international protection was successful. Having an overview of this data is important for understanding potential populations of interest when estimating the number of girls at risk of female genital mutilation. The chapter ends by presenting data on other sources (if any) that are collecting FGM in the country.

3.2.2 Migrant population

In Greece, there were 1,935 female migrants (aged 0-19) from FGM-practising countries in 2011. Of these, 71% (1,365) were aged 0-9 and 29% (570) are 10-19. There is no available data disaggregated by generation, as data on the migrant population has been approximated using data on the total population of permit-holders (see Figure 3.1 and section 3.3 for more information). 'Permit-holders' are foreign nationals who have received residence permits or another form of authorisation to reside in Greece. When interpreting data on the migrant population in Greece from FGM-practising countries, it is important to be aware that permits data does not provide a complete picture , due to the fact that it excludes young women who did not need a residence permit to live in the country, such as second-generation girls who have acquired Greek citizenship.

The size of the female migrant population from these countries is relatively stable across the years from 2011 to 2016, falling from 2011 onwards and then peaking at 1,874 in 2013 dropping to a minimum at 1,781 in 2014, returning to previous levels above 1,800 from 2015 onwards.

Figure 3.1 Total population of female permit-holders in Greece aged 0-19, from FGM-practising countries between 2011 and 2016



Notes: Country of origin defined by citizenship rather than country of birth. 'Permit-holders' are foreign nationals who have received residence permits or another form of authorisation to reside in Greece. As a result, it is considered to be an under-estimation of the migrant population in Greece, as it excludes young women who did not need a residence permit to live in the country, such as second-generation girls who have acquired Greek citizenship.

Source: Eurostat (all valid permits by age, sex, and citizenship on 31st December of each year, code: migr_resvas).

In terms of the distribution of age band, there is a clear decreasing trend of the proportion of girls aged 0-9 within this population, starting from 71% in 2011 and decreasing by an average of 4 percentage points by year to reach 48% in 2016.

Table 3.3 Age distribution of the female migrant population (aged 0-19) originating from FGM-practising countries, in Greece, 2011

	TOTAL	First generation	Second generation	TOTAL (%)	First generation (%)	Second generation (%)	Total generation (%)
0-9	1,365	n/a	n/a	71%	n/a	n/a	n/a
10-19	570	n/a	n/a	29%	n/a	n/a	n/a
TOTAL	1,935	n/a	n/a	100%	n/a	n/a	n/a

Source: Eurostat

Note: Reliable generation breakdown not available. Available data is only disaggregated in 5 year of age intervals and no data is provided for those only aged 19. The 'female migrant population' here covers the total population of female permit-holders (aged 0-19) from FGM-practising countries. As a result, it is considered to be an under-estimation of the migrant population in Greece.

Table 3.4 Age distribution of the female migrant population (aged 0-19) originating from FGM-practising countries, in Greece, 2012

	TOTAL	First generation	Second generation	TOTAL (%)	First generation (%)	Second generation (%)	Total generation (%)
0-9	1,207	n/a	n/a	66%	n/a	n/a	n/a
10-19	619	n/a	n/a	34%	n/a	n/a	n/a
TOTAL	1,826	n/a	n/a	100%	n/a	n/a	n/a

Source: Eurostat.

Note: Reliable generation breakdown not available. Available data is only disaggregated in 5 year of age intervals and no data is provided for those only aged 19. The 'female migrant population' here covers the total population of female permit-holders (aged 0-19) from FGM-practising countries; it is a likely under-estimation of the migrant population.

Table 3.5 Age distribution of the female migrant population (aged 0-19) originating from FGM-practising countries, in Greece, 2013

	TOTAL	First generation	Second generation	TOTAL (%)	First generation (%)	Second generation (%)	Total generation (%)
0-9	1,168	n/a	n/a	62%	n/a	n/a	n/a
10-19	706	n/a	n/a	38%	n/a	n/a	n/a
TOTAL	1,874	n/a	n/a	100%	n/a	n/a	n/a

Source: Eurostat (all valid permits by age, sex, and citizenship on 31st December of each year, code: migr_resvas).

Note: Reliable generation breakdown not available. Available data is only disaggregated in 5 year of age intervals and no data is provided for those only aged 19. The 'female migrant population' here covers the total population of female permit-holders (aged 0-19) from FGM-practising countries; it is a likely under-estimation of the migrant population.

Table 3.6 Age distribution of the female migrant population (aged 0-19) originating from FGM-practising countries, in Greece, 2014

	TOTAL	First generation	Second generation	TOTAL (%)	First generation (%)	Second generation (%)	Total generation (%)
0-9	974	n/a	n/a	55%	n/a	n/a	n/a
10-19	807	n/a	n/a	45%	n/a	n/a	n/a
TOTAL	1,781	n/a	n/a	100%	n/a	n/a	n/a

Source: Eurostat (all valid permits by age, sex, and citizenship on 31st December of each year, code: migr_resvas).

Note: Reliable generation breakdown not available. Available data is only disaggregated in 5 year of age intervals and no data is provided for those only aged 19. . The 'female migrant population' here covers the total population of female permit-holders (aged 0-19) from FGM-practising countries; it is a likely under-estimation of the migrant population.

Table 3.7 Age distribution of the female migrant population (aged 0-19) originating from FGM-practising countries, in Greece, 2015

	TOTAL	First generation	Second generation	TOTAL (%)	First generation (%)	Second generation (%)	Total generation (%)
0-9	954	n/a	n/a	51%	n/a	n/a	n/a
10-19	918	n/a	n/a	49%	n/a	n/a	n/a
TOTAL	1,872	n/a	n/a	100%	n/a	n/a	n/a

Source: Eurostat (all valid permits by age, sex, and citizenship on 31st December of each year, code: migr_resvas).

Note: Reliable generation breakdown not available. Available data is only disaggregated in 5 year of age intervals and no data is provided for those only aged 19. The 'female migrant population' here covers the total population of female permit-holders (aged 0-19) from FGM-practising countries; it is a likely under-estimation of the migrant population.

Table 3.8 Age distribution of the female migrant population (aged 0-19) originating from FGM-practising countries, in Greece, 2016

	TOTAL	First generation	Second generation	TOTAL (%)	First generation (%)	Second generation (%)	Total generation (%)
0-9	887	n/a	n/a	48%	n/a	n/a	n/a
10-19	965	n/a	n/a	52%	n/a	n/a	n/a
TOTAL	1,852	n/a	n/a	100%	n/a	n/a	n/a

Source: Eurostat (all valid permits by age, sex, and citizenship on 31st December of each year, code: migr_resvas).

Note: Reliable generation breakdown not available. Available data is only disaggregated in 5 year of age intervals and no data is provided for those only aged 19. The 'female migrant population' here covers the total population of female permit-holders (aged 0-19) from FGM-practising countries; it is a likely under-estimation of the migrant population.

Table 3.1 Total female migrant population from FGM-practising countries, by age groups (2011-2016)

Age Breakdown	Year					
	2011	2012	2013	2014	2015	2016
0-4	653	507	454	249	219	204
5 to 9	712	700	714	725	734	683
10 to 14	377	417	493	574	622	640
15 to 19	193	202	213	233	296	325
Total	1935	1826	1874	1781	1871	1852

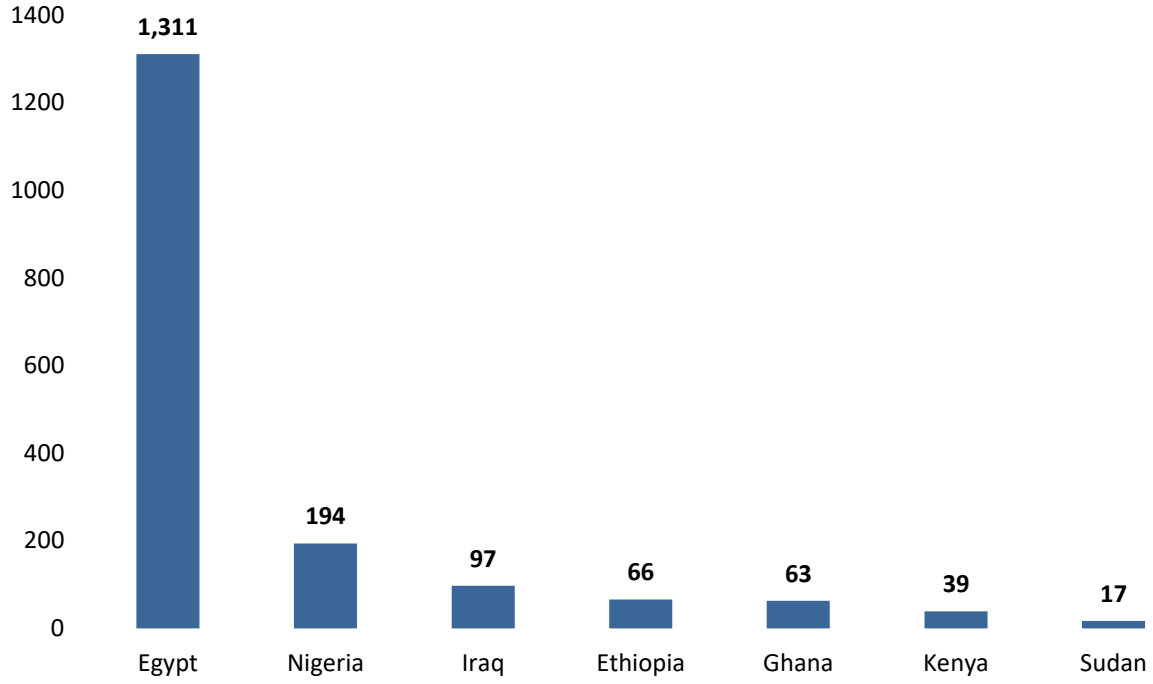
Notes: Reliable generation breakdown not available. Available data is only disaggregated in 5 year of age intervals and no data is provided for those only aged 19. The 'female migrant population' here covers the total population of female permit-holders (aged 0-19) from FGM-practising countries; it is a likely under-estimation of the migrant population.

Source: Eurostat (all valid permits by age, sex, and citizenship on 31st December of each year, code: migr_resvas).

The Tables above presents the annual number (for the years 2011-2016) of valid permits (on 31 December of each year) for the female migrant population aged 0-19 from the 30 FGM-practising countries. The Table shows the same data broken down by five-year age groupings. Here, 'originating from' refers to the migrants' country of citizenship, as data on their country of birth is not available. Available data follows the relevant legal framework and is disaggregated by type of residence permits. Those with valid permits are those who have been granted a residence permit or another form of authorisation to reside in Greece.

The above data shows a decrease of valid permits from 2011 until 2016. It must be noted that for all the years examined (2011-2016), the highest number of valid permits is for girls aged 5-9 years old. In 2011 and 2012, the next largest group with permits is those aged 0-4 years old, although from 2013 onwards those aged 10-14 years old are the second biggest group of permit-holders (after 5-9 year olds).

Figure 3.2 Number of girls (aged 0-19) living in Greece by most represented countries of origin, 2016



Notes: Country of origin defined by citizenship rather than country of birth. Generation breakdowns not available.

Source: Eurostat (all valid permits by age, sex, and citizenship on 31st December of each year, code: migr_resvas).

In Greece, according to the data for 2016, most female migrants (with valid residence permits) aged 0-19 years old who originate from countries where FGM is documented are from (in descending order): Egypt, Nigeria, Iraq, Ethiopia, Ghana, Kenya and Sudan. Data provided presents the number of valid residence permits issued by Greece (on 31 December of 2016) and is not available by generation or region of origin.

3.2.3 Inflows and outflows

To get a sense of migration patterns over time, it is worthwhile to consider 'inflows' and 'outflows' from FGM-practising countries. The former covers immigrants (inflows): people arriving or returning from abroad to take up residence in a country for 12 months or more, having previously been resident elsewhere. The latter covers people who are leaving the country where they usually reside and effectively taking up residence in another country. An individual is a long-term emigrant if he/she leaves his/her country of previous usual residence for a period of 12 months or more. A positive 'net inflow' indicates that more people are arriving than leaving Greece, within a given year.

In Greece, data on migration flows is collected and published by the Hellenic Statistical Authority (ELSTAT). Data available on inflows is not disaggregated by country of origin, but by groups of countries of origin according to their level of development[22]. That means that female migrants from FGM-practising countries cannot be identified. Data available on outflows (i.e. those leaving Greece in a particular year) is not disaggregated by country of origin or by group of countries of origin.

Despite these gaps, the total relevant data for the year 2015 shows that 44.8% of incoming migrants (from *all countries*[23]) were women (28,857 out of 64,446) and that 21.2% of those women were aged between 0-19 years old. Similarly, since 2011, data on the inflow of migrants shows that the percentage of women ranged between 45.5% and 46.6% of all incoming migrants. The data available for the outflows of migrants shows that, since 2011, the estimated number of emigrants has increased. In 2015, 40.3% of the total number of emigrants were women and 21.6% of these women were between 0-19 years old.

3.2.4 Irregular migration

In Greece, data on irregular migration is collected and published by the Police. On an annual basis, the Greek Police publishes data – provided by Police and Port authorities – that presents the number of persons arrested for illegal entering or staying in Greece. Available data is disaggregated by country of citizenship, but not by sex or age. Since 2011, 163,950 persons originating from FGM-practising countries were arrested in Greece, according to Police data; 102,818 of them were arrested in 2015, which is the year that irregular migrants/asylum seeker inflows reached the highest level. Since 2011, the vast majority of irregular migrants who originated from FGM-practising countries have been from Iraq. After Iraq, the sixth largest groups of irregular migrants from FGM-practising countries were from Somalia, Eritrea, Egypt, Nigeria, Cameroon and Côte d' Ivoire.

3.2.5 Asylum-seekers

Greece has seen significant overall increases of asylum-seekers (all ages) from all countries, with over 51,000 applicants (from all countries) in 2016 (fourfold increase from 2015) (Asylum Information Database, 2016); it has thus established a fast-track border procedure for arrivals after 20 March 2016 where the entire procedure must be completed within 14 days.

There were a total of 1,123 female asylum-seekers (aged 0-17) specifically from FGM-practising countries in 2016. Out of these, over 98% (1,103) were asylum-seeking girls from seven FGM-practising countries, as presented in the Table below. Within this group of asylum-seekers from seven countries, 84% (928) were aged 0-14 and 94% (1,032) are citizens of Iraq. Data is not available for ages 18 and 19.

Table 3.2 Number of asylum-seeker girls (aged 0-17) living in Greece, by age groups and most represented countries of origin, 2016

FGM practising country	Total number of female asylum seekers aged 0-17	Aged 0-14	Aged 14-17
Cameroon	7	6	1
Egypt	7	6	1
Eritrea	24	15	9
Iraq	1032	874	158

[22] Citizenship is defined by ELSTAT according to groups of countries: for example, Least Developed Countries/LDC, Middle Development Countries/MDC, Higher Development Countries/HDC, countries of the EU, etc. This means in the same group one may find FGM-practising countries and non-practising countries.

[23] Not only FGM-practising countries.

Nigeria	6	5	1
Somalia	14	12	2
Yemen	13	10	3
Total	**1103**	**928**	**175**

Notes: Data not available on those aged 18 and 19. Country of origin defined by country of citizenship.

Source: Asylum Service, Ministry of Migration Policy, Greece (available on request)

Figure 3.3 Number of asylum-seeker girls 0-17 living in Greece by most represented countries of origin, 2016

Notes: Data not available on those aged 18 and 19. Country of origin defined by country of citizenship.

Source: Asylum Service, Ministry of Migration Policy, Greece (available on request)

The seven FGM-practising countries most represented amongst the female asylum-seeking population (aged 0-17) in Greece in 2016 were (in descending order): Iraq, Eritrea, Somalia, Yemen, Cameroon, Egypt and Nigeria. These countries have been the most represented within the asylum-seeking population since 2011. However, there are significant differences when it comes to the number of applications for each year since 2011; in 2016 the number of female applicants 0-17 years old with citizenship of FGM-practising countries was 1,123, whereas in 2015 the number was 114, in 2014 it was 44, in 2013 41, in 2012 15 and in 2011 10. However, the data source differs, which makes it difficult to compare these data, especially for the period 2011-2012 and 2013-2016[24]. For 2016, Iraq, Egypt and Nigeria are also included in the most represented FGM-practising countries amongst regular female migrants (see Figure 3.2 above). Moreover, six out of the seven countries in Figure 3.3 (all except Yemen) are the countries from which the largest nationality groups of arrested irregular migrants were recorded in 2016 by the Greek Police.

Regarding the FGM-related applications received and granted in Greece, there is no data available. There is data regarding the *reasons invoked by asylum-seekers*, but reasons related to FGM are classified under a

[24] Data from 2013-2016 are provided by the Asylum Service. Data for the years 2011 and 2012 was not collected by the Greek Asylum Service as this Service was created in 2013. Instead, the 2011 and 2012 data referred to here is taken from Eurostat, 'Asylum and first time asylum applicants by citizenship, age and sex Annual aggregated data (rounded)' [migr_asyappctza]

wider category according to the applicable legal framework, which includes all vulnerable groups (paragraph 2 of Article 11, Law 3907/ 2011: unaccompanied minors, people with disabilities, elderly people, pregnant women, single parents with minor children, victims of torture, rape or other forms of psychological, physical or sexual violence or exploitation and victims of human trafficking). An additional difficulty with collecting data related asylum applications received and granted is that in most cases FGM is one of the multiple reasons why an asylum seeker applies for asylum. Furthermore, when authorities accept an individual's application for Asylum Status (or Subsidiary Protection), this is not classified by the specific reasons of why the request was granted.

3.2.6 Other records collecting information on FGM in Greece

The official sources in Greece for data relevant to FGM are the Asylum Service and the Department of Statistics of the Ministry of Migration Policy, the Hellenic Police and the Hellenic Statistical Authority (ELSTAT). Moreover, the UNHCR Office in Greece collects, provides and publishes regularly primary and secondary data (demographics, arrivals, most common nationalities etc.) on refugees' situation in the country.

Decision 419/2014 of the Administrative Court of Appeals, regarding international protection, on the grounds of fear of Female Genital Mutilation, is the first decision of the Greek Courts in response to a request for international protection (in accordance with the Geneva Convention of 1951) dealt with FGM. The Administrative Court of Appeals temporarily suspended the decision of return of a Kenyan woman along with her three minor children in her homeland, based on the highly likely possibility of suffering irreparable harm, "*consisting in exposure to risk their physical integrity*."

In recent years, the current refugee crisis and increased migration flows have meant that Greece has become a catalyst for the activation of the Greek civil society and international organizations in the field. In particular, many organizations provide accommodation services and other supporting services in Reception and Identification Centres , as well as collecting relevant data. These sources can offer useful information, although it is worth bearing in mind that they may be based on regional activities not implemented at the national level; furthermore, their quality cannot be assessed accurately. The Report of *Médecins Sans Frontières* (MSF) (2017, pp. 7, 15) presents data collected by teams providing medical care on the island of Lesbos. In particular, the Report shows that almost half of the 245 women who came to the MSF clinic for gynaecological consultations (Jan-mid-June 2017) had been victims of sexual violence (1/3 in their country of origin and 2/3 during their journey); in most cases, they explained that they had not disclosed their experience of sexual violence. The Report stresses that the number of victims of violence is likely much higher than the population identified by MSF (given that invisible vulnerabilities may go unidentified). Additionally, it emphasizes the lack of relevant adapted screening tools and the shortage of female medical doctors and trained cultural mediators.

In 2006, the first cognitive study[25] in Greece documenting female genital mutilation among African Immigrants was published (Grassivaro Gallo, Iordanidou, Viviani, 2006, pp. 93-102). In all, 73 obstetricians/gynecologists from two public hospitals took part in the survey. Of the participants, 41% claimed that they had examined adult women victims of FGM for problems resulting from their mutilation. They reported that they had encountered 95 of such women in total.

3.3 Estimation of the number of girls at risk of FGM in Greece and possible trends of FGM risk

The following section provides data on the estimated number of girls at risk of FGM in Greece, following the methodology in EIGE's step-by-step guide. It begins by presenting estimates of the number of girls at

[25]https://www.researchgate.net/profile/Franco_Viviani/publication/251260734_Female_Genital_Mutilation_Among_African_Immigrants_in_Greece_The_First_Cognitive_Study/links/568f89ad08ae78cc0517e942/Female-Genital-Mutilation-Among-African-Immigrants-in-Greece-The-First-Cognitive-Study.pdf

risk within the 'regular' migrant population, although there are some significant limitations regarding the data on the second generation, as described below.

In Greece, a range of data are available for the years 2011-2016. However, since information on births are available only for selected years and for selected mothers' country of births, this information was dropped. Instead, the estimates for the 'regular' migrant population in Greece used two sources: the female population holding residence permits (Eurostat, code: migr_resvas) and the 2011 census. Permits data is not available broken down by generation. The distinction between first and second generation is estimated using the proportion observed for 2011 (census) comparing the proportion of first generation (foreign-born) girls to total residence permits (in the few cases where the foreign born population outnumbers those with residence permits, the proportion of foreign born is considered 100%).

Due to the lack of sufficient births data, the second generation are estimated as a fraction of the total residence permit-holders and does not include girls without residence permits (for example, with a EU father, born to asylum seekers, born to naturalized women or born to undocumented mothers). This means the number of second-generation girls at risk is a likely under-estimate. It is problematic that a fuller picture of the second-generation in Greece cannot be obtained.

After presenting the estimates data on the 'regular' migrant population, this section presents the estimates for asylum-seeking girls. Asylum-seekers are not included within the migrant population (unlike, for example, recognised refugees). The estimates for asylum-seekers cannot distinguish between a high and low scenario, as technically all asylum-seekers being considered are from the first generation.

3.3.1 Estimation of girls at risk within the regular migrant population

The table below presents a summary of the number of girls at risk of female genital mutilation in from 2011 to 2016.

The table below shows that girls at risk of FGM in Greece ranged from 161 to 817 in 2011, 141 to 715 in 2012, 133 to 666 in 2013, 107 to 536 in 2014, 103 to 519 in 2015 and finally 92 to 454 in 2016. The trend in both the high and low scenarios from 2011 to 2016 is negative – i.e. the total number and proportion of girls at risk appears to be dropping. However, it is worth bearing in mind the likely under-estimation of second-generation girls at risk (see introduction). In all of these years, the vast majority of girls at risk are in the 0-9 age group. There were no girls at risk aged 19 from 2011 to 2016.

In 2011, between 8% and 42% of girls (aged 0-19) were at risk; in 2012, between 8% and 39% of girls were at risk; in 2013, between 7% and 36% of girls were at risk; in 2014, between 6% and 30% of girls were at risk; in 2015, between 6% and 28% of girls were at risk; and, in 2016, between 5% and 25% of girls were at risk.

The table below shows the number of girls at risk of FGM (aged 0-19) between 2011 and 2016. The trend in both the high and low scenarios from 2011 to 2016 is negative – i.e. the total number and proportion of girls at risk appears to be dropping. However, it is worth bearing in mind the likely under-estimation of second-generation girls at risk (see introduction). In all of these years, the vast majority of girls at risk are in the 0-9 age group. There were no girls at risk aged 19 from 2011 to 2016.

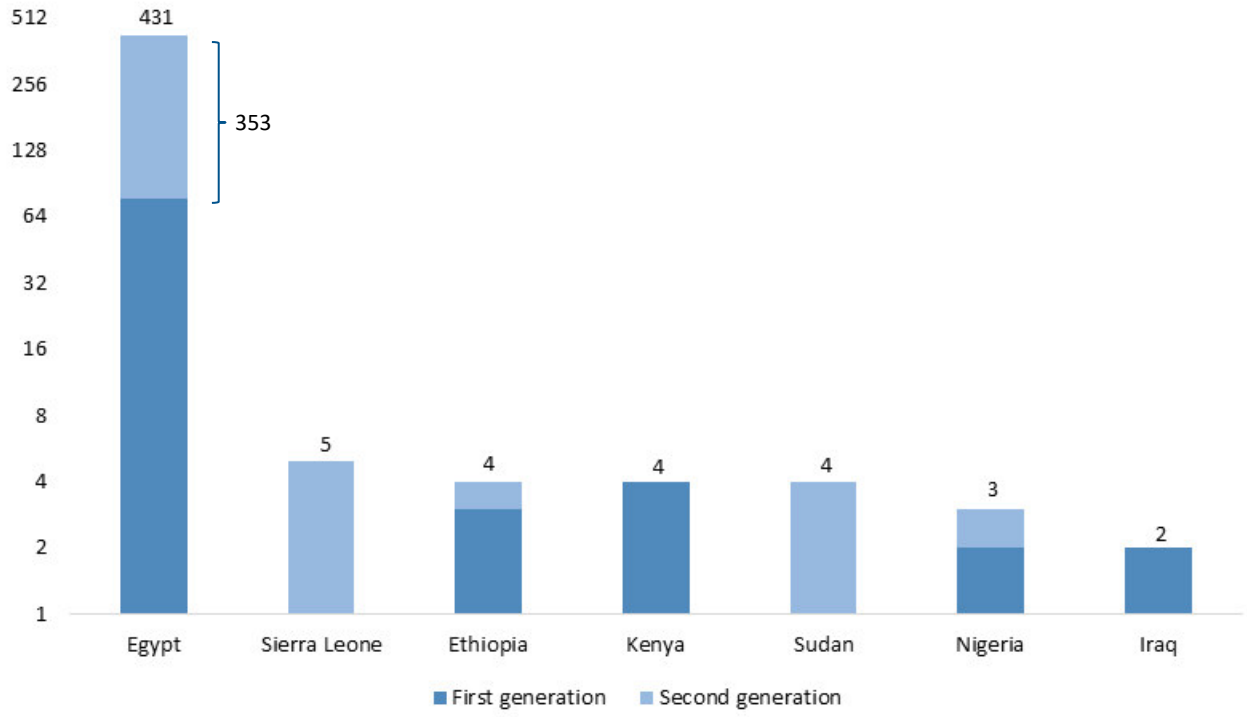
Table 3.3 Number of female migrants (agedo-18 and 0-19) living in Greece at risk of FGM

	Female migrant population					
	HIGH SCENARIO			LOW SCENARIO		
	TOTAL at risk	First generation	Second generation	TOTAL at risk	First generation	Second generation
2011: TOTAL (0-19)	**817**	**161**	**656**	**161**	**161**	**0**

2011: TOTAL (0-18)	**817**	**161**	**656**	**161**	**161**	
2011: Ages 0-9	815	161	654	161	161	0
2011: Ages 10-18	2	0	2	0	0	0
2012: TOTAL (0-19)	**715**	**141**	**574**	**141**	**141**	**0**
2012: TOTAL (0-18)	**715**	**141**	**574**	**141**	**141**	
2012: Ages 0-9	713	141	572	141	141	0
2012: Ages 10-18	2	0	2	0	0	0
2013: TOTAL (0-19)	**666**	**133**	**533**	**133**	**133**	**0**
2013: TOTAL (0-18)	**666**	**133**	**533**	**133**	**133**	
2013: Ages 0-9	664	133	531	133	133	0
2013: Ages 10-18	2	0	2	0	0	0
2014: TOTAL (0-19)	**536**	**107**	**429**	**107**	**107**	**0**
2014: TOTAL (0-18)	**536**	**107**	**429**	**107**	**107**	
2014: Ages 0-9	534	107	427	107	107	0
2014: Ages 10-18	2	0	2	0	0	0
2015: TOTAL (0-19)	**519**	**103**	**416**	**103**	**103**	**0**
2015: TOTAL (0-18)	**519**	**103**	**416**	**103**	**103**	
2015: Ages 0-9	516	102	414	102	102	0
2015: Ages 10-18	3	1	2	1	1	0
2016: TOTAL (0-19)	**454**	**92**	**362**	**92**	**92**	**0**
2016: TOTAL (0-18)	**454**	**92**	**362**	**92**	**92**	
2016: Ages 0-9	452	91	361	91	91	0
2016: Ages 10-18	2	1	1	1	1	0

The figure below shows the top seven countries by total (first and second generation) of girls aged 0 to 19 residing in Greece in 2016. Egypt is the most represented country of origin from which girls were at risk: 78 first generation girls and 353 as second generation. This pattern is stable from 2011 up to 2016.

Figure 3.4 Estimated number of girls (aged 0-19) living in Greece in 2016 who were at risk of FGM, by generation and most represented countries of origin



Notes: Uses High Scenario data. Number of second-generation girls at risk is a likely under-estimation. Due to the large differences across countries the scale on the y axis is logarithmic.

Source: present study

The table below discusses a summary of results of the FGM risk estimations for both high and low scenarios in terms of numbers and % at risk.

High scenario	In 2016, a total number of 1,852 girls aged 0-19 from FGM-practising countries were residing in Greece, of which 454 were likely to be at risk of FGM. **This means 25% of girls aged 0-19 from FGM risk countries (either born in the country of origin or in Greece) were at risk of female genital mutilation.**
Low scenario	In 2016, a total number of 1,852 girls aged 0-19 from FGM-practising countries were residing in Greece, of which 92 were likely to be at risk of FGM. **This means 5% of girls aged 0-19 from FGM risk countries (either born in the country of origin or in Greece) were at risk of female genital mutilation.**

Source: present study

3.3.2 Estimation of asylum-seeking girls at risk

Table 3.4 Estimated number of asylum-seeking girls (aged 0-17) at risk of FGM in Greece, from 2011-2016

	Total number of girls (0-17) from FGM-practising countries	Total number at risk	Proportion of girls at risk
2011	10	0	0%
2012	15	6	40%

2013	41	6	15%
2014	44	6	14%
2015	114	11	10%
2016	1,123	33	3%

Notes: Data is available for girls aged 0-17 only.

Source: present study

Between 2011 and 2016, there has been a marked increase in the number of asylum-seeking girls in Greece from FGM-practising countries, with a big jump in particular from 2015 to 2016. For 2016, the top country of origin for girls at risk was Iraq (23 girls at risk), followed by Somalia (6 girls). The remaining FGM-practising countries accounted for 2 or fewer asylum-seeking girls at risk in 2016.

Underlying data for these estimations is available in Annex 3.

3.4 Effective measures and challenges for tackling FGM in Greece

The Greek government has not undertaken specific policy initiatives that aim to support women and girls who have undergone FGM or who are at risk of FGM. There are no services (e.g. health, education, social) specifically targeting these groups, although they may be able to access mainstream services. In fact, the focus group discussions showed that many women who have arrived in Greece and who have undergone FGM often face humiliating conditions, treated by doctors and medical staff as rare specimens. Although FGM is criminalized by law, women and girls from FGM-practising countries remain at risk, and can lack information on how to seek assistance. Nonetheless, community attitudes amongst migrants form FGM prevalent countries appear to be changing, mainly because of the efforts of migrant and religious communities to conform with European standards, as well as the spread of international campaigns that alert them to the risks that FGM poses for the sexual and reproductive health of women and girls across the globe through the social media. Furthermore, it is possible that this situation will improve now that the Victims' Rights Directive has been transposed into national legislation (Greek Law 4478/2017) and now that preparations are underway for ratification of the Istanbul Convention[26].

3.5 Conclusions from Greece

Despite some fluctuation, overall there was decrease in the size of the female migrant population (permit-holders) from FGM-practising countries in Greece between 2011 and 2016. This included a high of 1935 girls in 2011, and a low of 1781 in 2014, which then levelled out in 2016 (to 1852). However, this data should be treated with caution, as it is likely a significant under-estimate of the total female migrant population from FGM-practising countries in Greece. This is because it excludes any migrant who does not require a residence permit to live legally in the country, such as second-generation girls who may be Greek citizens. Unlike in other Member States, it was not possible to use live births data to gain a truer picture of the second generation in Greece, as information on births are available only for selected years and for selected mothers' country of births.

The Greek Police publish statistics on irregular migration, which indicated that 163,950 persons from FGM-practising countries were arrested in Greece since 2011 - over 100,000 of these were arrested in 2015, the year that irregular inflows reached its highest level. The vast majority of these were from Iraq. However, it is not possible to ascertain the proportion of irregular migrants that were women.

[26] Confirmed at an experience-sharing meeting held for this study in Athens in November 2017. Participants included representatives of the Greek government.

Between 2011 and 2016 in Greece, the number of girls at risk of FGM has steadily decreased (aged 0-19). In 2016, the proportion of girls at risk ranged from 5%-25% from a total population of 1,852 girls from FGM-practising countries. In the High Scenario, the total number of girls at risk has almost halved (from 817 in 2011 to 454 in 2016). The size of the second generation at risk, considered in the high estimate, is consistently at least three times greater than the first generation.

Egypt was the most represented country of origin in Greece from which girls were at risk (78 first generation and 353 second generation). In descending order, the next most represented countries had substantially fewer girls at risk: Sierra Leone (5), Ethiopia (4), Sudan (4), Kenya (4), Nigeria (3) and Iraq (2).

In Greece, the communities that took part in the focus groups included women from Egypt and Sudan; second generation women from Nigeria and Egypt; men from Egypt and Iraq; and first generation women from Somalia. Participants offered the perspective of the community in Greece with the most girls at risk (Egypt), as well the perspective of countries about which less is known about the practice of FGM (Iraq).

Overall, the focus groups revealed that FGM is considered a more important community issue in the Somalian and Sudanese communities of Greece, than in the Egyptian, Iraqi or Nigerian communities. The Somali and Sudanese communities were also more open to discussing FGM, as opposed to Egyptian and Nigerian participants who viewed the issue as a private matter. Furthermore, younger women were generally more reserved than the older women who discussed personal experiences more openly. All particpants agreed that FGM is not happening in Greece, or even Europe more widely. Second generation participants stated that parents realise the harmful effects of FGM upon arrival into Europe. However, some participants felt that girls can be easily taken back to the country of origin to be cut. Yet even the male participants, of whom some were in favour of the practice, agreed that it is relatively rare for a family living in Greece to send their daughter back to the country of origin to undergo FGM. In this regard, restrictions until 2016 on second-generation children born in Greece travelling to the country of origin may have contributed to limited numbers of migrants opting for this option.

Generational differences were apparent, with abandonment of the practice sometimes negatively impacting relations with family elders. Similarly, men and women often had differing views – with some Egyptian men perceiving FGM positively. According to mothers and second generation women, younger second generation boys are against FGM. The role played by religion was also highlighted, with most women agreeing that FGM is a cultural practice instead of religious.

FGM is criminalised in Greece through general provisions, and there are plans to add a specific reference of FGM to the Penal Code following Greece' ratification of the Istanbul Convention. There are currently no specific policy initiatives in Greece to tackle FGM or support girls at risk, or affected women may be able to access mainstream services. This is particularly problematic when considered in relation to the Somali focus group participants' view that perspectives on FGM change following contact with Civil Society Organisations. Greece faces the challenge of educating relevant professionals across the health, education and social sectors to reduce instances of poor treatment upon examination by medical staff, as noted by focus group participants. Improvements to monitoring systems related to FGM, such as the systematic recording of cases of FGM in hospitals, is also recommended. Increases to the immigrants (inflows) of migrants provide an opportunity for Greece to focus FGM prevention on its asylum networks, such as promoting awareness of asylum granted for reasons of gender violence linked to FGM.

4 Female genital mutilation risk estimation in France

4.1 Summary of findings from focus group discussions organised in France

4.1.1 Overview of the focus group discussions

In France, four focus group discussions were held during September 2017. Two discussions were held respectively with older women and men from Mali (over 25 years); younger, second-generation women from Mali, Senegal and Gambia; and older hard-to-reach women from Guinea-Conakry. Thus the two communities with the largest number of girls at risk (see section 4.3.1) were therefore consulted as part of this research (Guinea-Conakry and Mali).

The older women and men from Mali mostly had children, whereas none of the younger women from mixed West African backgrounds. All participants in the four discussions were Muslim. The table below presents an overview of the profile of participants in all the focus group discussions.

Overview of focus group discussions and socio-demographic profile of participants in France

Key characteristics of focus groups	Focus group discussion 1: Older women	Focus group discussion 2: Younger women	Focus group discussion 3: Men	Focus group discussion 4: Hard-to-reach/recent migrants
Number of participants:	7	8	9	4
Countries of origin represented[27]:	Mali	Mali - Senegal - Gambia	Mali	Guinea-Conakry
Sex of participants:	Women	Women	Men	Women
Age range:	Over 25	18-25	25-60	28-61
Generation (first/second):	First	Second	First and Second	First
Average residence (number of months) & previous residence in other countries	19.5	0	Average of months in France: 210.7 (approx. 17.5 years)	Average of months in France: 228 (19 years)
Number of second-generation participants who have lived their parents' country of birth	N/A	0	N/A	N/A
Civil status of participants:	1 divorced 6 married	1 married 7 non-married	1 divorced 1 single 7 married	All Married
Number of participants with/without children	7 with children	8 without children	1 without child 8 with children	4 with children
Religion:	Muslim	Muslim	Muslim	Muslim
Ethnic groups (if available):	4 Soninké/ 2 Bambara/ 1 Arabic/	6 Bambara/ 1 Serere/ 1 Diakhanke	9 Soninke	3 Diakhanke 1 Peulh
Level of education:	1 primary / 1 high school/ 1 coranic school/ 3 no education	students	Never went to school: 4 Madrassa : 1 Secondary school level : 2 High School level : 1 College education : 1	1 went to high school 3 never went to school
(For first generation): Shortest and longest	4 and 30	N/A	Longest: 43 years Shortest : 5 years	Longest: 25 years Shortest : 7 years

[27] This is the country of birth of first-generation migrants (FGM-practising countries); country of birth of parents of second-generation migrants (FGM-practising countries). Here, someone is second-generation if he/she is not born in an FGM-practising country but he/she has at least one parent is born in an FGM-practising country.

Key characteristics of focus groups	Focus group discussion 1: Older women	Focus group discussion 2: Younger women	Focus group discussion 3: Men	Focus group discussion 4: Hard-to-reach/recent migrants
amount of time residing in France				
Date of session:	16 September 2017	16 September 2017	13 September 2017	28 September 2017

4.1.2 Key findings from the focus group discussions

Identity and attitudes about the importance of FGM

In the focus group discussion with younger women, as with men, nearly all participants were unanimous: in their country of origin, FGM contains to be important and is practised in rural areas as in urban areas. Once in France, however, social norms appear to affect migrants' identities and values. Older women and men from Mali distinguish consistently between their perception of FGM in France and in their country of origin. Some older Malian women in the first focus group discussion, for example, feel that they are forbidden even from talking about their community of origin. The concept of group membership and reference here plays an important role. In the country of origin, FGM would be a social norm, whereas in the host country (France), FGM does not correspond to tradition and is prohibited by law.

This conflict between expectations and norms in the host country and country of origin is captured by the words of participants. An older Malian man explained: "as soon as we get back to the country of origin, we do what we want, so no problems." Others take the new standard in France and claim the ban as their own. According to an older Malian woman (with children): "when we proved it was forbidden, my husband refused [to do it]".

Maintaining/abandoning the practice can affect relationships with family members in the country of origin as compared to members of the community living in EU. As reported by an older Malian woman (with children), "when you show that your child is not excised, the child is considered [...] dirty [...]. It is an insult when you're not excised."

The practice also relates to family expectations in terms of female purity and marriageability in the country of origin and host country. The issue of virginity is essential. Women from Guinea-Conakry explained, for example, that much of the Guinean diaspora try to respect customs at the time of marriage. Although female genital mutilation is an important issue, virginity is even more important. Similarly, for Malian men, the question repeatedly arose of the preservation of the young girls' chastity until marriage.

For all the participants in the mixed focus group discussion with younger, second generation women, FGM is practised especially for religious reasons and family honour. FGM represents a form of respectability for the girls 'cut'.

It appears that some older Malian women consciously resist social pressure and refuse FGM for their children. For example, many referred to the law and its application. One such participant (with children) explained that: "in my village they practice excision and refuse to drop the practice of excision. And two times where I went I refused [to] excise my girls [...] when I came back to France each time a review was conducted by the hospital [...]". For these women, French law was acting as a deterrent and was known to the families living in the country of origin.

For the Malian men, there was a certain degree of conformity with social pressure. Amongst younger women of the second generation (mixed communities), there was some fatalism about the practice of FGM, even though all the participants in the focus group were positioned openly and firmly against it. These women were very happy that there is a law in France banning the practice of FGM; furthermore, their families are well-aware that FGM is prohibited. However, the young women felt that this is a weak

protection in practice against the decisions of families and the importance of maintaining the customs of the country of origin.

One Guinean woman (first-generation) talked about religion as a means of resistance: "we thought it was religion and when we knew it was not, it gave us the strength to stop and that's how we can stop." This woman's perspective reflects that there can be conflicting perceptions about what religion requires when it comes to FGM, given that other focus group participants (also Muslim) saw religion as a reason in favour of the practice.

The first and the second generation women in the focus group discussions completely integrated the notion of illegality of the practice on the French territory.

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

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

On the other hand, the communities in three out of four focus groups considered that FGM amongst communities living in their country of origin was much more extensive. Excision also remains a common practice, according to several participants in this focus group discussion with men, even in Malian villages that have openly called to stop the practice. In fact, only Guinean migrants indicated that the practice had decreased in their country of origin.

Participants in the focus group discussions appear unconcerned by the type of procedure carried amongst the community. Malian men spoke of the difference between female circumcision and infibulation (FGM Type III), to "ensure virginity" before the marriage of young girls.

Key risk factors for FGM

Some factors contribute to the maintenance of the practice. Many participants of the four focus group discussions spoke of the difficulty, on return to the country of origin, in opposing their family (grandmothers, uncles, aunts, etc). Younger women from the second generation repeatedly stressed the important role of elders, and to some extent appeared fatalistic about their prospects.

Conversely, the focus group discussion results indicate clear factors that reduce the risk of girls of experiencing FGM. The law and its application have played an essential role for the reduction of the practice of FGM, particularly the trial reported in the media of Hawa Greou[28] and the checks carried out in hospitals and Maternal and Infant Protection Centers (PMI)[29].

Focus group participants also pointed to awareness-raising, prevention campaigns as a discouraging factor, including on African television. One older, first-generation Malian woman said that she had received information through television programs broadcast from the regions where excision is practised. Another Malian woman confirmed she had had access to information on African television. A Guinean woman also stated that awareness-raising takes place in her country of origin.

[28] Malian female circumciser who was sentenced to 8 years' imprisonment for having mutilated on the French territory at least 200 in February 1999.

[29] The PMI are free clinics for the follow-up of pregnancies and child health from 0 to 6 years.

4.2 Female migrant population aged 0-19 originating from FGM-practising countries

Table 4.1 Overview of data availability in France

Type of data	Summary of data availability and sources:
Risk estimation	
Sources used in risk estimation	French Population Census, National Institute of Statistics and Economic Studies (INSEE), National Archive of Data from Official Statistics-Maurice Halbwachs Center (ADISP-CMH). Available for 2011 and 2014.
Data issues:	To estimate the age distribution of the first and second generation for 2014, the research team used the age structure of the data on foreign-born, available from the 2011 census.[30] Furthermore, five-year intervals were used, therefore making it necessary to approximate a single age group as 20% of the girls in each interval. Generation breakdown means it was not necessary to use any live births data to project the size of the second-generation.
Overview data presented on the migrant population	
Female migrant population originating from FGM-practising countries	French Population Census, National Institute of Statistics and Economic Studies (INSEE), National Archive of Data from Official Statistics-Maurice Halbwachs Center (ADISP-CMH)
Years available	2014, 2011
By age	0-19, with breakdowns by five-year age groups: 0-4, 5-9, 10-14, 15-19.
By country of origin	Available
By first and second generation	Available.
By regional level	Unavailable
By age of arrival	Partially available
Data issues	For many countries with low numbers, cases by exact age are subject to "statistical confidentiality" (numbers < 20). Regarding the 2014 data: The French "renovated" census of the population is carried out continuously and is updated each year. Nevertheless, the data 'refresh' only covers one-fifth of municipalities (with fewer than 10,000 inhabitants) and a fifth of the sample in municipalities with 10,000 or more inhabitants. Over a 5-year period, all the inhabitants of municipalities with less than 10,000 inhabitants and 40% of the population of municipalities with 10,000 inhabitants or more have been taken into account. Therefore, to obtain representative data, data are used for the last 5 years (2012-2016); the median year (2014) is considered as the reference year.
Female live births in EU to mothers originating from FGM-practising countries	National Institute of Statistics and Economic Studies (INSEE), via Réseau Quetelet (ADISP-CMH). Data collected by the Central birth registration office.
By country of mother	Available
By regional level of country of mother	Unavailable
By region of birth of the child	Available
Data issues	n/a
Female asylum seekers	French Office for the Protection of Refugees and Stateless Persons (OFPRA) - Studies and Statistics Office.
Years available	2011-2016
By age	0-18 years, with one-year breakdowns

[30] Available at: https://ec.europa.eu/CensusHub2/query.do?step=selectHyperCube&qhc=false

Type of data	Summary of data availability and sources:
By country of origin	Available.
By regional level	Unavailable
By age of arrival	Unavailable
Data issues	Some missing disaggregations (see above). Country of origin not consistently country of birth.
Female refugees	Unavailable (not possible to distinguish from other migration statistics)
Years available	
By age	
By country of origin	
By first and second generation	
By regional level	
By age of arrival	
Data issues	
Female irregular migrants	Unavailable.
Years available	
By age	
By country of origin	
By first and second generation	
By regional level	
By age of arrival	
Data issues	
Official registration – other sources on identified FGM cases	
Medical/hospital	Limited data available.
Child protection	Unavailable.
Police/judicial	Unavailable.
Asylum	Available: FGM-related asylum applications granted in France.
Other	Unofficial: NGO monitoring of court cases.

This section of the France chapter provides data (where available) on four groups: i) the recorded migrant population, who are legally present and 'usually resident' in the Member State; ii) recent immigrants and emigrants to the country; iii) irregular migrants, who do not – or no longer – fulfil the conditions for legal residence in the country; and iv) asylum-seekers, who are legally present but have not found out if their application for international protection was successful. Having an overview of this data is important for understanding potential populations of interest when estimating the number of girls at risk of female genital mutilation. The chapter ends by presenting data on other sources (if any) that are collecting FGM in the country.

4.2.2 Migrant population

In France, there were 215,258 girls (aged 0-19) originating from FGM-practising countries in 2014. Of these, 83% (177,649) were second generation. Of the total number of girls aged 0-19, around half (53%, 113,081) are aged 0-9 and 47% (102,177) are 10-19.

The vast majority of girls aged 0-9 are second generation (90%) and this is similar although a bit lower for those aged 10-19 (74%), as presented in the Table below.

Table 4.2 Age and generation distribution of the female migrant population (aged 0-19) originating from FGM-practising countries, in France, 2014

	TOTAL	First generation	Second generation	TOTAL (%)	First generation (%)	Second generation (%)	TOTAL generation (%)
0-9	113,081	11,029	102,052	53%	10%	90%	100%
10-19	102,177	26,580	75,597	47%	26%	74%	100%
TOTAL	215,258	37,609	177,649	100%	17%	83%	100%

Notes: France uses a slightly different definition of second-generation girls to the official definition in use in the study (explained in text below). One-year age disaggregations not available due to statistical confidentiality; provided in five-year groupings (0-4, 5-9, 10-14, 15-19). Due to the five-year groupings, the following age breakdowns are not given in this table: 0-9, 10-18, 19.

Source: French Census, 2014 (for the period 2012-2016); Tabulation sur mesure, INSEE, ADISP-CMH

The majority of girls from FGM-practising countries residing in France in 2014 are second generation migrants across the age bands between 0-19. For the second generation girls, over half are between the age of 0-9. In comparison, nearly three quarters of first generation girls are between the ages of 10-19.

If one compares the total numbers of girls (aged 0-19) from FGM-practising countries (215,258) to the total numbers of girls aged 0-19 and residing in France in 2014 (7,611,359), the girls aged 0-19 from FGM-practising countries represent 3% of the population of girls aged 0-19 in France, in 2014.

Table 4.3 Detailed age and generation distribution of the female migrant population (aged 0-19) originating from FGM-practising countries, in France, 2014

Age group	First generation	Second generation
0-4	3,659	47 604
5-9	7,370	54 448
10-14	10,512	43 749
15-19	16,068	31 848
Total (0-19)	**37,609**	**177 649**
Total (0-19)	**215 258**	

Source: French Census, 2014 (for the period 2012-2016); Tabulation sur mesure, INSEE, ADISP-CMH. France uses a slightly different definition of second-generation girls to the official definition in use in the study (explained in text below).

The data presented in the two Tables above come from the French Census for the median year 2014 covering the period 2012-2016 (data concern the five most recent years, 2012-2016)[31]. Data concern two generations of girls aged 0-19:

- The first generation are defined as all girls aged 0-19 resident in France and born in a FGM risk country;
- The second generation are defined as all girls aged 0-19 born in France or in another EU country with at least one parent (mother and/or father) born in a FGM-practising country.

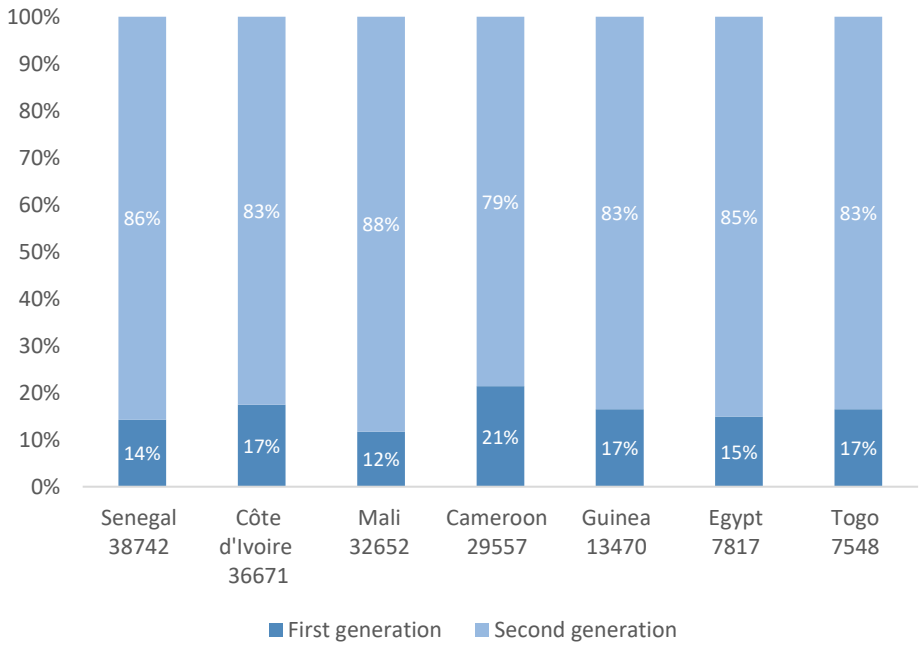
Data are broken down by five-year age groups (0-4, 5-9, 10-14, 15-19) and the generation structure was estimated. Data by one-year age intervals exists but, due to the "statistical confidentiality" (numbers <20),

[31] The French "renovated" census of the population is carried out continuously and is updated each year. Nevertheless, the data 'refresh' only covers one-fifth of municipalities (with fewer than 10,000 inhabitants) and a fifth of the sample in municipalities with 10,000 or more inhabitants. Over a 5-year period, all the inhabitants of municipalities with less than 10,000 inhabitants and 40% of the population of municipalities with 10,000 inhabitants or more have been taken into account. Therefore, to obtain representative data, data are used for the last 5 years (2012-2016); the median year (2014) is considered as the reference year.

data are not available by age: in fact, in most countries, numbers by age are too small. The variable 'age of arrival' exists but is not workable due to an important percentage of missing data (almost more than 50% for all countries). The region of origin is not available in the French Census.

The Figure below presents the seven countries from the largest number of female migrants (aged 0-19) originate in France, broken down by generation.

Figure 4.1 Number of girls (aged 0-19) living in France by generation and most represented countries of origin, 2014



Source: French Census, 2014 (for the period 2012-2016) ; Tabulation sur mesure, INSEE, ADISP-CMH

Notes: The data for 2014 was given as 2014 is the median year for the period 2012-2016. These countries are presented in descending order when it comes to the size of the communities (with Senegal being the highest and Togo being the lowest). However, they are shown on the same scale to enable percentage comparison per generation.

In 2014, there were a total of 166,457 female migrants (first and second generation) living in France from these seven countries. Overall, the seven countries represent approximately 77% of the entire female migrant population living in France from FGM-practising countries. Broken down by generation, they represent 71% of the first-generation population and and nearly 80% of the second-generation population from all FGM-practising countries.

The seven FGM-practising countries with the most first generation and second generation female migrants (aged 0-19) in 2014 were (in descending order): Senegal (38,742), Côte d'Ivoire (36,671), Mali (32,652), Cameroon (29,557), Guinea (13,470), Egypt (7,817) and Togo (7,548). Of these seven FGM-practising countries with the largest numbers living in France, five are countries from West Africa (Senegal, Côte d'Ivoire, Mali, Guinea, Togo). For each of these seven countries, the number of second generation girls is at least three times as great as the number of first generation girls.

4.2.3 Inflows and outflows

To get a sense of migration patterns over time, it is worthwhile to consider 'inflows' and 'outflows' from FGM-practising countries. The former covers immigrants (inflows): people arriving or returning from abroad to take up residence in a country for 12 months or more, having previously been resident elsewhere. The latter covers people who are leaving the country where they usually reside and effectively

taking up residence in another country. An individual is a long-term emigrant if he/she leaves his/her country of previous usual residence for a period of 12 months or more. A positive 'net inflow' indicates that more people are arriving than leaving France, within a given year.

Official data regarding immigrants (inflows) and emigrants (outflows) from FGM-practising countries (aged 0-19) is not available.

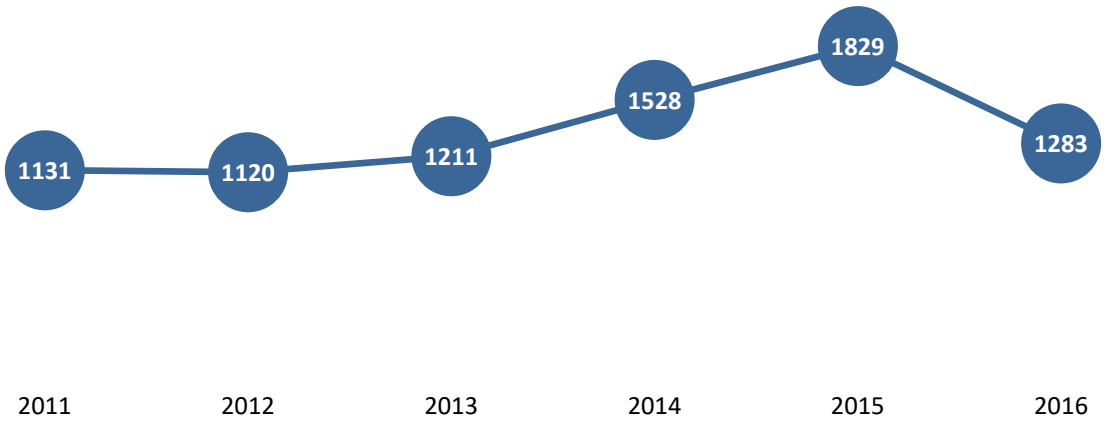
4.2.4 Irregular migration

Official data on the total number of irregular migrants in France is not available.

4.2.5 Asylum-seekers

The total number of female asylum seekers from FGM-practising countries who originated in France between 2011-2016 has increased steadily from 2011-2015, and then decreased in 2016 (Figure 4.2). The majority of female asylum seekers from FGM-practicing countries in France between 2011-2016 are between 10-18 years old (Figure 4.3). See Annex 1 for a full one-year age breakdown per year for all the countries where it is available.

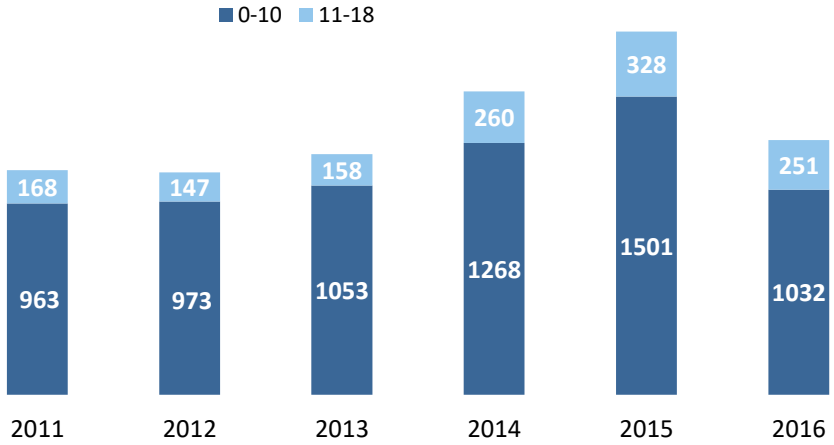
Figure 4.2 The total number of female asylum-seekers (aged 0-18) from FGM-practising countries in France between 2011-2016



Notes: Data only concerns minors aged 0-18 years, as the statistical unit of this data is 'female minor accompanying'. The country of origin covers the country of birth of the parent of this minor. In most cases, the country of birth of the minor and the parent will be the same.

Source: French Office for the Protection of Refugees and Stateless people (OFPRA).

Figure 4.3 Number of female asylum-seekers from FGM-practising countries in France between 2011-2016, by age



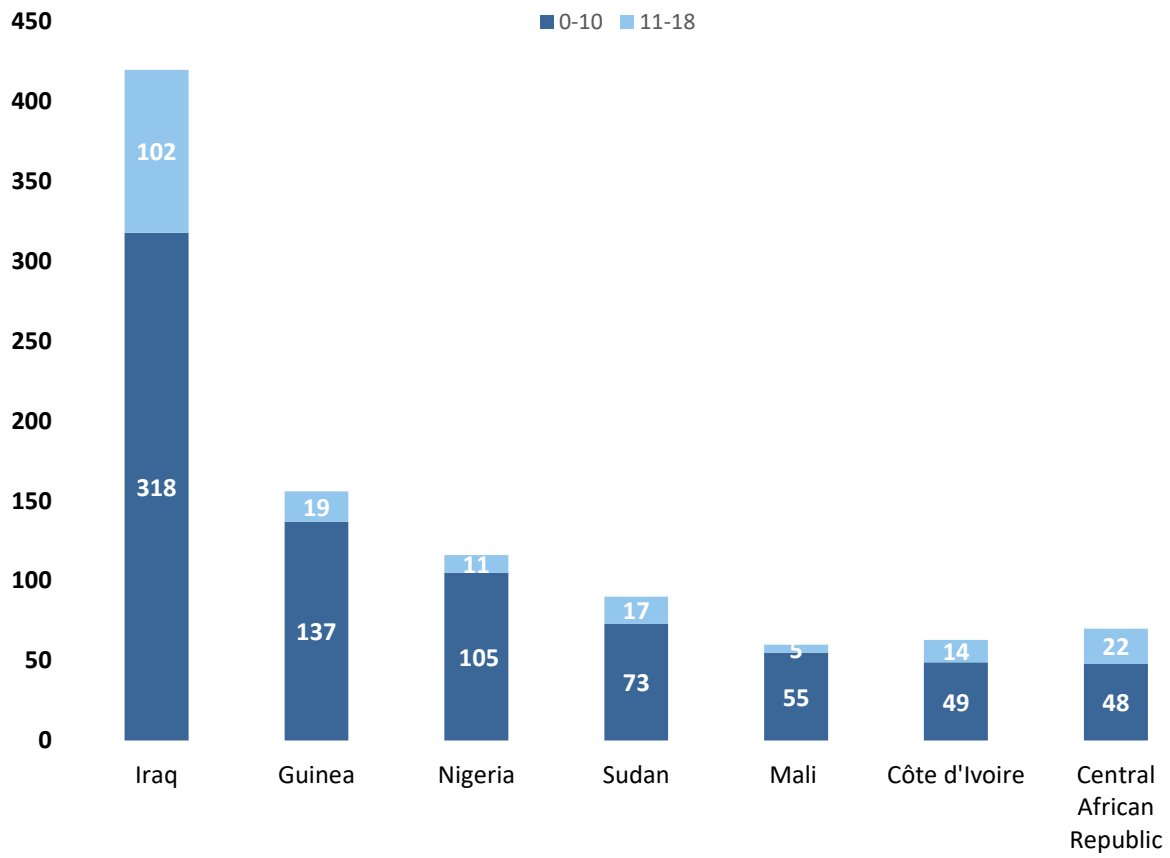
Notes: Data only concerns minors aged 0-18 years, as the statistical unit of this data is 'female minor accompanying'. The country of origin covers the country of birth of the parent of this minor. In most cases, the country of birth of the minor and the parent will be the same.

Source: Office for the Protection of Refugees and Stateless people (OFPRA), France.

In 2016, the total number of asylum seekers originating from FGM-practising countries was 1,283. Iraq accounted for just over a third (33%) of the total female asylum-seeking population (0-18), and Guinea and Nigeria accounted for roughly a tenth each (12% and 9% respectively). Overall, 81% of the asylum seekers presented in Figure 4.3 are below the age of 10, and just over half (53%) are below the age of 5.

In 2016, the seven FGM-practising countries from which the largest number of female asylum-seekers (aged 0-18) originated were Iraq (420 female asylum-seekers aged 0-18), Guinea-Conakry (156), Nigeria (116), Sudan (90), Central African Republic (70), Côte d'Ivoire (63) and Mali (60). Overall, this is a total of 975 young female asylum-seekers from these seven countries, of which 785 (over 80%) are aged 0-10. For each of country of origin, girls aged 0-10 are also a majority of these female asylum-seekers. As explained below, data are not available by country of origin on female asylum-seekers aged 19.

Figure 4.4 Number of asylum-seeker girls 0-18 living in France, by age and most represented countries of origin, 2016



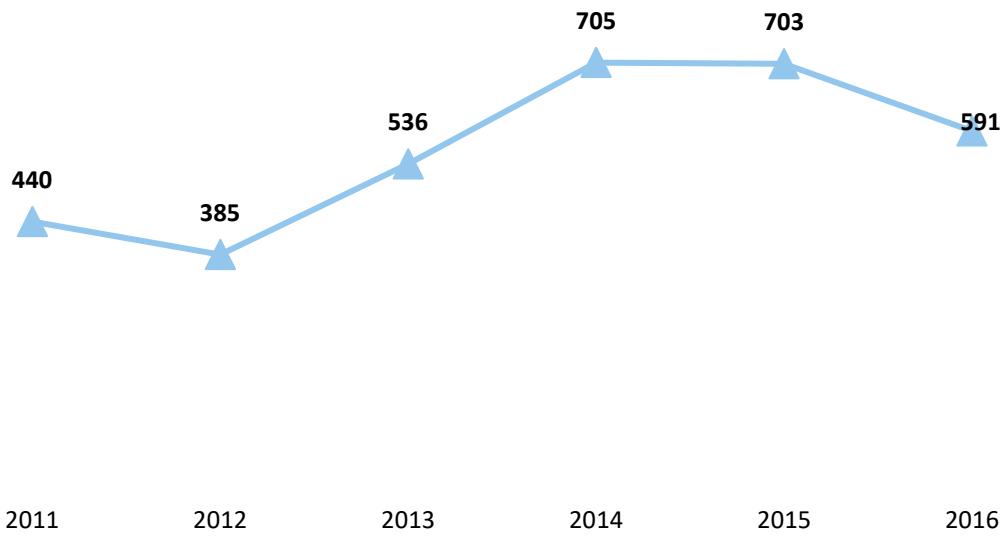
Notes: Data only concerns minors aged 0-18 years, as the statistical unit of this data is 'female minor accompanying'. The country of origin covers the country of birth of the parent of this minor. In most cases, the country of birth of the minor and the parent will be the same.

Source: Office for the Protection of Refugees and Stateless people (OFPRA), France.

As mentioned, in 2016, the country with the largest number of asylum seekers was Iraq. This was one of the largest countries of origin from 2014 onwards, which may be linked to the international context and crisis in the Middle East region. In 2016, the Central African Republic appears in the first seven countries with a more unusual trend: girls aged 10-18 represent approximately one third of the total, against less than 20% for the other countries. Since 2011, the largest countries of origin for asylum-seekers have been similar, for example Guinea-Conakry, Mali, Côte d'Ivoire, Nigeria and Sudan.

These numbers concern only girls who are accompanying others and not unaccompanied girls, which are a very small numbers according to the French Office for the Protection of Refugees and Stateless people (OFPRA).

Figure 4.5 Number of FGM-related asylum applications granted in France since 2011 for girls aged 0-19, from FGM-practising countries



Notes: Statistical unit based on girls (0-19 years) protected against the risk of FGM. Data are not available on the total number of FGM-related asylum applications received in each of these years.

Source: Office for the Protection of Refugees and Stateless people (OFPRA), France.

The number of FGM-related asylum applications granted in France increased from 2011 to 2014 (from 400 to 700). Since 2014, the number has been constant at around 600-700. Since 2011, 70% of the applications granted concern two countries: Guinea-Conakry and Mali, two countries with very high FGM prevalence (more than 90%)[32].

The French Office for the Protection of Refugees and Stateless people (OFPRA) do not provide statistics by reason for protection (for example, FGM risk), so it is not possible to have the differential between FGM-related asylum applications received and those granted. The FGM-related asylum agreement is defined following the interview with mothers[33]. Numbers concern only girls accompanying adults; however, the number of girls not accompanying adults is very low, according to the French Office for the Protection of Refugees and Stateless people (OFPRA).

4.2.6 Other records collecting information on FGM in France

Two hospitals (cities of Saint-Denis and Montreuil) that offer reconstructive surgery after FGM collect records on the practice. It is possible that some Non-Governmental Organisations also collect data on the practice, amongst those that access their services. No other sources were identified in France that collect data on identified cases of FGM.

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

[33] The data on FGM-related asylum applications granted comes from the cross-checking of various information following the interviews with mothers (when they consider that there is a risk of excision for their daughters in the country of origin).

4.3 Estimation of the number of girls at risk of FGM in France and possible trends of FGM risk

The following section provides data on the estimated number of girls at risk of FGM in France, following the methodology in EIGE's step-by-step guide. It begins by presenting estimates of the number of girls at risk within the 'regular' migrant population, then presents the estimates for asylum-seeking girls. This is an important difference, as asylum-seekers are not included within the migrant population (unlike, for example, recognised refugees). It is worth remembering that the estimates for asylum-seekers cannot distinguish between a high and low scenario, as technically all asylum-seekers being considered are from the first generation.

Risk estimates for the regular migrant population were calculated using 2011 annnd 2014 data from French Population Census, National Institute of Statistics and Economic Studies (INSEE), National Archive of Data from Official Statistics-Maurice Halbwachs Center (ADISP-CMH). To estimate the age distribution of the first and second generation for 2014, the research team used the age structure of the data on foreign-born, available from the 2011 census.[34] Furthermore, five-year intervals were used, therefore making it necessary to approximate a single age group as 20% of the girls in each interval.

Data on the number of female live births in France to mothers originating from countries where FGM is documented is available. However, as data on the female migrant population is available disaggregated by generation, it was not necessary to project the size of the second generation by using female live births, unlike most other Member States in this study.

4.3.1 Estimation of girls at risk within the regular migrant population

For the age group 0-19, in 2011, the number of girls at risk of female genital mutilation in France varied between 1,968 and 5,886. In 2014, this varied between 2,304 and 23,930. This means that between 4% and 13% of girls were at risk of FGM in 2011, and between 1% and 11% in 2014. The increase in the number of girls at risk between 2011 and 2014 is remarkable, almost four times for the High Scenario. Despite this, the percentages of girls at risk have decreased, suggesting that, similar to Belgium, the expansion in the number of girls at risk is related to a growing population of FGM-affected communities living in the country.

If one restricts the age range to 0-18, the figures remain the same in this case as there are no girls aged 19 at risk. The proportions, however, increase slightly: in 2011, between 5% (1968) and 14.2% (5886) of girls were at risk (out of total population of 41,558), while in 2014, this was between 1.1% and 11.6% (out of total population of 205,676).

The table below gives a summary of results. Underlying data for these estimations is available in Annex 2.

Table 4.4 Estimated number of girls (0-18 and 0-19) living in France at risk of FGM, in 2011 and 2014

	Female migrant population					
	HIGH SCENARIO			LOW SCENARIO		
	TOTAL at risk	First generation	Second generation	TOTAL at risk	First generation	Second generation
2011: TOTAL (0-19)	**5 886**	**1 968**	**3 918**	**1 968**	**1 968**	**0**

[34] Available at: https://ec.europa.eu/CensusHub2/query.do?step=selectHyperCube&qhc=false

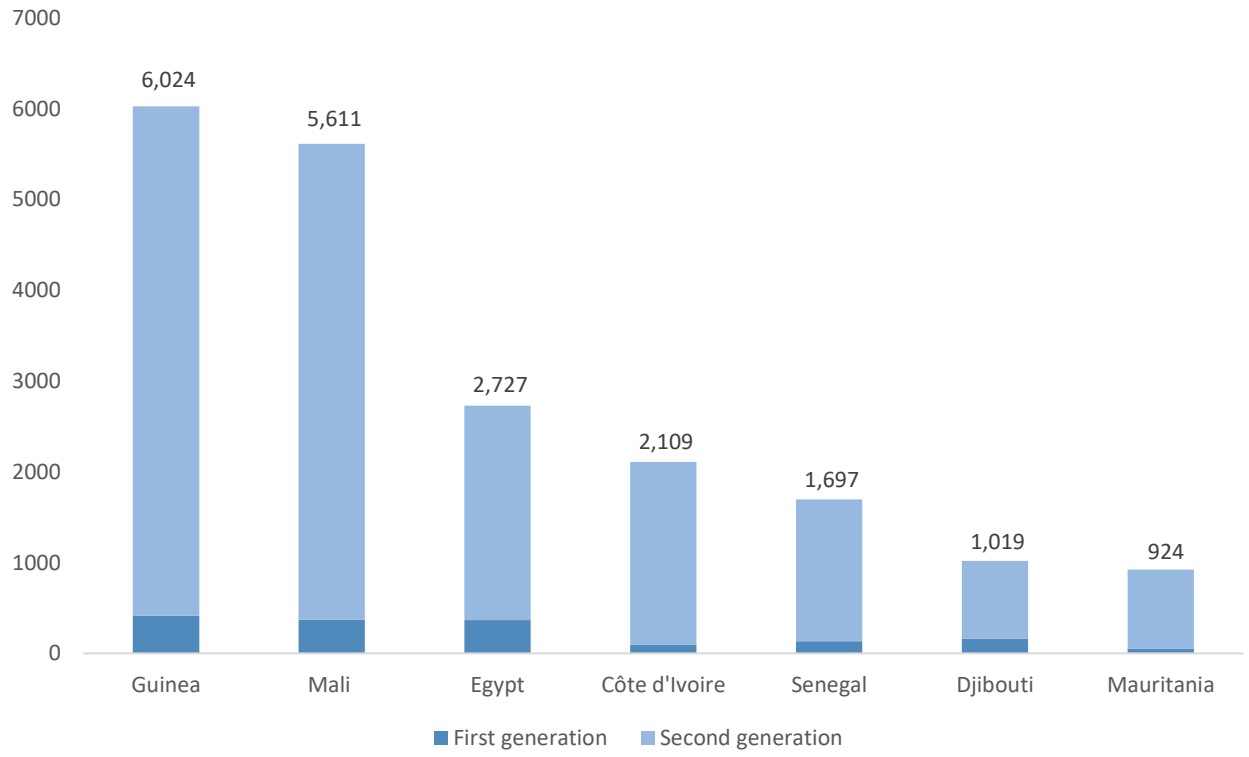
2011: TOTAL (0-18)	**5886**	**1968**	**3918**	**1968**	**1968**	
2011: Ages 0-9	5,750	1,832	3,918	1,832	1,832	0
2011: Ages 10-18	136	136	0	136	136	0
2011: Age 19	0	0	0	0	0	0
2014: TOTAL (0-19)	**23 930**	**2 304**	**21 626**	**2 304**	**2 304**	0
2014: TOTAL (0-18)	**23930**	**2304**	**21626**	**2304**	**2304**	
2014: Ages 0-9	23,438	2,160	21,278	2,160	2,160	0
2014: Ages 10-18	492	144	348	144	144	0
2014: Age 19	0	0	0	0	0	0

Notes: First generation is defined here as the number of girls (0-19 years) resident in France and born in a FGM-practising country. Second generation is defined here as the number of girls (0-19 years) born in France or another EU country, with at least one parent (mother and/or father) born in a FGM-practising country. As data on the female migrant population is available disaggregated by generation, it was not necessary to project the size of the second generation by using female live births.

Source: present study

For both 2011 and 2014, most girls at risk are younger than 10. For girls aged 0-9, in 2011, between 8.9% and 28% girls were at risk; and between 1.9% and 21% in 2014. For girls aged 10-18, in 2011, between 0.6% and 1% girls were at risk, in 2014, between 0.2% and 1%.

Figure 4.6 Estimated number of girls (aged 0-19) living in France in 2014 who were at risk of FGM by generation and most represented countries of origin



Notes: First generation is defined here as the number of girls (0-19 years) resident in France and born in a FGM-practising country. Second generation is defined here as the number of girls (0-19 years) born in France or another EU country, with at least one parent (mother and/or father) born in a FGM-practising country. As data on the female migrant population is available disaggregated by generation, it was not necessary to project the size of the second generation by using female live births.

Source: present study

The largest number of girls who were at risk originate from Guinea: respectively 415 and 5,609 girls from the first and second generations; this is very closely followed by girls from Mali and then Egypt. Smaller groups of girls at risk originate from Côte d'Ivoire, Senegal, Djibouti and Mauritania.

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

FGM risk in France in 2014: summary of results

High scenario	In 2014, a total number of 215,258 girls aged 0-19 originating from FGM risk countries (born in the country of origin or in France) were residing in France, of which 23,930 girls were likely to be at risk of female genital mutilation. **Proportionally, 11% of girls aged 0-19 originating from FGM risk countries (born in the country of origin or in France) were at risk of female genital mutilation.**
Low scenario	In 2014, a total number of 215,258 girls aged 0-19 originating from FGM risk countries (born in the country of origin or in France) were residing in France, of which 2,304 girls were likely to be at risk of female genital mutilation. **Proportionally, 1% of girls aged 0-19 originating from FGM risk countries (born in the country of origin or in France) were at risk of female genital mutilation.**

4.3.2 Estimation of asylum-seeking girls at risk

Table 4.5 Estimated number of asylum-seeking girls (aged 0-18) at risk of FGM in France, from 2011-2016

	Total number of girls (0-19) from FGM-practising countries	Total number at risk	Proportion of girls at risk
2011	1,131	520	46%
2012	1,120	504	45%
2013	1,211	535	44%
2014	1,528	632	41%
2015	1,829	601	33%
2016	1,283	327	25%

Notes: Data on asylum-seekers aged 19 not available.

Source: present study

Between 2011 and 2016, the proportion of asylum-seeking girls at risk of FGM reduced in France, despite rises in the total number of asylum-seeking girls from FGM-practising countries from 2011-2015.

In 2016, the country of origin with the most asylum-seeking girls estimated to be at risk of FGM was Guinea-Conakry (117), followed by Sudan (51), Mali (40), Somalia (24) and Chad (13). Each of the remaining FGM-practising countries accounted for 12 or fewer girls at risk.

Underlying data for these estimations is available in Annex 3.

4.4 Effective measures and challenges for tackling FGM in France

FGM is a criminal offence in France, as in all other Member States. France ratified the Istanbul Convention in 2014, and it entered into force later that year. France has not developed FGM-specific laws; instead, the practice can be prosecuted under general legislation on Intended bodily harm causing permanent infirmity or mutilation (Articles 222–9 and 222–10 of Penal Code) and Acts of torture and barbarity (Articles 221–2, 222–3, 222–5 of Penal Code). Similarly, general provisions for child protection and professional secrecy (Article 226–14 of the Penal Code; Article 44 of the Code of Medical Ethics) can be applied in cases of FGM.

The principle of extraterritoriality is applied, with the new Article 222-16-2 added to the French criminal code to sanction and punish FGM practised on French girls when they are abroad, even if they originated from another country. There is no doubt amongst focus group participants the law and its application play a role in decreasing the practice of FGM. The 30th court case on FGM took place in France in May 2012[35]; however, official monitoring systems on judicial investigations and prosecutions have not been established.

The 2015 reform of France's asylum law (CESEDA) makes a special provision for FGM as a serious form of psychological, physical or sexual violence, which must be considered in relation to an individual's asylum application and accommodation needs.

Specific policies to tackle FGM are relatively thorough in France's 'Fifth inter-ministerial plan for the prevention of violence against women 2017 - 2019', which focuses on violence against women more broadly. The plan sets out specific actions related to health and education, including developing a partnership between the Ministries in charge of public health and education, alongside civil society, to effectively prevent FGM. Thus, overall France has made several attempts to address FGM in both a legislative and policy context.

In France, some services (for example, health, education, social) are available for those who have experienced FGM and who are at risk; however, the level of community awareness of these is very weak for the participants of the four focus group discussions. Indeed, the only known and recognized services are health services (hospitals and services offering 'reconstructive' surgery for those who undergone FGM, as well as Maternal and Infant Protection Centers). It was considered challenging to increase awareness in schools. The strongest prevention/protection policies and services appear to be in the health sector. According to expert interviews conducted for this study, health professionals are the most proactive compared, for example, to the education sector to fight against FGM. Some interviewees recommended the introduction of large-scale training of all relevant service professionals (health, education, social, justice) to improve the their consideration of female genital mutilation.

As for measures to improve levels of awareness of legislation and available services amongst migrant communities, results from the focus group discussions suggest that communities are aware of the law in France that prohibits FGM, but that some families decide to practise cutting on their children in their country of origin. However, since 2006, the extraterritoriality principle has been applied in law, meaning that perpetrators of FGM can be prosecuted even if they carry out the practice abroad, regardless of the child's nationality. This suggests that communities may have only a partial understanding of the law, without recognising the extraterritoriality principle. It therefore seems necessary to strengthen the training of professionals so that they can inform affected communities both individually and collectively on the reality of the French legislation on FGM. In addition, information in mass media could aide this. The objective here would be to empower communities who use the law to protect their daughters from FGM.

France faces challenges in tackling FGM, as shown clearly after the organization of the focus group discussions. FGM is linked to the taboo of sexuality. This was clearly stressed during the focus group discussion with young women. Even though they were born in France, they explained very distinctly the

[35] Gillette-Faye, I. (2017), 'La juridiciarisation de l'excision : historique', Edition GAMS France, January 2017

intimacy and taboo dimension that one must take into consideration when talking about FGM. It is a challenge that goes beyond the framework of FGM but remains present in France.

4.5 Conclusions from France

In 2014, there were 215,258 female migrants from FGM-practising countries living in France, with the second generation population more than four times larger than the first generation (177,649 and 37,609 respectively). France has seen an overall steady increase in the number of female asylum-seekers (aged 0-18) from FGM-practising countries between 2011 and 2016 (from 1131 to 1283, peaking at 1829 in 2015). Iraq accounted for just over a third (33%) of this female asylum-seeking population (aged 0-18). Since 2014, the number of FGM-related asylum applications granted in France has remained fairly stable at around 600-700, with 70% of applications coming from applicants from Guinea-Conakry and Mali; countries with very high FGM prevalence (over 90%).

In France, the percentage of girls at risk of FGM (aged 0-19) ranged from 1% to 11% in 2014, which represents between 2304 and 23,930 girls from a total population of 215,258. Most of these girls are under 10 years old. Although in 2011, the proportion of girls at risk was higher, the total number of girls at risk was far smaller (5,886 in 2011 compared with 23,930 in 2014 – High Scenario). Most of this growth is due to a rise in the number of second generation girls at risk (3918 in 2011, reaching 21,626 in 2014).

The seven countries of origin in France with the largest number of girls at risk in 2014 (aged 0-19), from largest to smallest, were Guinea-Conakry (6024), closely followed by Mali (5611), and then Egypt (2727), Cote d'Ivoire (2109), Senegal (1697), Djibouti (1019) and Mauritania (924). The second generation was far larger in all communities, for instance, Guinea-Conakry is made up of 415 first generation and 5609 second generation girls.

Four focus group discussions were held. The two communities in France with the largest number of girls at risk were therefore consulted as part of this research (Guinea-Conakry and Mali). All participants stated that FGM is occurring in their country of origin, in both rural and urban areas. The social pressures to carry out FGM were connected with marriageability and virginity by the senior women and women from Guinea-Conakry, while younger women attributed the practice to religion. Amongst older migrant women from Mali, the law seems to be acting as an effective deterrent against FGM; indeed, sometimes they use it as a tool to persuade other family members not to support FGM. Indeed, the first and the second generation women in the focus group discussions completely integrated the notion of illegality of the practice on the French territory.

Change is apparently slower amongst Malian men, who were significantly the only focus group to insist on the importance of maintaining FGM, with many feeling the pressure to conform to avoid their daughters being perceived negatively. Younger women also expressed concern that French protection measures were not enforced adequately in the country of origin, particularly due to the sizable influence held by older generations and role of extended family members in encouraging that girls undergo FGM.

Despite concerns expressed particularly by younger female focus group participants around FGM being carried out in their country of origin, FGM is a criminal offence in France and the principle of extraterritoriality is applied. Further FGM-related measures include the 2015 reform of France's asylum law (CESEDA) which makes a special provision for FGM to be considered in asylum claims, and explicit mention of FGM in France's 2017-19 NAP on violence against women. A major challenge highlighted in all focus groups is a lack of awareness of support services or awareness-raising initiatives. Older women and men,

both from Mali, recommended implementing anti-FGM educational messages, and for essential work to be done in schools to tackle FGM. The mass media could be a useful tool for disseminating these messages, such as regarding the law on FGM.

5 Female genital mutilation risk estimation in Italy

5.1 Summary of findings from focus group discussions organised in Italy

5.1.1 Overview of the focus group discussions

Four focus group discussions were held In Italy in September and October 2017. Discussions were held with: Egyptian men of first and second generation; Egyptian women from the first generation; Nigerian women from first generation and recent migrants; young women from the second generation, of mixed backgrounds. In addition to a small focus group discussion, two semi-structured interviews were held with two young women of the second generation. This was done to increase the input from the second generation in the study, given the difficulties in encouraging second generation to participate in a group discussion (see section 8.1.3 below). The contributions from Egyptians offered the perspective of Italy's biggest community with girls at risk of FGM (see section 5.3 below). The viewpoints from Nigerians were also especially interesting, considering they embodied a high number of female migrants at risk of FGM, as well as most asylum seekers from FGM-practising countries.

Most participants in all the focus group discussions had children, apart from in the discussion with younger, second-generation women (where all participants were childless). The Egyptian participants were all Muslim, whereas the Nigerian participants were Christian, and the younger women had mixed religious affiliations. The table below presents an overview of the profile of participants in the four focus group discussions.

Table 5.1 Overview of focus group discussions and socio-demographic profile of participants in Italy

Key characteristics of focus groups	Focus group discussion 1: Older women	Individual interviews and focus group discussion 2: Younger women	Focus group discussion 3: Men	Focus group discussion 4: Hard-to-reach/recent migrants
Number of participants:	8	4	8	6
Countries of origin represented[36]:	Egypt	3 participants have both parents from, respectively: Ethiopia, Nigeria, Eritrea; 1 participant: Father: Egyptian, Mother: Moroccan	Egypt	Nigeria
Sex of participants:	Women	Women	Men	Women
Age range:	Over 25	18-27	25-60	23-49
Generation (first/second):	First	Second	First and second	First and second
Average residence (number of months) & previous residence in other countries	17 years of residence in Italy	21 years of residence in Italy	13 years of residence in Italy	11 years of residence in Italy
Number of second-generation participants who have lived their parents' country of birth	0	1	1	0
Civil status of participants:	9 married	Single	6 married	3 married

[36] This is the country of birth of first-generation migrants (FGM-practising countries); country of birth of parents of second-generation migrants (FGM-practising countries). Here, someone is second-generation if he/she is not born in an FGM-practising country but he/she has at least one parent is born in an FGM-practising country.

Key characteristics of focus groups	Focus group discussion 1: Older women	Individual interviews and focus group discussion 2: Younger women	Focus group discussion 3: Men	Focus group discussion 4: Hard-to-reach/recent migrants
Number of participants with/without children	9 with children	No children	5 with children	5 with children
Religion:	Muslim	2 Christian/2 not religious	Muslim	Christian
Ethnic groups (if available):	N/A	N/A	N/A	Urhobo, Edo-Bini, Igbo
Level of education:	High school	High school and University student	High school to University	No formal education through to diploma and University degree
(For first generation): Shortest and longest amount of time residing in Italy:	1 to 26 years	n/a (second generation)	6 to 27 years	1 to 21 years
(For first generation): Shortest and longest amount of time residing in other European Member State:	N/A	N/A	N/A	N/A
Date of session:	26 September 2017	4 and 5 September 2017 (interviews); 29 of November 2017 focus group discussion	20 September 2017	2 October 2017

5.1.2 Key findings from the focus group discussions

Identity and attitudes about the importance of FGM

According to the participants of the focus group discussions , the main aim of the practice is related to the sexual control of girls and women. In particular, the size of the clitoris was seen as the element which mostly influences the sexual desire of women.

Cutting of the clitoris, for the Egyptian women and men was said to allow for the adoption of more virtuous and approved behaviour. Sexual control was also central in the Nigerian women's narrative, for whom the practice remains important, even if there have been relevant changes in the type of genital modification undertaken. More broadly, young women of the second generation, saw FGM as a question of gender and power between men and women, in which the role of women is defined by a patriarchal society.

Both Egyptian men and women generally agreed that the practice is more linked to tradition than religion, even if those who were still practising it perceived FGM as a religious obligation. Young women (mixed backgrounds) saw FGM as a traditional and cultural element of the countries of origin of their relatives, which was not relevant to their identity as Italians. Egyptian men were clearly divided into those in favour of, and against, the practice, but both of these groups felt that the decision affects their personal identity as men and their self-representation. Those in favour tended to underline the religious values involved in the FGM practice (although the religious argument was controversial among participants). However, according to the Egyptian women, the position adopted by religious groups has highlighted that religion has nothing to do with the practice of FGM, and which has likely led to a decrease in the number of girls undergoing it. According to these women, nowadays a third "modern" aesthetic justification for FGM arises.

Concerning the marriageability for both Egyptian women and men, they felt that a girl "not cut" could still get married without problems[37].

[37] According to many women, men apparently do not notice the situation of their partner and on the contrary, for them it would be even better to marry a woman who has not been cut, because she would be more active from a sexual point of view.

For men, the encounter with the host society played a role in changing some opinions but in a selected manner: virginity was still important, but FGM could be left behind (this was valid for those who were against FGM). To Nigerian women, it seemed that the practice was not a precondition for marriage and that it depended on the man, but at the same time women still believed that men preferred small clitorises. However, for first-generation women (both Egyptian and Nigerian), migration and the encounter with the host society did not play a role in the decision to cut (or not) their daughters and more broadly on their overall awareness about gender-based violence, women's rights or women's empowerment.

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

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

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

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

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

The medicalization of the procedure, although known to be forbidden in Egypt and in the EU, was seen to make the cut acceptable in certain cases, as it was perceived as more hygienic and less painful and dangerous for the health of the girl. It was reported as the current way to practise FGM in Egypt (when practised), even among the migrant communities returning back to Egypt.

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

Key risk factors for FGM

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

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

According to the analysis of both focus group discussions with Egyptians, and the first-hand experience of a young woman with an Egyptian father[38], it seems that in the Egyptian community returning to their home country can be an indicator of risk of FGM for girls living in Europe.

Nigerian women claimed to have not have their daughters cut but instead to have replaced the cut, with a milder form aimed at reducing the clitoris (see above). This recent genital modification restricted significantly the perception of practising FGM, as they all felt far from the "bloody" practice they carried out long ago, although the reasons around the practice remain unchanged. It seemed that the key persons involved in the decision-making process were the mother and grandmother, even back in Nigeria.

5.2 Female migrant population aged 0-19 originating from FGM-practising countries

Table 5.2 Overview of data availability in Italy

Type of data	Summary of data availability and challenges
Risk estimation	
Sources used in risk estimation	Eurostat, Population on 1 January split by: 5-year age group, sex and country of birth. - migr_pop3ctb. Registration for births in the Municipal Population Registers (Rilevazione degli iscritti in anagrafe per nascita)
Data issues:	Births for 2016 are not available so the number of second generation girls is underestimated for the estimation of 2016. This affects only the high-risk scenario estimate. It may explain why the number of girls at risk in 2016 is less than the number at risk in 2015. Births are available only as far back as 1999, meaning that for estimations from 2015 to 2013 data on older girls (i.e. born before 1999) are missing. This is less of an issue for the number of girls at risk, as girls above the median age for cutting are not considered at risk

[38] "In Morocco I have never heard of FGM, only of male circumcision, perhaps in rural areas, while in Egypt it is still practiced, according to women and relatives. I do not go there because my mother has not allowed them to infibulate me. This is why I do not go to Egypt anymore. They organized a party to do my FGM while my mother was not there, she was in Cairo; my mother took me away, we took the first plane and we never came back".

Type of data	Summary of data availability and challenges
	anymore. However, it is not possible to know the total proportion of girls aged 0-19 who are at risk (because the total denominator is not available). For the years 2011 and 2012, data on births do not allow for an estimation of second-generation girls aged 14 in 2011 and 2012, which was the median age for cutting in some countries of origin.
Overview data presented on the migrant population	
Female migrant population originating from FGM-practising countries	Eurostat, Population on 1 January split by: 5-year age group, sex and country of birth-migr_pop3ctb.
Years available	2011-2016
By age	0-19, with breakdowns by five-year age groups: 0-4, 5-9, 10-14, 15-19.
By country of origin	Available
By first and second generation	First-generation data available only in Eurostat - migr_pop3ctb.
By regional level	Unavailable
By age of arrival	Unavailable
Data issues	Residence permits statistics was also provided by the Italian National Statistical Institute (ISTAT), but ultimately not used. Permits data covers all third country nationals who received a residence permit in Italy. All categories of legal migrants are included (including refugees). However, this includes temporary migration (less than 12 months) and it is not possible to break it down by generation. Due to this, Eurostat data was ultimately used.
Female live births in EU to mothers originating from FGM-practising countries	Registration for births in the Municipal Population Registers (Anagrafi)
By country of mother	Available.
By regional level of country of mother	Unavailable
By region of birth of the child	Available
Data issues	Registration carried out by ISTAT since 1 January 1999. Latest year for which data are available is 2015. Country of origin is mother's citizenship, not country of birth.
Female asylum seekers	Residence permits statistics provided by ISTAT (Italian National Statistical Institute). Refer to third country nationals who applied for international protection (and subsidiary protection) in Italy.
Years available	2011-2016
By age	0-19 years, with 5-year breakdowns: 0-4, 5-9, 10-14, 15-19
By country of origin	Available.
By regional level	Unavailable
By age of arrival	Unavailable
Data issues	To ensure anonymity of individuals, ISTAT did not provide data disaggregated by one-year age groups.
Female refugees	ISTAT (Italian National Statistical Institute). Refers to third country nationals granted residence permits of stay due to: international protection status; refugee status & subsidiary protection, Humanitarian reasons.
Years available	2011-2016
By age	0-19 years, with 5-year breakdowns: 0-4, 5-9, 10-14, 15-19

Type of data	Summary of data availability and challenges
By country of origin	Available
By first and second generation	n/a
By regional level	Unavailable
By age of arrival	Unavailable
Data issues	To ensure anonymity of individuals, ISTAT did not provide data disaggregated by one-year age groups.
Female irregular migrants	Official data unavailable. Unofficial data available from Fondazione ISMU – Initiatives and Studies on Multi-ethnicity[39]
Years available	Latest: 2010
By age	Unavailable
By country of origin	By citizenship only
By first and second generation	Unavailable
By regional level	Unavailable
By age of arrival	Unavailable
Data issues	Missing disaggregations (see above)
Official registration – other sources on identified FGM cases	
Medical/hospital	Unavailable
Child protection	Unavailable
Police/judicial	Unavailable.
Asylum	Unavailable.
Other	Health survey data

This section of the Italy chapter provides data (where available) on four groups: i) the recorded migrant population, who are legally present and 'usually resident' in the Member State; ii) recent immigrants and emigrants to the country; iii) irregular migrants, who do not – or no longer – fulfil the conditions for legal residence in the country; and iv) asylum-seekers, who are legally present but have not found out if their application for international protection was successful. Having an overview of this data is important for understanding potential populations of interest when estimating the number of girls at risk of female genital mutilation. The chapter ends by presenting data on other sources (if any) that are collecting FGM in the country.

5.2.2 Migrant population

The following section presents data on the regular migrant population in Italy. These data are calculated by combining migrant population data from Eurostat (migr_pop3ctb) with live births data from the Municipal Population Registers (Anagrafi). It was necessary to combine these sources due to the lack of a generation breakdown for the permits data available. When interpreting these data, note the following:

- Age is only available by 5-year age groupings; one-year breakdowns are estimated.

[39] http://www.ismu.org/en/

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

It is worth bearing these issues in mind when interpreting data on the female migrant population in Italy.

In Italy, there were 61,384 female migrants (aged 0-19) originating from FGM-practising countries in 2011.Of these, 64% (39,058) were second generation. Of the total number of girls aged 0-19, more than half (68.8%, 42,220) were aged 0-9 and 28.5% (17,500) were 10-18. Of the girls aged 0-9, 80% were second generation; this fell to 30% for those aged 10-19. As in other Member States (Belgium and France), the youngest girls tended to be more likely to be drawn from the second generation than the first.

The number of female migrants from FGM-practising countries for 2016 reached 77,580, which represents a 26% increase compared to 2011. By 2016, the generation distribution followed a similar pattern but was even more pronounced with 73 % (56,931) as second generation and 27% (20,649) as first. Of girls aged 0-9, 85% were second generation, 5 percentage points higher compared to 2011. The proportion of girls aged 10-18 who were second-generation doubled to 60% in 2016, suggesting a growing second-generation within FGM-affected communities (both in absolute terms and as a proportion of all girls).

Table 5.3 Age and generation distribution of the female migrant population (aged 0-19) originating from FGM-practising countries, in Italy, 2011

	TOTAL	First generation	Second generation	TOTAL (%)	First generation (%)	Second generation (%)	TOTAL generation (%)
0-9	42,220	8,330	33,890	68.8%	20%	80%	100%
10-18	17,500	12,332	5,168	28.5%	70%	30%	100%
19	1,664	1,664	0	2.7%	100%	0%	100%
TOTAL	61,384	22,326	39,058	100%	36%	64%	100%

Note: Sources combined due to lack of generation breakdown in permits data. Births prior to 1999 are missing, leading to some under-estimation of older second-generation girls. The total number by age band do not add up exactly, as for some specific age counts were coded as '<4'. However, the divergence is minimal and does not affect the % figures.

Source: Eurostat, Population on 1 January split by: 5-year age group, sex and country of birth- migr_pop3ctb; combined with Registration for births in the Municipal Population Registers (Anagrafi)

Table 5.4 Age distribution of the female migrant population (aged 0-19) originating from FGM-practising countries, in Italy, 2016

	TOTAL	First generation	Second generation	TOTAL (%)	First generation (%)	Second generation (%)	TOTAL generation (%)
0-9	45,532	6,900	38,632	59%	15%	85%	100%
10-19	30,508	12,209	18,299	39%	40%	60%	100%
19	1,540	1,540	0	2%	100%	0%	100%
TOTAL	77,580	20,649	56,931	100%	27%	73%	100%

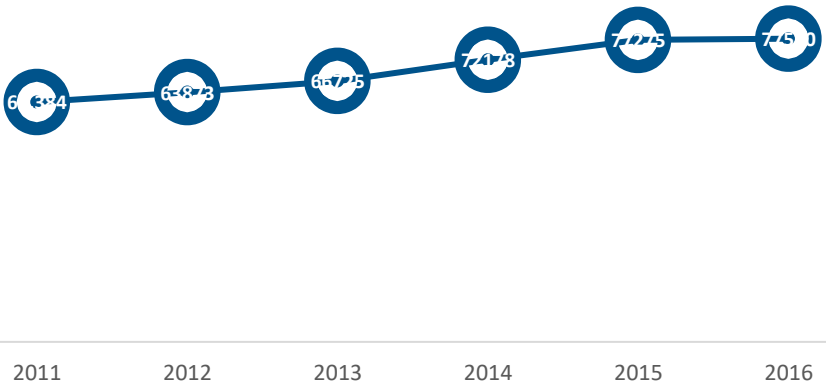
Note: Sources combined due to lack of generation breakdown in permits data. Births prior to 1999 and for 2016 itself are missing, leading to some under-estimation of older second-generation girls and girls younger than 1. Births in 2016 itself are missing. The total number by age band do not add up exactly, as for some specific age counts were coded as '<4'. However, the divergence is minimal and does not affect the % figures.

Source: Eurostat, Population on 1 January split by: 5-year age group, sex and country of birth- migr_pop3ctb; combined with Registration for births in the Municipal Population Registers (Anagrafi)

In 2016, girls younger than 10 years from FGM-practising countries in Italy represented 59% of the total number of the female migrants from these countries, while the girls aged 10 and above represent 41% of the total.

Over period 2011-2016, there was an overall and steady increase in the number of female migrants aged 0-19 from the 30 FGM-practising countries in Italy.

Figure 5.1 Total number of female migrants in Italy from FGM-practising countries aged 0-19, between 2011 and 2016



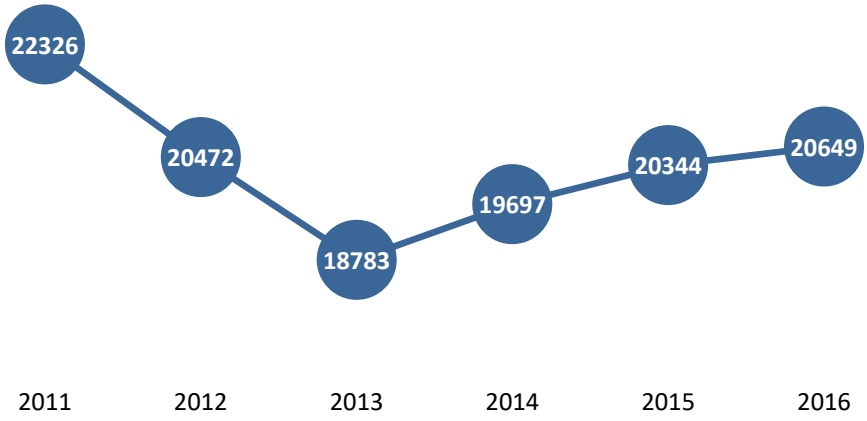
Note: Sources combined due to lack of generation breakdown in permits data. Data issues contribute to some under-estimation of second-generation.

Source: Eurostat, Population on 1 January split by: 5-year age group, sex and country of birth- migr_pop3ctb, combined with Registration for births in the Municipal Population Registers (Anagrafi)

However, the number of first-generation migrants decreased over time. The data in Figure 5.2 represents the total number of female migrants aged 0-19 from the 30 FGM-practising countries in Italy, in the period 2011-2016. Here, the individuals' migration status is based upon being born in an FGM-practising country. For this reason, the Figure includes (by definition) only first-generation migrants[40].

[40] There are limits to the comparability of the two datasets. For example, data on residence permits may overestimate the resident population because they include also temporary residence permits and long-term residence permits (valid for life).

Figure 5.2 Total number of **first-generation** female migrants in Italy from FGM-practising countries aged 0-19, between 2011 and 2016

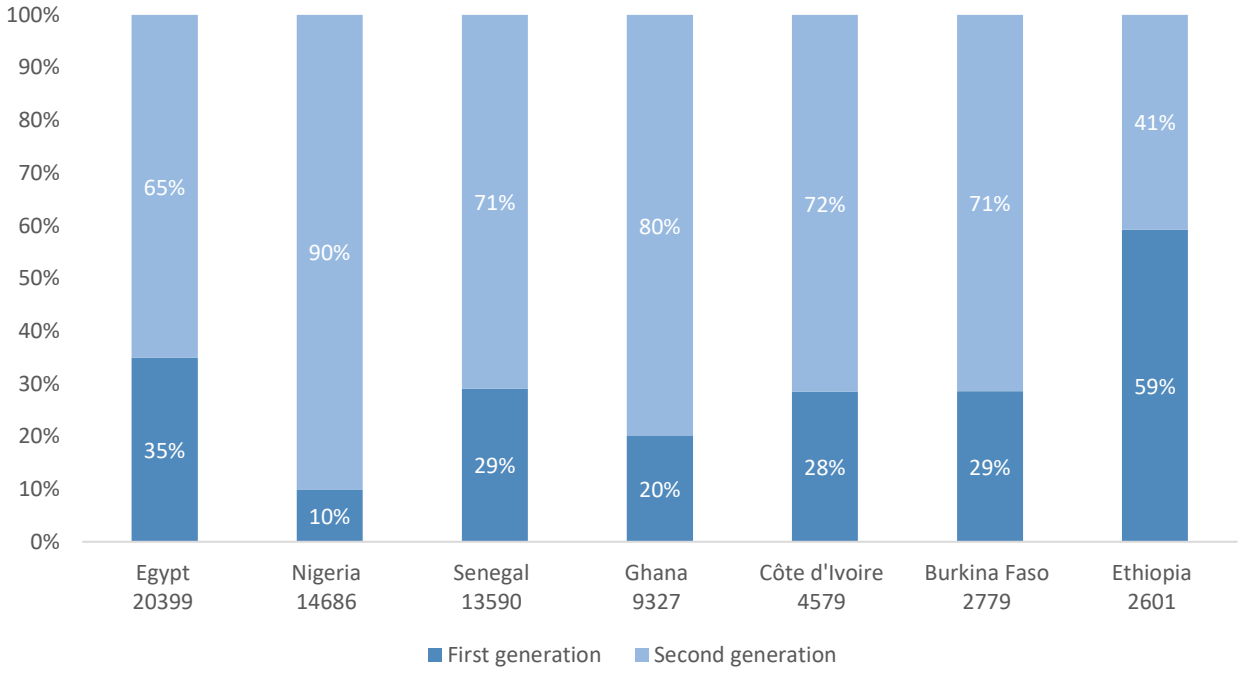


Note: Population data, mandatory and voluntary, are collected by Eurostat from National Statistical Institutes on an annual basis from the EU Member States.

Source: Eurostat, Population on 1 January split by: 5-year age group, sex and country of birth- migr_pop3ctb.

Data for this indicator stem from Eurostat, on the basis of an estimation made every year by the Italian National Statistical Institute (ISTAT). The estimation is based on the registration of population in the municipality registers (Anagrafi). This estimation is provided to Eurostat under the Regulation 1260/2013 on European demographic statistics.

Figure 5.3 Number of girls (aged 0-19) living in Italy by most represented countries of origin, 2016



Notes: Sources combined due to lack of generation breakdown in permits data. Data issues contribute to some under-estimation of second-generation.

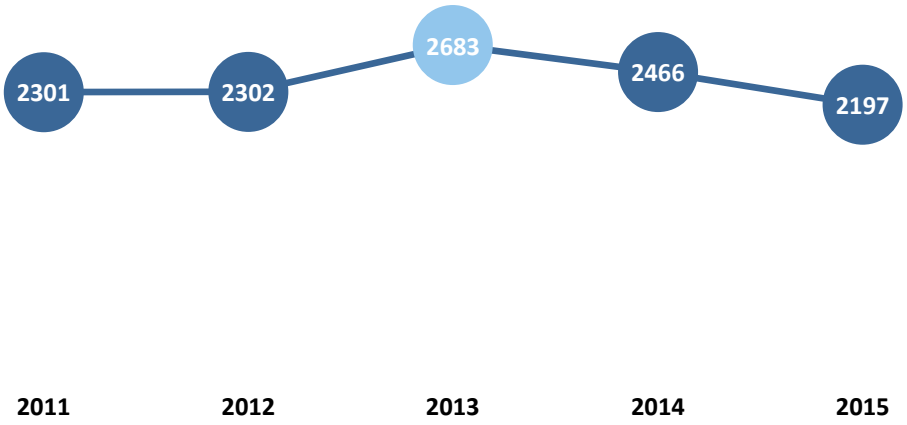
Source: Eurostat, Population on 1 January split by: 5-year age group, sex and country of birth- migr_pop3ctb, combined with Registration for births in the Municipal Population Registers (Anagrafi)

In Italy in 2016, the seven FGM-practising countries from which the largest number of female migrants (aged 0-19) originated are: Egypt (20,399), Nigeria (14,686), Senegal (13,590), Ghana (9,327), Côte d'Ivoire (4,579), Burkina Faso (2,779) and Ethiopia (2,601) .

5.2.3 Inflows and outflows

To get a sense of migration patterns over time, it is worthwhile to consider 'inflows' and 'outflows' from FGM-practising countries. The former covers immigrants (inflows): people arriving or returning from abroad to take up residence in a country for 12 months or more, having previously been resident elsewhere. The latter covers people who are leaving the country where they usually reside and effectively taking up residence in another country. An individual is a long-term emigrant if he/she leaves his/her country of previous usual residence for a period of 12 months or more. A positive 'net inflow' indicates that more people are arriving than leaving Italy, within a given year.

Figure 5.4 Net female immigrants (inflows) to Italy originating from the 30 FGM-practising countries (aged 0-19, first generation), 2011-2015



Source: Eurostat: Eurostat's annual collections of statistics on international migration flows.

The total female immigrants (inflows) and emigrants (outflows) of migrants originating from the 30 FGM-practising countries are relatively constant over the period 2011-2015. Inflows are about 2,500 thousand girls per year, outflows are between 131 and 207 per year. A slight increase of outflows was recorded in 2014 and 2015, with a consequent slight decrease of net migration.

Data stem from the Registration for immigration in the municipality registers (Anagrafi) and were provided by Eurostat for the period 2011-2015. Inflows and outflows data were collected based on the country of birth of migrants. Data matches the definitions requested. The year 2016 is not yet available.

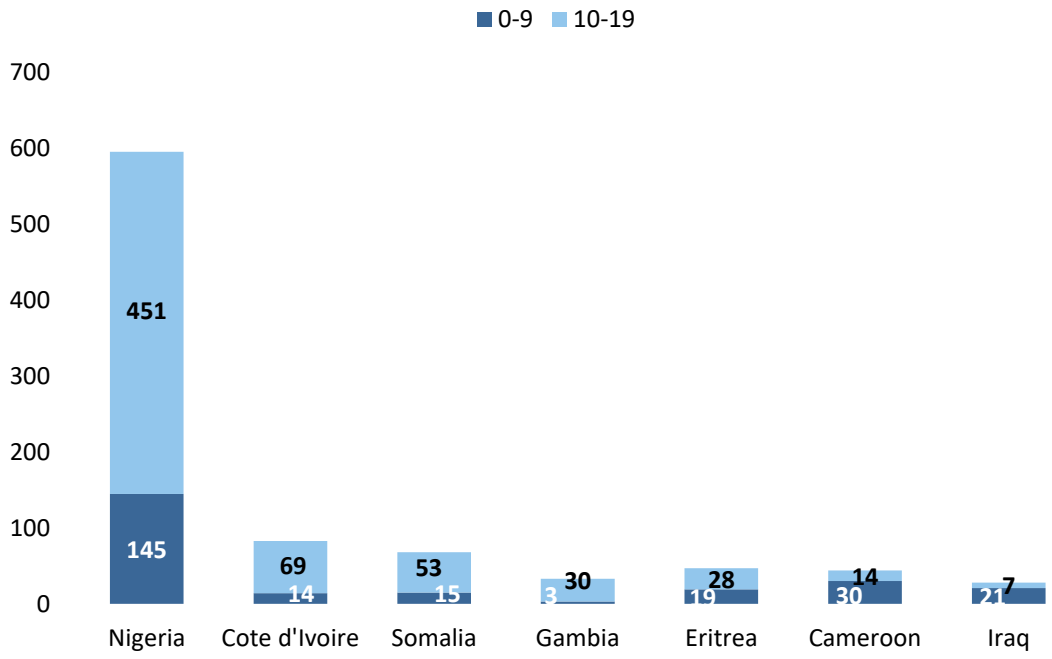
5.2.4 Irregular migration

No official information is available on irregular migrants for the study period (2011-2016). The Italian National Institute of Statistics (ISTAT) does not collect information on irregular migration. The Fondazione ISMU – Initiatives and Studies on Multi-ethnicity (http://www.ismu.org/en/) provides estimate on irregular migration in Italy. However, the last estimation available was for the year 2010.

5.2.5 Asylum-seekers

In Italy, there were 1,009 asylum-seeking young women (aged 0-19) from 30 FGM-practising countries in 2016. Out of these, approximately 88% (889) were asylum-seeker girls 0-19 from the 7 most represented countries. Within this group, 72% (652) were aged 10-19 and 66% (596) came from Nigeria.

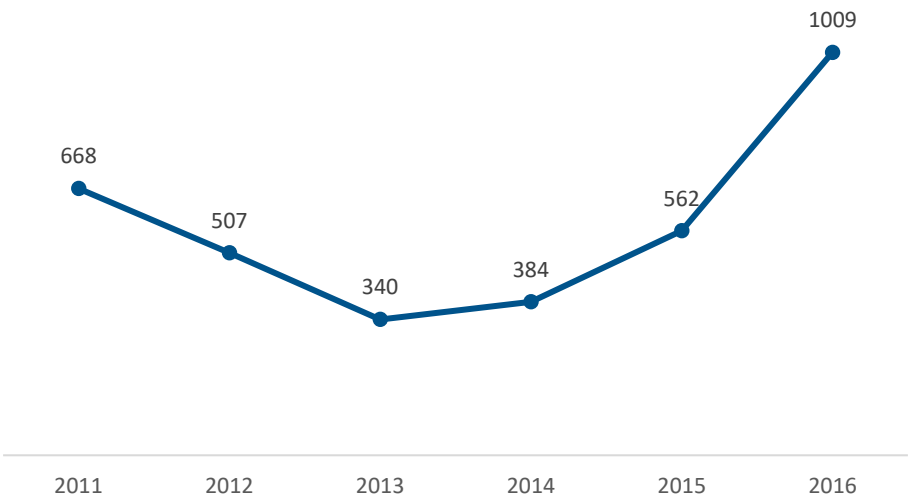
Figure 5.5 Number of asylum-seeking girls (aged 0-19) living in Italy, by 10-year age group and most represented countries of origin, 2016



Source: Italian National Statistical Institute (ISTAT)

In 2016, the seven most represented countries of female asylum seekers in Italy were: Nigeria, Côte d'Ivoire, Somalia, Eritrea, Cameroon, Gambia and Iraq. Three out of seven of these (Nigeria, Côte d'Ivoire and Cameroon) are also among the countries that make up the highest number of regular female migrants in Italy (originating from the 30 FGM-practising countries).

Figure 5.6 Number of asylum-seeking young women (aged 0-19) in Italy from FGM-practising countries, 2011-2016



Source: Italian National Statistical Institute (ISTAT)

As shown in the Figure above, over the period 2011-2016, after a fall in the first two years, there was a rise from 2013 in the number of female asylum-seekers from FGM-practising countries in Italy, reaching a peak of 1,009 in 2016. In particular, there was a strong increase (+77%) in the number of asylum seekers among girls aged 0-19 coming from Nigeria, while the number of asylum seekers originating from the remaining 6 countries was stable and quite low, except for a significant increase for Côte d'Ivoire between 2015 and 2016. Nigeria is the country in Italy that forms the highest number of asylum seekers. The trend of Nigerian young women is consistent with the number of applications of Nigerians overall (except that there has been a larger percentage rise for Nigerian men).

Data are not collected in Italy on the number of FGM-related asylum applications received and granted in Italy since 2011 for girls aged 0-19.

5.2.6 Other records collecting information on FGM in Italy

The First Italian Survey of the Sexual and Reproductive Health of Migrant Women was carried out by the Regional Institute of Statistics (Eupolis) and the University of Milan-Bicocca. This cross-sectional survey included 2,011 migrants aged 15-49 living in the Italian region of Lombardy in 2010 and is representative of the region's main nationalities. Undocumented and naturalized women were included in the sample. A subsample of the cross-sectional survey was comprised of women from countries where FGM is practised, and for which it was developed a form modelled after the latest DHS standard form. Data are available on request.

Older data are available in the estimation made in 2009 by Istituto Piepoli S.p.A. data and results of the study are publicly available[41].

5.3 Estimation of the number of girls at risk of FGM in Italy and possible trends of FGM risk

The following section provides data on the estimated number of girls at risk of FGM in Italy, following the methodology in EIGE's step-by-step guide. It begins by presenting estimates of the number of girls at risk

[41] http://ods.ars.marche.it/Portals/0/Materiale%20MGF/Valutazione%20Quantitativa%20e%20Qualitativa%20MGF%20Italia_2009.pdf

within the 'regular' migrant population, then presents the estimates for asylum-seeking girls. This is an important difference, as asylum-seekers are not included within the migrant population (unlike, for example, recognised refugees). It is worth remembering that the estimates for asylum-seekers cannot distinguish between a high and low scenario, as technically all asylum-seekers being considered are from the first generation.

Risk estimates for the regular migrant population are calculated by combining Eurostat population data and live births data from the Municipal Population Registers (Anagrafi). It is necessary to combine these, due to the lack of a generation breakdown for residence permits data. These estimations for Italy require some key caveats:

- Births for 2016 are not available so the number of second generation girls is underestimated for the estimation of 2016. This lack of data bias only the high-risk scenario estimate. That is why the number of girls at risk in 2016 is less than the number at risk in 2015.
- Births are available only as far back as 1999, meaning that for estimations from 2015 to 2013 data on older girls (i.e. born before 1999) are missing. This is less of an issue for the number of girls at risk, as girls above the median age for cutting are not at risk anymore. However, it is not possible to know the total proportion of girls aged 0-19 who are at risk (because the total denominator is not available).
- For the years 2011 and 2012, data on births do not allow for an estimation of second-generation girls aged 14 in 2011 and 2012, which was the median age for cutting in some countries of origin.

5.3.1 Estimation of girls at risk within the regular migrant population

The table below presents a summary of the number of girls (aged 0-19) at risk of female genital mutilation in 2011 to 2016. Underlying data for these estimations is available in Annex 2.

In 2011, between 5% and 19% of female migrants (aged 0-19) were at risk; in 2012, between 4% and 18% of female migrants (aged 0-19) were at risk; in 2013, between 3.5% and 18% female migrants (aged 0-19) were at risk; in 2014, between 3% and 17% female migrants (aged 0-19) were at risk; in 2015, between 3% and 17% female migrants (aged 0-19) were at risk; and in 2016, between 3% and 15% girls were at risk.

The Table below shows that the total number of girls at risk of FGM (aged 0-19) in Italy ranged from 2,946 to 11,655 in 2011, 2,658 to 11,758 in 2012, 2,316 to 11,837 in 2013, 2,467 to 12,399 in 2014, 2,534 to 12,761 in 2015 and finally from 2,496 to 11,501 in 2016. The year 2015 has seen a peak in the High scenario compared to the other years.

In all of these years, the majority of girls at risk were younger than 10 years old. There were no girls aged 19 at risk.

For the age group 0-18, in 2011, there were between 5% and 20% girls at risk in Italy, between 4% and 19% in 2012, 3% and 18% in 2013, between 3% and 18% in 2014, 3% and 17% in 2015 and between 3% and 15% in 2016.

Table 5.5 Estimated number of girls (aged 0-19) living in Italy who are at risk of FGM, 2011-2016

	Female migrant population					
	HIGH SCENARIO			LOW SCENARIO		
	TOTAL at risk	First generation	Second generation	TOTAL at risk	First generation	Second generation
2011: TOTAL (0-19)	**11,655**	2,946	8709	2,946	**2,946**	0

2011: TOTAL (0-18)	**11655**	2946	8709	2946	2946	
2011: Ages 0-9	11,613	2,929	8684	2,929	2,929	0
2011: Ages 10-18	42	17	25	17	17	0
2012: TOTAL (0-19)	**11,758**	2,658	9100	2,658	**2,658**	0
2012: TOTAL (0-18)	**11758**	2658	9100	2658	2658	
2012: Ages 0-9	11,712	2,643	9069	2643	2,643	0
2012: Ages 10-18	46	15	31	15	15	0
2013: TOTAL (0-19)	**11,836**	2,316	9,520	2,316	**2,316**	0
2013: TOTAL (0-18)	**11,836**	2316	9520	2316	2316	
2013: Ages 0-9	11,796	2,303	9493	2,303	2,303	0
2013: Ages 10-18	40	13	27	13	13	0
2014: TOTAL (0-19)	**12,399**	2,467	9,932	2,467	**2,467**	0
2014: TOTAL (0-18)	**12,399**	2467	9932	2467	2467	
2014: Ages 0-9	12,354	2,451	9903	2,451	2,451	0
2014: Ages 10-18	45	16	29	16	16	0
2015: TOTAL (0-19)	**12,761**	2,534	10,227	2,534	**2,534**	0
2015: TOTAL (0-18)	**12761**	2534	10227	2543	2543	
2015: Ages 0-9	12,716	2,520	10196	2,520	2,520	0
2015: Ages 10-18	45	14	31	14	14	0
2016: TOTAL (0-19)	**11,501**	2,496	9,005	2,496	**2,496**	0
2016: TOTAL (0-18)	**11501**	2496	9005	2496	2496	
2016: Ages 0-9	11,453	2,482	8971	2,482	2,482	0
2016: Ages 10-18	48	14	34	14	14	0

Notes: The number of second generation girls does not include girls born in 2016 or girls born before 1999 (under-estimate).

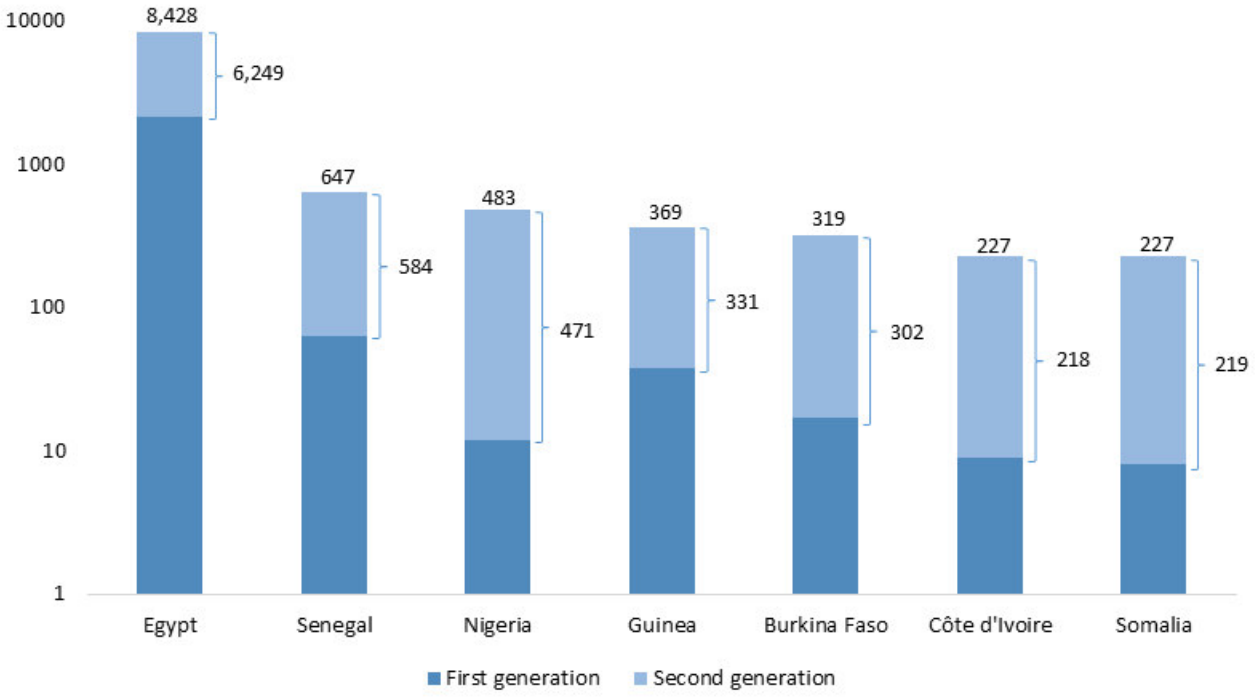
Source: Present study[42].

The figure below shows the top seven countries of origin (first and second generation) of female migrants aged 0 to 19 residing in Italy in 2016[43]. Egypt represents most of them, with 2,179 first generation and

[42] Estimates combine Eurostat data on Population by sex, age and country of birth (used to estimate number of first-generation migrants) with ISTAT data on female live births (available for the period 1999-2015).
[43] Here, the number of second generation girls has been projected using live births data.

6,249 second generation. This pattern is stable across 2013 to 2016. Smaller groups of girls at risk originate from Senegal, Nigeria, Guinea, Burkina Faso, Côte d'Ivoire and Somalia. Also for such countries, the number of girls at risk for first and second generations is stable over the period 2013-2016.

Figure 5.7 Estimated number of female migrants aged 0-19 living in Italy in 2016 who are at risk of FGM, by generation and seven most represented countries of origin



Notes: Includes only the number of girls up to (but not including) the median age of cutting. The number of second generation girls does not include girls born in 2016 or girls born before 1999 (under-estimate). Due to the large differences across countries the scale on the y axis is logarithmic.

Source: Present study

The table below discusses a summary of results of the FGM risk estimations for both high and low scenarios in terms of numbers and percentage at risk.

High scenario	In 2016, a total number of 77,580 girls aged 0-19 from FGM risk countries were residing in Italy, of which 11,501 were likely to be at risk of FGM. **This means 15% of girls aged 0-19 from FGM risk countries (either born in the country of origin or in Italy) were at risk of female genital mutilation.**
Low scenario	In 2016, a total number of 77,580 girls aged 0-19 from FGM risk countries were residing in Italy, of which 2,496 were likely to be at risk of FGM. **This mean, 3.2% of girls aged 0-19 from FGM risk countries (either born in the country of origin or in Italy) were at risk of female genital mutilation.**

Source: Present study. In the high scenario, the number of second generation girls does not include girls born in 2016 or girls born before 1999 (thus is a likely under-estimate).

5.3.2 Estimation of asylum-seeking girls at risk

Table 5.6 Estimated number of asylum-seeking girls (aged 0-19) at risk of FGM in Italy, from 2011-2016

	Total number of girls (0-19) from FGM-practising countries	Total number at risk	Proportion of girls at risk
2011	668	95	14%
2012	507	108	21%
2013	340	54	16%
2014	384	64	17%
2015	562	38	7%
2016	1,009	52	5%

Source: Present study

Since 2013, there has been an increase in the number of asylum-seeking number of girls (aged 0-19) from FGM-practising countries. The proportion of asylum-seeking girls at risk has been on average 12% from 2011 to 2016, peaking at 21% in 2012 and (positively) reaching its lowest levels in 2015 (7%) and in 2016 (5%).

In 2016, Nigeria was the main country of origin for asylum-seeking girls at risk (16 girls), followed by Somalia (14). The rest of the FGM-practising countries accounted for three or fewer asylum-seeking girls at risk.

Underlying data for these estimations is available in Annex 3.

5.4 Effective measures and challenges for tackling FGM in Italy

In Italy, since 2006 there has been a specific criminal law provision concerning FGM[44]. The principle of extraterritoriality is applicable, making FGM punishable even if it is committed outside the country. General child protection provisions can be applied in cases of FGM. FGM can also be incorporated using general asylum provisions[45], and general professional secrecy provisions[46]. No official monitoring systems of judicial investigations or prosecutions have been established. Italy has developed multiple policy initiatives to eradicate FGM, including a strategic national plan (2007) followed by an agreement between the State and the regions (2011), both targeting FGM and funding prevention, research and training projects.

Italy ratified the Istanbul Convention in 2013, which subsequently entered into force in 2014. FGM is explicitly referenced in the 'Special Action Plan against Sexual and Gender Based Violence 2015-2017', outlining the need for training that raises awareness on FGM and offering support to victims and girls at risk. In 2017 the Country adopted the National Strategic Plan on 'Men's violence against women (2017-2020)'[47] . In line with the Istanbul Convention, it goes further and specifically addresses the issue of FGM, including in the context of the reception system of asylum seekers and refugees.

The results of stakeholder interviews identify the increasing flows of asylum seekers and refugees as a key challenge for Italy. This may lead one to expect an increase in the population potentially affected by FGM and consequently the number of girls at risk. As a result, the system may be put under serious strain. The

[44] 2006: legge 9 gennaio n.7. Disposizioni concernenti la prevenzione e il divieto delle pratiche di mutilazione genitale femminile
[45] In the combined provisions of Article 7, paragraph 2, letter A; Article 8, paragraph 1, letter D and Article 3, paragraph 4 of the Decreto legislativo 251/2007(45)
[46] Articles 361, 361 and 365 of Penal code under any criminal offence.
[47] Piano strategico nazionale sulla violenza maschile contro le donne 2017-2020

current available services are not necessarily adapted to this challenge. Stakeholders identified three main areas for improvement: 1) the EU should further support Italy in tackling FGM in the asylum context by including the issue in the broader asylum agenda to give continuity to the actions; 2) more numerous and regular training should be addressed to personnel working in the reception centres of asylum seekers and refugees; 3) direct and regular channels of communication must be put in place between the structures receiving asylum seekers and refugees, and the "*asylum commissions*" who are in charge of assessing the asylum status of women. This last measure would both contribute to effectively implementing gender-sensitive asylum procedures and increase the access of women to dedicated services.

The results of stakeholder interviews in Italy suggest that, although services exist, they are mostly focused with health and there is a lack of coordination and communication among local administrations in charge of providing *multi-sectoral* services. This results in a lack of homogeneity (at national level) and of continuity of services provided to women and girls. A recommended measure to improve availability of services is their institutionalisation in existing structures (with regular funding) including prevention and protection services that should be integrated with other services on gender-based violence in a referral system (health, school, social, judicial, migrants' reception system). To further prevent FGM and protect girls, training should target in particular the personnel in daily contact with girls at risk and their families such as teachers, educators, paediatricians and social workers. In September 2017, Italy's Department of Equal Opportunities announced its intention to finance the drafting of guidelines for the early identification of victims of FGM and other harmful or discriminatory practices. These guidelines are now available for health professionals, social workers, cultural mediators, those working in first aid reception centres, and reception centres for asylum seekers[48]. Focus group results suggest that target population does not know that specific services are available to women and girls affected by FGM (at least in their region). In particular, Nigerian and Egyptian women claimed not to experience health complications linked to FGM. Egyptian women reported that psychological problems may arise and if so they are aware of this that they can visit a psychologist.

According to the focus group discussion results, participants' awareness of legislation in migrant communities is very high: it is clear to everybody that FGM is forbidden in Italy, in the EU and in the countries of origin. It is also clear that FGM is not a "European" practice, meaning that it is not a tradition in the Member States of the EU. The legislation seems to have an ambiguous impact; despite the high level of awareness of its existence, focus group discussions results suggest that those in favour of FGM tend to bring their daughter to their country of origin to have FGM performed by a medical doctor. Interview results suggest that Italy should further cooperate with countries of origin on awareness raising, women's empowerment, and the implementation of laws.

The focus group discussion results suggest that few participants are aware about specific campaigns on the topic. Nigerian women suggested to further inform people (in Italy and in Nigeria) who are convinced that FGM must be practised of the possible negative effects of the practice on the health of girls and women. Egyptian women believe that currently there is no need to continue huge campaigns against FGM; instead, those in favour of FGM should be specifically targeted and informed/sensitized on the danger of the practice. Egyptian men showed little interest in suggesting strategies of action to European institutions in terms of services and support. They stated that it remains a private question, and if the change must happen it should be through the family dimension. Young women from the second generation suggested to further inform, sensitise and undertake an intercultural dialogue with communities affected by FGM, paying attention to avoid stigmatisation.

[48] Linee guida per il riconoscimento precoce delle vittime di mutilazioni genitali femminili e altre pratiche dannose. Per operatori dei CPSA, CDA e CARA" A cura di Associazione Parsec Ricerca e Interventi Sociali; Coop.Soc.Parsec; Università di Milano-Bicocca; A.O. San Camillo Forlanini; Nosotras Onlus e Associazione Trama di Terre. http://www.pariopportunita.gov.it/media/3422/linee-guida_-it.pdf

The results of stakeholder interviews suggest that the campaigns should be tailored differently, according to the community they are targeting. Moreover, members of the second generation should be considered as a different target group.

5.5 Conclusions from Italy

Between 2011 and 2016 in Italy, the total number of female migrants (aged 0-19) originating from FGM-practising countries has increased by 26%, from 61,384 to 77,580. The second generation makes up a majority of the population; the proportion has increased over time. Of girls aged 0-9, 85% were second generation, 5 percentage points higher compared to 2011. The proportion of girls aged 10-18 who were second-generation doubled to 60% in 2016, suggesting a growing second-generation within FGM-affected communities (both in absolute terms and as a proportion of all girls).

Net inflows of female immigrants from 30 FGM-practising countries peaked in 2013 at 2683, and have since reduced to 2,197 in 2015. In terms of asylum seekers, there were 1,009 asylum-seeking young women (aged 0-19) from 30 FGM-practising countries in 2016, of which 72% (652) were aged 10-19 and 66% (596) came from Nigeria.

The share of first/second generation migrants (given above) was approximated by combining population with live births data, to gain a truer, 'expanded' picture of the size of the second-generation.

From a total of 77,580 girls aged 0-19 from FGM-practising countries, it is estimated that 3% to 15% of girls were at risk in Italy in 2016 (between 2496 and 11,501 in real terms). There has generally been an increase in the total population size of girls at risk since 2011, reaching a peak of 12,761 girls in 2015. A slight dip in 2016 is attributed to an under-estimate in second generation girls, as those born in 2016 have not been included. The proportion of first and second generation girls at risk has remained fairly stable, with the latter often far exceeding the former; for example, in 2015, 2,534 first generation girls were at risk compared to 10,227 second generation girls (High Scenario).

The seven countries of origin in Italy with the largest number of girls at risk were Egypt (8428), Senegal (647), Nigeria (483), Guinea (369), Burkina Faso (319), Somalia (227) and Cote D'Ivoire (227) (girls aged 0-19) (High Scenario). In Egypt specifically, this included 2179 first generation girls and 6249 second generation girls. In every case, the size of second generation population at risk exceeded the first generation.

Focus group discussions in Italy were carried out with first generation women from Egypt; first and second generation men from Egypt; second generation women from Ethiopia, Nigeria, Eritrea and a mixed background; and also first and second generation women from Nigeria. The contributions from Egyptians offered the perspective of Italy's most sizable community with girls at risk of FGM. The viewpoints from Nigerians were also especially interesting, considering they embodied a high number of female regular migrants at risk of FGM, as well as the majority of asylum seekers from FGM-practising countries.

The primary reason for practising FGM, upon which most participants agreed upon, was the perception that FGM controls women's sexual desires. Egyptian women and men generally agreed that FGM is a tradition, and not a religious practice. The views of the younger, second generation particpants were noticeably

different, attributing FGM to living a patriarchal society, and not as something connected to their 'afro-Italian' identity. An interesting discussion on the decision-making process, and who has the ultimate authority, emerged from the focus group discussions. For Egyptian and Nigeran women, migration and encounters with a host country did not play a role in the decision to cut their daughters. They perceived this decision to be down to older generations (grandmothers) or as their decision as mothers. Whilst Egyptian men also perceived pressures from the country of origin, they felt the decision for a girl to be cut ultiatmely lay with them. By contrast, the younger participants were the only group to discuss the freedom of choice and rights that women should possess. The practice of FGM was considered widespread in Egypt, particularly in rural areas and by less educated people, however, a decline in recent years was perceived by Egyptian participants.

Amongst Egyptians, the medicalization of the procedure, although known to be forbidden in Egypt and in the EU, was seen to make the cut acceptable in certain cases, as it was perceived as more hygienic and less painful and dangerous for the health of the girl. Both women and men in favour of FGM saw the advice of the medical doctor as a critical factor for deciding whether or not to cut their daughter, regardless of the traditional, religious and/or aesthetic motivation behind the practice.

There was a consensus that FGM is not occurring in Italy, or Europe more broadly – as was the case in almost all focus groups held in the other countries. It appears that amongst Nigerian women, some alternatives to FGM may be emerging, such as massage techniques to reduce the growth of the clitoris. This reflects that while some communities may be moving towards the abandonment of FGM, this does not always mean that their desire to protect female purity and control women's sexual urges has disappeared. Egyptian men were relatively split in their views towards FGM, with some seeing 'pros'. However, many men noted the benefits of having an uncut partner, who is likely to be more sexually active, and all men stressed that FGM is forbidden by law in Italy.

Attempts to prevent FGM in Italy include a specific law on FGM (since 2006); an agreement to tackle FGM between the State and various Italian regions (2011); and a specific mention of FGM in the 2015-17 National Action Plan on sexual and gender-based violence. Italy has also ratified the Istanbul Convention, and addresses FGM is the National Action Plan on 'Men's violence against women (2017-2020)'. The main challenge to eradicating FGM in Italy, as identified by interviewees for this study, is the increasing flows of asylum seekers and refugees into Italy. The need for improved training of personnel working in asylum and refugee reception centres was therefore highlighted. A lack of communication and coordination between different sectors and administrations was also emphasised, as at present most efforts are concentrated in the health sector. As a positive development, in 2017, the Italian government financed the drafting of guidelines for the early identification of victims of FGM and other harmful practices for health professionals, social workers, cultural mediators, those working in first aid reception centres, and reception centres for asylum seekers.

According to focus group discussions and stakeholders interviews, attention must be paid to increasing awareness of prevention initiatives and campaigns, particularly amongst migrant communities. The heterogeneous needs of affected communities must be acknowledged in campaigns, and efforts must be made to tailor messages to the needs of the community being targeted. Moreover, members of the second generation should be considered as a different target group.

6 Female genital mutilation risk estimation in Cyprus

6.1 Summary of findings from focus group discussions organised in Cyprus

6.1.1 Overview of the focus group discussions

Four focus groups were held in Cyprus in September 2017. Discussions were held with: older and younger first-generation Somali women; first-generation Somali men of mixed ages; and recent migrants from mixed backgrounds. Some of the largest communities were not reached. For example, according to the latest published statistics of nationalities of persons seeking asylum in Cyprus in 2017, 4% of applicants are from Somalia, 4% from Egypt, 3% from Cameroon and 2% from Nigeria.[49] Although the Somali community was covered in three focus group discussions, there were no participants from Egypt or Cameroon[50]. In the fourth focus group discussion, there was one woman from Nigeria.

In the focus group discussions with Somalis, all participants were Muslim; most of the older women had children, whilst most of the younger women did not. Slightly more than half of the Somali men were married, and a few had children. The backgrounds of the participants in the focus group discussion with recent migrants were more mixed. The table below presents an overview of the profile of participants in the four focus group discussions.

Table 6.1 Overview of focus group discussions and socio-demographic profile of participants in Cyprus

Key characteristics of focus groups	Focus group discussion 1: Older women	Focus group discussion 2: Younger women	Focus group discussion 3: Men	Focus group discussion 4: Hard-to-reach/recent migrants
Number of participants:	7	14	7	5
Countries of origin represented[51]:	Somalia	Somalia	Somalia	Somalia, Ethiopia, Nigeria, Ivory Coast, Gambia
Sex of participants:	Women	Women	Men	Women
Age range:	Over 25	18-25	25-60	18-36
Generation (first/second):	First	First	First	First
Average residence (number of months) & previous residence in other countries	Not available (see Notes beneath table) No previous residence in other EU country.	Just under one year (estimate) No previous residence in other EU country.	18 months (estimate) No previous residence in other EU country.	5 years (estimate) No previous residence in other EU country. 1 lived in UAE for 10 years
Number of second-generation participants who have lived their parents' country of birth	n/a	n/a	n/a	n/a
Civil status of participants:	Not available (see Notes beneath table)	Married: 4 Unmarried:9 Divorced:1	Married: 4 Unmarried:3 Divorced:0	None of the participants were married, except one who was married but separated

[49] Please see website of the Asylum Service at www.moi.gov.cy/moi/asylum/asylumservice.nsf/asylumservice18_gr/asylumservice18_gr?OpenDocument

[50] Source: Asylum applications by country of origin at May 2017, Asylum Service, available at http://www.moi.gov.cy/moi/asylum/asylumservice.nsf/asylumservice18_gr/asylumservice18_gr?OpenDocument

[51] This is the country of birth of first-generation migrants (FGM-practising countries); country of birth of parents of second-generation migrants (FGM-practising countries). Here, someone is second-generation if he/she is not born in an FGM-practising country but he/she has at least one parent is born in an FGM-practising country.

Key characteristics of focus groups	Focus group discussion 1: Older women	Focus group discussion 2: Younger women	Focus group discussion 3: Men	Focus group discussion 4: Hard-to-reach/recent migrants
Number of participants with/without children	All participants had children	11 had no children 3 had children	3 had children	2 had no children 3 had children
Religion:	Muslims	Muslims	Muslims	Muslims and Christians
Ethnic groups (if available):	The Somalis present stated that there are no different ethnicities[52].	The Somalis present stated that there are no different ethnicities[53]	The Somalis present stated that there are no different ethnicities[54]	The participant from Nigeria was member of the Benin ethnic group. The Ivorian participant was a member of the Dioula ethnic group The Ethiopian participant was a member of the Oromo ethnic group The Gambian participant was a member of the Mandinka ethnic group
Level of education:	2 high school 2 secondary school 1 primary school 2 no education	1 high school 4 secondary school 1 primary school 8 no education	2 university graduate high school 2 secondary school 2 primary school 1 no education	3 secondary school 2 primary school
(For first generation): Shortest and longest amount of time residing in Cyprus	Not available (see Notes beneath table)	Shortest: 5 months Longest: 2 years	Shortest: 1 year Longest: 2 years and 3 months	Shortest: 3 months Longest: 11 years
(For first generation): Shortest and longest amount of time residing in other European Member State:	N/A	N/A	N/A	N/A
Date:	7 September 2017	8 September 2017	12 September 2017	28 September 2017

Notes: In the first focus group discussion, the participants did not fill out information as regards marital status and period of residence in Cyprus.

Although in general focus group discussion 2 was designed to be with second-generation younger women from FGM-practising countries, in Cyprus there are small numbers from this group who are over 18. Due to this, the decision was taken to tailor the recruitment criteria for this FGD to allow for recruitment of young women from the first generation. Thus the participants in all focus group discussions were all first-generation migrants. They had all been through the asylum system – either as applicants, as those who have been granted a status of international protection, or as rejected applicants awaiting appeal determination. The latter was only the case with a few men, as Cyprus implements a policy of granting protection to all women who had been subjected to FGM.[55] Their status does not carry the right to travel to their countries of origin and therefore the option of returning for a holiday to have their daughters cut is not available to them. For the vast majority of the participants, the encounter with legal and cultural norms viewing FGM as a crime and a fundamental right violation has been brief.

[52] This appears inconsistent with Belgium; however, it may be that Somalis participating in Cyprus had a diferent understanding of the term, for example perhaps they may use the term 'minority' instead of 'ethnicity'.

[53] Ibid.

[54] Ibid.

[55] Interview with UNHCR Cyprus, 18 October 2017.

6.1.2 Key findings from the focus group discussions

Identity and attitudes about the importance of FGM

'Normal' but not part of their identity

From the narrative of the participants of all ages and from all countries, it was clear that FGM although seen as undesirable and negative, was at the same time perceived as normal standard practice that no one escapes from: *"No one can stop it. It is like food. You need food. You reach 8 years old, you need to do it"* (focus group discussion 1, Interpreter). All the participants agreed that it was not part of their communal identity and that nothing would be lost if FGM was eradicated. Some of the Somali men reported that eradicating FGM would be a progression, rather than a loss. The older women were clear that health and personal welfare were more important than tradition and that the problems generated by FGM did not justify any communal beliefs about tradition. As a woman put it: "*If it's part of our tradition? I don't care*!" (focus group discussion 4, young woman from Nigeria).

Marriageability

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

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

A participant from Gambia described a rather different situation: it is a common belief in Gambia that if a girl is not cut then "she will have a lot of feelings for a man", however it is possible for an uncut woman to get married and some have done so. The participant herself stated that even as a child she always felt that FGM was wrong. Gambia is the only country amongst those researched in Cyprus where FGM was banned

with a law adopted in 2015[56] and there is a grassroots anti-FGM movement struggling against popular misconceptions and misconstructions of Islam.

Who decides?

There did not seem to be a definitive answer to the question as to who makes the decision to perform FGM on a girl. In some countries (Ivory Coast, Ethiopia) the men have the final say although it is the women who are more pro-FGM, as they are more prone to traditional values and believe they have a duty to safeguard their daughters' marriageability. The grandparents and extended family also have a key role in the decision. In the focus group with the men, the participants said that the decision was made by the men in the family; in the focus group with the senior women the participants said the decision was made by the women; in the FGD with the younger women, the participants said the decision was made by both parents. The picture emerging from the participants' narrative was that performing FGM was the norm, much like a default position that is not necessarily preceded by an active decision-making.

The impact of the migration experience

For the African diaspora living in Europe, there does not appear to be any pressure to perform FGM. However, this does not mean that they have altogether stopped practising FGM, but rather that those who do practice it do so out of a personal conviction rather than because of community pressure. There is also no particular profile of the person who decides to cut his or her daughter.

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

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

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

The participants were not aware of the extent of the practice in other communities either living in Europe or in other African countries. Some of the women in the mixed focus group discussion reported having no

[56] Mamonyane Lekoetje, A. (2016) 'FGM ban begins a pivotal era for women and girls in The Gambia', UNDP, 05 Feb 2016, available at www.undp.org/content/undp/en/home/blog/2016/2/5/FGM-ban-begins-a-pivotal-era-for-women-and-girls-in-The-Gambia.html (Last accessed on 18 December 2017); Lyons, K (2015), 'The Gambia bans female genital mutilation', The Guardian, 24 November 2015, available at www.theguardian.com/society/2015/nov/24/the-gambia-bans-female-genital-mutilation (Last accessed on 18 December 2017).

contact with other members of their communities in Cyprus as there were very few of them (Ivory Coast, Gambia); they were also unaware of the practices of their compatriots or other African communities in other parts of the EU.

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

The Somali women, senior and younger, expressed the conviction that FGM was no longer practised in Egypt because of a new law that rendered FGM unlawful.[57] At the same time, however, the participants were adamant that even if the law was to change in Somalia rendering FGM unlawful this would not impact the practice because tradition is stronger than the law and because political leaders and policy makers are all men from FGM practising communities with a strong belief in FGM. Younger women reported that the adoption of legislation in Somalia against FGM will not yield results because there is a wider state of lawlessness, the government was weak and there was a general disregard for human life and safety. The Somali men reported that in Somalia "tradition is the rule of law".

The fourth focus group discussion combined participants from five different countries, including Somalia. There was one person from each of these countries and therefore the findings must be seen in light of this small sample. In Nigeria, FGM is reportedly practised throughout the country by all ethnicities and religions including Muslims and Christians; what differs from region to region and from one ethnicity to another is the age of cutting, which varies from a few weeks' old to adult women including women in advanced pregnancy. According to popular belief in Nigeria, infants did not feel pain and it was therefore best for FGM to be performed as soon as possible after birth. FGM is also practised throughout the country in the Gambia and Ethiopia, albeit not uniformly. In Ethiopia, the participant argued that FGM is practiced 100% in the countryside, but in the cities the practice has lessened, largely as a result of the new generation being more educated. In Gambia, there are ethnicities which do not practise FGM. The procedure in Gambia is somewhat different in that the wound from the cutting is not treated and the blood which dries up forms a type of 'sealing' of the vagina. This 'seal' is opened just before a bride is delivered to the groom for the sexual act, as part of the marriage ceremony and sexual contact following this procedure is very painful.

Key risk factors for FGM

There was consensus from all participants that when an uncut young girl returns home for a holiday there will be immense pressure from the community on the parents to perform FGM; however, if the stay is short-term then the pressure is manageable. In the case of the Ivory Coast and Nigeria (but not in Ethiopia), it is possible that the grandmothers perform FGM on girls when a family living in Europe returns to the home country for a holiday, without the parents' permission or knowledge, pretending that they will take the girl for a walk. The general perception of the participants was that, amongst the African diaspora in Europe, there are not many who would take their daughters back to their countries of origin to be cut. In Ethiopia, there is a considerable financial cost involved because the community expects a ceremonial party and many Ethiopians living in Europe are unable/unwilling to undertake this cost.

[57] In 2007 Egypt outlawed FGM without however succeeding in eradicating it altogether: see Human Rights Watch (2016) 'Egypt: New Penalties for Female Genital Mutilation', 9 September 2016, available at www.hrw.org/news/2016/09/09/egypt-new-penalties-female-genital-mutilation (Last accessed on 18 December 2017); Morlin-Yron, S. (2017) 'Cut in secret: the medicalization of FGM in Egypt', CNN, 7 February 2017, available at http://edition.cnn.com/2017/02/06/africa/africa-view-egypt-fgm/index.html (last accessed 18 December 2017). In 2016 Egypt introduced toughter sentences for FGM: http://allafrica.com/stories/201608290760.html

In the case of Cyprus, and as pointed above, the option of returning to the country of origin for a holiday is available only to those few individuals who are granted Cypriot nationality; persons enjoying international protection will lose their status if they travel to their countries of origin.[58] To estimate the risk of FGM being performed during a short visit to the country of origin, one would have to examine the numbers of persons from practising countries who have received Cypriot nationality rather than the entire population of persons from practising communities living in Cyprus.

As a rule, FGM is not performed in hospitals in the practising countries but only by old women in rural areas. One participant expressed the view that FGM would gradually be eradicated when the old women performing the procedure eventually die, because there would be no-one to replace them (young Ethiopian woman, mixed focus group discussion). As society is gradually modernised, the new generation is more educated and less interested in taking up such an occupation, thus eventually leading to the demise of the profession. During the focus group with the men, the participants discussed the possibility of paying money to the cutters to pull them away from the practice, however the suggestion was soon withdrawn from the table as one participant pointed out, and all others agreed, that the cutters are not practising FGM for the money or only for the money but rather because they believe they are doing a commendable service to the community.

Education in the FGM--practising countries was identified as key to tackle FGM. Some of the male participants had a clear preference for the more drastic methods of police arrests and criminal prosecutions – possibly out of anger and frustration and a need to see quick results, rather than a belief that these measures would be more effective.

6.2 Female migrant population aged 0-19 originating from FGM-practising countries

Table 6.2 Overview of data availability in Cyprus

Type of data	Summary of data availability and sources
Risk estimation	
Sources used in risk estimation	For 2011: Cyprus Statistical Service data on the foreign-born, disaggregated by first and second generation, but with age breakdowns (one-year intervals) available for the total.
Data issues:	To estimate the age distribution of the first and second generation for the 2011 data, it was necessary to use the age structure of the data on the foreign-born population, available from the 2011 Census. More recent data (2012-2016) is available on residence permits disaggregated by age (1 year intervals). However, this covers the total number of permit-holders, and it is not possible to break it down by generation. Furthermore, as permit data is not available for 2011, it is not possible to use the census data to infer the generation and age breakdowns for permit-holders. Due to this, only the older data (2011) has been presented for the estimation. When working with 5-year age intervals, it was necessary to approximate single age group as one-fifth of the girls in each interval (i.e. to assume uniform distribution across the age bracket).
Overview data presented on the migrant population	
Female migrant population originating from FGM-practising countries	1) Cyprus Statistical Service 2) Residence permits data

[58] Interview with UNHCR Cyprus, 18 October 2017.

Type of data	Summary of data availability and sources
Years available	1) 2011 2) 2012-2016
By age	0-19: One-year age intervals
By country of origin	Available
By first and second generation	Available for 2011 data, not available for 2012-2016 data (residence permits).
By regional level	Unavailable
By age of arrival	Available
Data issues	There were a few countries where the age of arrival of all female migrants from countries where FGM was documented was not stated.
Female live births in EU to mothers originating from FGM-practising countries	Civil Registry and Migration department (CRMD).
By country of mother	Available.
By regional level of country of mother	Unavailable.
By region of birth of the child	Unavailable.
Data issues	Limited number of years provided (up to 2000).
Female asylum seekers	Unavailable. Sources consulted: (1) Asylum service of the Ministry of Interior (2) UNHCR (Cyprus) (3) Future Worlds Centre
Years available	n/a
By age	Unavailable
By country of origin	Unavailable.
By regional level	Unavailable
By age of arrival	Unavailable
Data issues	For 2002-2006 and 2007-2016, data is not disaggregated by country of origin or nationality, but only on the number of cases, persons and outcome of the application.
Female refugees	Unavailable (not possible to distinguish from other migration statistics)
Years available	
By age	
By country of origin	
By first and second generation	
By regional level	
By age of arrival	
Data issues	
Female irregular migrants	Unofficial police data on irregular female migrants.
Years available	2017
By age	0-19
By country of origin	Nationality
By first and second generation	Unavailable
By regional level	Unavailable

Type of data	Summary of data availability and sources
By age of arrival	Unavailable
Data issues	No metadata was provided.
Official registration – other sources on identified FGM cases	
Medical/hospital	Unavailable.
Child protection	Unavailable.
Police/judicial	Unavailable.
Asylum	Unavailable.
Other	n/a

This section of the Cyprus chapter provides data (where available) on four groups: i) the recorded migrant population, who are legally present and 'usually resident' in the Member State; ii) recent immigrants and emigrants to the country; iii) irregular migrants, who do not – or no longer – fulfil the conditions for legal residence in the country; and iv) asylum-seekers, who are legally present but have not found out if their application for international protection was successful. Having an overview of this data is important for understanding potential populations of interest when estimating the number of girls at risk of female genital mutilation. The chapter ends by presenting data on other sources (if any) that are collecting FGM in the country.

6.2.2 Migrant population

In Cyprus, there were 812 girls (aged 0-19) originating from FGM-practising countries in 2011. Of these, 57% (460) were first generation. Of the total number of girls aged 0-19, more than half (58%, 467) are aged 0-9 and 38% (310) are 10-18, with only 35 (4%) aged 19.

Of the girls aged 0-9, 61% are second generation, which falls to 19% for those aged 10-19.

Table 6.3 Age and generation distribution of the female migrant population (aged 0-19) originating from FGM-practising countries, in Cyprus, 2011

	TOTAL	First generation	Second generation	TOTAL (%)	First generation (%)	Second generation (%)	TOTAL generation (%)
0-9	467	181	286	58%	39%	61%	100%
10-18	310	251	59	38%	81%	19%	100%
19	35	28	7	4%	80%	20%	100%
TOTAL	812	460	352	100%	57%	43%	100%

Source: 2011 Census of population - Cyprus Statistical Service

Notes: Country of origin defined by country of birth. The Census is publically available on the Statistical Service's website, however it is not disaggregated by all countries. Also there are age brackets rather than age per one-year interval.

Table 6.4 Detailed age and generation distribution of the female migrant population (aged 0-19) originating from FGM-practising countries, in Cyprus, 2011

Age group	First generation	Second generation
0-4	45	209
5-9	136	77

10-14	139	34
15-19	140	32
Total (0-19)	**460**	**352**
Total (0-19)	**812**	

Notes: Country of origin defined by country of birth.

Source: National Statistics Office (based on the 2011 Census)[59], Cyprus.

The Cyprus Statistical Service has provided information on the total number of female migrants aged 0-19, disaggregated by age, generation, country of origin (birth) and age of arrival for 2011. The data is based on the Census of 2011.

The Statistical Service uses the following definitions: information on the country of birth is based on the international boundaries existing on 1 January 2011. The generational definitions comply with those in use for this study: 'first-generation migrant' means a person usually residing in Cyprus for a period that is, or is expected to be, at least 12 months, having previously been a usual resident in another Member State or a third country; 'second-generation migrant' means a person with at least one parent born in a country where FGM is commonly practised[60].

The total number of female migrants aged 0-19 from the FGM-practising countries in Cyprus for 2011 was 812. This number includes both first and second generation migrants and the data is disaggregated by one-year age breakdowns. The number of first generation migrants from FGM practising countries in 2011 was 460; of these, 181 female migrants were aged between 0-9; 251 were aged between 10-18; and 28 were aged 19.

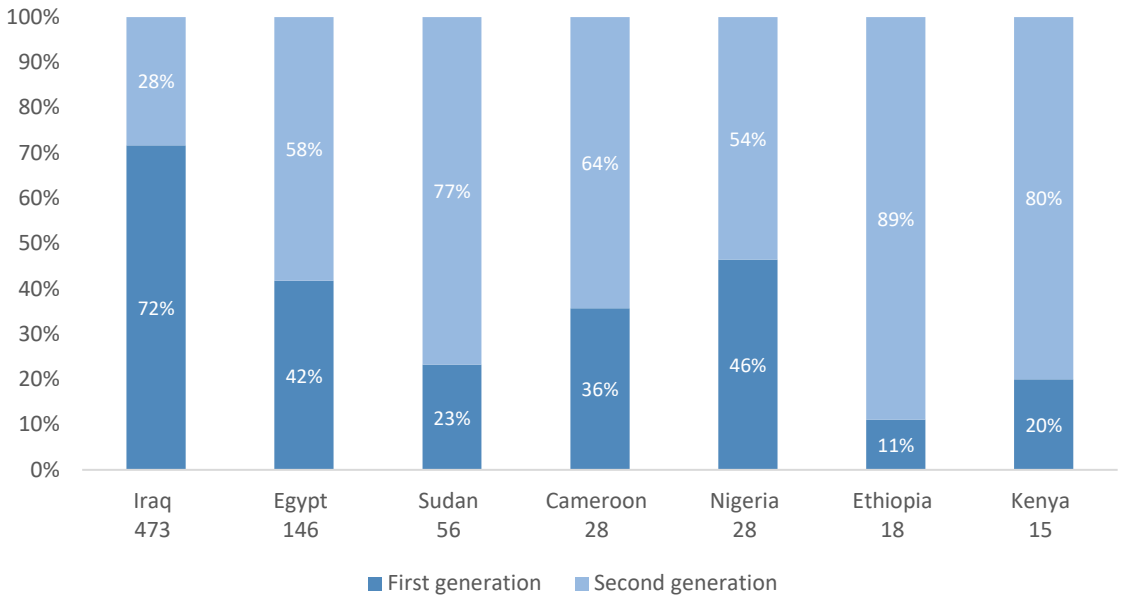
With respect to second generation female migrants aged 0-19, the total number for 2011 was 352. From this data, 286 second generation female migrants were aged 0-9, 59 were aged 10-18 and 7 were aged 19.

There is no available data regarding the breakdown by region of origin, only by country of origin. Although more recent permits data is available for Cyprus (2012-2016), it was not possible to break this down by generation, and trends cannot be analysed with statistical certainty.

[59]http://www.cystat.gov.cy/mof/cystat/statistics.nsf/populationcondition_22main_en/populationcondition_22main_en?OpenForm&sub=2&sel=3#

[60]In addition, 'place of birth' is defined as the place of usual residence of the mother at the time of the birth, or, if not available, as the place in which the birth took place.

Figure 6.1 Number of girls (aged 0-19) living in Cyprus by generation and most represented countries of origin, 2011



Notes: Country of origin refers to country of birth. These countries are presented in descending order when it comes to the size of the communities (with Iraq being the highest and Kenya being the lowest). However, they are shown on the same scale to enable percentage comparison per generation.

Source: Cyprus Statistical Service (2011 Census)[61]

The Cyprus Statistical Service provided data for the migrant communities in Cyprus, based on the 2011 Census. The data was disaggregated by age, generation, country of origin and sex. The countries of origin of the largest number of first generation and second generation female migrants (aged 0-19) in 2011 were Iraq (473), followed by Egypt (146), Sudan (56), Cameroon (28), Nigeria (28), Ethiopia (18) and Kenya (15).

With respect to the total number of *first generation* female migrants in Cyprus in 2011 aged 0-19, there were 339 female migrants from Iraq, 61 from Egypt, 13 from Sudan, 10 from Cameroon, 13 from Nigeria, 2 from Ethiopia and 3 from Kenya. The total number of second generation female migrants aged 0-19 in 2011 were as follows: 134 from Iraq, 85 from Egypt, 43 from Sudan, 18 from Cameroon, 15 from Nigeria, 16 from Ethiopia and 12 from Kenya. Apart from Iraq, the number of girls in the second generation consistently outnumbered those in the first generation for these seven countries.

The Statistical Service uses the same definitions as Eurostat.

6.2.3 Inflows and outflows

To get a sense of migration patterns over time, it is worthwhile to consider 'inflows' and 'outflows' from FGM-practising countries. The former covers immigrants (inflows): people arriving or returning from abroad to take up residence in a country for 12 months or more, having previously been resident elsewhere. The latter covers people who are leaving the country where they usually reside and effectively taking up residence in another country. An individual is a long-term emigrant if he/she leaves his/her country of previous usual residence for a period of 12 months or more. A positive 'net inflow' indicates that more people are arriving than leaving Cyprus, within a given year.

[61] http://www.cystat.gov.cy/mof/cystat/statistics.nsf/populationcondition_22main_en/populationcondition_22main_en?OpenForm&sub=2&sel=3#

Official data is not available on inflows/outflows. The Statistical Service and the Civil Registry and Migration Department of the Ministry of Interior do not collect data on total immigrants (inflows) and emigrants (outflows) from FGM-practising countries (aged 0-19). It was also not possible to identify relevant data collected by Non-Governmental Organisations.

6.2.4 Irregular migration

The Statistical Service and the Civil Registry and Migration Department of the Ministry of Interior do not collect data on irregular migration. Civil society organisations also do not hold this information, although the Police do collect some data on migrants overstaying their permits.

In January 2018, the Cypriot Police (Statistics and Chartography Office) provided data on the number of identified irregular female migrants aged 0-19 from FGM-practising countries in 2017. The total number of such of individuals was 63, of which 50 were Somali nationals and the remainder were from Iraq (7), Egypt (3) and Cameroon (3). However, this data was not provided with detailed metadata, so it is not possible to assess the quality of this data in depth.

6.2.5 Asylum-seekers

Data provided by the Asylum service of the Ministry of Interior and organisations working with asylum seekers in Cyprus are not available disaggregated simultaneously by country of origin, sex or age.

Statistical data for the years 2002-2016 posted on the Asylum Service are disaggregated only by the number of cases, persons and outcome of applications received. Statistics are provided on the number of asylum *applicants* disaggregated by country of origin but not by sex or age.

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

Lastly, there appears to be an inconsistency between the different records of asylum seeking children. In some publicly available reports[62], unaccompanied minors are in a separate category to children. In other reports it is not clear whether the number of asylum seeking children includes unaccompanied minors. The data for these categories is incomplete, without definitions or disaggregation by age, sex or country of origin of the applicants.

The Asylum service of the Ministry of Interior provided information regarding the number of applications received and approved. The Asylum service does not systematic record information regarding the country of origin, sex and age of applicants; one representative provided fragmented data for the period January-October 2017 from the individual case files. According to this representative, six female FGM-related applications were received from girls aged 0-19 from FGM-practising countries during this period; of these six, three were granted. All six applications received by the Asylum service in 2017 were made by Somali females. Because this data (provided by a service representative informally) is not being collected on a systematic basis, it is not possible to analyse a trend from previous years and assess the long-term success rate of asylum applications.

[62]For example, see http://www.asylumineurope.org/reports/country/cyprus

6.2.6 Other organisations collecting information on FGM in Cyprus

UNHCR Cyprus and Future Worlds Centre appear to be the only organisations that collect data on applications for asylum. Whilst data may be held on FGM-related applications, they are not collected in a systematic fashion for public dissemination for the analysis of trends and other issues. It is not known whether other organisations hold data relevant to FGM in Cyprus.

6.3 Estimation of the number of girls at risk of FGM in Cyprus and possible trends of FGM risk

The following section provides data on the estimated number of girls at risk of FGM in Cyprus, following the methodology in EIGE's step-by-step guide. It presents estimates of the number of girls at risk within the regular migrant population. As data on the number of asylum-seeking girls from FGM-practising countries are not available, estimates for this group are not presented.

When interpreting the data, it is important to be aware of the following:

- There are two sets of data available:
  - For 2011, data has been provided by the national statistical office on the foreign-born, disaggregated by first and second generation, but with age breakdowns (one-year intervals) only available for the total. In order to estimate the age distribution of the first and second generation for the 2011 data, it was necessary to use the age structure of the data on the foreign-born population, available from the 2011 Census.
  - More recent data (2012-2016) is available on residence permits disaggregated by age (1 year intervals). However, this covers the total number of permit-holders, and it is not possible to break this down by generation. Furthermore, as permit data is not available for 2011, it is not possible to use the census data to infer the generation and age breakdowns for permit-holders. Due to this, only the older data (2011) has been used for the estimation.
- When working with 5-year age intervals, it was necessary to approximate single age group as one-fifth of the girls in each interval (i.e. to assume uniform distribution across the age bracket).

6.3.1 Estimation of girls at risk within the regular migrant population

The table below presents a summary of the number of girls at risk of female genital mutilation in 2011. Underlying data for these estimations is available in Annex 2.

For the year group 0-19, the number of girls at risk of female genital mutilation in Cyprus varied between 4% and 13%. For the age group 0-18, the proportions at risk were very similar (between 4% and 14%), because no girl aged 19 was at risk.

Table 6.5 Estimated number of girls (aged 0-18 and 0-19) living in Cyprus who were at risk of FGM in 2011

	Female migrant population					
	HIGH SCENARIO			LOW SCENARIO		
	TOTAL at risk	First generation	Second generation	TOTAL at risk	First generation	Second generation
2011: TOTAL (0-19)	**105**	**29**	**76**	**29**	**29**	**0**
2011: TOTAL (0-18)	**105**	**29**	**76**	**29**	**29**	
2011: Ages 0-9	105	29	76	29	29	0

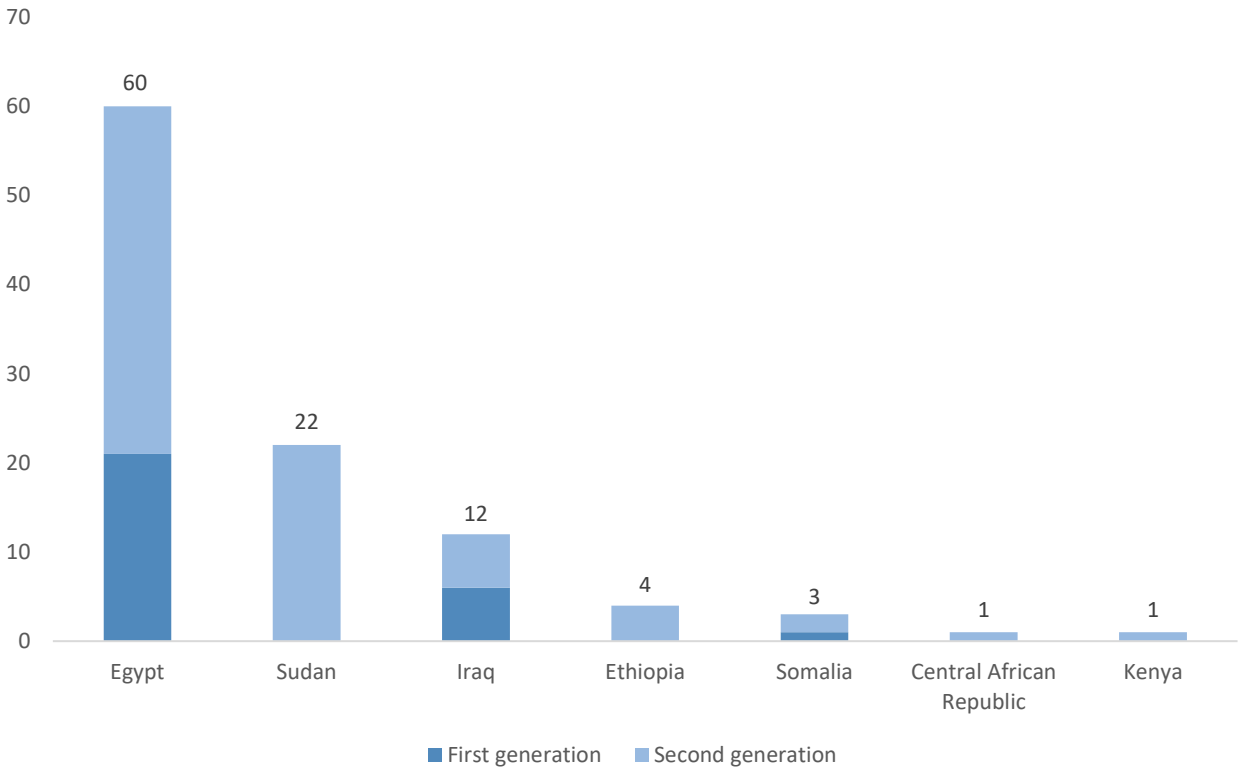
2011: Ages 10-18	0	0	0	0	0	0
2011: Age 19	0	0	0	0	0	0

Source: present study

The table above shows that girls in the regular migrant population at risk of FGM in Cyprus ranged from 29 to 105 in 2011. All those at risk were younger than 10. Considering only girls aged between 0 and 9, between 6% and 22% were at risk in 2011.

The figure below shows the seven most represented countries of origin for girls (aged 0 to 19) who were at risk of FGM in Cyprus in 2011. Egypt represents the largest country of origin, with 21 first generation girls and 39 second generation girls followed by Sudan with 22 girls at risk of FGM (all second generation).

Figure 6.2 Estimated number of girls (aged 0-19) living in Cyprus in 2011 who were at risk of FGM by generation and most represented countries of origin



Source: present study

The table below discusses a summary of results of the FGM risk estimations for both high and low scenarios in terms of numbers and % at risk.

High scenario	In 2011, a total number of 812 girls aged 0-19 from FGM risk countries were residing in Cyprus, of which 105 were likely to be at risk of FGM. **This means 13% of girls aged 0-19 from FGM risk countries (either born in the country of origin or in Cyprus) were at risk of female genital mutilation.**
Low scenario	In 2011, a total number of 812 girls aged 0-19 from FGM risk countries were residing in Cyprus, of which 29 were likely to be at risk of FGM. **This means 4% of girls aged 0-19 from FGM risk countries (either born in the country of origin or in Cyprus) were at risk of female genital mutilation.**

Source: present study

6.3.2 Estimation of asylum-seeking girls at risk

Data are not available for calculating the number and proportion of asylum-seeking girls from FGM-practising countries who are at risk of FGM in Cyprus.

6.4 Effective measures and challenges for tackling FGM in Cyprus

Since 2003, FGM is a crime, punishable with up to five years' imprisonment[63]. However there have never been any FGM-related prosecutions to date. The Istanbul Convention was ratified in July 2017.[64] There is no comprehensive legislation in Cyprus covering violence against women, although (as of January 2018) legislation is being drafted to bring national legislation into line with the Istanbul Convention. Some of the Convention's provisions are found scattered in various legislative instruments, mainly in the field of domestic violence, trafficking, child abuse and the Victims' Rights Directive, which was transposed in 2016.[65] The Convention's articles 19-28 regarding information and support were only partly covered in piecemeal legislation, mainly in the field of domestic violence and in transposing the Victims' Rights Directive. There is no specific provision in Cypriot legislation creating legal obligations for the provision of information and support to FGM affected women or to girls at risk of FGM.

Regarding the obligations created by the Victims' Rights Directive, other than the printing of a leaflet by the police,[66] no other measures were adopted to inform victims of crime of their rights under this Directive. No other legislation applies directly or indirectly to the practice of FGM and action plans for gender equality make no mention of it.

Cyprus has not developed a policy framework that specifically targets FGM. However, there is currently a policy in place for granting international protection to all women who can prove to have undergone FGM. This policy is more geared towards protecting victims rather than tackling FGM or protecting girls at risk.

Health services

The focus group discussions identified three major health provision gaps:

- Asylum-claiming women are obliged to undergo a vaginal examination to prove their claim that they have been cut. The doctor performing the examination is not necessarily a woman nor is he/she necessarily trained in the different types of FGM. UNHCR pointed out that there have been instances of inconsistent findings between different doctors, with one doctor confirming that a woman has been cut and another doctor claiming that she was not cut. This is a weakness of both the asylum procedure itself and of the health system which does not follow a gender-sensitive and FGM-sensitive approach. UNHCR has recommended that the Asylum Service should not require female applicants to undergo the vaginal examination to prove whether they have been cut or not and that a general gynaecological health screening policy should be adopted instead, performed with sensitivity and care. According to UNHCR, if a vaginal

[63] Cyprus, Criminal Code Cap 154, article 233A, available at www.cylaw.org/nomoi/enop/ind/0_154/section-sc1bcfobbb-fd64-6192-4d9c-63a09c0e8193.html

[64] Law ratifying the Convention of the Council of Europe for prevention and combating violence against women and domestic violence, N. 14(III)/2017, 28 July 2017, available at www.cylaw.org/nomoi/arith/2017_3_014.pdf

[65] Cyprus, Law establishing minimum standards on the rights, support and protection of victims of crime (Ο περί θέσπισης ελάχιστων προτύπων σχετικά με τα δικαιώματα, την υποστήριξη και την προστασία θυμάτων της εγκληματικότητας νόμος του 2016) N. 51(I)/2016, 22 April 2016, article 2, available at http://cylaw.org/nomoi/arith/2016_1_51.pdf

[66] Cyprus police, 'Victims of crime: Rights, support and protection of victims' (Θύματα εγκληματικότητας: Δικαιώματα, υποστήριξη και προστασία θυμάτων) 2017 Available at http://www.police.gov.cy/police/police.nsf/All/C0D1A91BDAACCEE7C225813A00232765/$file/thimata_eglimatikotitas.pdf?OpenElement

examination is necessary at all, then this should be done only in the context of a general health screening test (Interview, UNHCR Cyprus).

- Most women participants reported that health practitioners have demonstrated insensitive behaviour when treating FGM-affected women in labour or in relation to other health issues, often expressing shock and dismay in a manner that makes the women feel uncomfortable. Doctors and nurses were reported to have asked FGM victims insensitive questions and made inappropriate comments, evidencing serious training and policy gaps in dealing with FGM at the level of healthcare.
- Whilst all women in the focus groups stated that they were in need of counselling and support, they did not know where to turn to for help with mental health issues or for dealing with the health complications and marital tensions resulting from FGM. Only one woman out of all focus group participants reported having received counselling, who has been living in Cyprus for over ten years.

  Out of all focus group participants, only one had heard of reconstruction surgery; all however expressed a keen interest to find out about it.

  Social Services

  None of the participants were aware of where to turn to for assistance. UNHCR reported that some NGOs are providing help to individuals with access to welfare and housing, however NGO assistance is limited and mainly covers persons in reception facilities or unaccompanied minors in shelters.

  Prevention/protection

  Only a few of the participants had heard about anti-FGM awareness campaigns, but all participants were aware that FGM is illegal in Europe.

  In an interview, a UNHCR representative explained that asylum seekers and refugees living in the community rather than in reception facilities were hard to reach in terms of NGO services. Only a few participants were aware of the different types of FGM as defined by the WHO, but were aware of the different methods used in rural and urban settings.

  None of the participants knew what to do or where to turn in Cyprus if they knew that a girl would be going back to get cut and few reported being prepared to go to the police with such information. The discussion in the focus group with the men revealed a certain hesitation in reporting other members of their community to the police and a preference to do so anonymously. The policy followed in other European countries of monitoring the exit and re-entry of families from FGM affected countries – to investigate if FGM was performed during their visit to the country of origin – was commented upon in a very positive light. The example of the Dutch authorities was extensively discussed in the mixed group of women, where immigration officials warn the departing parents of prosecution in case their daughter is found, upon her return to the Netherlands, to have been cut. The participants expressed a sense of satisfaction over this rigorous implementation of the anti-FGM laws and were pleased to hear that the FGM-practising parent was jailed and deported.

  Migration flows

  The migration into Cyprus of girls from practising communities is a fairly recent phenomenon which only started about 5 years ago. The travel restrictions imposed on the status of persons in the asylum system effectively means that the option of travelling to their countries of origin for performing FGM does not pose a serious risk; however it may be an issue to consider for the next generation of migrants whose parents originate from FGM practising countries. According to UNHCR, this is where education, rights awareness and integration is key, to protect girls and women who may be potentially at risk (interview).

  Cyprus has not witnessed a sharp increase in the inflow of migrants and refugees in recent years, as other EU countries have experienced; however, there was an increase in the number of unaccompanied children

from Somalia who initially arrived in Cyprus with a view to travelling elsewhere.[67] More recently, however, because of the manner in which the Dublin III Regulation (No 604/2013) is implemented, these children remain in Cyprus. The Somali community of Cyprus is therefore growing and unless both men and women are educated on their rights this may lead to an increased risk of FGM. According to UNHCR, most of the women and girls who migrated to Cyprus from FGM-affected countries have already been cut but education is essential to prevent FGM from being performed on their children.

Gender-sensitive policies

Gender sensitive policies are used in the context of the asylum procedure to the extent that women are interviewed by women, they are offered interviews separately from men, there is a choice of interpreters and if they produce a medical certificate that they have been subjected to FGM, they will be granted international protection. However, there is no procedure for identifying victims of gender-based violence and safeguarding their rights, except in the context of unaccompanied children, because of the involvement of the Social Welfare Services who are automatically appointed as Guardian.

In general, there is no mechanism in place to ensure systematic identification and addressing of the needs of vulnerable asylum seekers, in terms of either reception or the asylum procedure, including early identification and prioritisation of their claim, as required by the Asylum Procedures Directive 2013/32. According to the UNHCR, this may happen in some instances but it is not systematic in Cyprus (interview).

Initiatives and challenges

Many training and awareness initiatives are in place, offered mainly by UNHCR and NGOs targeting both migrants from affected countries and government officials. However, this is not systematic and it is not offered at government level. According to an UNHCR representative, a more integrated approach is needed, through the adoption of a holistic integration action plan at the level of the Ministry of the Interior, to provide for constant training of government officials working in the field of asylum, health, immigration and law enforcement and for regular awareness-raising. In addition, procedures must be introduced for the effective consultation and participation of the refugee communities in policy development and implementation.

6.5 Conclusions from Cyprus

Over half of the girls (aged 0-19) from FGM-practising countries in Cyprus in 2011 belonged to first generation – 460 girls compared with 352 second generation girls (total 812 girls). No data on migration inflows and outflows from FGM-practising countries is available for Cyprus. Moreover, the only data by generation is only available for 2011; thus, trends cannot be analysed, despite some more recent permits data being available.

[67] Interview with UNHCR Cyprus, 18 October 2017.

From the 812 girls from FGM-practising countries in Cyprus in 2011, estimates of girls at risk ranged from 29 to 105, which represented between 4% and 13% of the population. All of the girls at risk were under 10. For girls aged between 0 and 9, between 6% and 22% were at risk in 2011.

The seven countries of origin with the largest number of girls at risk in descending order were Egypt (60), Sudan (22), Iraq (12), Ethiopia (4), Somalia (3), Central African Republic (1) and Kenya (1). Egypt was the country of origin with the most girls at risk in Cyprus, with 21 first generation girls and 39 second generation girls. In all these communities, the number of second generation girls at risk exceeded those from the first generation.

Three separate focus group discussions were held with Somali community members; specifically, with older women, younger women and men. The fourth focus group was attended by five women with a relatively longer presence in Cyprus originating from Ethiopia, Nigeria, Ivory Coast, Somalia and the Gambia. All participants were first-generation migrants, of whom most (except a few of the men) were the beneficiaries of international protection. The anti-FGM feeling was strong in all discussions: it was particularly strong in the case of the women; and it was the dominant frame in the discussion with the men, where peer pressure from the younger and more educated Somali men quickly marginalised some shyly expressed views about cut women being more 'pure'. FGM was described by the participants as a widespread and standard tradition, particularly in the countryside, but nevertheless an undesirable and objectionable practice that must be stopped.
FGM was not seen as based on religion: in Nigeria, it is practised by both Christian and Muslims; and in Somalia religious leaders clarified that it is not condoned by Islam. In their home countries, there is a *presumption* at the level of the community that a girl will be cut; the presumption is rebutted very rarely and only where the parents jointly decide to rebel; this appears to be more frequent or likely in some countries (e.g. Gambia, Ethiopia) and less in others (e.g. Somalia, Nigeria). Marriageability and fear of ostracisation from the community emerged as the key incentives for parents to allow the cutting of their daughters. However, both of these considerations lose their significance for the African diaspora in Europe, who appear largely to have abandoned the practice.

Key incentives for the African diaspora in Europe when it comes to abandoning FGM are the loss of sexual pleasure for both women and men, the health complications, FGM-related marital problems, the information campaigns and the laws in Europe prohibiting FGM. Community pressure to get a girl cut when they return to the country of origin can be significant, but it was described as "bearable" if the visit was brief. The policy of some EU countries to prosecute parents who had cut their daughters during a holiday to their home countries was seen to serve as a significant aide in withstanding this pressure. Somali men took a strong anti-FGM stand, mainly due to the human and financial cost of the health complications and the reduced sexual pleasure in their marriage.

FGM has been a crime in Cyprus since 2003 and the Istanbul Convention was ratified in 2017, but there have not been any FGM-related prosecutions. Current asylum policy grants international protection status to all women who can prove they have undergone FGM, but there is no specific support structure for FGM victims, nor is there an FGM-sensitive policy framework. Cyprus does not monitor travel to FGM-practising

countries; however, the status granted under the current asylum policy does not permit the travel of a beneficiary to his/her country of origin, which somewhat reduces the risk. Travelling outside Cyprus to perform FGM may, in the future, place girls at risk if their status allows travel to FGM-practising countries other than their home countries.

Challenges in the health sector include a lack of gender-sensitive and FGM-relevant training of doctors and nurses in public hospitals in all their contact with FGM-affected women. Vaginal examination is obligatory for all women claiming asylum on the ground of FGM; the lack of specialised support services particularly in the field of mental health, the absence of marital counselling and limited information about where to apply for support and help. There is no structured or friendly system of reporting suspicions about girls being at imminent risk of FGM and participants were not informed as to who they should alert if they suspected a girl was at risk. Awareness raising is not systematic and there are no adequate or concerted prevention strategies.

7 Female genital mutilation risk estimation in Malta

7.1 Summary of findings from focus group discussions organised in Malta

7.1.1 Overview of the focus group discussions

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

In both the Nigerian sessions, participants were all from a Christian community and were already acquainted with one another. Most Nigerian women came from the Delta state and had children; most of the men came from the North or Northwest of Nigeria and were relatively highly educated. In the focus group discussion with second generation migrants, the two Egyptian women both arrived to Malta when they were under five years of age and both were from the north of Egypt. In the final focus group discussion, also with the Egyptian female community, participants had different religions, with the majority being Muslim and two being Coptic; all the participants were married and most had children. The table below presents an overview of the profile of participants in the four focus group discussions.

Table 7.1 Overview of focus group discussions and socio-demographic profile of participants in Malta

Key characteristics of focus groups	Focus group discussion 1: Older women	Focus group discussion 2: Younger women	Focus group discussion 3: Men	Focus group discussion 4: Hard-to-reach/recent migrants
Number of participants:	6	2	5	5
Countries of origin represented[68]:	Nigeria	Egypt	Nigeria	Egypt
Sex of participants:	Women	Female	Men	Women
Age range:	31-34	18-25	38-55	29-36
Generation (first/second):	First	Second	First	First
Average residence (number of months) & previous residence in other countries	84 months. The majority have never lived in other European countries.	42 months. The participants only lived in their country of origin and never lived in other European countries	115 months. The majority have never lived in other European countries.	81 months. The majority have never lived in other European countries.
Number of second-generation participants who have lived their parents' country of birth	N/A	Both participants lived in their parent's country of birth until the age of 3 and 4 years respectively	N/A	N/A
Civil status of participants:	5 out of 6 participants were married	All participants were married	All participants were married	All participants were married
Number of participants with/without children	4 out of 5 participants had children. The other participant was expecting her first child	All participants had children	3 out of 5 participants had children. 2 participants did not have children	4 out of 5 participants had children. The other participant was expecting her first child

[68] This is the country of birth of first-generation migrants (FGM-practising countries); country of birth of parents of second-generation migrants (FGM-practising countries). Here, someone is second-generation if he/she is not born in an FGM-practising country but he/she has at least one parent is born in an FGM-practising country.

Key characteristics of focus groups	Focus group discussion 1: Older women	Focus group discussion 2: Younger women	Focus group discussion 3: Men	Focus group discussion 4: Hard-to-reach/recent migrants
Religion:	All participants were Christian	All participants were Muslim	4 out of 5 participants were Christian whilst one practiced the Urhobo religion	3 participants practised the Muslim religion whilst 2 practised the Christian religion
Ethnic groups (if available):	One participant belonged to the Esan ethnic group	None	None	None
Level of education:	3 participants had a secondary level education, one has attended senior school whilst another has not attended any educational institute.	One participant had a Diploma level of education whilst the other had a secondary level education	One participant has a secondary level education whilst the other have a high level of education.	One participant has a secondary school education whilst others have a high level of education.
(For first generation): Shortest and longest amount of time residing in your Member State:	The shortest amount is 4 years whilst the longest is 11 years.	n/a	The shortest amount of time is 1 month whilst the longest amount of time is 20 years	The shortest amount of time is 9 months living in Malta whilst the longest amount of time is 14 years
(For first generation): Shortest and longest amount of time residing in other European Member State:	None	n/a	The shortest and longest amount of time is 27 years	The shortest and longest amount of time is 4 years
Date of session:	22 September 2017	12 January 2018	23 September 2017	25 September 2017

7.1.2 Key findings from the focus group discussions

The Nigerian participants were very perceptive and forthcoming. There was a lively debate, particularly amongst the female participants. Both male and female participants were aware of the practice in their country, however the majority were against the practice. Some female participants also stated that their families back in Nigeria spoke against the practice; however all participants agreed that ultimately it is up to the father to decide whether daughters have FGM or otherwise.

With regards to the male participants, they also said that they are against the practice and they agreed that it is the man's decision as to whether daughters or wives, depending on the cultural context, are to have FGM. All Nigerian participants stated that the practice of FGM is dying in Nigeria and that in some states, particularly in the South and North of the country, there are large campaigns against the practice and some states have made the practice illegal customarily.

The Egyptian participants, had a different opinion. The religious backgrounds of the participants were mixed. Those that were of Coptic faith stated that although the practice exists amongst that religious group, it is rare. Amongst the Muslim participants, the view was different. Some participants claimed that the practice emanates from the Quran, whilst others stated that the practice is a cultural one and that no one should interfere in the practice. They all agreed that the practice is done by a qualified doctor and ultimately it is the doctor who decides whether their daughters are to be cut or otherwise. Some Egyptian participants were aware of other forms of FGM; however they said that only FGM Type I was practised in Egypt.

The second generation participants who were Egyptian were both against the practice and agreed that although it is ultimately the girl who takes the decision, she should follow the doctor's advice. Whilst agreeing that the practice is now illegal in Egypt, they both agreed that in some communities, particularly those that live in desert and those that live in the South still followed the practice. Only one of the participants was aware of other kinds of FGM.

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

With regards to awareness campaigns, some Nigerian participants stated that in at present there are nation-wide campaigns being held around Nigeria dissuading the practice of FGM and highlighting the harm that the practice causes, especially AIDS and HIV. Amongst the Egyptian elder participants, they were aware of debates that were held on national television were Imams and other religious leaders were present in debate on the topic. However, they are not aware of any national campaigns being held in Egypt. Second generation participants were also unaware of any national campaigns held in Egypt. Both Nigerian and Egyptian participants agreed on the fact that they have never heard of any services or campaigns done in Malta. Only one Nigerian male participant and the second generation participants were aware of campaigns in Europe and none of the participants were conscious of any services provided on the island.

When asked about the role that European institutions should have, Nigerian participants said that they should provide Nigeria with as much support as possible to help eradicate the practice. The Egyptian elder participants did not agree with the same idea. They felt that any form of outside intervention or support would be tantamount to interference. Some participants stressed that the practice is cultural and thus no one should interfere. Contrastingly, the second generation Egyptian participants whilst agreeing that European institutions should not interfere, were firm on the idea that more information should be distributed and services should be provided.

Identity and attitudes about the importance of FGM

The Nigerian participants (men and women) did not give importance to the practice of FGM and all emphasised that with time this practice is being extinguished. It was however highlighted that there are some rural communities who still practise FGM, whilst explaining the need to educate these areas. All the participants stated that since this practice has been eradicated, it is not affecting their relationships with the family. However, some participants explained that although this is the case, they were still worried about what their family would say if they were to find out that their daughters were not cut. In fact, some participants expressed concern, before reiterating that their family has explained to them the eradication of the practice and that the majority (of family members) do not expect this nowadays. Most participants agreed that FGM would not affect one's chances of marriageability or her social status. Some however emphasised that for some families this could still be an important criterion since a cut woman is seen as pure.

The participants, having mostly been in Malta or in other European countries for a number of years, all emphasised that FGM is not part of their identity and so they do not feel any feeling of loss. Although all participants agreed that the practice is being eradicated, they mostly explained this was as a result of the health risks and deaths that were consequential to cutting. None of the participants explained that women's empowerment is affecting the abandonment of the practice.

With regards to men's changing attitudes towards the practice, the female Nigerian participants agreed that this would help a lot since Nigerian is a "fathers' land", with men having the ultimate say. The Nigerian men agreed and said that their attitude is important for the same reason; ultimately they are also affected by the practice because the women is someone's daughter, someone's sister or someone's wife.

The elder Egyptian participants had a different opinion on the practice of FGM. Those practising the Muslim religion all agreed with the practice and said that this decision is left in the hands of the doctor. The other two Christian participants disagreed and said that the practice should be extinguished. The elder Egyptian

participants however agreed that nowadays various campaigns are being organised in their home country to eliminate the practice. The second generation Egyptian participants, who were Muslim, explained that their religion is divided, with some supporting the practice and the others campaigining against it. They both said that nowadays FGM is illegal in Egypt except when the doctor recommends it. However, they both highlighted that FGM is still being done illegally in some parts of the country.

Most of the elder Egyptian participants felt that FGM does not affect one's chances of marriageability whilst saying that the practice is part of the tradition and thus it is normally practised and expected. The participants also disagreed on whether this practice affects their identity, with one participant emphasising that this is her culture, her identity and that it cannot be changed. All elder participants agreed however that their relationships with family members in the country of origin would not be affected since no-one speaks about the practice. The family would not even ask whether circumcision had been performed on their daughters. The second generation participants also agreed that this does not effect one's marriageability and that the practice is not part of their identity.

Most participants explained that Western societies and values are affecting their sense of identity. The majority also believed that the European institutions should not get involved. The participants explained that men would probably not ask about the practice but would speak about it in general. Some participants expressed that some men would view the practice positively since it contains the female's sexual urges, whilst others think about it negatively since the affected woman would not have any feelings.

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

The Nigerian participants explained that FGM is no longer being practised in Nigeria, except for some rural areas, whilst also explaining that they do not know of cases in Malta. One participant however believed that there is a possibility that it is done in Europe upon payment. The female Nigerian participants were only aware of one kind of FGM, mainly FGM Type I, whilst one participant mentioned that in some areas the female genitalia is stamped by a hot iron. The male participants were more knowledgeable about the subject, whereby some were aware of the different kinds of FGM. The majority of them however only knew of Type I.

The Egyptian participants agreed that FGM is not done in Europe, although one expressed doubt and said that it happens in Germany. The majority of the participants only knew of FGM Type I; however one elder Egyptian participant and one second generation participant were aware of the different kinds that existed. A differentiation was made between being cut and being circumcised, whereby some cutting referred to Type I whilst others referred to Type II, emphasising that this is a crime in Egypt.

Key risk factors for FGM

The Nigerian participants explained that the main factor that can contribute to reducing FGM is by creating awareness and educating the people. They all agreed that although campaigns are making a lot of difference, more needs to be done. The male participants pointed out that one must be aware of the approach that needs to be taken in this regard, since this is ultimately a tradition and one must not blame the people practising it. The female participants in particular explained that men need to be more aware about the subject given that they are the ultimate decision-makers. The male participants explained that one should focus on educating high-profile people in the village, who can influence others whilst also highlighting the importance of sharing information between local and European Civil Society Organisations.

The majority of elder Egyptian participants were in favour of the practice and were not willing to discuss factors, which would either reduce or increase the risk of girls of FGM. They were mostly unaware of such factors since they held that the topic of FGM was not discussed in an open manner. They however agreed that it is the mother or the parents to initiate the discussion of FGM, and that the final decision would be left up to the husband. On this point, the second-generation Egyptian participants agreed and said that it is either the father or the mother's father who would take the final decisions. The elder Egyptian

participants who were against the practice believed that there should be more education. Most participants agreed that awareness campaigns are having an effect towards the abandonment of the practice. On the other hand, the second generation participants both disagreed with the practice and believed that more information should be made available, mainly through an institution that would help girls who are about to experience, or who have already undergone, FGM.

7.2 Female migrant population aged 0-19 originating from FGM-practising countries

Table 7.2 Overview of data availability in Malta

Type of data	Summary of data availability and sources
Risk estimation	
Sources used in risk estimation	2011 Census data and Live Births data (both via National Statistical Office).
Data issues:	Census data on the number of foreign-born residents was used to calculate first generation migrant data. Data on second generation migrants was calculated using information on the number of live births to resident as well as non-resident mothers, using data was provided from 1997 – 2016. However, data was only provided in grouped age brackets (1997 – 1999; 2000 – 2004; 2005 – 2009; and 2010 – 2016), and therefore it was necessary to apply the hypothesis of uniform distribution in order to estimate births by single years.
Overview data presented on the migrant population	
Female migrant population originating from FGM-practising countries	National Statistical Office (NSO)
Years available	2011
By age	0-19, with breakdowns by five-year age groups: 0-4, 5-9, 10-14, 15-19.
By country of origin	Only for 2011; more recent years aggregate countries of origin (see below)
By first and second generation	Unavailable
By regional level	Unavailable
By age of arrival	Unavailable
Data issues	Whilst NSO confirmed they produce annual migration estimates as stipulated by Article 3 of the European Regulation (EC) No. 862/2007, these estimates are calculated in aggregate form by broad country groups (i.e. "Non-EU countries"). As a result, recent data which complied with the disaggregation requested for the 30 countries where FGM is documented, was not available.
Female live births in EU to mothers originating from FGM-practising countries	National Statistics Office
By country of mother	Partially available
By regional level of country of mother	Unavailable.
By region of birth of the child	Unavailable
Data issues	Live births to resident as well as non-resident mothers were included. Data is collected in aggregated form by Eurostat from each country, and therefore NSO was able to provide a breakdown on request. Some country of origin data suppressed for confidentiality. Given confidentiality procedures, four-year brackets were used.

Type of data	Summary of data availability and sources
	Some cases where the country of birth of the mother is unspecified.
Female asylum seekers	The Office of the Refugee Commissioner in Malta.
Years available	2011-2016
By age	0-17, with these breakdowns: 0-13 and 14-17.
By country of origin	Available.
By regional level	Unavailable
By age of arrival	Unavailable
Data issues	Country of origin data is by citizenship, not by country of birth. Given the implementation of new guidelines in 2013, there may be a 'methodological break' in series for asylum data before and after 2014.
Female refugees	Available.
Years available	2011-2016
By age	0-17, with these breakdowns: 0-13, 14-17
By country of origin	
By first and second generation	n/a
By regional level	Unavailable
By age of arrival	Unavailable
Data issues	Eurostat data is rounded to the nearest five in line with confidentiality rules; likely over-estimates the number of refugees. Country of origin is by citizenship.
Female irregular migrants	Immigration and Security Police Department has data on number of illegal female minors (0-18) arriving to Malta by boat.
Years available	2011, 2012, 2013, 2014, 2016
By age	Unavailable.
By country of origin	Declared nationality
By first and second generation	Unavailable (presumed first generation).
By regional level	Unavailable
By age of arrival	Unavailable
Data issues	Under-estimate: excludes those found to be illegally present arriving by other means. Migrants state their nationality upon arrival (no clear definition of 'origin'). No metadata provided.
Official registration – other sources on identified FGM cases	
Medical/hospital	Partially available.
Child protection	Unavailable.
Police/judicial	Unavailable.
Asylum	Unavailable.
Other	Unavailable

This section of the Malta chapter provides data (where available) on four groups: i) the recorded migrant population, who are legally present and 'usually resident' in the Member State; ii) recent immigrants and emigrants to the country; iii) irregular migrants, who do not – or no longer – fulfil the conditions for legal

residence in the country; and iv) asylum-seekers, who are legally present but have not found out if their application for international protection was successful. Having an overview of this data is important for understanding potential populations of interest when estimating the number of girls at risk of female genital mutilation. The chapter ends by presenting data on other sources (if any) that are collecting FGM in the country.

7.2.2 Migrant population

Considering the migrant population from FGM-practising countries in Malta, reliable data was only available for first generation migrants born in these countries and residing in Malta at the census reference date (with the intention of residing in the country for a certain period), and for broad age groups of five years[69]. Data was also not separately available for second generation migrants, whose parents were born in a country where FGM is commonly practised, or by regional origin. Due to this, numbers on the regular migrant population in Malta were calculated using a combination of the census and live births data

In 2011, there were 490 female migrants aged 0-19 originating from the 30 FGM-practising countries. Slightly over half (58%) were second-generation. The vast majority of these girls (86%, 423) were younger than 10; most of these girls under 10 (61%, 257) were second-generation. Considering the age range 10-18, the split between first and second generation was relatively even (53% versus 47%). This data is presented in the table below.

Table 7.3 Age distribution of the female migrant population (aged 0-19) originating from FGM-practising countries, in Malta, 2011

	TOTAL	First generation	Second generation	TOTAL (%)	First generation (%)	Second generation (%)	TOTAL generation (%)
0-9	423	166	257	86%	39%	61%	100%
10-18	62	33	29	13%	53%	47%	100%
19	5	5	0	1%	100%	0	100%
TOTAL	490	204	286	100%	42%	58%	100%

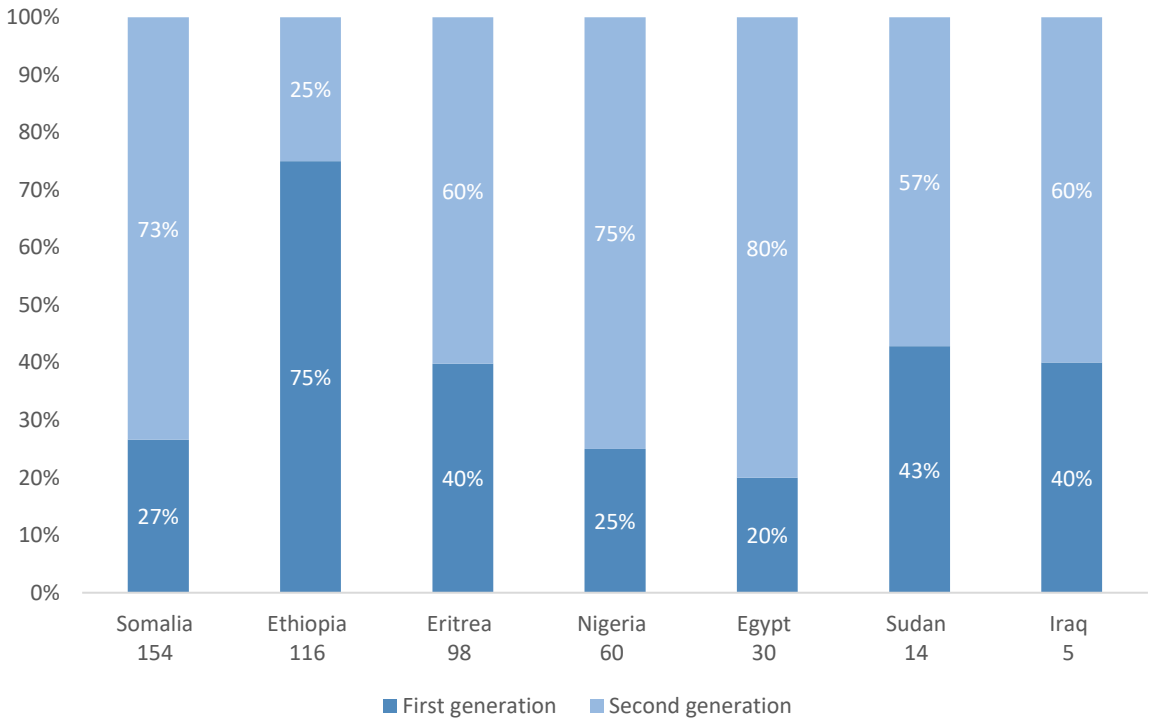
Source: 2011 Census data and Live Births data – both via National Statistical Office, Malta.

Note: There is only available census data for 2011 and by five-year age groups (Under 5, 5-9, 10-14 and 15-19) instead of one-year age intervals, due to confidentiality rules. Data on second generation migrants was calculated using information on the number of live births to resident as well as non-resident mothers, using data was provided from 1997 – 2016. Data was only provided in grouped age brackets (1997 – 1999; 2000 – 2004; 2005 – 2009; and 2010 – 2016), and therefore it was necessary to apply the hypothesis of uniform distribution in order to estimate births by single years.

Given that data is only available for one year, it is not possible to analyse any trends in migration from FGM-practising countries.

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

Table 7.5 Number of girls (aged 0-19) living in Malta by most represented countries of origin, 2011



Source: 2011 Census data and Live Births data – both via National Statistical Office, Malta.

Note: There is only available census data for 2011 and by five-year age groups (Under 5, 5-9, 10-14 and 15-19) instead of one-year age intervals, due to confidentiality rules. Data on second generation migrants was calculated using information on the number of live births to resident as well as non-resident mothers, using data was provided from 1997 – 2016. Data was only provided in grouped age brackets (1997 – 1999; 2000 – 2004; 2005 – 2009; and 2010 – 2016), and therefore it was necessary to apply the hypothesis of uniform distribution in order to estimate births by single years.

In 2011, the biggest number of girls from FGM-practising countries originated from Somalia (154), Ethiopia (116), Eritrea (98), Nigeria (60), Egypt (30), Sudan (14) and Iraq (5). Other than for Ethiopia, a majority of the female migrants from these communities were second-generation.

7.2.3 Inflows and outflows

To get a sense of migration patterns over time, it is worthwhile to consider 'inflows' and 'outflows' from FGM-practising countries. The former covers immigrants (inflows): people arriving or returning from abroad to take up residence in a country for 12 months or more, having previously been resident elsewhere. The latter covers people who are leaving the country where they usually reside and effectively taking up residence in another country. An individual is a long-term emigrant if he/she leaves his/her country of previous usual residence for a period of 12 months or more. A positive 'net inflow' indicates that more people are arriving than leaving Malta, within a given year.

According to data from the 2011 census (provided via the National Statistical Office in Malta), the total number of (first generation) female immigrants aged 0-19 arriving in Malta, after residing in one of the 30 FGM-practising countries, is estimated at 34[70]. Importantly, this figure is approximate and may underestimate the total inflow of female immigrants; due to confidentiality rules, data was supressed when

[70] This indicates immigrants to Malta who left their country of residence at least 12 months ago.

there were fewer than three female immigrants originating from an FGM-practising country, and therefore this calculation assumes only one immigrant will have arrived in Malta from this country in 2011.

Data is not available for the total outflows of emigrants originating from the 30 FGM-practising countries in 2011, and therefore it is not possible to calculate the net inflows.

7.2.4 Irregular migration

Data on the number of irregular female migrants, aged 0-18, arriving to Malta by boat from FGM-practising countries is available from the Immigration and Security division of the Police Department for 2011 – 2016, though no data is available for 2015. This specific definition of a 'female migrant' does not take into account third country nationals found to be illegally present in Malta arriving by other transport methods. Furthermore, migrants' nationality is self-reported upon arrival, which means that there is no single definition of 'country of origin': this can be country of birth, previous country of residence or country in which citizenship is held.

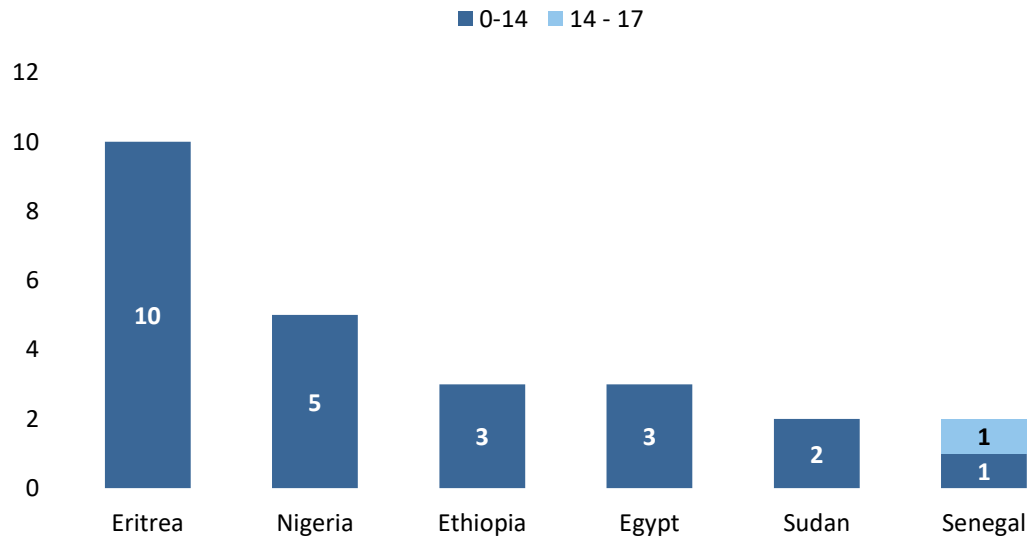
Since 2011, there have been 172 female irregular migrants aged 0-18 arriving in Malta by boat, although numbers have significantly decreased since 2013 when there were 58 illegal female immigrants age 0-18 arriving by boat, with 46 from Somalia alone. Most recently, in 2016, there were only four record female immigrants in this age group arriving from Somalia, Sudan and Iraq.

Data is not available by age of arrival or by generation.

7.2.5 Asylum-seekers

In Malta, there were 28 asylum-seeking young women (aged 0-17) from the 30 FGM practising countries in 2016. Of these, most (25) were asylum-seeking girls from seven countries, as presented in the Figure below. Within this group, 96% (24) were 0-14 and 40% (10) came from Eritrea.

Figure 7.1 Number of asylum-seeker girls (aged 0-17) living in Malta by broad age groupings, 2016



Notes: In this Figure, countries of origin are defined by countries of citizenship rather than countries of birth.

Source: Office of the Refugee Commissioner in Malta (data not publicly available but available on request)

Data from the Office of the Refugee Commissioner for 2016 shows that there were 28 female asylum seekers, aged 0-17 and originating from one of the 30 FGM-practising countries (defined by their

citizenship). There was variation between countries; 10 female asylum seekers were from Eritrea, compared to five from Nigeria, three from Ethiopia and Egypt respectively, and two from Senegal and Sudan respectively. Most of these countries are the same as those making up the highest number of first-generation regular migrants; the exception is Senegal which does not feature in the list of regular migrants.

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

Data is not available for the number of FGM-related asylum applications received and granted in Malta since 2011 for girls aged 0-19 from FGM-practising countries.

7.2.6 Other records collecting information on FGM in Malta

Data relating to FGM is scarce in Malta, and information on the prevalence of the practice is not collected by national authorities or other organisations. A representative of the Migrant Health Unit highlighted that the Obstetrics and Gynaecology Department records the number of mothers who come from FGM prevalent countries who give birth at one hospital; anecdotal evidence suggests that no FGM cases have been identified to date in this hospital.

7.3 Estimation of the number of girls at risk of FGM in Malta and possible trends of FGM risk

The following section provides data on the estimated number of girls at risk of FGM in Malta, following the methodology in EIGE's step-by-step guide. It begins by presenting estimates of the number of girls at risk within the 'regular' migrant population, then presents the estimates for asylum-seeking girls. This is an important difference, as asylum-seekers are not included within the migrant population (unlike, for example, recognised refugees). It is worth remembering that the estimates for asylum-seekers cannot distinguish between a high and low scenario, as technically all asylum-seekers being considered are from the first generation.

Risk estimates for the regular migrant population in Malta are calculated using a combination of the census and live births data. There are some key caveats to note. Firstly, census data are only available for 2011, therefore estimates are likely to be outdated. Census data on the number of foreign-born residents was used to calculate first generation migrant data. Data on second generation migrants was calculated using information on the number of live births to resident as well as non-resident mothers, using data was provided from 1997 – 2016. However, data was only provided in grouped age brackets (1997 – 1999; 2000 – 2004; 2005 – 2009; and 2010 – 2016), and therefore it was necessary to apply the hypothesis of uniform distribution in order to estimate births by single years.

In addition, as data on age was aggregated, in order to calculate the number of girls below the median age for cutting, it was necessary to assume a uniform distribution of girls across the ages of each bracket[71].

7.3.1 Estimation of girls at risk within the regular migrant population

The table below presents a summary of the number of girls at risk of female genital mutilation in 2011. Underlying data for these estimations is available in Annex 2.

Table 7.6 Estimated number of girls (aged 0-19) living in Malta who are at risk of FGM

	Female migrant population

[71] For example, if the median age is 4, the number of girls at risk are (4/5)*(girls aged 0-4)

	HIGH SCENARIO			LOW SCENARIO		
	TOTAL at risk	First generation	Second generation	TOTAL at risk	First generation	Second generation
2011: TOTAL (0-19)	183	47	136	47	47	0
2011: TOTAL (0-18)	183	47	136	47	47	0

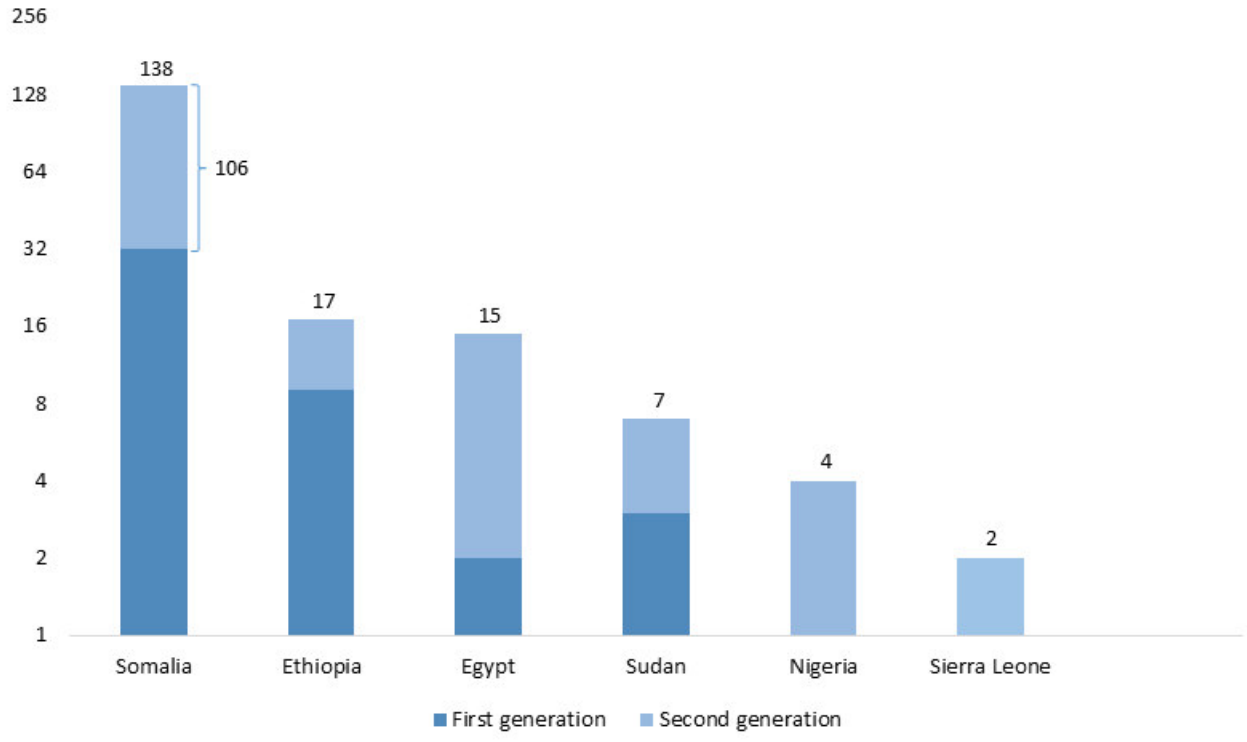
Source: present study

Note: All of these girls are younger than 10 (age category 0-9), so separate age disaggregations for the categories 10-18 and 19 have not been provided.

In 2011, between 9.6% and 37% of female migrants (aged 0-19) were at risk of FGM in Malta. If this is restricted to the 0-18 population, the proportions at risk are slightly higher (9.7% to 38%). However, the number of girls at risk is the same in both cases (between 47 and 183), as all girls at risk are aged under 10. Most girls at risk were drawn from the second generation.

The figure below shows the top seven countries by total (first and second generation) of girls aged 0 to 19 residing in Malta in 2011. Somalia represents most of them, with 32 first generation girls and 106 second generation girls followed by Ethiopia with 9 and 8 respectively.

Figure 7.2 Estimated number of girls living in Malta (aged 0-19) in 2011 who are at risk of FGM, by generation and most represented countries of origin



Source: present study

The table below discusses a summary of results of the FGM risk estimations for both high and low scenarios in terms of numbers and % at risk.

High scenario	In 2011, a total number of 490 girls aged 0-19 from FGM risk countries were residing in Malta, of which 183 were likely to be at risk of FGM. **This means 37% of girls aged 0-19 from FGM risk countries (either born in the country of origin or in Malta) were at risk of female genital mutilation.**
Low scenario	In 2011, a total number of 490 girls aged 0-19 from FGM risk countries were residing in Malta, of which 47 were likely to be at risk of FGM. **This mean, 9.6% of girls aged 0-19 from FGM risk countries (either born in the country of origin or in Malta) were at risk of female genital mutilation.**

Source: present study

7.3.2 Estimation of asylum-seeking girls at risk

Table 7.7 Estimated number of asylum-seeker girls (aged 0-17) at risk of FGM in Malta, from 2011-2016

	Total number of girls (0-17) from FGM-practising countries	Total number at risk	Proportion of girls at risk
2011	53	8	15%
2012	39	12	31%
2013	64	7	11%
2014	28	3	11%
2015	47	18	38%
2016	28	4	14%

Notes: Data is available for girls aged 0-17.

Source: present study

The proportion of asylum-seeking girls at risk of FGM reached a low (11%) in 2013 and 2014, before peaking in 2015 (38%), then reducing again in 2016 (14%). The numbers of asylum-seeking girls in Malta from FGM-practising countries have been relatively low, peaking at 64 in 2013.

For most of the years, Somalia was the main country of origin for asylum-seeking girls at risk of FGM, with low counts from other FGM-practising countries.

Underlying data for these estimations is available in Annex 3..

7.4 Effective measures and challenges for tackling FGM in Malta

In 2014, Malta introduced a provision specifically criminalising the practice of FGM as well as the failure of whoever seeks to wilfully avert the authorities.[72] This was the key legislative measure and no other amendments have taken place. Until February 2012, no policy documents on the practice were present in Malta, although the topic was openly discussed in detention centres by the Migrant Health Unit and the Jesuit Refugee Service.[73] Training to professionals was given in 2010 although no policy guidelines are

[72] Article 251E, Chapter 9 of the laws of Malta (Criminal Code)
[73] http://deputyprimeminister.gov.mt/en/phc/mhlo/Documents/fgm.pdf

present as of yet.[74] In 2015, the National Commission for the Promotion of Equality (NCPE) had also published a research titled 'Female Genital Mutilation in Malta-Research study', the result of which led to leaflets being provided to healthcare professionals and migrant women.[75] In the same year, a legal thesis on the subject was published, aiming to evaluate the social and legal implications for Maltese society.

As to the services available, the health care sector does not provide systematically knowledge to professionals. The research study conducted by the National Commission for the Promotion of Equality confirmed that most professionals gained information predominantly through their own initiative and none received any training in Malta. The primary resource identified was the Migrants Health Liaison Office and some training sessions.[76] In an interview done with the Health Minister in 2015 by Dr. Jeanise Bonnici, he confirmed that guidelines were being drafted for health professionals.[77]

A Maltese academic in an interview for this study confirmed that Malta does not yet have any social services available but explained that the local Civil Society Organisation Migrant Women's association will soon be running a project to provide counselling to migrant women who have undergone FGM. In fact, Malta is still in the process of transposing the provisions of the Istanbul Convention into national law, which will oblige it to provide for refuge, therapy and awareness on gender-based crimes, including FGM. There are no national provisions requiring training and awareness-raising and therefore criminal law provisions act as the primary piece of legislation. Most participants in the focus group discussions expressed the need for more education and awareness-raising on the practice. All participants in fact were not aware of any campaigns being organised in Malta, with the majority not even knowing that it is a crime in Malta. This shows that much more needs to be done on the subject.

Focus group participants have recommended that there should be more counselling services for females who have gone through the practice, to help with the psychological trauma involved. Many have also expressed the wish for more awareness and education to be present in healthcare centres and among the migrant community.

One of the key challenges faced by Member States is the difficulty to gather information from the migrant population about the subject. This can be due to the stigma still connected to the topic. This was also evident in the difficulty of the recruitment process of focus group discussions. Another key challenge faced by Malta when researching the topic is the fact that FGM is a criminal offence, making it very difficult for people to talk about it. The focus group discussions suggest that participants had no knowledge at all about the situation in Malta, which made them even more hesitant to discuss the topic in a confidential space.

It is recognised that the health sector has been experiencing difficulties when they meet FGM cases in Malta.[78] This is also seen through the experience of one individual interviewed for this study who, faced with the lack of knowledge on the existing Maltese law, spoke about FGM in hospital and consequentially was met by two policeman and a social worker to discuss the subject. Focus group discussions results in fact suggest that there is no awareness on the subject among the migrant population.

7.5 Conclusions from Malta

In 2011, there were a total of 490 female migrants aged 0-19 originating from 30 FGM-practising countries were residing in Malta, although the size of the second-generation is estimated. In addition, there were 28 asylum-seeking young women (aged 0-17) from the 30 FGM practising countries in 2016, mostly from

[74] http://deputyprimeminister.gov.mt/en/phc/mhlo/Documents/fgm.pdf
[75]http://ncpe.gov.mt/en/Documents/Projects_and_Specific_Initiatives/Forms%20of%20Violence/Report%20-%20FGM.PDF; https://ncpe.gov.mt/en/Documents/Projects_and_Specific_Initiatives/Forms%20of%20Violence/FGM%20Leaflet_EN.pdf
[76]NCPE (2015), p.33. See http://ncpe.gov.mt/en/Documents/Projects_and_Specific_Initiatives/Forms%20of%20Violence/Report%20-%20FGM.PDF
[77] Jeanise Bonnici, 'Regulating Female Genital 'Mutilation' in Malta, University of Malta Thesis, 114
[78] http://www.independent.com.mt/articles/2015-02-07/newspaper-leader/Zero-tolerance-to-female-genital-mutilation-6736130231

Eritrea. The 2011 census data indicates a net inflow of 34 female immigrants arriving in Malta from an FGM-risk country (ages 0-19). Numbers of irregular migrants arriving by boat into Malta has significantly decreased between 2011 and 2016. Since 2011, there have been 172 female irregular migrants aged 0-18 arriving in Malta by boat. The numbers of asylum seekers were very low in 2016 compared with previous years.

In Malta in 2011, the number of female migrants from FGM-practising countries at risk of FGM ranged from 47 (9.6%, Low Scenario) to 183 (37%, High scenario). This was from a total of 490 girls aged 0-19 from FGM-practising countries living in Malta.

The country of origin in Malta with most girls at risk in 2011 was Somalia, with 32 first generation and 106 second generation girls at risk of FGM (138 in total). This drops significantly for the remaining country of origin communities represented in Malta; in descending order these were Ethiopia (17), Egypt (15), Sudan (7) and Nigeria (4).

Four focus groups were held; two with first generation Nigerian participants (one with women, one with men), and two with Egyptian female participants (over 25 and first generation; and under 25 and second generation). All participants linked the motivation for FGM to women's purity and sexual control, despite many acknowledging that there is no truth to these suggestions. The majority of Nigerian participants were against the practice, stating that FGM is reducing in Nigeria due to campaigns and knowledge of the health risks for women. Generational differences emerged between Egyptian participants, with all second generation, younger girls against FGM. In contrast, elder, Muslim Egyptians were largely pro-FGM, and saw it as a cultural practice to be sustained, arguing it emanates from the Quran. Opinions on European interventions in the country of origin were also mixed; with Nigerians believing this could be helpful, whilst Egyptians were not in favour. Increased time spent in Malta led many Nigerians to stress that FGM is not part of their identity as they have been influenced by western values. Both Nigerian and Egyptian participants did not believe FGM was occurring in Malta, or Europe more broadly, except for one participant who suggested that the practice may be happening in Germany.

Measures to prevent FGM in Malta are primarily in the form of the FGM-specific law introduced in 2014, and the research study on FGM in Malta carried out by the National Commission for the Promotion of Equality (NCPE) in 2015, which led to leaflets being provided to healthcare professionals and migrant women. The focus groups and interviews for this study highlighted a limited awareness of the law, and warned that criminalisation can make it difficult for people to talk about FGM (i.e. due to fear of the consequences). Health sector staff have experienced difficulties when meeting cases, and a need for training and awareness-raising was stressed. Counselling services to support affected girls and women would help with trauma. Further, awareness-raising campaigns on a national basis would bring attention to the issue in Malta.

8 Comparative analysis of findings across Member States

8.1 Findings across the six Member States of the study

8.1.1 Estimations of girls at risk (results)

Using EIGE's methodology, the number of girls at risk of FGM has been calculated for the six Member States of this study, with the latest results presented in the table below. The population number of girls aged 0-19 should be taken into account when comparing these results as this varies between Member States due to the size of the migrant population from FGM-practising countries and the level of FGM prevalence within those countries of origin. As used in Chapters 2-7, a High Scenario and Low Scenario for the number of girls at risk of FGM is included, as well as the 2011 estimates to enable comparison.

Table 8.1 Estimated number and proportion of girls (aged 0-19) at risk in the six Member States of the study in 2011

Member State (Year)	Total population of girls (aged 0-19) from FGM-practising countries	LOW SCENARIO: Proportion of girls at risk	HIGH SCENARIO: Proportion of girls at risk	LOW SCENARIO: Number of girls at risk	HIGH SCENARIO: Number of girls at risk
Belgium (2011):	15,074	8.3%	24%	1,254	3,555
Greece (2011):	1,935	8%	42%	161	817
France (2011):	44,293	4%	13%	1,968	5,886
Italy (2011):	61,384	5%	19%	2,946	11,655
Cyprus (2011):	812	4%	13%	29	105
Malta (2011):	490	9.6%	37%	47	183

Notes: Belgium 2011 estimate is a likely under-estimate, due to data gaps affecting the second-generation. In Greece, due to the lack of data, the second generation are estimated as a fraction of the total residence permit-holders and does not include girls without residence permits, making it an the number of second-generation girls an under-estimate. In Italy, in the high scenario, the number of second generation girls does not include girls born in 2016 or girls born before 1999 (thus is a likely under-estimate).

Table 8.2 Estimated number and proportion of girls (aged 0-19) at risk of FGM in Greece, France and Italy in 2014

Member State (Year)	Total population of girls (aged 0-19) from FGM-practising countries	LOW SCENARIO: Proportion of girls at risk	HIGH SCENARIO: Proportion of girls at risk	LOW SCENARIO: Number of girls at risk	HIGH SCENARIO: Number of girls at risk
Greece (2014)	1,781	6%	30%	107	536
France (2014):	215,258	1%	11%	2,304	23,930
Italy (2014)	72,178	3%	17%	2,467	12,399

Notes: 2016 estimates are not available for the other three Member States. In Greece, due to the lack of data, the second generation are estimated as a fraction of the total residence permit-holders and does not include girls without residence permits, making it an the number of second-generation girls an under-estimate. In Italy, in the high scenario, the number of second generation girls does not include girls born in 2016 or girls born before 1999 (thus is a likely under-estimate).

Source: present study

Table 8.3 Estimated number and proportion of girls (aged 0-19) at risk of FGM in Belgium, Greece and Italy in 2016

Member State (Year)	Total population of girls (aged 0-19) from FGM-practising countries	LOW SCENARIO: Proportion of girls at risk	HIGH SCENARIO: Proportion of girls at risk	LOW SCENARIO: Number of girls at risk	HIGH SCENARIO: Number of girls at risk
Belgium (2016):	22,984	2.6%	20%	596	4,612
Greece (2016):	1,852	5%	25%	92	454
Italy (2016)	77,580	3%	15%	2,496	11,501

Notes: 2014 estimates are not available for the other three Member States. See also the 'Notes' for the previous Table.

Source: present study

The table above presents a High Scenario and Low Scenario for the number of girls at risk of FGM (as used in Chapters 3-8), as well as the 2011 estimates to enable comparison.

Estimates of girls aged 0-19 at risk of FGM created for each case study country may vary due to differences in numbers of first and second generation migrants within the case study country, as well as differences in the dominant countries of origin. For each country, the data shows that:

- **Belgium**: in 2016, out of 22,984 girls aged 0-19 from FGM-practising countries (first and second generation), 2.6-20% of girls were at risk of FGM. In 2011, out of a total population of 15,074 girls aged 0-19 from FGM-practising countries (first and second generation), between 8.3% and 24% of girls from FGM-practising countries were at risk of FGM in Belgium. Whilst the proportions at risk have decreased, the numbers of girls at risk have increased.
- **Cyprus:** in 2011, out of 812 girls aged 0-19 from FGM-practising countries (first and second generation), 4%-13% of girls were at risk of FGM.
  France: in 2014, out of 215,258 girls aged 0-19 from FGM-practising countries (first and second generation), 1%-11% of girls were at risk of FGM. In 2011, between 4% and 13% of girls from FGM-practising countries were at risk of FGM in France. The proportions have decreased, but there has been a significant rise in the actual number of girls at risk of FGM in France.
- **Greece:** in 2016, out of 1852 girls aged 0-19 from FGM-practising countries (first and second generation), between 5% and 25% of girls were at risk of FGM. In 2011, between 8% and 42% of girls from FGM-practising countries were at risk of FGM. Since 2011, the level of high risk has decreased steadily. However, the number of second-generation girls at risk is an under-estimate, as it does not include those without residence permits. This is highly problematic for getting a full picture of those at risk.
- **Italy:** in 2016, out of 77,580 girls aged 0-19 from FGM-practising countries (first and second generation), 3%-15% of girls were at risk of FGM. In 2011, between 5% and 19% of girls from FGM-practising countries were at risk of FGM. The overall level of risk has decreased in both Scenarios. However, trends data should be treated with caution, due to missing data on second-generation girls, affecting estimates in between 2013-2016. Also, for 2011 and 2012, data on births do not allow for an estimation of second-generation girls aged 14, which was the median age for cutting in some countries of origin.
- **Malta:** in 2011, out of 490 girls aged 0-19 from FGM-practising countries (first and second generation migrants) 9.6% to 37% were at risk of FGM.

The scale of the issue

The data demonstrates that FGM is an issue that affects all six Member States, but to varying extents. In the latest available years, France and Italy have the highest number of girls at risk of FGM: between 2,304 and 23,930 girls in France (2014) and between 2,496 and 11,501 girls in Italy (2016). However, Malta is the

country with the highest percentage of girls at risk from the total population of girls from FGM-practising countries (9.6-37% at risk from 490 female migrants aged 0-19 in 2011). Despite France having the highest *number* of girls at risk, the percentage at risk is lowest (1%-11% from 215,258 girls aged 0-19 from FGM-practsing countries (first and second generation)). This demonstrates the importance of considering *both* the number and the proportion of girls at risk when interpreting FGM risk estimations.

The size of the overall population of FGM-affected communities in 2011 differs substantially across the six Member States, ranging from 490 (Malta) to 61,384 (Italy). Malta and Greece had the smallest overall populations from FGM practising countries and the highest proportion of girls at risk (8%-42% in Greece in 2011; 9.6%-37% in Malta in 2011). The countries with the lowest proportions of girls at risk in 2011 were Cyprus and France (both 4%-13%). As in the latest available year, however, both France and Italy have the greater *number* of girls at risk – between 1,968 and 5,886 in France and between 2,946 and 11,655 in Italy. This reflects again that the proportions alone do not reflect the scale of policy intervention necessary to reach out to all girls at risk in a given country. Furthermore, the fact that community size does not automatically correspond to greater number of girls at risk reflects that there is no straightforward relationship between greater migration and FGM risk. Low FGM prevalence in certain countries of origin means that some of the biggest migrant communities in specific Member States are not amongst the main countries of origin for girls at risk. For example, in Belgium (2016), the seven largest groups of female migrants (aged 0-19) from FGM-practising countries were from Guinea Conakry (3,907 girls, including first and second generation), Cameroon (3,278 girls), Iraq (2,579), Ghana (2,345), Nigeria (1,887) , Somalia (1,220) and Togo (988). However, the seven most represented countries of origin of girls at risk in this year (according to High Scenario estimates) were Guinea Coinakry (2,523), Somalia (644), Egypt (294), Sierra Leone (217), Djibouti (132), Djibouti (132) and Sudan (107). Policy interventions must therefore reach out to communities most affected by FGM, as opposed to judging this purely by the *number* of girls aged 19 and under.

Ranges between Low-Risk and High-Risk scenarios are variable across the six Member States. They range from a difference of nearly 30 percentage points between the two scenarios in Malta in 2011, through to 9% for Cyprus in 2011. This range is generally a good indicator of the difference in size of the first- and second-generation in a country in a given year.

Trends over time

Comparison across time between countries is problematic for a number of reasons. First of all, recent data is not available for all countries – in Malta and Cyprus, estimates are only possible for 2011 (the year of the last census). Data is available for more than one year in Belgium, France, Greece and Italy. However, some specific data remains missing. For example, whilst data is available for the 2016 estimations for Belgum and Italy, the number of second generation girls is under-estimated for Italy and missing for Belgium, which creates a bias for the High Scenario. These factors make a comparison with available data from the same year between Belgium, France, Greece and Italy particular problematic. The following cross-country trends comparison must therefore be treated with caution.

- **Belgium:** the Low Scenario shows a decrease from 1,254 to 596 at risk of FGM between 2011 and 2016. This trend is reflected in the percentage of girls at risk (8.3% in 2011 to 2.6% in 2016). Although in the High Scenario the proportion of girls at risk also fell, the number at risk increased from 3,555 in 2011 to 4,612 girls in 2016.
- **France**: the Low Scenario shows an increase in the number of girls at risk of FGM, from 1,968 in 2011 to 2,304 in 2014. In terms of percentages, however, France has seen a decrease between 4% of girls at risk of FGM out of the total population of girls from FGM-practising countries in 2011, to 1% in 2014. The maximum number of girls at risk has increased significantly between 2011 and 2014 – from 5,886 in 2011 to 23,930 in 2014. However, as with Belgium, the percentage of girls at risk of FGM has decreased in France from 13% in 2011 to 11% in 2014.

- **Greece:** it is possible to record the biggest change from 2011 to 2016, in comparison with the other Member States where data is available for more than one year. In fact, between 2011 and 2016, in the Low-Risk scenario there has been a decrease from 161 girls at risk to 9w girls at risk, which translates to a decrease from 8% to 5% of girls at risk of FGM, in relation to the total population of girls from FGM-practising countries. For the High-Risk scenario, a decrease in the number of girls at risk of FGM from 817 in 2011 to 454 in 2016 is recorded. This trend translates in percentages to a decrease from 42% of girls at risk of FGM out of the total population of girls from FGM-practising countries in 2011 to 25%.
- **Italy:** according to the estimation for the Low-Risk scenario, it is possible to register a decrease in the number of girls at risk from 2,946 in 2011 to 2,496 in 2016. This trend is also confirmed by a decrease in the percentage of girls in relation to the total population of girls from FGM-practising countries, from 5% in 2011 to 3% in 2016. In Italy, the estimation for the High-Risk scenario shows a small decrease in the number of girls at risk between 2011 and 2016, from 11,655 girls in 2011 to 11,501. In terms of percentages, in 2011, 19% of girls were at risk, while in 2016, 15% girls were at risk of FGM.

Overall, across the four Member States where data is available for more than one year, it is possible to recognise a decrease in the percentage of girls at risk of FGM since 2011. However, the situation in Belgium and France is more nuanced, where there has actually been a rise in the number of girls at risk; indeed, in France, the number of girls at risk in 2016 was nearly four times as high as in 2011 (High Scenario). As shown in Chapters 2 and 4, this relates to the expanding second-generation within these two Member States. In Italy, the number of girls at risk has remained fairly constant, with only a small decrease in the High Scenario (from 11,655 to 11,501). Greece, unlike the other three Member States, experienced a big fall in the number of girls at risk between 2011 and 2016. Amongst other things, this may relate to the decrease in the total female migrant population (with residence permits) (aged 0-19) living in Greece. However, it is not possible to get a picture of the size of the migrant population without residence permits in Greece, many of whom are likely to be second-generation girls within the 'at risk' age category.

Recurring communities

When specifically looking into the country reviews presented in this report, it is possible to compare the seven most represented countries of origin of girls at risk of FGM in the six Member States and identify certain overlaps. In particular, Egypt, Somalia and Sudan are the three countries which are identified in between four to six Member States. More precisely, Egypt is the most represented country of origin (in all six Member States) and is in the top three most represented countries of each Member State, although the estimations for the number of girls at risk of FGM from Egypt vary depending on the Member State. Guinea-Conakry accounts for the highest number of girls at risk in both Belgium and France. This information can usefully inform policy design and implementation. In this sense, it is essential to collect more reliable and comparable data regularly and over time. However, there is a need to be careful when it comes to how data is collected, used and interpreted, to ensure that privacy concerns are respected and that processes of stigmatisation are avoided.

Challenges in data collection

Similar challenges in data collection and, therefore, in the calculations of estimates were encountered across the six Member States. For example, reliable and complete data on second generation migrants is missing because information on individuals' parents' country of birth is not routinely collected. This can create bias or underestimation, especially in the estimation of the High Scenarios. In each country, because of the lack of data, the estimations are calculated by utilising a number of expedients that can allow for more precise calculations. For example, in Greece, the second generation are estimated as a fraction of the total residence permit-holders and does not include girls that do not have or need residence permits (potentially leading to underestimation). In Malta, second generation data was calculated using information on the number of live births to resident as well as non-resident mothers. However, data was

only provided in grouped age brackets, and therefore it was necessary to apply a hypothesis of uniform distribution in order to estimate births by single years.

Moreover, a breakdown by region of origin is not available. This could allow for a further in-depth analysis of the available data, as FGM risk and prevalence can be extremely variable within an FGM-practising country, depending on the region of origin[79]. Data collected by migration services at national level could address this lack of regularly and recently collected data. Policy needs to take into account the strong need for regularly updated data in this context. Across the countries, it is rare for other administrative records to routinely collect FGM data[80]. Furthermore, irregular migrants constitute a "hidden population" for which it is not possible to have an overview of prevalence and risk of FGM among girls.

8.1.2 Interpreting the situation from the qualitative perspective

Focus group discussions

An understanding of FGM risk requires an understanding of the factors that motivate and discourage people from practising. The qualitative results reveal different social norms, conceptions and trends among the different migrant communities residing in the EU.

'Encouraging factors': What makes the practice desirable among migrant communities in the EU?

In the focus groups discussions across the six countries, various factors that may motivate women and men to have their daughters cut were evoked. These factors were also mentioned in the previous EIGE study (2015) and are commonly known in the social science literature on FGM (Ahmadu 2000, 2007, 2009; Boddy 1982, 1989, Gruenbaum 1996, 2001; Hosken 1976, 1981; Johnsdotter 2007; Johnson 2007; Johansen 2007; Kratz 2007; Lightfoot-Klein 1989; Shell-Duncan and Hernlund 2000, 2007; Shell-Duncan 2008, Shweder 2005, etc). The following 'encouraging factors' for FGM emerged, affecting different communities to varying extents: expectations for marriage and social pressure ('marriageability'); control of a woman's sexual urges; and concerns over purity and aesthetics. These factors are explored further; considering in particular how an individual's country of origin, country of residence, sex, age and generation can affect the weight that he/she assigns to each of these factors.

Marriageability was perceived as a fundamental aspect among all communities but with varying degrees of importance. Somalis, Sudanese, Guineas and Malians stated that in their countries of origin the social expectation was that girls should be cut before marriage. Egyptians and Nigerians however stated that in their countries of origin the decision to cut was an individual one and not particularly linked to pressure from the family or society.

Marriageability and social pressure amongst Somalis living in Belgium, Cyprus and Greece

In **Cyprus,** female and male participants from Somalia reported that, particularly in rural areas of Somalia, it was impossible for a girl to marry if she had not undergone FGM. The focus group with young Somali women voiced similar concerns by saying "100% No!" Although in the city things were changing, the general consensus among men, older and younger women was that irrespective of where a woman lived "it is something mandatory that every girl has to undergo". Considering unmarried Somali girls who have grown up in Europe returning Somalia for marriage, it was suggested that it was impossible for her to get married if she was not circumcised. "There would be too much shame" (older, first-generation Somali women in Cyprus); "they would call her names" and that she would be cut off from the community (Somali men in Cyprus). Somali men and women living in Cyprus equally characterised the social pressure to have a girl circumcised as unbearable, even if they were from a younger age group. However, all these focus group

[79] See for example, the regional FGM prevalence rates available through the Demographic and Health Surveys.

[80] A key exception, however, is Belgium, where hospital/medical records provide additional and complementary data.

discussions were conducted with individuals from the first generation, which may reduce the impact of migration upon their views.

In **Belgium**, Somali women (aged 26-47) and men (aged 21-39) from the first generation expressed a more nuanced position; whilst acknowledging the social pressure, they differentiated between types of cutting. Rural men expected their wives to have gone through pharaonic circumcision (Type III), whereas some Somali men in cities or residing in Europe may prefer their wives to have undergone sunna (Type I or II). Furthermore, they found that for "a Somali mother living in Europe, if she's already integrated, will not want to have her daughter cut" and "it is also possible that a man will not accept a girl who says that she has Pharaonic, whether in Europe or in Somalia" (Somali men's group Belgium). Some unmarried male participants said that they objected to marrying a woman who had undergone any type of FGM. This may demonstrate that amongst Somalis living in Belgium, the expectation to marry a woman who has undergone FGM – particularly Type III – is weakening. However, as it was not possible to conduct a focus group discussion with young Somali women from the second generation, one cannot judge whether they too are coming to see FGM as less necessary for marriage. Nonetheless, it is of interest that attitudes amongst first-generation Somalis in Belgium seem to be changing to some degree, whereas in Cyprus there appears to have been a limited shift of opinion on this issue.

In **Greece**, Somali women (aged 21-40) of the first generation agreed that it was mostly older people that still cut girls. In the past in Somaliland, if a man wanted to marry a woman, she had to be cut, but this is no longer the case. To these women, most younger men do not like their women cut anymore. Some added that "sunna" circumcision (Type I or II) was also fine. Regarding the marriageability of uncut Somali women who have grown up in Europe, these female participants said that it depended on the area. In smaller cities, the girls cannot get married if they are not cut. Argesha, however, "is free", as they characteristically said.

Marriageability and social pressure amongst Malians in France

Male participants suggested that in rural Mali, an uncut girl could not get married as she was considered impure and not able to control her sexual desire when her husband was away. "Those who have not been circumcised are always pregnant, even when their husbands are not there. If you don't cut your daughter, her behaviour will be of great shame to her brothers, cousins, uncles and aunts." (Malian men, France).

As a key difference to the men, second generation girls of Malian origin did not perceive the practice to be an important factor for marriage in France. The mentality was different; the husband would find out if a girl was cut after marriage. This reflects a disjuncture between the views of different sexes and generations in the same community, but also a difference in expectation depending on whether one is discussing marriage *in France* or *in Mali.*

Marriageability and social pressure amongst Sudanese in Greece

Older female participants (aged 38 and over) from the first generation told of various cases of uncut girls being returned to their parents after the wedding night and they were not accepted back until they had been infibulated. Sometimes negotiations took place as to whether the bride should go through sunna or pharaonic infibulation (Type III). The women were convinced that men liked small holes (closed through infibulation) because it gave them more pleasure to penetrate. The following proverb describes the value of infibulation: "Where can I find shoes made of this leather. You cut it and you stitch it and it's never destroyed".

Marriageability and social pressure amongst Nigerians in Italy and Malta

Women and men living in Malta and in Italy did not perceive FGM as an important criteria for marriage. Although in both countries Nigerians mentioned that the practice helps women to control their sex drive and stay faithful to their husbands until "death do them part" (older women, Malta), women and men said that the practice was disappearing in Nigeria as society was changing. FGM was no longer standard procedure among ethnicities that are known to practice; nevertheless, there may be individual cases where a man may request his wife to be cut to reduce her sex drive.

Marriageability and social pressure amongst Egyptians in Italy, Malta and Greece

Despite the high prevalence of FGM in Egypt, respondents in all three Member States stated that the practice was not a specific request upon marriage, nor was there any social pressure among members of the community or among in-laws to assure that the bride has undergone the practice. "It is preferable but it is not adamant to marriage. Circumcised or not, they get married" (men's group, Italy). In Malta, older women from Egypt responded that "the girl would still have a complete life" even if she was not cut. When Egyptian women spoke of female cutting in relation to marriage in Malta, they spoke of it in the context of well-being rather than as a marriage criteria imposed by the community. Young Egyptian women who had migrated to Malta under the age of 5 believed that virginity was more important than circumcision for marriage and that no one would actually know whether a woman had been cut or not, except for the parents. One participant was of the opinion that a young man would reject FGM for his sisters and daughters but prefer to marry an circumcised woman.

In Greece, older Egyptian women were shocked by Sudanese women's accounts of in-laws rejecting young brides because the girls had not gone through pharaonic circumcision. They could not believe that a man would enjoy having sex with a wife who had gone through more severe forms of FGM and did not believe that these practices were a reflection of Islamic tradition. One second-generation Egyptian woman said that FGM was practiced to assure the virginity of the girl upon marriage and that men would not want to marry an uncut woman. Another participant disagreed saying that cut women may end up spinsters and that uncut girls could marry whoever they wanted. None of the second generation girls suggested that FGM was mandatory for marriage.

For Egyptians, the importance of the practice was more strongly linked to aesthetic aspects than to marriageability.

Marriageability and social pressure amongst Guineans in Belgium and France

Second-generation women from Guinea-Conakry in Belgium explained that FGM was practised to make sure that a girl is a virgin upon marriage. Although they rejected FGM, they agreed that virginity was extremely important for the honour of the family and the respectability and reputation of the girl. In France, first-generation Guineans also emphasized the importance of virginity upon marriage.

Marriageability and social pressure amongst Iraqis in Belgium

The participants did not speak of the practice as a criterion for marriage.

Marriageability among second generation women of mixed backgrounds (Ethiopian, Nigerian, Eritrean, Egyptian) in Italy

Second-generation young women in Italy had more distant perspectives on FGM and marriageability, as if this was not a criterion that personally concerned them:

"Maybe in more rural areas it is very linked to marriageability whereas in an urban context it should be more linked to (social) respectability, you can brag and say I have a daughter who is 100% pure, there is no doubt about that. In Nigeria I think men are very proud when their daughters and wives have undergone the practice."

"In my opinion a non-mutilated woman cannot marry in Ethiopia, because she is considered impure… what a horrible thing! (…) It should not be like this, I might be romantic, but the way [I] think about the idea of love, you get married because you are in love, not because you are of a certain characteristics."

Control of a woman's sexual urges

Across all six EU Member States, the control of women's sexuality was mentioned as an important reason for practising FGM. This was expressed in different ways: Somali women in Cyprus said that uncut women were thought to be "running after every man" by the older generations and called "sex animal[s]". In Greece, first generation older Somali women said that if a girl was "closed" she would not sleep with other

men. Mothers liked their daughters to be cut so that they would no longer have to be afraid of them losing their virginity before marriage. If they were not cut, they had to be locked inside the house. If they are cut, young girls have more freedom. In Italy, the consensus among Nigerian women was "If they don't circumcise female children, any time when they grow up, it scratches there … feeling like making sex all the time"; "the non-circumcised lose control" (Nigerian women, Italy)

Although many participants were against the practice and accepted abandonment, they were concerned about girls' control of desire, discipline and education as expressed in the following way by older Egyptian women in Malta: "Something bad is going to happen if they stop tahara. (…) they use it to calm down the girls, not for sex but like I told you before … I have already tahara. I am already cut so I can control myself so I am afraid for my kids. If they stop tahara I am really afraid for them" (Egyptian women, Malta).

Second-generation Guineans in Belgium confirmed the above findings regarding control of sexuality – FGM is performed to reduce women's pleasure. However, they were not sure whether women's pleasure is actually reduced through the practice or whether this was an erroneous belief.

In Greece, some older women from Sudan suggested that in Egypt and Sudan it was very hot, which was why people are "in the mood" all the time (older women's group, Greece). Similar conceptions were expressed by some men; FGM was a form of birth control that is practised to protect women and make them safe. Women in hot climates have different body types than those in the North. "When it's hot, women are hot too" (men's group, Greece). Although there was general agreement with this statement, some Egyptians vehemently disagreed with the idea that FGM needs to be performed as a form of birth control so that girls don't get pregnant too early. Nevertheless, the belief was also common that if a "well developed girl[]" gets pregnant at an early age, her body will be destroyed by the time she is 40 and she will be sick all the time. Some Egyptian men felt it was selfish to take a woman's desire away from her for the benefit of men (men's group, Greece).

Iraqis in Belgium said that although FGM was commonly performed among their grandparents' generation for control of sexuality, it was almost non-existent during Saddam Hussein's rule, except by some groups in the South. Recently Daesh have caught girls and cut them by force in public places. FGM is practised by these militant groups as a form of violence and social control "*One cannot say that these people, Daesh and Malisjad, that they have a religion, have a certain thinking, they are people from different thoughts, different countries. It is done only to hurt the woman, to remove her feelings…*" (Iraqi woman, Belgium).

Purity

In Belgium, Somali older women explained that "Halalese" – one of the words referring to the practice meaning purification – is an expression that is clearly linked to Islamic practice. In France, Malian men also mentioned that uncut women produce more liquid and are less clean than cut women. Egyptian men in Italy emphasized that female cutting, like male circumcision, was an act of purification in their Islamic practice. However, there was a general consensus that it was up to the doctors who perform the cutting to judge "the shape of the clitoris to understand how and which parts should be cut" to ensure purity. Older Egyptian women stated that 'religious groups' instructed that the girl has to be taken to the doctor to decide. Young Egyptian women who had lived in Malta since their early childhood explained "some girls always have a bad smell and so they go to the doctor to do an examination. If they realise that the extra skin is bigger than usual, the doctor would give his medical opinion and ultimately the girl decides whether to do the surgery. Therefore, *hitan* is done for hygienic reasons."

None of the second generation participants in Belgium and France mentioned purity or hygiene as a reason for practising.

Aesthetics

Older Egyptian and Nigerian women (first generation) in Italy spoke of the aesthetics of the female genitals at great length, stating that this was the major motivation for the practice. Egyptian women in Italy unanimously stated that it necessary to bring one's daughter to the family doctor; if the doctor thinks that

"the part" does not grow "out of the body" too much, from the labia, then the young woman can avoid circumcision. Without going into as much detail, the same need for the doctor's evaluation was stated among Egyptians in Malta. Middle Eastern men (Egypt and Syria) in Greece also suggested that it was important to observe the development of the girl to evaluate whether she needed to be cut.

Older Nigerian women in Italy explained at great length that rather than performing FGM, other efficient techniques have been developed to reduce the growth of the clitoris. Various participants reported massaging or pressing a hot cloth onto their daughter's clitoris twice a day. This massage, according to the woman, has been successful, since her daughter's clitoris has not developed "really I did it to my daughter, now she is 6, she is not circumcised *and her clitoris is not pumped up*" (Nigerian women's group, Italy).

Second-generation girls in Greece, Belgium and France did not mention aesthetics as a reason for practising.

'Discouraging factors': What makes the practice undesirable among the different migrant communities?

Across all six Member States participants mentioned aspects that made FGM undesirable and would deter people from practising.

Loss of sexual feeling

In all countries, participants said that the disadvantage of the practice was that the woman loses sensation, even during intercourse with her husband. However, amongst some groups this was viewed positively, as shown below.

Egyptian migrants' views on loss of sexual feeling, in Greece, Italy and Malta

In Italy, women stated that "for 90% of husbands it is better if the woman has not done it (…) Because after that bit is removed she loses desire… to have sex, have marital intercourse." In Malta, women (young, first generation) only spoke of control of desire and reduced sensations in a positive way, that this would ensure the girls' behaviour; no disadvantages to this were expressed. Many women believed that men could not tell whether their wives were cut or not. Among Egyptian men (first and second generation) in Italy, the loss of sexual sensation was not discussed in a negative way either, only one man mentioned that he was against the practice the practice "because you cannot do surgery to withhold pleasure from a woman." In Greece, some Egyptian men felt "a lady who has circumcision becomes less happy" (Egyptian men's group, Greece).

Nigerian migrants' views on loss of sexual feeling, in Malta

In Malta, men (first generation) did not mention any sexual problems related to the practice. Some women said that they had no sexual problems; others complained of loss of feeling: "I feel bad because they took everything [that] make[s] you feel like a women, [that] is gone. It is dead, you can't wake it. So when you start to look into it, you find more details about it, you feel completely out". Other Nigerian women mentioned no sexual problems but instead felt that the practice helped them control their sexual urges better.

Somali migrants' views on loss of sexual feeling, in Belgium, Cyprus and Greece

Women in Belgium, Cyprus and Greece said that they suffered from lack of 'feeling' during intercourse and that it was painful. In Belgium, various women said that they did not experience pleasure during sex; some had not had sex for many years, had separated from their partners and said that they only started reflecting about their own lack of sexual pleasure once they came to Belgium – but not previously in Somalia. Various women said that they were married by force in Somalia and that they had no desire for their (ex-) husbands. In Greece, some women said that FGM affected their relationships with men and were concerned about their fidelity: "My husband gets angry because I do not feel anything and I don't like it. He tells me that he will leave me and go with a woman who is uncut." (Somali women. Greece). Furthermore they were seeking solutions to improve their sensations during sex: "I don't like men so much. They told me that in Europe you

can take this medicine and then you feel and you like men more. The man will go away because I don't like it and I don't feel.''

Somali men also showed themselves touched by sexual consequences. After marriage, sex is "too painful for her and a disaster for him" (Somali men's group, Cyprus). In Belgium, men discussed that sex was better with uncut women or those who have undergone sunna (Type I, II or IV) instead of pharaonic circumcision (Type III), which caused a lot of problems in their view. "Personally, I see women who have done Pharaonic, they marry and the couple divorce after a year (…) because the woman (…) says to her husband 'how is your presence useful for me, I feel no pleasure during sexual relations? (…) But the woman who has just done Sunna, she will keep her husband because she has pleasure with him."

Malian migrants' views on loss of sexual feeling, in France

Malians put more emphasis on the psychological consequences linked to sexuality. The second-generation young women said that sexual intercourse is performed among girls that have been cut as a form of rebellion against the values of sexual control among members of their community. A Malian woman who had gone through reconstructive surgery confessed: "I've been repaired but personally it hasn't helped. Perhaps I was already cut inside my head, because the surgery hasn't had any effect. A psychological follow up is really important. I've done a lot of mental work on myself and that really helps. Many women are ashamed and don't understand why you'd want to be repaired. As if feeling desire was something to be ashamed of and that that is something you're not supposed to feel.". As there is a great taboo around women experiencing pleasure, few Malians openly admit to experiencing sexual problems.

Sudanese women's views on loss of sexual feeling, in Greece

Women in Greece suggested that with Sunna (Type I or II), women still feel, whereas with Pharaonic circumcision (infibulation: Type III), there is just pain and all sensation is lost.

Guinean migrants' views on loss of sexual feeling, in Belgium and France

Some Guineans in France said that FGM affected women's sexual well-being and that they no longer liked sleeping with men after the cutting. In Belgium, second generation Guineans girls were not sure if women actually suffered from loss of pleasure as a result of the cutting or not.

Health problems and pain and psychological consequences

Participants talked of negative health consequences in different ways. Some spoke from personal experience and some did so in a more abstract way, pointing to campaigns that suggested there were consequences, which they themselves had not experienced.

Egyptian migrants' views on health consequences

Female participants in Italy (first generation) said that there were no health problems related to the practice, only psychological issues. Egyptian men spoke of the health problems in a more abstract way, as a reason for the ban on FGM. In the focus group discussion in Malta, the views regarding health consequences were mixed. Some suggested that European institutions have to understand that there are no health consequences to the practice and it does not affect their lives. Others said that the practice will affect the girls' health, that it will taint her memory and that it "kills the girl's soul". Egyptian women in Greece mentioned lack of sanitation during the cutting, which may lead to infections.

Nigerian migrants' views on health consequences, amongst those living in Italy and Malta

Nigerian men in Malta mentioned health complications due to unsterilized blades, which put the girls at risk of contracting HIV, problems during childbirth as well as psychological issues. Some men were not aware of any health complications and suggested it was the same as male circumcision. Women mentioned infection and had heard of infants bleeding to death after the cutting. Nigerian women in Italy did not speak of any negative health consequences but believed that the practice helped during labour "a non-mutilated

woman struggles to give birth because she struggles pushing" and "we (meaning her ethnic group) also believe that if you are not circumcised your baby will die".

Somali migrants' views on health consequences, amongst those living in Belgium, Cyprus and Greece

Somali women in Belgium and in Cyprus complained a great deal about the problems they had experienced, such as pain during infibulation and re-infibulation, period pains, complications during labour and witnessing girls die of excessive bleeding. "I suffered a lot in Somalia, where they always opened, closed, opened, closed at each birth. But I did not have any children here so I didn't suffer in Belgium". In Greece, birth complications linked to infibulation were described, such as children born with mental health problems, which was why doctors preferred to do cesareans. Fear of the baby's head being insured if de-infibulation took place during labour was also expressed.

Somali men in Belgium and in Cyprus were aware of these kinds of health problems linked to FGM.

Malian migrants' views on health consequences, amongst those living in France

Malian women in France were also aware of the health complications without going into explicit detail. One participant complained of stomach aches and problems urinating as a result of the practice. The psychological effects were more prominent in their descriptions. Malian men focused more on the aspects of the practice linked to honour rather than the consequences of FGM. "For little girls, age 2-3. It's very easy to do and they don't even realize what is happening to them. Their wound is taken care of easily and there are not problems until they return here." This reflects that men in the Malian community in France appear less aware of negative health consequences of FGM than women.

Sudanese women's views on health consequences

Various women told stories of complications linked to infibulation and death: "A friend of my father brought his daughter in and she had her periods and the blood couldn't run. She was in pain and she was screaming. She had to have an operation after [...] to open it, but the doctor had to give her a certificate that she was 'open' for medical reasons. Because nobody would marry her. After few years, she died."

Iraqi women's views on health consequences, amongst those living in Belgium

The women spoke of the practice as a form of psychological violence and control. "The young woman is full of life, and when they do that to her, she is destroyed, she becomes weak, they have taken a part of who she is..."

Stigma, especially when accessing health and asylum services

First-generation Malian and Somali women in France and Cyprus complained a great deal about being made uncomfortable due to the practice. In France, women felt that they were being treated differently because people knew that most Malians practise FGM. It made them feel as if they had no desire or sexual sensation and as if they were not "complete women" (older women's group, France). Medical examinations were also perceived as humiliating, if the medical staff reacted with shock or had never seen it before.

In Cyprus, older and younger women (both first generation) also told of embarrassing encounters with health-staff such as a doctor exclaiming "what happened here?" expressing shock during the consultation. As part of the asylum procedure, women were also asked if they had undergone FGM and later on doctors wanted to verify this. These procedures made women feel uncomfortable and they felt like they were "not the same as Western women". A Somali woman in Greece told the following story: "I was in the sea and I was sick. In a boat. Then there were four doctors who came to see me. And they looked there and it was all cut. They didn't know what I was [...] They asked me: are you a man or a woman? They asked me: did you have an operation? It was the first time they saw something like this.". Another Sudanese woman in Greece said that when she gave birth the doctors wanted to train medical students and asked if they could take photos of her; this made her feel very uncomfortable and she refused.

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

Women's accounts regarding stigmatisation show that their psychosocial well-being in some Member States is affected by health-care professionals' (1) limited experience with FGM-affected women, (2) limited sensitivity when addressing the issue, and (3) limited awareness of the socio-cultural complexity of FGM and the perpetuation of stigmatising messages that FGM is "backward" and "barbaric".

Services and reconstructive surgery

A Somali woman in Greece said that she had a lot of problems with doctors in Greece. She has been to the hospital many times and they never do anything for her, just examine her, but offer no services. They only give her painkillers but do not explain anything to her. The Sudanese in Greece also confirmed that there was a lack of services for women with FGM. Various participants said that they had heard of reconstructive surgery and would like to have it done. One Sudanese woman stated: "..there was a girl in Greece that had an operation for her clitoris.." Other participants asked her why she wanted to have an operation and she responded "I'll get married after I have a new, plastic organ. I don't want to get married now''. In Cyprus, none of the Somali participants had heard of reconstructive surgery but were keen to find out more about it and eagerly shouted "yes" once they had understood.

Although Guineans in France had heard of reconstructive surgery, they were not willing to talk about it; it was perceived as a taboo. Some second-generation Guineans in Belgium had heard about the surgery, others had not. There was a lot of curiosity about the practice and they wondered whether it could restore virginity. Somali participants were aware that this surgery is possible but they did not discuss it in detail. Malian participants in France had not heard of reconstructive surgery.

Men's awareness of stigma

Men from Somalia in Belgium and Cyprus expressed no awareness of women being stigmatized in any way. Nigerian and Egyptian men and women in Italy and Malta were not aware of any kind of stigma due to the practice in Europe nor for uncircumcised women when returning home. Men's lack awareness of women's sense of being stigmatised as 'mutilated' points to limited of communication between women and men about the practice. Previous studies have shown that men and women are very uncomfortable talking to each other about FGM (see, for example, O'Neill et al, 2017; Kaplan et al., 2013), which may explain why women do not share their psychosocial issues with their partners and acquaintances.

Have attitudes towards the practice changed?

In all six Member States, participants confirmed that attitudes towards the practice were changing among migrants living in Europe as well as in their country of origin. Somali male and female migrants said that 'less severe' forms of FGM were becoming more popular, particularly among younger generations. Egyptian men explained that the practice used to have religious justifications but nowadays it was perceived as linked to aesthetics and purity. Nigerian women and men stated that there was no longer a need to perform the practice; the mentality was changing because people travel and discover the ways of life in societies where the FGM was not common. They said that the practice was gradually perceived as "outdated" and "backward". Sudanese women in Greece said "it used to be shameful not to do circumcision. It's no longer the case. Five years ago, it was different". Malian women and men in France also distinguished between expectations back home in contrast to France where the practice entails serious legal consequences.

This is in line with previous research showing that migration has an impact on women and men's attitudes towards FGM (Johnsdotter et al., 2009; Wahlberg et al, Isman et al 2013; Gele et al., 2012; Morison et al

2004). Furthermore, some evidence suggests that the longer migrants stay in EU, the less likely they become to want to continue with the practice (Johnsdotter et al., 2009, Gele et al 2012, Morison et al 2004).

Awareness of the Law and Campaigns

In all six Member States, participants were generally aware that in their EU Member State of residence, FGM was illegal, except for some Somali men in Belgium. Particularly in France, participants were very afraid of the law and that their daughters were cut against their will when they returned home.

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

Iraqis were not aware of the law in Belgium but knew that FGM was illegal in some countries outside of Iraq[81]. As for Guineans in France, some had never heard of the practice being performed in France because of fear of the law; others said that regardless of the law Guineans continued practising. Egyptians and Sudanese in Greece were also aware of the law but mentioned that that was why some people returned home to have the practice done. Nigerians and Egyptians in Malta and Italy also showed awareness of the law. However, whereas Nigerians showed no interest in continuing with FGM, for Egyptians returning home to have the practice done was not excluded as an option.

These results show that the degree of awareness of campaigns varies greatly across study countries. Although there is awareness among female and male participants that FGM is illegal in Europe, some do not feel as threatened by the law and perceive returning home as an option to have the practice performed. Not all were aware of the principle of extra-territoriality whereby individuals can still be prosecuted even if FGM happens abroad.

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

It may be valuable to raise awareness of the extraterritoriality principle in national legislation, whereby individuals can still be prosecuted even if FGM happens abroad.

Risk of FGM in EU

None of the participants admitted to knowing about the practice being performed in their immediate surroundings.[82] Numerous participants seemed to suggest that it was easier to return home to perform the practice rather than trying to have it performed in the EU because it was illegal. Except for France, discussions around facing legal consequences upon their return were limited. This may be due to the fact

[81] However, the participants had only been in Belgium for a short period of time.

[82] They may be linked to respondent bias and social desirability bias. Furthermore, although the participants of the Focus Groups were assured that all information would be kept confidential and their identities would be kept anonymous, the respondents may have feared admitting to knowing anything knowing about the performance of the practice in case divulging this information may incriminate them in the future.

that, in Belgium, Italy, Cyprus, Greece and Malta, prosecutions for practising FGM are rare and thus migrants simply do not know what will happen to people who arrange for their daughters to be cut.

Risk of returning home

Somali migrants in Cyprus and Belgium, as well as Malian participants in France, suggested that the risk of being cut upon one's return to the country of origin could not be excluded as it was common practice there. Many participants said that their own families/communities were still practising and described the social pressure and negative reputation that uncut women have in those communities. For instance, various second-generation Guinean girls in Belgium described how older women enquired about whether they were cut when they visited their relatives in Guinea during the holidays. Some parents feared leaving their daughters alone with their relatives in rural Guinea and preferred to stay in Conakry. The participants said that many people told them to say that they had gone through the practice if enquiries were made. Although the girls clearly indicated that there was a risk they did not seem to be afraid or discouraged from returning home for a visit.

Somalis in Greece also suggested that it was more common to have girls cut back home than in the EU – although the law deterred many people as it was seen as too risky to have it done. The Sudanese and Egyptian participants in Greece suggested that people who wanted the practice performed on their daughters returned home. Nigerians and Egyptians in Italy and Malta did not perceive there to be a particular risk upon return, because the performance of the practice was the decision of the parents only – the wider community would not get involved. However if someone felt that it was important to perform the practice – either upon the husband's request or a doctor's recommendation – then it would be performed.

Concluding remarks on girls at risk in Belgium, Cyprus, France, Greece, Italy and Malta

An understanding of risk of FGM requires an understanding of the factors that motivate and discourage people from practising. Motivating factors include fears around girls becoming sexually promiscuous at an early age, marital infidelity and unwanted pregnancies. Further aspects were aesthetics and notions around purity. The importance of these factors was heightened if any of this was linked to a girl's marriageability, such as in Mali, Somalia, Guinea and Sudan. Aspects that discouraged the practice were health and psychological consequences, loss of desire, as well as stigmatization due to FGM in Europe and the law against the practice. The latter are strongly discouraging – people feared the consequences of the law more than the consequences of not practising – particularly in France. Among communities where there is limited awareness of the law and the consequences of FGM, research participants were more open to the option of returning home for the practice (i.e. Egyptians for reasons linked to aesthetics or their daughters' control of desire).

Stigmatisation frustrated and deterred women from many communities from desiring the practice for their own daughters. Surprisingly, second-generation girls and men were hardly aware of the psychosocial issues women who had gone through FGM were experiencing on a personal level nor when using health facilities. The presence of campaigns against the practice and awareness of the legal consequences seemed to have an effect on people's attitudes and to the feasibility of returning home for the practice. Migrants who were well-informed of the legal consequences and who felt stigmatized due to the practice did not show much interest in having their daughters cut – in contrast to people who had little awareness of the consequences, had limited knowledge of legal situation and for whom stigmatization was not an issue.

The less time individuals had spent living in the EU, the stronger their ties to their families and the social norms back home.

Additional insights from interviews

As part of this study, interviews with a range of key stakeholders were undertaken, including with: national ministry representatives with responsibility for FGM, senior academics with relevant expertise, public servants with key experience (for example, staff in health services), and NGO representatives.

Scale of the issue

Challenges for eradicating FGM

A wide range of challenges to tackling FGM were mentioned by the interviewees. The following sub-headings outline the most commonly mentioned perceived barriers to eradication of the practice.

Need for training

Interviewees echoed the idea of the limited competence of some health professionals – an idea that emerged frequently in the focus group discussions (see above). The need for training was cited by civil servants and NGO representatives at EU and Member State level (Belgium, Cyprus, Italy, Malta). Interviewees from Italy and Cyprus stressed the need for training to occur on a systematic, national basis, thereby avoiding uncomfortable instances of doctors coming across FGM for the first time with patients, as recalled in by several focus group participants. A public servant in Malta stated:

"sometimes I am shocked, even health professionals, they've heard it before but they don't know really what it implies and how many types [there are]"

Difficulty reaching affected communities

The challenges caused by the covert nature of FGM are heightened due to the difficulty of reaching affected communities: a point referred to by many interviewees, including national government representatives in Greece and Malta, NGO representatives, many academics and the European Commission. Some interviewees attributed the unwillingness of some women to share their experiences to the fact that many women do not consider themselves 'victims', as cultural norms mean they do not view FGM as abusive. This should be considered in line with the reasons mentioned in the focus group discussions for undergoing the practice, with FGM influencing girls' perceived respectability and reputation.

The importance of avoiding treating migrant communities as one homogenous group was reiterated by numerous interviewees (from Malta, France, Italy and the EU level). For instance, a Maltese interviewee described the regular movements of the Somali community, which mean that they are a difficult community to reach. Also, from the experiences of this interviewee, Somali men were shocked when informed about what FGM entails and did not want their daughter to become a victim. This mirrors the a limited awareness amongst Somali men in Belgium and Cyprsu regarding the stigmatisiation experienced by cut women, as noted in the focus group discussions. Numerous interviewees emphasised the importance of acknowledging the differences between communities, which in turn impacts strategies to prevent FGM; one representative from an EU level argued that it is the EU's responsibility to support people within affected communities to bring about change from within.

Need for action in the country of origin

In line with the focus group discussions, social pressures in the country of origin were likewise highlighted in the interviews. The Belgian academic argued that engaging communities that reside in Belgium will not help if nothing is done in terms of campaigns and legislation in the country of origin. This was echoed by Italian interviewees, who recommended further cooperation between Member States and countries of origin. An EU level interviewee stressed that different strategies are needed in different countries of origin; the social pressures encountered by a girl from Mauritania is very different from a girl from Somalia or Egypt.

Reaching the general public

A lack of awareness of FGM as an existing problem in EU countries was mentioned by many interviewees from both the EU and Member State level (Italy, Cyprus, Malta, Greece, Belgium). The clandestine nature of FGM, as noted by some of these interviewees, heightens this problem, with FGM widely perceived as "something happening somewhere else". The importance of informing the public about FGM was seen as important by several interviewees, with some emphasising the need for dialogue between informed

members of the public and affected communities. Whilst an NGO representative claimed that information campaigns will avoid prejudice, awareness-raising attempts must ensure they acknowledge the socio-cultural complexity of FGM to avoid stigmatising messages, as raised in the focus groups.

Prosecutions

A lack of reported cases of FGM, as well as extremely few convictions, was the picture presented by interviewees from Member States (Belgium, Greece) and the EU level. An EU-level interviewee pointed out that, given that FGM is illegal in all Member States, this demonstrates the challenges of the law not being enforced adequately. One reason outlined for this was the fear that children will be taken away from their families, as can occur in child abuse cases, but which does not necessarily occur with FGM. Another EU-level interviewee also emphasised a sense of frustration that, if FGM is indeed reported, no action is taken.

Controversial national debates and lack of political will

The controversial nature of debates around FGM was referenced by some interviewees, such as whether medical examinations of young girls' genitals should occur, which is not common practice in the EU. Numerous interviewees felt that there is a lack of political will to deal with FGM, both at Member State level (Cyprus, Malta, France, Belgium) and EU level. This was often cited in relation to asylum provisions, undoubtedly a politically sensitive topic at present.

Lack of funding

A lack of funding, particularly in relation to training provision, was identified as a challenge in Italy and Belgium. An EU-level interviewee felt that the effectiveness of policies is essentially down to the adequate provision of resources.

Harmonisation at the EU level

The primary challenge at the EU level was the need for improved harmonisation and cooperation between Member States (mentioned by several interviewees, from Belgium, Cyprus, France and the EU level). A French interviewee emphasised the benefits of sharing good practice, whilst a Cypriot interviewee argued for more uniformity at the scale of the EU. Likewise, one representative focussed on the lack of homogeneity in the context of asylum procedures. A slight contradiction surfaced between the views of an academic and an EU-level representative. The former believed that FGM should be tackled alongside all sorts of violence against girls and women (e.g. forced marriage, intra-partner violence). The latter representative raised concerns around FGM becoming a diluted issue through a more mainstreamed approach in instruments at EU level, causing difficulties when providing practical support at the micro-level.

Impact on FGM of recent arrivals of migrants, refugees and asylum-seekers

Member State and EU-level in-flows

In many interviews, there was a sense that the prevalence of FGM is increasing alongside 'influxes' of migrants from FGM-practising communities into the EU (according to a range of interviewees from Member State governments, academia and NGOs). Interviewees from Cyprus and Italian argued that this means the level of attention that the issue receives must increase as a result. However, interviewees from different Member States expressed varying opinions on how the number of migrants they had accepted compared with other Member States. A UNHCR representative felt that the increases in Cyprus were not comparable to other Member States. Moreover, interviewees from Malta agreed that the demographics of migrant communities in Malta have changed from Somali migrants to those from the Middle East, with different needs. Academics from France and Italy discussed the relatively unknown impact of, and potential opportunity posed by, growing second-generation communities, with regards to the population at risk of FGM.

Impact of Member State law and policy on in-flows

Differences between Member States in terms of their policy and legislation on FGM was noted as impacting flows to the country, as well as the treatment received by migrants upon their arrival. For example, an interviewee drew attention to the attractive conditions of Cyprus' policy of granting protection to all girls and women who have undergone FGM. However, it was felt that there is a need for more coordination between the services dealing with migrants upon their arrival, such as cooperation between the Social Welfare Services, the Asylum Service, the staff at Reception Facilities, and wider immigration staff.

Gender-sensitive asylum procedures

Interviewees highlighted the difficulty experienced by many women seeking asylum on FGM grounds in proving their claim or being taken seriously, particularly alongside their reliance upon a cultural mediator to portray the correct information. This point is worth considering in relation to concerns expressed by the European Asylum Support Office around the treatment of vulnerable people following accelerated procedures in place following the Europe-wide increases of migrants. This was echoed by a Greek representative, who argued that the extremely high numbers of asylum seekers, in combination with different types of vulnerabilities among this population, hinders the Asylum Service from responding to vulnerabilities on an individual basis. The system being under strain, and a limited availability of rooms, are also problems for responding to the needs of vulnerable asylum seekers, according to an Italian interviewee.

The revised Asylum Procedures Directive 2013/32/EU, which aims to ensure that all EU Member States consider gender in relation to asylum applications and develop gender-sensitive procedures, was discussed in interviews. Some interviewees were positive about the level of compliance with the requirements of the Directive. However, two EU-level interviewees felt that insufficient investment for financial and political reasons could halt progress in Member States.

The interviewees consistently conveyed concerns around a lack of training in gender-sensitive asylum provisions. Many critiqued the sporadic nature of training which is leading to, for instance, inconsistencies in the medical examination of applicants. An interviewee from Cyprus noted some implementation of training of asylum seekers by Non-Governmental Organisations; however, given that FGM is seen as a low priority, there is limited knowledge, awareness and experience of professionals on the issue. A government representative from Malta highlighted the value of training they have provided to stakeholder around integrating a gender perspective. The work of the European Asylum Support Office, which is gradually enlarging and goes in the direction of supporting gender-sensitive procedures, was praised by multiple interviewees.

Legislative framework

Member State level legislation

Without a clear legislative framework, one NGO representative asserted that efforts to eradicate FGM, such as training provision, are simply "words in the wind". This supports the view expressed by focus group participants that fear of the law prevents FGM from taking place. Interviewees from Belgium, Italy, France and Malta all praised various legislation to prevent FGM. For example, an interviewee from Belgium perceived substantial progress due to the specific criminal law on FGM since 2001 (Article 409 in the Penal Code) and the social security system reimbursing multidisciplinary care (medical, paramedical, psychological and social support, reconstruction) for women suffering from FGM.

However, a series of legislative limitations were also discussed in the interviews. In Greece, this was principally due to a lack of FGM-specific provision in the law, as mentioned by multiple interviewees from this Member States. The primary problem with legislation was a lack of enforcement and effective implementation (cited as an issue by Belgian, Italian and EU-level interviewees). This reflects the consensus amongst French focus group particpants that strict law enforcement has a strongly discouraging effect. An Italian interviewee felt there were elements of their law that warrant updating, such as the emergency landline that was established but is no longer in use.

EU Level legislation

It was predominately felt that legislation on FGM at the EU level is adequate, as reflected by the recognition of FGM victims as a vulnerable group in Article 21 of the Reception Directive, to use the example given by one interviewee. However, the main problem identified by interviewees at Member State and EU level is the effective implementation of EU legislation. Many interviewees drew attention to differing standards between Member States, in legislation terms and the extent to which FGM is a priority issue. Several interviewees referred to the Istanbul Convention, praise it for being a uniting force across the EU.

Policy framework

Awareness-raising campaigns

A wide range of different policy initiatives led by various organisations are operating across the Member States. Many interviewees referenced the important work being done by national and international Civil Society Organisations, which is beneficial considering the views expressed in the focus group discussions that people's attitudes towards FGM are influenced by the presence of campaigns against the practice. Three interviewees also mentioned the integration of FGM in their country's National Action Plans. Interviewees in Italy, including a government representative, mentioned the forthcoming National Action Plan on male violence against women, which will include a reference to FGM.

Limitations in policy initiatives

In Greece, one interviewee suggested that FGM is not considered a priority issue on a policy level, thus, policies are not specific to FGM. This supports the lack of campaigns in Greece mentioned in the focus group discussions. This view was shared by an interviewee in Cyprus, who felt Cyprus needs more campaigns, training of professionals and lobbying initiatives. Italian interviewees mentioned poor coordination between initiatives organised by different organisations and across different regions. Furthermore, a lack of adequate funding was seen as a barrier to the effectiveness of the work of Civil Society Organisations in Belgium.

EU Level policy initiatives

The interviews were somewhat inconsistent about the extent to which policy initiatives at the EU level are adequate, with some debating the extent to which FGM is a priority issue. The EASO has undertaken various initiatives, such as an online training module on gender for asylum officers, which includes information on FGM. Nonetheless, as noted previously, there is a lack of harmonisation and differing policy standards between Member. This relates to a point raised by an EU level interviewee around the difficulty of enforcing EU actions in Member States.

The role of services in tackling FGM

The importance of establishing an integrated approach to tacking FGM between relevant services was regularly addressed by various interviewees from Belgium, Cyprus, Italy and Malta.

Health

The role of health services received the most attention in the interviews (mentioned by government officials, NGO representatives and academics in Belgium, Italy and Malta). This in in line with the importance of the negative health, pain and psychological consequences of FGM, as mentioned by focus group discussion participants across all Member States. Interviewees listed various examples within the sector in their respective Member States to tackle FGM. For example, a Belgian interviewee claimed that the health sector is more active than other sectors, using the example of two medical centres established for women affected by FGM with total reimbursement by social security for their services provided (e.g. psychological, surgery). Likewise, an Italian interviewee felt that the health service is the most proactive. A Maltese interviewee listed various training provided to practitioners, arguing that midwives and nurses are more aware of FGM, as is reflected in them actively asking migrants if they have undergone FGM and keeping records of mothers giving birth to girls who could be at risk. To this interviewee, obstetrics and gynaecology departments, and emergency departments, are also more aware, due to FGM being viewed

as an important health issue of the last few years. However, another interviewee believed that FGM was "not tackled very well", due to limited policy guidelines for healthcare practitioners. Likewise, another Maltese interviewee felt that more training of professionals working with victims and girls at risk to enhance their sensitivity was required.

Education

Interviewees from Cyprus, Italy and Malta viewed the education sector as being of paramount importance in the prevention of FGM. Safeguarding measures were cited by the Italian government official, whilst a Maltese public servant mentioned that teachers are trained to look out for certain behaviours in girls that could indicate they are at risk of FGM.

Asylum

Much of the discussion in relation to the role of the asylum services in tackling FGM related to the provision of gender-sensitive asylum procedures. Various examples of efforts made in each country's asylum services were discussed by interviewees. For example, Belgium pursues the 2016-17 'FGM Global Approach' by the Asylum and Migration and Integration Funds (AMIF), GAMS and INTACT in partnership with FEDASIL (Agency federal for the reception of asylum seekers). This offers training in FGM for asylum seekers within 30 days of arrival and offer gender-sensitive medical, psychological and legal assistance. The interviewees from Cyprus and Greece did not mention FGM-specific asylum service provisions, but drew upon training and guidance offered by UNHCR. The mention of focus group participants from Cyprus being informed of FGM awareness-raising campaigns at Cypriot asylum centres is perhaps reflective that this training is having some impacts. The Italian government official perceived the health and asylum services as being most proactive in terms of tackling FGM, with the Ministry of Foreign Affairs and International Cooperation (MAECI) viewed as treating FGM as a priority. The Maltese public servant mentioned two focus groups that they arranged in open centres, which offered direct access to affected communities.

Other services

Several other services were mentioned in the interviews as having a role in tackling FGM. Some interviewees highlighted the role of women's services that are not FGM-focussed, such as shelters for women experiencing gender-based violence. Interviewees from Malta and Belgium mentioned the police's impact on prevention, with both feeling that more training of the police in handling reports of FGM is needed. An EU level academic also highlighted the role of youth institutions in the Netherlands.

8.1.3 Applying the risk estimation methodology

Qualitative component:

Recruitment channels

All six research teams liaised with civil society organisations to recruit participants for the focus group discussions, for example, Future Worlds Centre in Cyprus, a civil society organisation providing support to asylum seekerns and refugees in Cyprus. Institutions working with migrants were often relied upon, such as the health centre for forced migrants (SaMiFo) in Italy. Contact with second generation organisations was specified by the research teams in Ital and Greece, whilst migrant/cultural mediators were utilised by France, Greece and Italy. Less typical recruitment pathways used by the research teams include contacting Imams from different mosques in Italy, assistance from the UN Refugee Agency in Malta, and targeting participants that could speak English via the Mediterranean Institute of Gender Studies in Cyprus. Research teams relied upon a combination of snowballing, word of mouth and dissemination of information through various communication channels, including phone calls, emails and social media.

Recruitment challenges and solutions

The research teams encountered various challenges whilst recruiting for the focus group discussions. Across all six Member States the teams encountered difficulties recruiting second generation girls aged

over 18, particularly in Italy, Cyprus and Malta. In Italy and Malta this was primarily due to the number of young women in this sub-group being relatively small, with Malta specifically experiencing reductions in the size of the migrant population since 2012. In Malta, from the small number of migrants that are in the country, only a few were found to have had daughters who were either born in Malta or who had reached Malta younger than the age of 5 and were still residing in the country. To some extent, Malta is deemed as a transitory country, where few migrants settle long term. The French and Italian researchers highlighted that second generation women have fewer links to organisations working on the issue. Likewise, in Greece, it appeared that young women did not know a lot about the practice. Another issue is that there are not always specific places where second generation women with a shared country of origin group together (like mosques or traditional restaurants etc.), as they may not be integrated into their parents' networks.

A reluctance of participants to discuss such a sensitive subject matter was a barrier to recruitment identified by the Belgian, Greek and Maltese research teams. In Malta, this was due to fear and stigmatisation surrounding the topic. In Greece, migrant women and men from FGM-affected communities were concerned about discussing the issue with other community members. For instance, two female migrant activists feared hostility from community members if they discussed the "sensitive issue", despite anonymity protections and their clear position against FGM. This unwillingness to engage with FGM also extended beyond individuals, to migrant and refugee networks and organizations. The research team noted that this reluctance may stem from a lack of experience discussing FGM in a research setting or due to its omission from wider public debates. Sensationalist articles appear occasionally, and local migrant and refugee communities often consider their portrayal in the media is offensive or stereotyped. The focus group discussions, however, showed that for migrants and refugees in Greece, it is very important to open up the discussion on FGM in ways that are not offensive.

The short timeframe to arrange the focus groups was a logistical issue that made recruitment very difficult in some countries. A logistical obstacle for Malta was that many participants were single mothers with only limited childminding help. Some groups – already identified as 'hard-to-reach' – were difficult to engage due to their limited contact with existing services or FGM clinics, such as Iraqis in Belgium or Somalis in Malta.

A range of solutions were used to overcome the various recruitment challenges in the six Member States. In some cases, incentives were used to recruit participants. Hot meals were commonly provided as an incentive for individuals to participate. In Cyprus, there was an offer of supermarket coupons by MIGS, in lieu of a hot meal. As a result of this incentive, for the first two focus group discussions, the actual turnout on the day by far exceeded the amount of persons who had confirmed.

With regards to hard-to-reach groups in Malta and Belgium, the research teams adapted their target population. In Malta, an inability to reach Somalis meant it was decided that these two focus groups would be held with Nigerian participants, since they were the second largest group of applicants in the country. They were also easier to reach and expressed interest in participating. In Belgium, female Iraqi asylum-seekers participated, as Iraqi women residing in Belgium for a longer time could not be recruited.

Other challenges and solutions

Although every effort was made to maintain a neutral position on FGM and to give the space to the focus group participants to express themselves freely, to some extent, the very decision to discuss FGM means to some extent that the discussants are willing to question it; furthermore, some individuals may have feared expressing pro-FGM views in light of possible criminal consequences. Both these factors contribute to possible bias in the perspectives of those who choose to attend focus group discussions. To overcome this as far as possible, national research teams recruited widely and emphasised that all views expressed would be kept anonymous and confidential, in line with the applicable national legal framework on FGM.

An additional factor that may have influenced the results of the focus group discussions was peer pressure and dynamics amongst the participants themselves. For example, in Cyprus this was particularly the case in the focus group with the men. To overcome this, facilitators emphasised that the sessions represented a

'safe space' and aimed to make all participants as comfortable as possible in expressing their views. Another solution that appeared to mitigate against this issue was the use of mixed sessions; when participants came from different communities and most had not met before, this appeared to reduce the influence of peer pressure on the discussion. The Greek research team emphasised the importance of including different communities within focus groups to ease peer pressure and enable productive discussions. It was important to also ensure that participants who spoke the same language were brought together (e.g. Arabic, Greek and English).

Quantitative component:

A number of common challenges when applying the risk estimation methodology across the six Member States can be identified:

- Most often, no data on the number of female migrants was available disaggregated by region of origin/ city of birth. This was the case for all six Member States. This undermines the accuracy of the FGM risk estimations, as it is not possible to tell whether individuals come with regions with above- or below-average FGM prevalence rates. In addition to the lack of this data, in some specific cases, data was not available because of confidentiality procedures, depending on legislation at the national level. Furthermore, data was generally not available by father's country of origin and, in some cases, information of the mother's country of origin was not recorded or unclear. Although it was not possible to overcome these difficulties, each country chapter indicates the limitations at the beginning and in Notes beneath tables/figures, for methodological transparency.
- Data was in some cases not disaggregated by first and second generation. Where this data gap was identified, records from the national censuses could be used for the calculation of estimations. This was the case, for example, for Greece. Without such a step, the risk estimations for the Low and High-Risk scenarios could not be calculated. As indicated in the country chapter, this was, however, particularly problematic in Greece, where the permits data is likely to under-estimate significantly the number of second-generation girls at risk of FGM.
- It is extremely unusual for age and generation disagreggations to be available alongside one another, necessitating the combination of some datasets.
- Even where the data is collected, it was often not publicly available. Across the Member States, only partial data was publicly available, and further disaggregated data was to be requested specifically to the relevant authorities. In some cases, no data was publicly available at all. However, as specific data requests were made to all statistical institutions in good time, this did not ultimately pose an issue to the delivery of the research.
- Data collection on irregular migrants aged 0-19 from FGM-practising countries was in most cases problematic, as this is not officially compiled by national statistical institutes. To overcome this, the team also considered non-official sources. Civil Society Organisations in Belgium and Greece collected some indirect data that could be used as proxies. For example, in Belgium, Médicins du Monde conducted some data collection activities that were useful for this specific purpose. Malta could provide the most data: however, there were still challenges.
- In general, across the Member States, data and information on specific groups is collected according to specific definitions as to what they entail and encompass. In the specific case of 'irregular migrants', the present study refers to a group of people that do not, or no longer, fulfil the legal conditions for stay or residence in a country. However, at a practical level, data collection in the Member States might be conducted according to a different definition. For example, Malta is the Member State with the closest definition of 'irregular migrant': this might be the reason why it is the only country that could provide most needed data in this context. However, Malta's definition does not include third country nationals found to be illegally present who arrive by transport methods other than boat. This is one of the reasons why the collected data is likely an under-estimate. These difficulties are highlighted for methodological transparency in the country chapter.

- Discrepancies in definitions reflected in the data collection can be identified in other Member States as well. For example, this study defines 'first-generation migrant' as a person usually residing in the territory of a country for a period that is, or is expected to be, at least 12 months, having previously been a usual resident in another Member State or a third country (Eurostat). However, in Belgium, some migrants can be in the country for less than 12 months and they can be registered in the National Population Register if they have the relevant residence permit. This difficulty is highlighted for methodological transparency in the country chapter.
- Data for the number of migrants from FGM-practising countries that enter/leave the Member State was difficult to collect. Belgium and Italy have the closest available data, but a number of disaggregation characteristics were missing.
- It is particularly rare for Member States officially to collect data via other public records. However, there are some exceptions, such as Belgium, where medical/health records can provide some additional information. This is, for example, the case when it comes to the collection of data for the number of FGM cases identified amongst girls aged 0-19. Belgium was the only Member State that could provide some information in this context, specifically using medical records.
- Concerning the number of FGM-related asylum applications received and granted in the Member States, since 2011 for girls aged 0-19, only Belgium and France were able to provide some data. However, in Belgium, not of the requested disaggregations were available; in France, it was possible only to find data on the number of FGM-related asylum applications granted (not received). In the remaining four Member States, no data was available. Greece collects some information on the reasons invoked by asylum-seekers: however, the reasons are classified under wider categories, and, therefore, no FGM-specific ones could be identified.
- Overall, it was often possible to retrieve data only for specific intervals and years. For example, in Malta, data was available only for 2011. Thus, identifying trends over time was problematic.
- Further country-specific problems for estimating girls at risk resulting from the available data were identified for each Member State, and are explained in more detail at the start of each country chapter, as well as the solutions adopted.

8.2 Comparing the findings from the six Member States with the findings from Ireland, Portugal and Sweden in EIGE's earlier study

8.2.1 Estimations of girls at risk (results)

EIGE's 2015 study on the Estimation of girls at risk of female genital mutilation in the European Union was pilot-tested in Ireland, Portugal and Sweden. Key findings can be compared to the ones from the six Member States in the present study.

- Ireland: in 2011, out of 14,577 girls aged 0-18 (first of second generation) 1 %-11% of girls were at risk of FGM.
- Portugal: in 2011, out of 5,835 girls aged 0-18 (first or second generation) 5%- 23% of girls were at risk of FGM.
- Sweden: in 2011, out of 59,409 girls aged 0-18 from FGM-practising countries (first and second generation), 3%-19% of girls were at risk of FGM.

This information is presented in the Table below, alongside the results from this round of this study. Although this study focused mainly on the age category of 0-19, here the risk estimates are provided for the age group 0-18, to ensure comparability with the last study.

Table 8.4 Estimated number and proportion of girls at risk in the six Member States of the study in 2011

Member State (Year)	Total population of girls from FGM-practising countries	LOW SCENARIO: Proportion of girls at risk	HIGH SCENARIO: Proportion of girls at risk	LOW SCENARIO: Number of girls at risk	HIGH SCENARIO: Number of girls at risk
Ireland (ages 0-18)	14,577	1%	11%	158	1,632
Portugal (ages 0-18)	5,835	5%	23%	269	1,365
Sweden (ages 0-18)	59,409	3%	19%	2,016	11,145
Belgium (ages 0-18)	14,825	8%	24%	1,254	3,555
Greece (ages 0-18)	1,896	8%	43%	161	817
France (ages 0-18)	41,558	5%	14%	1,968	5,886
Italy (ages 0-18)	59,720	5%	20%	2,946	11,655
Cyprus (ages 0-18)	777	4%	14%	29	105
Malta (ages 0-18)	485	9.7%	38%	47	183

The most represented countries of origin of girls at risk of FGM in Ireland, Portugal and Sweden, as found in EIGE's 2015 study, are represented in the following table.

Table 8.5 Most common countries of origin for girls at risk of FGM in Ireland, Portugal and Sweden, 2011 (presented in descending order, from largest to smallest)

Ireland	Portugal	Sweden
Nigeria, Somalia, Sudan, Egypt, Sierra Leone	Guinea-Bissau, Guinea-Conakry, Senegal (extremely low numbers from other countries)	Somalia, Iraq, Egypt, Ethiopia, Gambia, Eritrea

Source: Table retrieved from data from EIGE (2015, pp. 56, 65, 76).

There are some similarities with the most represented countries of origin of girls at risk of FGM in Ireland, Portugal and Sweden and in the six Member States reviewed in the present study. Egypt, Eritrea, Guinea Conakry, Iraq, Nigeria, Senegal, Somalia and Sudan are countries that one can see represented at different levels across the data of the nine Member States.

The variety of most represented countries of origin of girls at risk of FGM across the Member States countries shows a need for Member States to design and implement policies that are sufficiently tailored to the needs of the FGM-affected communities they target. More regular and disaggregated data collection is essential for this purpose.

8.2.2 Interpreting the situation from the qualitative perspective

As in the previous study, this study shows that there is awareness of the law, of health consequences and religious requirements of FGM among different FGM practising migrant communities across the six Member States. However, the degree of importance of these attitude-changing determinants varied. Malian participants in France were not only aware of the law but terrified that their daughters would be cut

against their will when they returned home and that this would have life-changing consequences for themselves and their families. Guineans on the other hand, who are a minority group in France, were aware of the law but did not seem as threatened by it, suggesting that some people who want their girls to be cut still find ways of having it done.

The law discouraged people to varying degrees in Belgium, Malta, Italy, Greece and Cyprus. In this year's results, most participants took for granted that FGM was not a religious requirement but for some it had importance as a Prophetic recommendation or 'Sunna'[83]. Health and psychological consequences were mentioned by participants across all six Member States to varying degrees of importance: some spoke from personal experience, others in a more abstract way as a reason for the law. Additionally, in all focus group discussions, loss of sexual feeling was mentioned as a negative consequence of the practice by women and men. Although a few participants did not perceive this to be a negative but a positive aspect of the practice, the majority linked it to psychological consequences, the breakdown of relationships, divorce and a sense of "loss of womanhood" in the European context. These psychological consequences, in combination with a sense of stigmatisation at health-centres, in media messages and in the attitudes that FGM is 'barbaric' and 'backward', seemed to have a strong impact on women (and men's) attitudes towards the practice.

As in the previous EIGE study, people find it difficult to speak about the FGM cross-gender and across generations, because it is a taboo. Multiple studies have been done on lack of communication about FGM since the UNICEF Report (2013) showed that significantly more men in Sub-Saharan Africa want to stop the practice than women think, but there is no communication between married couples, brothers and sisters, parents and children about FGM. Research has shown that the provision of adequate information, the involvement of men and the encouragement for women and men to communicate about the practice have a positive impact on people's attitudes towards abandonment in Europe, Sub-Saharan Africa and beyond (Kaplan et al 2013 , O'Neill et al 2017, Varol etc).

The previous EIGE study also suggested, in line with previous research (Kaplan 2013, O'Neill et al 2017), that women are the main decision-makers regarding the performance of the practice, men are mostly not involved in the practical arrangements and not always aware of when their daughters are cut. However, when men do get involved their decision dominates over women's wishes. A number of participants in this year's research mentioned occasions in the past when men requested for their brides to be infibulated and returned them to their parents. Various young male participants said that they rejected the practice and preferred for their wives not to be cut. These are powerful messages, as research shows that marriageability is a crucial aspect affecting the continuation or abandonment of the practice. This year's findings showed that first and second generation migrants in Europe were concerned with respectability and virginity upon marriage. Although most women and men across all Member States would prefer for girls' sexuality not to be controlled through FGM, many seemed very concerned about girls 'losing control' or becoming promiscuous, and were somewhat helpless as to what else could be done to protect and preserve girls. Educational messages and programmes helping parents and girls to deal with these fears, expectations and ideologies are needed because if these concerns are unresolved girls are at a higher risk of getting cut.

8.2.3 Applying the risk estimation methodology

EIGE's 2015 study reports similar challenges to the ones encountered in the data collection for the present study. The information collected at national level did not provide details on migrants' region of origin. As previously indicated, this would allow for more enhanced estimation since FGM rates vary widely within the countries of origin (EIGE, 2015, p. 79). A common challenge in data collection for both studies entails the

[83] Research shows that for many FGM practising communities the question of whether FGM is a religious requirement or merely a recommendation of the Prophet Mohammed (hadith) or Islamic tradition (sunna) is crucial. Those who believe that it is a religious requirement are impervious to abandoning the practice. Those who come to interpret the practice as a recommendation, such as cutting one's fingernails or pubic hair (fitra) (Abu-Salieh 2001), are more open to abandonment if they understand the negative consequences of the practice (O'Neill 2013, O'Neill et al 2017 more refs to be added)

exclusion of irregular and undocumented migrants in the estimations. In EIGE's 2015 study, some micro data was available in Ireland where, however, the numbers were very low and, therefore, additional information could not be provided to the researchers due to privacy concerns (EIGE, 2015, p. 79).

EIGE's 2015 study considered the lack of data when developing the methodology, and used 'proxies' to overcome the gaps when calculating estimations. For the present study, this was often the case because of incomplete data on the second generation, and the need to project the size of this population using live births data from 1997 to the present day.

The limitations in data collection encountered by researchers in EIGE's 2015 investigation also concerns the accessibility to specific datasets. In Portugal and Sweden, for example, some datasets could only be obtained upon payment of a fee (EIGE, 2015, p. 79). In this study, similar challenges were encountered for France and Italy, although the data was ultimately provided for free due to the public nature of this research.

In EIGE's 2015 study, the team encountered a range of challenges in applying the risk estimation methodology to Ireland, Portugal and Sweden. Challenges common to the three pilot Member States (EIGE, 2015, p. 79) were as follows:

- None of the datasets required for estimating FGM risk were available through the internet in any of the three countries
- None of the countries' information contained data on migrants' region of origin
- Need to be careful when collecting data ofn female asylum seekers and refugees: 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 factrs for migration are different when compared to the resident migrants
- Exclusion of irregular/undocumented migrants in the estimations: data for this group generally not available. Case of Ireland: microdata exists, but numbers are very low. Therefore, data could not be provided because of privacy concerns.
- FGM risk estimation could only rely on data about mother's origin
- FGM risk estimates cannot be completely accurate due to the private nature and secrecy around the practice and ethical concerns

The unrealistic options for data collection, as identified by EIGE's step by step guide on FGM risk estimation, read as follows:

- Collect information about the father's country of origin
- Collect data about ethnicity
- Use micro-data from Eurostat about the concerned population living in the EU Member States

The present study has encountered similar challenges to the ones identified in EIGE's 2015 study, in terms of data availability and data collection. This shows that, unfortunately, the unrealistic options for data collection are still unrealistic and need to be the basis for further discussion, and to further inform data collection processes at national and EU level.

The previous study team made efforts to retrieve data from other administrative sources, by Member State and by type of record in EIGE's 2015 study, as demonstrated in the Table below.

Table 8.6 Mapping administrative data sources on FGM in EIGE's previous study (2015)

	Ireland	Portugal	Sweden
Health records	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) collate by the National	Some data collected from 2012 up to September 2014 was available through the IT software system of the public healthcare facilities in Portugal	Data from the National Board of Health and Welfare (NBHW) were not made available

	Ireland	Portugal	Sweden
	Maternal Health Care Record (NMHCR). As the first specialised FGM 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.	Data between 1 October 2013 and 25 August 2014 was available in the IT system referring to the National Programme for Infantile and Juvenile Health (PNSIJ)	
Police and judiciary records	The timeframe for the current study did not allow for processing of the required An Garda Siochana research application and data processing agreement, therefore Irish police data on female genital mutilation cases (if any) could not be assessed.	Police and judiciary records were not recorded in Portugal at the time of the study	No recorded crime based on the law against FGM in the period 2012-2013 was registered
Child protection records	No data available, as communicated by the new Irish national Child and Family Agency (Tusla)		FGM is not traceable in the child protection records
Asylum records			FGM is not traceable in the asylum records

Source: Reproduced from EIGE's 2015 study.

As the Table shows, there were many challenges in using administrative records to gain a fuller picture of FGM in these Member States. This is also a problem for the Member States considered in this present study, with the possible exception of Belgium.

8.3 Comparing the findings from the six Member States with other countries that have used EIGE's methodology or a related extrapolation method

8.3.1 Estimations of girls at risk

Between 2014 and July 2017, one study (Van Baelen et al., 2016) was undertaken to estimate the prevalence and/or risk of female genital mutilation across the entire European Union since 2014. This study cannot be used for comparison with the present study as it provides only prevalence estimates for girls and women aged 10 and over. It specifically used data from the 2011 EU census from each Member State, in addition to information about the prevalence of FGM in the countries of origin. At the country level, 10 studies specifically made FGM risk and/or prevalence estimations by extrapolating statistics on the occurrence of FGM within the country of origin (the extrapolation method).

At national level, these extrapolation studies were conducted in Belgium (2014), Germany (2015, 2016, 2017, 2017), Italy (2016), Portugal (2016), the United Kingdom (2014, 2015) and in one non-Member State, Norway (2016). The Table below provides an overview of these studies, their authors and their key findings.

Table 8.7 Extrapolation studies (2014-2017)

Country	Study reference (author, year)	Did the study estimate prevalence, risk or both?	Results
Belgium	Antwerp Institute of Tropical Medicine, 2014	Risk and prevalence	Since 2014: 13,112 victims (women and girls) and an additional 4,084 women and girls at risk. Estimation: 2,943 girls under the age of 5 are at risk; 1,300 female asylum-seekers are most likely victims of FGM.
Germany	Terre des Femmes, 2015	Risk and prevalence	5,956 girls under 18 at risk of FGM, and 35,715 women (aged 18 and over) residing in Germany were affected by FGM.
Germany	Terre des Femmes, 2016	Risk and prevalence	9,300 girls under 18 at risk of FGM, and 48,000 women (aged 18 and over) residing in Germany affected by FGM.
Germany	Terre des Femmes, 2017	Risk and prevalence	13,320 girls under 18 at risk of FGM, and over 58,093 women (aged 18 and over) residing in Germany affected by FGM.
Germany	Integra: Federal Ministry of Family Affairs, Senior Citizens, Women and Youth, BMFSFJ, 2017	Risk and prevalence	Between 1,558 and 5,684 (under 18 and without German nationality) at risk of FGM, and at least 47,359 women affected.
Italy	Patrizia Farina, Livia Elisa Ortensi, Alessio Menonna, 2016	Prevalence. No estimation of girls at risk.	In 2010, 57,302 women (aged 15-49) from FGM-practising countries were estimated to be victims of FGM.
Portugal	A.L. Teixeira, M. Lisboa, 2016	Prevalence. No particular emphasis on the distinction between girls at risk and girls that are excised.	6,576 women (aged 15- 49) estimated to have undergone FGM, and 1,830 girls under 15 living in Portugal estimated to have undergone or are likely to undergo FGM.
United Kingdom (England and Wales only)	Alison Macfarlane, Efua Dorkenoo, 2014	Prevalence. No particular emphasis on the distinction between girls at risk and girls that are excised.	In 2011, out of a total population of girls from FGM-practising countries of 137,000 in 2011, 10,000 women (aged 15-49), 24,000 (aged over 50), and 10,000 girls (aged 14 and under) who have undergone or are likely to undergo FGM.
United Kingdom (England and Wales only)	Alison Macfarlane, Efua Dorkenoo, 2015	Prevalence. No particular emphasis on the distinction between girls at risk and girls that are excised.	Regional analysis was added in this report, showing that London had by far the highest prevalence.
Norway	Mai M. Ziyada, Marthe Norberg-Shulz, R. Elise B. Johansen, 2016	Risk and prevalence. Assumption that first-generation immigrants older than the customary age of cutting upon arrival in host countries were already subjected to FGM in a similar proportion to the prevalence rates in their countries of origin.	Between 3,000 and 7,000 girls estimated to be at risk of FGM. Out of 44,467 first and second generation female immigrants residing in Norway from FGM-practising countries, around 17,787 of them are estimated to have already been subjected to FGM prior to immigration to Norway.

Overall, it is possible to notice that the number of girls and women estimated in the studies since 2014, as shown by Table 8.7, are on average closer to the High-Risk scenario identified in the present study across the six Member States, or even higher. However, it is evident that a comparison of the key findings of the studies conducted at national level since 2014 with the results from the six Member States of the present study is complex, because of different research methodologies used, as well as differing age disaggregations, definitions of girls at risk and migrant populations considered. For example, Macfarlane & Dorkenoo (2014, 2015), for example, looked at groups 0-14, 14-49 and over 50. Different age

disaggregations are used also in the other studies. Moreover, the countries that are taken into account present different situations in terms of the number of migrant populations, and as well in terms of integration policies, and policies that specifically tackle FGM, specifically, and gender-based violence, more broadly. It is possible to make some observations across some specific Member States.

Belgium and Italy are two of the Member States that are central to the present study, and they are also central to two of the studies conducted at national level since 2014 (i.e. Antwerp Institute of Tropical Medicine, 2014; Farina, Ortensi & Menonna, 2016). In Belgium, according to the estimation of EIGE's present study, in the latest available year 2016, between 597 and 4,612 girls from FGM-practising countries were at risk of FGM. According to the 2014 study by the Antwerp Institute of Tropical Medicine, since 2014, it is possible to estimate 13,112 victims (women and girls) of FGM, and an additional 4,084 women and girls at risk. Moreover, the study further identifies 2,943 girls under the age of 5 as as at risk, and 1,300 female asylum-seekers that are most likely victims of FGM. In this case, even if the data taken into account refers to different collection years, it is possible to see that the estimation of girls at risk in the 2014 study falls within the range presented in EIGE's present study.

In the case of Italy, data collection for the study by Farina, Ortensi & Menonna (2016) was conducted in 2010. Because of this, the team has taken into account the closest available data from the present study, namely 2011. In Italy, the present study estimates that, in 2011, between 2,947 and 11,654 girls from FGM-practising countries were at risk of FGM. In the latest available year (2016), between 2,495 and 11,503 girls from FGM-practising countries were at risk of FGM, out of a total population of girls from FGM-practising countries of 77,580. Farina, Ortensi & Menonna (2016) estimated that out of around 146,154 from FGM-practising countries living in Italy in 2010, around 57,000 women (aged 15-49) were victims of FGM. The numbers estimated by Farina, Ortensi & Menonna (2016) are higher than the ones estimated by the present study: however, this is the case because the age disaggregation is different; Farina, Ortensi & Menonna (2016) include a different population (women aged 15-49). Moreover, they consider the number of girls who were already victims of FGM, without a specific estimation of girls at risk.

Some of the countries of origin of girls at risk of FGM identified by these extrapolation studies were Eritrea, Indonesia, Somalia, Egypt and Ethiopia. Except for Indonesia, the other countries are some of the most represented countries of origin for girls at risk of FGM in the six Member States of EIGE's present study.

8.3.2 Interpreting the situation from a qualitative perspective

It is particularly difficult to conduct a comparison between the ten national extrapolation studies and the present study from a qualitative perspective, as only the 2017 investigation in Germany, conducted by Integra, within the Federal Ministry of Family Affairs, Senior Citizens, Women and Youth provides a mixed-method approach, complementing the quantitative research with a qualitative methodology comprising of interviews within migrants' communities. A total of 52 interviews with women showed that there were very different attitudes and behaviours to general topics (e.g. education, childbearing) and on FGM practice between women and girls who had been in Germany for less than four years, and those who had been residing in Germany for more than four. This is one of the elements that need to be taken into account when observing factors that affect risk. The same study also notes that the average age of FGM in the countries of origin is generally lower than the average age of FGM in Germany.

Moreover, although it followed EIGE's methodology, the Norwegian study (Ziyada, Norberg-Shulz & Johansen, 2016) distinguished between girls with one and two parents from FGM-practising countries. In fact, the authors noted that the risk of FGM for girls with only one parent from a FGM-practising country is uncertain and, most likely, lower.

8.3.3 Applying the risk estimation methodology

The ten extrapolation studies conducted at national level since 2014 present differences in methodology with the present study. The Table below provides an overview of the differences in the methodologies of these studies, to facilitate the comparison.

Table 8.8 Differences in the methodologies of other extrapolation studies (2014- 2017)

Country	Study reference (author, year)	Key differences to EIGE's methodology
Belgium	Antwerp Institute of Tropical Medicine, 2014	• First-generation girls are considered as already excised, while all second generation girls were considered at risk • Median age of FGM not considered as a measure to distinguish excised girls from girls at risk • No correction provided for the influence of migration in changing attitudes (unlike EIGE's Migration and Acculturation Impact Factor)
Germany	Terre des Femmes, 2015 Terre des Femmes, 2016 Terre des Femmes, 2017	• Differentiation between adolescents assumed to be at risk and women assumed to be affected by FGM • Country of origin FGM prevalence rate to all female minors (first and second generation) to identify those at risk
Germany	Integra: Federal Ministry of Family Affairs, Senior Citizens, Women and Youth, BMFSFJ, 2017	• To calculate the number of girls at risk of FGM, the study authors have taken into account all girls aged 0-18. This differs from EIGE's approach, which proposes to take into account only those girls that have not exceeded the median age of cutting in the country of origin.
Italy	Patrizia Farina, Livia Elisa Ortensi, Alessio Menonna, 2016	• Combination of direct and indirect estimation • It includes only girls and women 15- 49 • No estimation of girls at risk
Portugal	A.L. Teixeira, M. Lisboa, 2016	• The median age of FGM is not considered as a measure to distinguish girls excised from girls at risk
United Kingdom (England and Wales only)	Alison Macfarlane, Efua Dorkenoo, 2014 Alison Macfarlane, Efua Dorkenoo, 2015	• Age-specific rates of prevalence of FGM countries of origin are applied: the prevalence rates for women aged 15- 19 were used to estimate the number of girls 0-14 victims of FGM • The median age of FGM is not considered
Norway	Mai M. Ziyada, Marthe Norberg-Shulz, R. Elise B. Johansen, 2016	• This study distinguished girls with one or two parents from FGM-practising countries, excluding girls with only one parent from FGM- practising country from the identified category of "girls potentially at risk"

The ten studies taken into consideration in this chapter encountered similar challenges to the ones encountered in the present study. For example, Ziyada, Norberg-Shulz & Johansen (2016) noted that not adjusting the data for ethnicity and regional origin may give some bias, and determine under or overestimations. However, similarly to the case of the six Member States at the centre of EIGE's present study, such data could not be collected in Norway due to legal and ethical reasons. Overall, all researchers had to face a lack of data availability, both in terms of timeframe and in terms of the details provided. Moreover, a lack of data on irregular migrants was registered across the studies, similarly to the case of the

present study: only Farina, Ortensi & Menonna (2016) included some data on undocumented migrants in Italy.

9 Conclusion on the risk of female genital mutilation across the six Member States

The scale of the issue

FGM is an issue that affects all six Member States of this study, but to varying extents. The estimated number of girls at risk of FGM in Belgium, Cyprus, France, Greece, Italy and Malta is given below. The overall female migrant population from FGM-practising countries differs substantially in size across the six Member States, ranging from 490 girls (Malta) to 61,384 girls (Italy) (both 2011). In recent years, this population has expanded significantly in France (215,258 girls in 2014), but also to a lesser extent in Italy (77,580 in 2016) and Belgium (22,984 in 2016).

Table 9.1 Estimated number and proportion of girls (aged 0-19) in the regular migrant population at risk in the six Member States of the study in 2011, and (when available) 2014 and 2016

Member State (Year)	Total population of girls (aged 0-19) from FGM-practising countries	LOW SCENARIO: Proportion of girls at risk	HIGH SCENARIO: Proportion of girls at risk	LOW SCENARIO: Number of girls at risk	HIGH SCENARIO: Number of girls at risk
Belgium (2011):	15,074	8.3%	24%	1,254	3,555
Greece (2011):	1,935	8%	42%	161	817
France (2011):	44,293	4%	13%	1,968	5,886
Italy (2011):	61,384	5%	19%	2,946	11,655
Cyprus (2011):	812	4%	13%	29	105
Malta (2011):	490	9.6%	37%	47	183
Greece (2014)	1,781	6%	30%	107	536
France (2014):	215,258	1%	11%	2,304	23,930
Italy (2014)	72,178	3%	17%	2,467	12,399
Belgium (2016):	22,984	2.6%	20%	596	4,612
Greece (2016):	1,852	5%	25%	92	454
Italy (2016)	77,580	3%	15%	2,496	11,501

Notes: Belgium, Greece and Italy estimates are a likely under-estimate, due to data gaps leading to under-estimation of the second-generation population. This affects Belgium's 2011 estimate particularly. 2011 is the latest available year for Cyprus and Malta that could be used in risk estimation.

Source: Present study

Considering the maximum number of girls at risk (High Scenario), France and Italy have the highest estimated number of girls (respectively 23,930 and 12,399 in 2014), whilst Malta has the highest percentage of girls at risk (37% in 2011). Despite France's high numbers, the percentage at risk was lowest (1%-11%, 2014). This demonstrates the importance of considering both the number and the proportion of girls at risk when interpreting FGM risk estimations.

When data is available for more than one year, there was a decrease in the percentage of girls at risk of FGM since 2011. However, in Belgium and France there has been a rise in the *number* of girls at risk; in France, the number of girls at risk in 2014 was approximately four times as high as in 2011 (High Scenario). This relates to the expanding second-generations. In Italy, numbers of girls at risk has remained fairly constant, with only a small decrease in the High Scenario between 2011 and 2016 (from 11,655 to 11,501). Greece,

unlike the other three Member States, experienced a large fall in the number of girls at risk between 2011 and 2016. This may relate to a decrease in the total female migrant population (aged 0-19) living in Greece. Nonetheless, the proportion of girls at risk in Greece remains relatively high (between 5% and 25% in 2016).

Four of the Member States (Belgium, France, Greece, Italy) had a similar number of asylum-seeking girls from FGM-practising countries in 2016 (approximately 1,000, with slightly higher numbers in France and Greece). In 2016, there was a relatively high proportion of asylum-seeking girls at risk of FGM in some Member States, particularly in France in 2016 (25%) and to a lesser extent Belgium (17%).

Factors affecting the risk of FGM

FGM as an issue should be seen in the context of heterogeneous communities, affected by different motivations and norms when deciding whether to engage in the practice. The focus group discussions for this study provided an opportunity to hear directly from affected communities about their experiences.

Table 9.2 First- and second-generation migrant communities that took part in focus group discussions in this study

	Characteristics of participants in the four focus group discussions			
EU Member State	**Older women[84]**	**Young women[85]**	**Men**	**Hard-to-reach or recent migrants (women)**
Belgium	Somali	Guinean	Somali men (first generation)	Iraqi (first generation)
Cyprus	Somali	Somali	Somali (first generation)	Somali, Ethiopian, Nigerian, Ivory Coast, Gambian (first generation)
France	Malian	Malian	Malian (first and second generation)	Guinean (first generation)
Greece	Egyptian and Sudanese	Nigerian and Egyptian	Egyptian, Iraqi[86] (first and second generation)	Somali (first generation)
Italy	Egyptian	Ethiopian, Nigerian, Eritrean, Egyptian	Egyptian (first and second generation)	Nigerian (first and second generation)
Malta	Nigerian	Egyptian	Nigerian (first generation)	Egyptian (first generation)

Virtually all community members consulted for this study agreed that FGM is not practised within Europe itself, but rather takes place when a girl returns to her country of origin, often at the instigation of her parents. Returning to the home country can thus be a significant indicator of risk.

The focus group discussions revealed a range of common reasons for FGM across different communities. Motivating factors include fears around girls sexual promiscuity, marital infidelity, unwanted pregnancies, aesthetics and notions around purity. Aspects that discouraged FGM were health and psychological consequences, loss of desire, stigmatization in Europe and the law against the practice – particularly in France. Among communities where there is limited awareness of the law and the consequences of FGM, participants were more open to the option of returning home for the practice, such as for Egyptians.

Differences in motivations to perform FGM exist both between and also within communities. For instance, marriageability was perceived as a fundamental reason for practising among Somalis, Sudanese, Guineas and Malians. However, Somalis had differing stances depending on where they lived. Whilst Somalis in Cyprus (men and women) consider marriageability an important motivation, Somali women in Greece felt

[84] All first-generation.

[85] All either second generation or who arrived to the country when younger than 5.

[86] In addition, a Syrian individual attended, although note that Syria is not considered an FGM-practising country at the time of this study.

it is less important as men did not expect it as much. Focus group discussion were mixed with regards to religion being a motivating factor.

It is clear from many focus group discussions that FGM does not always achieve its desired ends. For instance, Egyptian and Nigerian female participants in Malta agreed that FGM does not control sexual urges or having multiple partners. The men had similar views.

Signs of change?

Once in Europe, there are strong signs that migration impacts attitudes amongst FGM-affected communities, particularly when one observes differences by generation and age. To give some examples:

- In Belgium, all women and most men from Guinea-Conakry and Somalia opposed FGM. Acquiring new information about the practice, the law and social norms against FGM, were all factors contributing to the FGM being abandoned. Moreover, second-generation Guinean women in Belgium would not practise FGM as they have grown up with the social norms prevalent in Belgium that reject FGM.
- In Cyprus, age differences emerged, with younger, more educated Somali men expressing anti-FGM views due to the health complications and reduced sexual desires experienced by affected women.
- In France, the situation was more nuanced. The law seems to be an effective deterrent for older Malian women. Change is apparently slower amongst Malian men, who were significantly the only group in this country to insist on maintaining FGM. Younger women stated that French protection measures were not enforced adequately in the country of origin, particularly due to the influence of older generations.
- In Greece, amongst Sudanese participants, generational differences were apparent, with young women's abandonment of the practice sometimes negatively impacting relations with family elders. Although older women (Egyptian and Sudanese) were more open about their own personal experiences with FGM, younger women were more reserved and did not discuss FGM as a personal experience.
- In Malta, generational differences emerged, with elder Egyptians largely pro-FGM as a cultural practice to be sustained, whilst younger girls were against FGM.

Within Europe, changes in attitudes are not always occurring at a uniform rate across the same communities, particularly between women and men. In Greece, Egyptian women were all against FGM, whereas some Egyptian men kept a positive view of FGM, even if they had lived in Greece for more than two years. This may be due to the immediate consequences for women to their bodies and health, whilst FGM is a question of ethics related to purity for men. Age may also be a factor. For instance, according to women from Egypt (both older and younger) in Greece, younger second generation boys are against FGM.

More generally, men and younger, second-generation women showed very little awareness of the stigma that women who have been cut may experience when living in Europe. Men from Somalia in Belgium and Cyprus expressed no awareness of women being stigmatized in any way. This may be due to limited communitication between men and women about FGM, as shown in previous studies (O'Neill et al, 2017; Kaplan et al., 2013). Men's awareness of sexual consequences also varies, with Nigerian men in Malta claimed not to notice any problems, whereas Somali men in Belgium and Cyprus were more aware of this. However, it is worth noting that, unlike in Nigeria, FGM Type III has more traditionally been practised in Somalia, which can be associated with most extreme negative sexual consequences.

Importantly, many focus group participants spoke of changes to attitudes within their country of origin. For example, Somali men in Belgium and Sudanese participants in Greece felt that FGM is being resisted by younger generations in their country of origin. Changes in attitudes do not always result in the abandonment of FGM altogether; for instance, Somali men in Belgium pointed to a transition from "Pharaonic" circumcision (FGM Type III) in favour of "Sunna" (FGM Type I or IV) within Somalia. Alternatives to FGM also appear to be emerging, such as the massage techniques to reduce the growth of the clitoris amongst some Nigerian women. This reflects that while some communities may be moving towards the abandonment of FGM, the desire to protect female purity and control women's sexual urges sustains. Indeed, participants more often explained that the practice was being abandoned due to the severe health risks (including death). It was rarer for participants to point to women's empowerment as the cause.

Policy and legislative implications

A significant disincentive to practising FGM is the law in the Member State. The fact that FGM is criminalised across the EU is significant. However, in some cases, focus group participants were unaware of the 'extraterritoriality principle', under which they could potentially be prosecuted for FGM even if it were to occur outside of Europe[87]. Also the law is not always an effective deterrent to the practice in FGM-practising countries, where in some cases FGM is also a crime[88]. This highlights the need to spread greater awareness of the law amongst FGM-affected communities.

Affected women pointed to a range of humiliating and sometimes degrading experiences when accessing health services, particularly in France, Cyprus and Greece. Fostering greater capacity amongst service professionals to respond to FGM – both in identifying girls at risk and in effectively supporting those who have been cut – is thus a priority. More generally, increasing awareness and understanding of FGM amongst the public within EU Member States represents a necessary step for challenging the practice and reducing the stigma that affected women experience.

[87] This principle currently applies in all six Member States of this study except Greece. Furthermore, at the time of writing, Greece is making plans to ratify the Istanbul Convention, which (if done) would bring this principle into Greek legislation as well.

[88] For example Egyptian men in Italy referred to the fact that, in Egypt, the practice is widespread, despite the prohibition by law.

Part A: ANNEXES

Annex 1 Glossary

Female genital mutilation (FGM) and the four Types:

Female genital mutilation (FGM): Comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons (World Health Organisation).

The World Health Organisation has developed a classification to distinguish between four Types of FGM[89]:

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

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

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

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

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

Terms commonly used to describe female genital mutilation (FGM) or its Types:

Bolokoli: Malian (Mende) expression for FGM

Clitoridectomy: Normally refers to FGM Type I.

Excision: Normally refers to FGM Type II.

Halalese: Somali expression for FGM, emphasizing the purifying aspect.

Hitan: Egyptian expression for FGM, mostly Types I, II and IV.

Infibulation: Normally refers to FGM Type III.

Pharaonic circumcision: Expression for FGM Type III.

Suningol: Fulani expression for FGM, meaning "doing the Sunna".

Sunna: Refers to FGM Type I or II[90].

This study uses these terms only when reflecting the words and views expressed by particular communities in focus group discussions.

Definitions used in risk estimation and quantitative data collection:

Asylum-seeker: An asylum seeker is considered someone who has submitted an application for international protection or has been included in such application as a family member during the reference period. 'Application for international protection' means an application for international protection as defined in Article 2(h) of Directive 2011/95/EU, i.e. a request by a third-country national

[89] Visual representation of the four Types is available here: http://www.dw.com/en/endfgm-the-scope-of-the-problem-in-graphics-and-numbers/a-18670295

[90] This term is mostly used to underline that it is an Islamic practice or that the practice was known to the Prophet Muhammad and he approved of it. There is, however, significant debate within Islam about whether the Prophet 'recommended' the practice. For more details on the debate see Abu-Salieh (2001).

or a stateless person for protection from a Member State, who can be understood to seek refugee status or subsidiary protection status, and who does not explicitly request another kind of protection, outside the scope of the Directive, that can be applied for separately.

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.

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 his or her residence, or where she or he has asked for international protection.

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

Emigrants (outflows): Emigrants (outflows) are people leaving the country where they usually reside and effectively taking up residence in another country. An individual is a long-term emigrant if he/she leaves his/her country of previous usual residence for a period of 12 months or more (1998 United Nations recommendations on the statistics of international migration (Revision 1), Eurostat).

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

FGM risk estimation in an EU Member State: The number of girls (either born in an FGM-practising country or whose mothers were born in an FGM-practising country) who are living in a Member State who might be at risk of FGM, expressed as a proportion of the total number of girls living in an EU Member State who originate from, or are born to a mother from, FGM-practising countries ([91]).

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

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

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

First-generation migrant: First-generation migrants cover those who were born in an FGM-practising country to one or more parents who were also born in these countries, and who established usual 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 (Eurostat).

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

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

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

Live births: Live births refer to the birth of a child breathing or showing evidence of life, i.e., beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles, regardless of gestational age (Eurostat).

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

Refugee: A refugee is considered a third-country national who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, political opinion or membership of a particular social group, is outside the country of nationality and is unable or, owing to this fear, unwilling to avail 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 this fear, unwilling to return to it, and to whom Article 12 of Council Directive 2004/83/EC does not apply (Council Directive 2004/83/EC).

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

Usual residence: According to 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.

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

Year of arrival: The year of arrival is the calendar year in which a person most recently established usual residence in the country. The year of the most recent arrival in the country shall be reported rather than the year of first arrival[92].

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

Annex 2 FGM risk estimations for regular migrant population

Table A2.1 Country of origin data

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

* population aged 0-11

A2.2 Country of destination data

Table A2.2 Female migrant population from FGM-practising countries (aged 0-19) in Belgium, 2016

Country of origin	Number of girls under the median age of cutting			National prevalence rate in country of origin for the age-group 15-19	Number of girls at risk in this Member State	
	First generation	Second generation	Total		Min.	Max
Benin	8	141	149	2.4	0	4
Burkina Faso	1	74	75	57.7	1	43
Cameroon	101	2079	2180	0.4	0	9
Central African Republic	8	34	42	17.9	2	7
Chad	4	68	72	31.8	1	23
Côte d'Ivoire	1	275	276	31.3	0	86
Djibouti	17	130	147	89.5	15	132
Egypt	55	367	422	69.6	38	294
Eritrea	0	0	0	68.8	0	0
Ethiopia	6	114	120	47.1	3	57
Gambia	1	38	39	76.3	1	30
Ghana	69	1346	1415	1.5	1	21
Guinea	400	2284	2684	94	376	2523
Guinea-Bissau	3	13	16	14.9	0	2
Indonesia	0	0	0	49	0	0
Iraq	448	1153	1601	4.9	22	78
Kenya	14	189	203	11.4	2	23
Liberia	9	123	132	31.1	3	41
Mali	2	61	63	90.3	2	57
Mauritania	4	64	68	65.9	3	45
Niger	2	153	155	1.4	0	2
Nigeria	1	581	582	15.3	0	89
Senegal	11	267	278	22.2	2	62
Sierra Leone	12	280	292	74.3	9	217
Somalia	111	555	666	96.7	107	644
Sudan	9	122	131	81.7	7	107
Togo	35	577	612	1.8	1	11
Uganda	9	80	89	1	0	1
Tanzania, United Republic of	5	79	84	4.7	0	4
Yemen	0	0	0	16.4	0	0
TOTAL	1346	11247	12593		596	4612

Table A2.3 Female migrant population from FGM-practising countries (aged 0-19) in Belgium, 2012

Country of origin	Number of girls under the median age of cutting	National prevalence rate in country of origin for the age-group 15-19	Number of girls at risk in this Member State

	First generation	Second generation	Total		Min.	Max
Benin	19	86	105	2.4	0	3
Burkina Faso	5	52	57	57.7	3	33
Cameroon	179	1316	1495	0.4	1	6
Central African Republic	8	30	38	17.9	2	6
Chad	3	66	69	31.8	1	22
Côte d'Ivoire	10	214	224	31.3	3	70
Djibouti	5	86	91	89.5	4	81
Egypt	68	275	343	69.6	47	239
Eritrea	0	0	0	68.8	0	0
Ethiopia	87	99	186	47.1	41	88
Gambia	0	38	38	76.3	0	29
Ghana	74	1047	1121	1.5	1	17
Guinea	304	1366	1670	94	286	1570
Guinea-Bissau	1	12	13	14.9	0	2
Indonesia	0	0	0	49	0	0
Iraq	335	625	960	4.9	16	47
Kenya	36	130	166	11.4	4	19
Liberia	24	108	132	31.1	8	41
Mali	5	48	53	90.3	5	48
Mauritania	5	59	64	65.9	3	42
Niger	6	176	182	1.4	0	3
Nigeria	15	470	485	15.3	2	74
Senegal	9	227	236	22.2	2	52
Sierra Leone	26	228	254	74.3	20	189
Somalia	60	344	404	96.7	58	391
Sudan	18	95	113	81.7	15	92
Togo	40	455	495	1.8	1	9
Uganda	8	34	42	1	0	0
Tanzania, United Republic of	7	52	59	4.7	0	3
Yemen	0	15	15	16.4	0	2
TOTAL	1357	7753	9110		523	3178

Table A2.4 Female migrant population from FGM-practising countries (aged 0-19) in Belgium, 2011

Country of origin	Number of girls under the median age of cutting			National prevalence rate in country of origin for the age-group 15-19	Number of girls at risk in this Member State	
	First generation	Second generation	Total		Min.	Max
Benin	34	78	112	2.4	1	3
Burkina Faso	16	56	72	57.7	9	42
Cameroon	568	1131	1699	0.4	2	7
Central African Republic	9	30	39	17.9	2	7

Chad	19	62	81	31.8	6	25
Côte d'Ivoire	86	199	285	31.3	27	89
Djibouti	35	73	108	89.5	31	97
Egypt	83	246	329	69.6	58	229
Eritrea	0	0	0	68.8	0	0
Ethiopia	26	84	110	47.1	12	52
Gambia	2	37	39	76.3	2	30
Ghana	205	970	1175	1.5	3	18
Guinea	700	1125	1825	94	658	1716
Guinea-Bissau	2	8	10	14.9	0	1
Indonesia	0	0	0	49	0	0
Iraq	40	498	538	4.9	2	26
Kenya	20	123	143	11.4	2	17
Liberia	71	103	174	31.1	22	54
Mali	67	46	113	90.3	61	102
Mauritania	131	59	190	65.9	86	125
Niger	30	167	197	1.4	0	3
Nigeria	33	429	462	15.3	5	71
Senegal	40	206	246	22.2	9	55
Sierra Leone	62	201	263	74.3	46	195
Somalia	187	303	490	96.7	181	474
Sudan	13	94	107	81.7	11	87
Togo	21	406	427	1.8	0	8
Uganda	22	29	51	1	0	1
Tanzania, United Republic of	352	41	393	4.7	17	18
Yemen	6	14	20	16.4	1	3
TOTAL	2880	6818	9698		1254	3555

Table A2.5 Female migrant population from FGM-practising countries (aged 0-19) in Greece, 2016

Country of origin	Number of girls under the median age of cutting			National prevalence rate in country of origin for the age-group 15-19	Number of girls at risk in this Member State	
	First generation	Second generation	Total		Min.	Max
Benin	0	0	0	2.4	0	0
Burkina Faso	0	0	0	57.7	0	0
Cameroon	2	0	2	0.4	0	0
Central African Republic	0	0	0	17.9	0	0
Chad	0	0	0	31.8	0	0
Côte d'Ivoire	0	0	0	31.3	0	0
Djibouti	0	0	0	89.5	0	0

Egypt	113	506	619	69.6	78	431
Eritrea	0	0	0	68.8	0	0
Ethiopia	6	3	9	47.1	3	4
Gambia	0	0	0	76.3	0	0
Ghana	4	24	28	1.5	0	0
Guinea	1	0	1	94	1	1
Guinea-Bissau	0	0	0	14.9	0	0
Indonesia	0	0	0	49	0	0
Iraq	36	0	36	4.9	2	2
Kenya	28	0	28	11.4	4	4
Liberia	0	0	0	31.1	0	0
Mali	0	0	0	90.3	0	0
Mauritania	0	0	0	65.9	0	0
Niger	0	0	0	1.4	0	0
Nigeria	12	8	20	15.3	2	3
Senegal	0	0	0	22.2	0	0
Sierra Leone	1	5	7	74.3	1	5
Somalia	0	0	0	96.7	0	0
Sudan	2	3	5	81.7	1	4
Togo	0	0	0	1.8	0	0
Uganda	2	0	2	1	0	0
Tanzania, United Republic of	2	2	3	4.7	0	0
Yemen	0	0	0	16.4	0	0
All countries of origin:	206	552	759		92	454

Table A2.6 Female migrant population from FGM-practising countries (aged 0-19) in Greece, 2015

Country of origin	Number of girls under the median age of cutting			National prevalence rate in country of origin for the age-group 15-19	Number of girls at risk in this Member State	
	First generation	Second generation	Total		Min.	Max
Benin	0	0	0	2.4	0	0
Burkina Faso	0	0	0	57.7	0	0
Cameroon	3	0	3	0.4	0	0
Central African Republic	0	0	0	17.9	0	0
Chad	0	0	0	31.8	0	0
Côte d'Ivoire	0	0	0	31.3	0	0
Djibouti	0	0	0	89.5	0	0
Egypt	129	581	710	69.6	90	494
Eritrea	0	0	0	68.8	0	0
Ethiopia	8	4	12	47.1	4	6
Gambia	0	0	0	76.3	0	0
Ghana	5	29	34	1.5	0	1
Guinea	2	1	2	94	2	2
Guinea-Bissau	0	0	0	14.9	0	0

Indonesia	0	0	0	49	0	0
Iraq	23	0	23	4.9	1	1
Kenya	22	0	22	11.4	2	3
Liberia	0	0	0	31.1	0	0
Mali	0	0	0	90.3	0	0
Mauritania	0	0	0	65.9	0	0
Niger	0	0	0	1.4	0	0
Nigeria	9	7	16	15.3	1	2
Senegal	2	0	2	22.2	0	0
Sierra Leone	2	8	9	74.3	1	7
Somalia	0	0	0	96.7	0	0
Sudan	2	3	4	81.7	1	3
Togo	0	0	0	1.8	0	0
Uganda	3	0	3	1	0	0
Tanzania, United Republic of	1	1	2	4.7	0	0
Yemen	0	0	0	16.4	0	0
All countries of origin:	209	633	842		103	519

Table A2.7 Female migrant population from FGM-practising countries (aged 0-19) in Greece, 2014

Country of origin	Number of girls under the median age of cutting			National prevalence rate in country of origin for the age-group 15-19	Number of girls at risk in this Member State	
	First generation	Second generation	Total		Min.	Max
Benin	0	0	0	2.4	0	0
Burkina Faso	0	0	0	57.7	0	0
Cameroon	4	0	4	0.4	0	0
Central African Republic	0	0	0	17.9	0	0
Chad	0	0	0	31.8	0	0
Côte d'Ivoire	0	0	0	31.3	0	0
Djibouti	0	0	0	89.5	0	0
Egypt	133	598	731	69.6	93	509
Eritrea	0	0	0	68.8	0	0
Ethiopia	11	6	17	47.1	5	8
Gambia	0	0	0	76.3	0	0
Ghana	6	32	38	1.5	0	1
Guinea	2	1	2	94	2	2
Guinea-Bissau	0	0	0	14.9	0	0
Indonesia	0	0	0	49	0	0
Iraq	14	0	14	4.9	1	1
Kenya	20	0	20	11.4	2	2
Liberia	0	0	0	31.1	0	0
Mali	0	0	0	90.3	0	0
Mauritania	0	0	0	65.9	0	0
Niger	0	0	0	1.4	0	0

Nigeria	12	9	22	15.3	2	3
Senegal	2	0	2	22.2	0	0
Sierra Leone	1	6	7	74.3	1	6
Somalia	0	0	0	96.7	0	0
Sudan	2	3	5	81.7	1	4
Togo	0	0	0	1.8	0	0
Uganda	2	0	2	1	0	0
Tanzania, United Republic of	2	2	3	4.7	0	0
Yemen	0	0	0	16.4	0	0
All countries of origin:	211	657	868		107	536

Table A2.8 Female migrant population from FGM-practising countries (aged 0-19) in Greece, 2013

Country of origin	Number of girls under the median age of cutting			National prevalence rate in country of origin for the age-group 15-19	Number of girls at risk in this Member State	
	First generation	Second generation	Total		Min.	Max
Benin	0	0	0	2.4	0	0
Burkina Faso	0	0	0	57.7	0	0
Cameroon	4	0	4	0.4	0	0
Central African Republic	0	0	0	17.9	0	0
Chad	0	0	0	31.8	0	0
Côte d'Ivoire	0	0	0	31.3	0	0
Djibouti	0	0	0	89.5	0	0
Egypt	164	739	903	69.6	114	628
Eritrea	0	0	0	68.8	0	0
Ethiopia	15	8	23	47.1	7	11
Gambia	0	0	0	76.3	0	0
Ghana	6	34	41	1.5	0	1
Guinea	2	1	3	94	2	2
Guinea-Bissau	0	0	0	14.9	0	0
Indonesia	0	0	0	49	0	0
Iraq	16	0	16	4.9	1	1
Kenya	19	0	19	11.4	2	2
Liberia	0	0	0	31.1	0	0
Mali	0	0	0	90.3	0	0
Mauritania	0	0	0	65.9	0	0
Niger	1	0	1	1.4	0	0
Nigeria	18	14	32	15.3	3	5
Senegal	2	0	2	22.2	0	0
Sierra Leone	2	9	10	74.3	1	8
Somalia	0	0	0	96.7	0	0
Sudan	3	6	9	81.7	3	8
Togo	0	0	0	1.8	0	0
Uganda	3	0	3	1	0	0

Tanzania, United Republic of	1	1	3	4.7	0	0
Yemen	0	0	0	16.4	0	0
All countries of origin:	257	812	1068		133	666

Table A2.9 Female migrant population from FGM-practising countries (aged 0-19) in Greece, 2012

Country of origin	Number of girls under the median age of cutting			National prevalence rate in country of origin for the age-group 15-19	Number of girls at risk in this Member State	
	First generation	Second generation	Total		Min.	Max
Benin	0	0	0	2.4	0	0
Burkina Faso	0	0	0	57.7	0	0
Cameroon	5	0	5	0.4	0	0
Central African Republic	0	0	0	17.9	0	0
Chad	0	0	0	31.8	0	0
Côte d'Ivoire	0	0	0	31.3	0	0
Djibouti	0	0	0	89.5	0	0
Egypt	177	795	972	69.6	123	677
Eritrea	0	0	0	68.8	0	0
Ethiopia	17	10	27	47.1	8	13
Gambia	0	0	0	76.3	0	0
Ghana	5	27	32	1.5	0	0
Guinea	2	1	3	94	2	2
Guinea-Bissau	0	0	0	14.9	0	0
Indonesia	0	0	0	49	0	0
Iraq	16	0	16	4.9	1	1
Kenya	14	0	14	11.4	1	1
Liberia	0	0	0	31.1	0	0
Mali	0	0	0	90.3	0	0
Mauritania	0	0	0	65.9	0	0
Niger	0	0	0	1.4	0	0
Nigeria	15	11	26	15.3	2	4
Senegal	2	0	2	22.2	0	0
Sierra Leone	2	8	9	74.3	1	7
Somalia	0	0	0	96.7	0	0
Sudan	4	8	12	81.7	3	10
Togo	0	0	0	1.8	0	0
Uganda	3	0	3	1	0	0
Tanzania, United Republic of	1	1	1	4.7	0	0
Yemen	0	0	0	16.4	0	0
All countries of origin:	262	860	1122		141	715

Table A2.10 Female migrant population from FGM-practising countries (aged 0-19) in Greece, 2011

Country of origin	Number of girls under the median age of cutting			National prevalence rate in country of origin for the age-group 15-19	Number of girls at risk in this Member State	
	First generation	Second generation	Total		Min.	Max
Benin	0	0	0	2.4	0	0
Burkina Faso	0	0	0	57.7	0	0
Cameroon	4	0	4	0.4	0	0
Central African Republic	0	0	0	17.9	0	0
Chad	1	0	1	31.8	0	0
Côte d'Ivoire	0	0	0	31.3	0	0
Djibouti	0	0	0	89.5	0	0
Egypt	203	915	1118	69.6	142	778
Eritrea	0	0	0	68.8	0	0
Ethiopia	15	8	23	47.1	7	11
Gambia	0	0	0	76.3	0	0
Ghana	5	28	33	1.5	0	0
Guinea	2	1	3	94	2	2
Guinea-Bissau	0	0	0	14.9	0	0
Indonesia	0	0	0	49	0	0
Iraq	28	0	28	4.9	1	1
Kenya	13	0	13	11.4	1	1
Liberia	0	0	0	31.1	0	0
Mali	0	0	0	90.3	0	0
Mauritania	0	0	0	65.9	0	0
Niger	0	0	0	1.4	0	0
Nigeria	15	11	26	15.3	2	4
Senegal	1	0	1	22.2	0	0
Sierra Leone	1	7	8	74.3	1	6
Somalia	0	0	0	96.7	0	0
Sudan	6	11	18	81.7	5	14
Togo	0	0	0	1.8	0	0
Uganda	2	0	2	1	0	0
Tanzania, United Republic of	1	1	1	4.7	0	0
Yemen	0	0	0	16.4	0	0
All countries of origin:	297	981	1278		161	817

Table A2.11 Female migrant population from FGM-practising countries (aged 0-19) in France, 2014

Country of origin	Number of girls under the median age of cutting	National prevalence rate in country of	Number of girls at risk in this Member State

	First generation	Second generation	Total	origin for the age-group 15-19	Min.	Max
Benin	254	2956	3210	2.4	6	77
Burkina Faso	102	440	542	57.7	59	313
Cameroon	1015	12899	13914	0.4	4	56
Central African Republic	681	3940	4621	17.9	122	828
Chad	233	1539	1772	31.8	74	564
Côte d'Ivoire	308	6430	6738	31.3	96	2109
Djibouti	182	956	1138	89.5	163	1019
Egypt	528	3390	3918	69.6	367	2727
Eritrea	0	0	0	68.8	0	0
Ethiopia	435	11	446	47.1	205	210
Gambia	5	216	221	76.3	4	169
Ghana	36	856	892	1.5	1	13
Guinea	441	5968	6409	94	415	6024
Guinea-Bissau	54	580	634	14.9	8	94
Indonesia	0	0	0	49	0	0
Iraq	117	764	881	4.9	6	43
Kenya	104	359	463	11.4	12	52
Liberia	7	207	214	31.1	2	67
Mali	411	5803	6214	90.3	371	5611
Mauritania	79	1323	1402	65.9	52	924
Niger	37	325	362	1.4	1	5
Nigeria	118	874	992	15.3	18	152
Senegal	608	7036	7644	22.2	135	1697
Sierra Leone	36	424	460	74.3	26	342
Somalia	58	334	392	96.7	56	379
Sudan	114	353	467	81.7	93	382
Togo	291	3174	3465	1.8	5	62
Uganda	4	32	36	1	0	0
Tanzania, United Republic of	3	68	71	4.7	0	3
Yemen	17	29	46	16.4	3	8
TOTAL	6278	61286	67564		2304	23930

Table A2.12 Female migrant population from FGM-practising countries (aged 0-19) in France, 2011

Country of origin	Number of girls under the median age of cutting			National prevalence rate in country of origin for the age-group 15-19	Number of girls at risk in this Member State	
	First generation	Second generation	Total		Min.	Max
Benin	230	234	464	2.4	6	11

Burkina Faso	100	119	219	57.7	58	126
Cameroon	1041	1568	2609	0.4	4	10
Central African Republic	675	264	939	17.9	121	168
Chad	205	104	309	31.8	65	98
Côte d'Ivoire	287	1620	1907	31.3	90	597
Djibouti	213	64	277	89.5	191	248
Egypt	437	189	626	69.6	304	436
Eritrea	0	23	23	68.8	0	16
Ethiopia	438	103	541	47.1	206	255
Gambia	4	53	57	76.3	3	43
Ghana	53	120	173	1.5	1	3
Guinea	301	859	1160	94	283	1090
Guinea-Bissau	32	68	100	14.9	5	15
Indonesia	0	71	71	49	0	35
Iraq	69	95	164	4.9	3	8
Kenya	111	45	156	11.4	12	17
Liberia	15	15	30	31.1	5	9
Mali	350	1504	1854	90.3	316	1674
Mauritania	72	279	351	65.9	47	231
Niger	40	98	138	1.4	1	2
Nigeria	69	318	387	15.3	11	59
Senegal	535	1764	2299	22.2	119	510
Sierra Leone	30	33	63	74.3	22	46
Somalia	40	34	74	96.7	39	72
Sudan	64	51	115	81.7	52	94
Togo	3	274	277	1.8	0	5
Uganda	200	10	210	1	2	2
Tanzania, United Republic of	4	12	16	4.7	0	1
Yemen	14	14	28	16.4	2	5
TOTAL	5632	10005	15637		1968	5886

Table A2.13 Female migrant population from FGM-practising countries (aged 0-19) in Italy, 2016

Country of origin	Number of girls under the median age of cutting			National prevalence rate in country of origin for the age-group 15-19	Number of girls at risk in this Member State	
	First generation	Second generation	Total		Min.	Max
Benin	27	219	246	2.4	1	6

Burkina Faso	30	524	554	57.7	17	319
Cameroon	109	1109	1218	0.4	0	5
Central African Republic	9	30	39	17.9	2	7
Chad	5	28	33	31.8	2	10
Côte d'Ivoire	28	697	725	31.3	9	227
Djibouti	0	16	16	89.5	0	14
Egypt	3131	8978	12109	69.6	2179	8428
Eritrea	0	0	0	68.8	0	0
Ethiopia	182	237	419	47.1	86	198
Gambia	4	30	34	76.3	3	26
Ghana	305	4231	4536	1.5	5	68
Guinea	41	352	393	94	38	369
Guinea-Bissau	12	42	54	14.9	2	8
Indonesia	0	0	0	49	0	0
Iraq	29	110	139	4.9	1	7
Kenya	180	285	465	11.4	21	53
Liberia	7	93	100	31.1	3	31
Mali	17	78	95	90.3	15	86
Mauritania	2	16	18	65.9	1	12
Niger	1	33	34	1.4	0	0
Nigeria	81	3078	3159	15.3	12	483
Senegal	282	2635	2917	22.2	63	647
Sierra Leone	13	151	164	74.3	9	122
Somalia	8	227	235	96.7	8	227
Sudan	21	147	168	81.7	17	137
Togo	61	407	468	1.8	1	8
Uganda	7	27	34	1	0	0
Tanzania, United Republic of	13	44	57	4.7	1	3
Yemen	0	0	0	16.4	0	0
All countries of origin:	4604	23824	28428		2496	11501

Table A2.14 Female migrant population from FGM-practising countries (aged 0-19) in Italy, 2015

Country of origin	Number of girls under the median age of cutting			National prevalence rate in country of origin for the age-group 15-19	Number of girls at risk in this Member State	
	First generation	Second generation	Total		Min.	Max
Benin	31	255	286	2.4	1	7
Burkina Faso	38	710	748	57.7	22	431
Cameroon	105	1200	1305	0.4	0	5
Central African Republic	6	32	38	17.9	2	7
Chad	5	30	35	31.8	2	11
Côte d'Ivoire	31	945	976	31.3	10	306
Djibouti	0	18	18	89.5	0	16
Egypt	3167	9723	12890	69.6	2204	8971

Eritrea	0	0	0	68.8	0	0
Ethiopia	210	332	542	47.1	99	255
Gambia	4	41	45	76.3	3	34
Ghana	316	4703	5019	1.5	5	75
Guinea	41	385	426	94	38	400
Guinea-Bissau	14	47	61	14.9	2	9
Indonesia	0	0	0	49	0	0
Iraq	33	121	154	4.9	2	8
Kenya	164	293	457	11.4	19	52
Liberia	9	95	104	31.1	3	32
Mali	15	98	113	90.3	14	102
Mauritania	0	20	20	65.9	0	13
Niger	0	46	46	1.4	0	1
Nigeria	81	4171	4252	15.3	12	651
Senegal	263	3450	3713	22.2	58	824
Sierra Leone	13	158	171	74.3	9	127
Somalia	11	263	274	96.7	11	265
Sudan	19	161	180	81.7	16	147
Togo	66	438	504	1.8	1	9
Uganda	7	35	42	1	0	0
Tanzania, United Republic of	14	46	60	4.7	1	3
Yemen	0	0	0	16.4	0	0
All countries of origin:	4663	27816	32479		2534	12761

Table A2.15 Female migrant population from FGM-practising countries (aged 0-19) in Italy, 2014

Country of origin	Number of girls under the median age of cutting			National prevalence rate in country of origin for the age-group 15-19	Number of girls at risk in this Member State	
	First generation	Second generation	Total		Min.	Max
Benin	29	266	295	2.4	1	7
Burkina Faso	47	701	748	57.7	27	432
Cameroon	106	1124	1230	0.4	0	5
Central African Republic	6	32	38	17.9	1	7
Chad	4	27	31	31.8	1	10
Côte d'Ivoire	40	960	1000	31.3	13	313
Djibouti	1	18	19	89.5	1	17
Egypt	3039	9336	12375	69.6	2115	8613
Eritrea	0	0	0	68.8	0	0
Ethiopia	222	333	555	47.1	104	261
Gambia	5	36	41	76.3	4	31
Ghana	331	4640	4971	1.5	5	75
Guinea	37	382	419	94	35	394
Guinea-Bissau	16	48	64	14.9	2	10
Indonesia	0	0	0	49	0	0
Iraq	39	128	167	4.9	2	8

Kenya	159	280	439	11.4	19	50
Liberia	14	93	107	31.1	4	33
Mali	18	88	106	90.3	16	95
Mauritania	0	26	26	65.9	0	17
Niger	0	48	48	1.4	0	1
Nigeria	82	4238	4320	15.3	13	661
Senegal	271	3362	3633	22.2	60	807
Sierra Leone	18	154	172	74.3	13	128
Somalia	15	269	284	96.7	14	274
Sudan	18	152	170	81.7	15	139
Togo	65	405	470	1.8	1	8
Uganda	7	34	41	1	0	0
Tanzania, United Republic of	14	41	55	4.7	1	3
Yemen	0	0	0	16.4	0	0
All countries of origin:	4602	27221	31823		2467	12399

Table A2.16 Female migrant population from FGM-practising countries (aged 0-19) in Italy, 2013

Country of origin	Number of girls under the median age of cutting			National prevalence rate in country of origin for the age-group 15-19	Number of girls at risk in this Member State	
	First generation	Second generation	Total		Min.	Max
Benin	27	268	295	2.4	1	7
Burkina Faso	50	688	738	57.7	29	426
Cameroon	92	1054	1146	0.4	0	5
Central African Republic	4	32	36	17.9	1	6
Chad	4	29	33	31.8	1	10
Côte d'Ivoire	38	991	1029	31.3	12	322
Djibouti	0	18	18	89.5	0	16
Egypt	2820	8815	11635	69.6	1963	8098
Eritrea	0	0	0	68.8	0	0
Ethiopia	200	343	543	47.1	94	256
Gambia	7	37	44	76.3	5	34
Ghana	311	4540	4851	1.5	5	73
Guinea	32	371	403	94	30	378
Guinea-Bissau	15	51	66	14.9	2	10
Indonesia	0	0	0	49	0	0
Iraq	43	136	179	4.9	2	9
Kenya	144	273	417	11.4	16	48
Liberia	14	93	107	31.1	4	33
Mali	20	70	90	90.3	18	81
Mauritania	4	28	32	65.9	3	21
Niger	0	41	41	1.4	0	1
Nigeria	74	4161	4235	15.3	11	648
Senegal	297	3321	3618	22.2	66	803
Sierra Leone	14	143	157	74.3	10	117

Somalia	23	269	292	96.7	22	282
Sudan	23	151	174	81.7	19	142
Togo	63	360	423	1.8	1	8
Uganda	8	35	43	1	0	0
Tanzania, United Republic of	16	44	60	4.7	1	3
Yemen	0	0	0	16.4	0	0
All countries of origin:	4344	26362	30706		2316	11836

Table A2.17 Female migrant population from FGM-practising countries (aged 0-19) in Italy, 2012

Country of origin	Number of girls under the median age of cutting			National prevalence rate in country of origin for the age-group 15-19	Number of girls at risk in this Member State	
	First generation	Second generation	Total		Min.	Max
Benin	35	264	299	2.4	1	7
Burkina Faso	84	675	759	57.7	48	438
Cameroon	113	950	1,063	0.4	0	4
Central African Republic	4	30	34	17.9	1	6
Chad	8	26	34	31.8	3	11
Côte d'Ivoire	50	999	1,049	31.3	16	328
Djibouti	1	18	19	89.5	1	17
Egypt	3,143	8,276	11,419	69.6	2188	7948
Eritrea	0	0	0	68.8	0	0
Ethiopia	267	344	611	47.1	126	288
Gambia	8	36	44	76.3	6	34
Ghana	396	4,425	4,821	1.5	6	72
Guinea	38	359	397	94	36	373
Guinea-Bissau	18	56	74	14.9	3	11
Indonesia	0	0	0	49	0	0
Iraq	55	132	187	4.9	3	9
Kenya	152	252	404	11.4	18	46
Liberia	12	90	102	31.1	3	32
Mali	23	69	92	90.3	21	83
Mauritania	4	28	32	65.9	3	21
Niger	0	43	43	1.4	0	1
Nigeria	94	4,171	4,265	15.3	14	653
Senegal	406	3,258	3,664	22.2	90	813
Sierra Leone	20	137	157	74.3	15	116
Somalia	33	277	310	96.7	32	299
Sudan	27	141	168	81.7	22	137
Togo	75	345	420	1.8	1	8
Uganda	7	37	44	1	0	0

Tanzania, United Republic of	16	47	63	4.7	1	3
Yemen	0	0	0	16.4	0	0
All countries of origin:	5,091	25,485	30,576		2658	11758

Table A2.18 Female migrant population from FGM-practising countries (aged 0-19) in Italy, 2011

Country of origin	Number of girls under the median age of cutting			National prevalence rate in country of origin for the age-group 15-19	Number of girls at risk in this Member State	
	First generation	Second generation	Total		Min.	Max
Benin	43	267	310	2.4	1	7
Burkina Faso	112	634	746	57.7	65	430
Cameroon	124	864	988	0.4	0	4
Central African Republic	6	28	34	17.9	1	6
Chad	9	22	31	31.8	3	10
Côte d'Ivoire	67	967	1,034	31.3	21	324
Djibouti	0	18	18	89.5	0	16
Egypt	3,439	7,898	11,337	69.6	2394	7891
Eritrea	0	0	0	68.8	0	0
Ethiopia	294	323	617	47.1	138	290
Gambia	8	39	47	76.3	6	36
Ghana	501	4,173	4,674	1.5	8	70
Guinea	48	336	384	94	45	361
Guinea-Bissau	23	50	73	14.9	3	11
Indonesia	0	0	0	49	0	0
Iraq	70	128	198	4.9	3	10
Kenya	162	223	385	11.4	18	44
Liberia	15	81	96	31.1	4	30
Mali	21	69	90	90.3	19	81
Mauritania	4	31	35	65.9	3	23
Niger	0	41	41	1.4	0	1
Nigeria	118	4,127	4,245	15.3	18	650
Senegal	537	3,058	3,595	22.2	119	798
Sierra Leone	23	120	143	74.3	17	106
Somalia	33	291	324	96.7	32	314
Sudan	31	131	162	81.7	25	132
Togo	97	292	389	1.8	2	7
Uganda	9	30	39	1	0	0
Tanzania, United Republic of	16	45	61	4.7	1	3
Yemen	0	0	0	16.4	0	0
All countries of origin:	5,809	24,286	30,095		2946	11655

Table A2.19 Female migrant population from FGM-practising countries (aged 0-19) in Cyprus, 2011

Country of origin	Number of girls under the median age of cutting*			National prevalence rate in country of origin for the age-group 15-19	Number of girls at risk in this Member State	
	First generation	Second generation	Total		Min.	Max
Benin	0	0	0	2.4	0	0
Burkina Faso	0	0	0	57.7	0	0
Cameroon	4	18	22	0.4	0	0
Central African Republic	2	4	6	17.9	0	1
Chad	1	0	1	31.8	0	0
Côte d'Ivoire	0	0	0	31.3	0	0
Djibouti	0	0	0	89.5	0	0
Egypt	30	56	86	69.6	21	60
Eritrea	0	0	0	68.8	0	0
Ethiopia	0	8	8	47.1	0	4
Gambia	0	0	0	76.3	0	0
Ghana	2	5	7	1.5	0	0
Guinea	0	0	0	94	0	0
Guinea-Bissau	0	0	0	14.9	0	0
Indonesia	0	0	0	49	0	0
Iraq	116	126	242	4.9	6	12
Kenya	0	11	11	11.4	0	1
Liberia	0	1	1	31.1	0	0
Mali	0	0	0	90.3	0	0
Mauritania	0	0	0	65.9	0	0
Niger	0	1	1	1.4	0	0
Nigeria	0	6	6	15.3	0	1
Senegal	0	0	0	22.2	0	0
Sierra Leone	1	1	2	74.3	1	1
Somalia	1	2	3	96.7	1	3
Sudan	0	27	27	81.7	0	22
Togo	0	0	0	1.8	0	0
Uganda	0	0	0	1	0	0
Tanzania, United Republic of	0	2	2	4.7	0	0
Yemen	0	0	0	16.4	0	0
TOTAL	157	268	425		29	105

Table A2.20 Female migrant population from FGM-practising countries (aged 0-19) in Malta, 2011

Country of origin	Number of girls under the median age of cutting	National prevalence rate in country of	Number of girls at risk in this Member State

	First generation	Second generation	Total	origin for the age-group 15-19	Min.	Max
Benin	0	0	0	2.4	0	0
Burkina Faso	0	0	0	57.7	0	0
Cameroon	1	0	1	0.4	0	0
Central African Republic	0	0	0	17.9	0	0
Chad	0	0	0	31.8	0	0
Côte d'Ivoire	0	0	0	31.3	0	0
Djibouti	0	0	0	89.5	0	0
Egypt	3	19	22	69.6	2	15
Eritrea	0	0	0	68.8	0	0
Ethiopia	20	17	37	47.1	9	17
Gambia	0	0	0	76.3	0	0
Ghana	1	1	2	1.5	0	0
Guinea	0	0	0	94	0	0
Guinea-Bissau	0	0	0	14.9	0	0
Indonesia	0	0	0	49	0	0
Iraq	0	0	0	4.9	0	0
Kenya	0	0	0	11.4	0	0
Liberia	0	0	0	31.1	0	0
Mali	0	0	0	90.3	0	0
Mauritania	0	0	0	65.9	0	0
Niger	0	0	0	1.4	0	0
Nigeria	9	19	28	15.3	1	4
Senegal	0	0	0	22.2	0	0
Sierra Leone	0	3	3	74.3	0	2
Somalia	33	110	143	96.7	32	138
Sudan	4	5	9	81.7	3	7
Togo	0	0	0	1.8	0	0
Uganda	0	0	0	1	0	0
Tanzania, United Republic of	1	0	1	4.7	0	0
Yemen	0	0	0	16.4	0	0
All countries of origin:	71	174	245		47	183

Annex 3 FGM risk estimations for asylum-seekers

Table A3.1 Country of origin data

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

* population aged 0-11

A3.1 Country of destination data

Table A3.2 Female asylum-seeking population from FGM-practising countries (aged 0-19) in Belgium, 2016

Country of origin	Number of girls under the median age of cutting	National prevalence rate in country of origin for the age-group 15-19	Number of girls at risk in this Member State
Benin	5	2.4	0
Burkina Faso	4	57.7	2
Cameroon	13	0.4	0
Central African Republic	0	17.9	0
Chad	5	31.8	2
Côte d'Ivoire	14	31.3	4
Djibouti	3	89.5	3
Egypt	6	69.6	4
Eritrea	0	68.8	0
Ethiopia	0	47.1	0
Gambia	0	76.3	0
Ghana	0	1.5	0
Guinea	83	94	78
Guinea-Bissau	0	14.9	0
Indonesia	0	49	0
Iraq	304	4.9	15
Kenya	2	11.4	0
Liberia	0	31.1	0
Mali	2	90.3	2
Mauritania	5	65.9	3
Niger	3	1.4	0
Nigeria	10	15.3	2
Senegal	6	22.2	1
Sierra Leone	0	74.3	0
Somalia	51	96.7	49
Sudan	10	81.7	8
Togo	2	1.8	0
Uganda	0	1	0
Tanzania, United Republic of	0	4.7	0
Yemen	0	16.4	0
TOTAL	**528**		**174**

Table A3.3 Overview of the female asylum-seeking population from FGM-practising countries (aged 0-17) in Greece, 2016

Country of origin	Number of girls under the median age of cutting	National prevalence rate in country of origin for the age-group 15-19	Number of girls at risk in this Member State

Benin	0	2.4	0
Burkina Faso	0	57.7	0
Cameroon	2	0.4	0
Central African Republic	0	17.9	0
Chad	0	31.8	0
Côte d'Ivoire	0	31.3	0
Djibouti	0	89.5	0
Egypt	3	69.6	2
Eritrea	0	68.8	0
Ethiopia	0	47.1	0
Gambia	0	76.3	0
Ghana	1	1.5	0
Guinea	0	94	0
Guinea-Bissau	0	14.9	0
Indonesia	0	49	0
Iraq	464	4.9	23
Kenya	0	11.4	0
Liberia	0	31.1	0
Mali	0	90.3	0
Mauritania	0	65.9	0
Niger	0	1.4	0
Nigeria	1	15.3	0
Senegal	0	22.2	0
Sierra Leone	1	74.3	1
Somalia	6	96.7	6
Sudan	2	81.7	1
Togo	0	1.8	0
Uganda	0	1	0
Tanzania, United Republic of	0	4.7	0
Yemen	0	16.4	0
All countries of origin:	480		**33**

Table A3.4 Overview of the female asylum-seeking population from FGM-practising countries (aged 0-18) in France, 2016

Country of origin	Number of girls under the median age of cutting	National prevalence rate in country of origin for the age-group 15-19	Number of girls at risk in this Member State
Benin	2	2.4	0
Burkina Faso	3	57.7	2
Cameroon	18	0.4	0
Central African Republic	58	17.9	10
Chad	41	31.8	13
Côte d'Ivoire	37	31.3	12
Djibouti	2	89.5	2
Egypt	11	69.6	8
Eritrea	0	68.8	0

Ethiopia	9	47.1	4
Gambia	7	76.3	5
Ghana	1	1.5	0
Guinea	124	94	117
Guinea-Bissau	2	14.9	0
Indonesia	0	49	0
Iraq	252	4.9	12
Kenya	3	11.4	0
Liberia	0	31.1	0
Mali	44	90.3	40
Mauritania	13	65.9	9
Niger	0	1.4	0
Nigeria	59	15.3	9
Senegal	24	22.2	5
Sierra Leone	3	74.3	2
Somalia	25	96.7	24
Sudan	63	81.7	51
Togo	1	1.8	0
Uganda	0	1	0
Tanzania, United Republic of	0	4.7	0
Yemen	5	16.4	1
TOTAL	**807**		**327**

Table A3.5 Overview of the female asylum-seeking population from FGM-practising countries (aged 0-19) in Italy, 2016

Country of origin	Number of girls under the median age of cutting	National prevalence rate in country of origin for the age-group 15-19	Number of girls at risk in this Member State
Benin	0	2.4	0
Burkina Faso	1	57.7	0
Cameroon	31	0.4	0
Central African Republic	0	17.9	0
Chad	1	31.8	0
Côte d'Ivoire	8	31.3	3
Djibouti	0	89.5	0
Egypt	2	69.6	1
Eritrea	0	68.8	0
Ethiopia	2	47.1	1
Gambia	2	76.3	2
Ghana	7	1.5	0
Guinea	3	94	2
Guinea-Bissau	0	14.9	0
Indonesia	0	49	0
Iraq	19	4.9	1
Kenya	2	11.4	0
Liberia	0	31.1	0
Mali	5	90.3	4
Mauritania	0	65.9	0
Niger	0	1.4	0

Nigeria	105	15.3	16
Senegal	5	22.2	1
Sierra Leone	6	74.3	4
Somalia	14	96.7	14
Sudan	4	81.7	3
Togo	0	1.8	0
Uganda	0	1	0
Tanzania, United Republic of	0	4.7	0
Yemen	0	16.4	0
All countries of origin:	216		52

Table A3.6 Overview of the female asylum-seeking population from FGM-practising countries (aged 0-17) in Malta, 2016

Country of origin	Number of girls under the median age of cutting	National prevalence rate in country of origin for the age-group 15-19	Number of girls at risk in this Member State
Benin	0	2.4	0
Burkina Faso	0	57.7	0
Cameroon	0	0.4	0
Central African Republic	0	17.9	0
Chad	0	31.8	0
Côte d'Ivoire	0	31.3	0
Djibouti	0	89.5	0
Egypt	1	69.6	1
Eritrea	0	68.8	0
Ethiopia	0	47.1	0
Gambia	0	76.3	0
Ghana	0	1.5	0
Guinea	0	94	0
Guinea-Bissau	0	14.9	0
Indonesia	0	49	0
Iraq	0	4.9	0
Kenya	0	11.4	0
Liberia	0	31.1	0
Mali	0	90.3	0
Mauritania	0	65.9	0
Niger	0	1.4	0
Nigeria	1	15.3	1
Senegal	0	22.2	0
Sierra Leone	0	74.3	0
Somalia	1	96.7	1
Sudan	1	81.7	1
Togo	0	1.8	0
Uganda	0	1	0
Tanzania, United Republic of	0	4.7	0
Yemen	0	16.4	0

All countries of origin:	4		**4**

Annex 4 Additional disaggregations (where available)

Table A4.1 Total female first-generation migrant population in Belgium from FGM practising countries in 2012 and 2016, by age

Ages	>1	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	All
Year: 2012	0	48	139	176	219	267	269	274	308	306	389	373	402	423	432	429	428	473	557	560	**6472**
Year: 2016	4	42	70	133	168	216	259	302	301	275	330	297	271	314	323	308	352	381	368	426	**5140**

Source: National Statistics Office, Belgium

Table A4.2 Total female second-generation migrant population in Belgium from FGM practising countries in 2012 and 2016, by age

Ages	>1	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	All
Year: 2012	1572	1376	1231	1099	936	834	764	595	588	474	395	303	266	319	243	10	NA	NA	NA	NA	11005
Year: 2016	1787	1728	1657	1622	1572	1376	1231	1099	936	834	764	595	588	474	395	303	266	319	243	10	17799

Source: National Statistics Office, Belgium

Table A4.3 Total female first-generation migrant population in Cyprus from FGM-practising countries in 2011, by age

Ages	>1	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	All
	1	4	8	17	13	28	27	20	33	30	29	33	28	18	31	29	23	34	33	21	**460**

Source: Cyprus Statistical Service

Table A4.4 Total female second-generation migrant population in Cyprus from FGM-practising countries in 2011, by age

Ages	>1	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	All
	68	63	29	32	19	13	20	14	17	11	9	8	9	2	6	3	6	7	7	9	**352**

Source: Cyprus Statistical Service

Table A4.5 Number of female asylum seekers aged 0-19 in Belgium, originating from countries where FGM is documented, by age and year

	Age																				Total
	<1	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	
2016	92	59	78	68	75	60	55	47	46	42	45	25	26	32	41	30	45	48	55	47	**1,016**
2015	67	71	81	83	53	69	51	51	46	55	35	27	36	33	29	34	56	49	56	53	**1035**
2012	0	101	67	44	31	27	29	29	32	20	20	20	14	19	17	25	12	42	78	55	**682**

Source: Federal Agency for the reception of asylum seekers (Fedasil), Belgium.

Table A4.6 Number of female asylum seekers aged 0-18 in France, originating from countries where FGM is documented, by age and year

	Age																			Total
	<1	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	
2016	220	145	99	69	85	83	59	75	76	65	56	57	46	39	25	31	22	27	4	**1283**
2015	332	289	160	126	110	95	104	70	76	74	65	48	55	42	51	45	49	32	6	**1829**
2014	382	263	130	96	73	81	57	51	51	44	40	42	27	50	42	36	27	29	7	**1528**
2013	335	221	100	77	74	54	48	29	45	40	30	26	28	24	22	21	15	20	2	**1211**
2012	318	210	98	79	53	43	45	36	34	25	32	27	19	26	17	21	23	12	2	**1120**
2011	298	226	97	64	56	37	47	28	35	35	40	35	25	29	26	23	15	13	2	**1131**

Source: Federal Agency for the reception of asylum seekers (Fedasil), Belgium.

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