European Institute for Gender Equality

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

Denmark, Spain, Luxembourg and Austria

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This report is a follow-up to EIGE's work in supporting prevention and combating female genital mutilation. More information and resources can be found on a dedicated web page (http://eige.europa.eu/gender-based-violence/eiges-studies-gender-based-violence/female-genital-mutilation).

European Institute for Gender Equality

The European Institute for Gender Equality (EIGE) is an autonomous body of the European Union established to strengthen gender equality across the EU. Equality between women and men is a fundamental value of the EU and EIGE's task is to make this a reality in Europe and beyond. This includes becoming a European knowledge centre on gender equality issues, supporting gender mainstreaming in all EU and Member State policies, and fighting discrimination based on sex.

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

Denmark, Spain, Luxembourg and Austria

Abbreviations

EU Member State codes

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

Other country codes

UK	United Kingdom

Frequently used abbreviations

CESAS	National Reference Centre for Emotional and Sexual Health (Luxembourg)
EIGE	European Institute for Gender Equality
EU-27	27 Member States of the EU
FGM	female genital mutilation
GAP III	gender action plan III
MEGA	Ministry of Equality between Women and Men (Ministère de l'Egalité pour les Femmes et les Hommes) (Luxembourg)
NGO	non-governmental organisation
OFPRA	French Office for the Protection of Refugees and Stateless Persons
ONA	National Reception Office (Luxembourg)
UNHCR	United Nations High Commissioner for Refugees

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Glossary

Female genital mutilation (FGM): 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. The World Health Organization (WHO) has developed a classification to distinguish between four types of FGM:

- **Type I:** partial or total removal of the clitoris and/or the prepuce (clitoridectomy).
- **Type II:** partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).
- **Type III:** narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (**infibulation**).
- **Type IV:** all other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterisation.

This study distinguishes between types of FGM only where 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 FGM.

Terms commonly used to describe 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, emphasising the purifying aspect.
- **Hitan:** Egyptian expression for FGM, mostly types I, II and IV.
- **Infibulation:** normally refers to FGM type III.
- **Pharaonic circumcision:** expression for FGM type III.
- **Suningol:** Fulani expression for FGM, meaning 'doing the sunna'.
- **Sunna:** Sayings, traditions and practices of the Islamic Prophet Muhammad. May consist of FGM type I or II.

Terms relating to FGM surgery and treatment

- **Deinfibulation:** reconstructive surgery of the scar tissue.
- **Reconstructive surgery:** a reconstructive procedure that may increase sexual function and appearance of the female genitals for patients who have undergone FGM.

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

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

Country of destination: The EU Member State where a person originating from a country where FGM is commonly practised decides to establish their residence, or where they have 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).

Dual criminality: for someone to be extradited, their alleged conduct has to be a criminal offence in both the surrendering and the requesting state.

Emigrants: Emigrants (outflows) are people leaving the country where they usually reside and effectively taking up residence in another country. An individual is a long-term emigrant if that person leaves their country of previous usual residence for a period of 12 months or more (1998 UN recommendations on the statistics of international migration (Revision 1), Eurostat).

Extraterritoriality: The exemption from the application or jurisdiction local law. In the context of FGM, the principle of extraterritoriality refers to the criminalising of FGM when committed abroad.

FGM-affected communities: This 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) 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 or are born to a mother from FGM-practising countries.

FGM-practising countries: This 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, The Gambia, Ghana, Guinea-Bissau, Guinea, Indonesia, Iraq, Kenya, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Somalia, Sudan, Togo, Uganda, Tanzania, Yemen.

FGM prevalence in an EU Member State: The proportion of girls and women who have undergone a form of FGM out of all girls and women currently residing in a Member State and who either originate 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. 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 seeker's protection due to having already experienced FGM.

First-generation migrant ([1]): First-generation migrants are those who were born in an FGM-practising country to one or more parents who were also born in those countries, and who have established usual residence in an EU Member State.

([1]) In Danish statistics, the terms 'immigrant' and 'descendent' are used rather than 'first generation' and 'second generation'. Accordingly, 'immigrant' refers to someone born in a foreign country (their country of origin), whilst 'descendant' refers to someone born in Denmark.

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

Gender-based persecution: Persecution that targets or disproportionately affects a particular gender.

Girls potentially at risk of FGM: Girls potentially at risk of FGM are defined as minor girls (aged 0–18) who come from FGM-practising countries or who were born to parents (or one parent) who originate from countries where FGM is commonly practised.

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

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

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

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

Refoulement: When used in relation to refugees and asylum-seekers, the removal of a person to a territory or frontiers of a territory where their life or freedom would be threatened on account of their race, religion, nationality, membership of a particular social group or political opinion. The duty of non-refoulement is a part of customary international law and is therefore binding on all States, whether or not they are parties to the Geneva Convention.

Refugee: A refugee is considered to be 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 their country of nationality and is unable or, owing to this fear, unwilling to avail 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).

Residence permit: A document or card authorising migrants to reside in a country for a fixed or indefinite length of time.

Secondary victimisation (or **re-victimisation**): Secondary victimisation occurs when the victim suffers further harm, not as a direct result of the criminal act but due to the manner in which institutions and other individuals deal with them in relation to the criminal act (Council of Europe, 2006).

Second-generation migrant ([2]): In this study, a second-generation migrant means a person who was not born in an FGM-practising country but who has at least one parent who was born in an FGM-practising country and who is usually resident in an EU Member State.

Temporary protection: An arrangement or device developed by States to offer protection

([2]) In Danish statistics, the terms 'immigrant' and 'descendent' are used rather than 'first generation' and 'second generation'. Accordingly, 'immigrant' refers to someone born in a foreign country (their country of origin), whilst 'descendant' refers to someone born in Denmark.

of a temporary nature to persons arriving en masse from situations of conflict or generalised violence, without prior individual status determination. Temporary protection is typically used in industrialised States.

Trafficking (human): The organised illegal movement of persons for profit.

Usual residence: According to Regulation (EU) No 1260/2013, 'usual residence' means the place where a person normally spends their daily period of rest, regardless of temporary absences for purposes of recreation, holidays, visits to friends and relatives, business, medical treatment or religious pilgrimage. The following persons alone shall be considered to be usual residents of a specific geographical area: (i) those who have lived in their place of usual residence for a continuous period of at least 12 months before the reference time; or (ii) those who arrived in their place of usual residence during the 12 months before the reference time with the intention of staying there for at least 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.

Unaccompanied minors: A child without the presence of a legal guardian.

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

Year of arrival: The year of arrival is the calendar year in which a person most recently established usual residence in the country. The year of most recent arrival in the country shall be reported, rather than the year of first arrival.

Executive summary

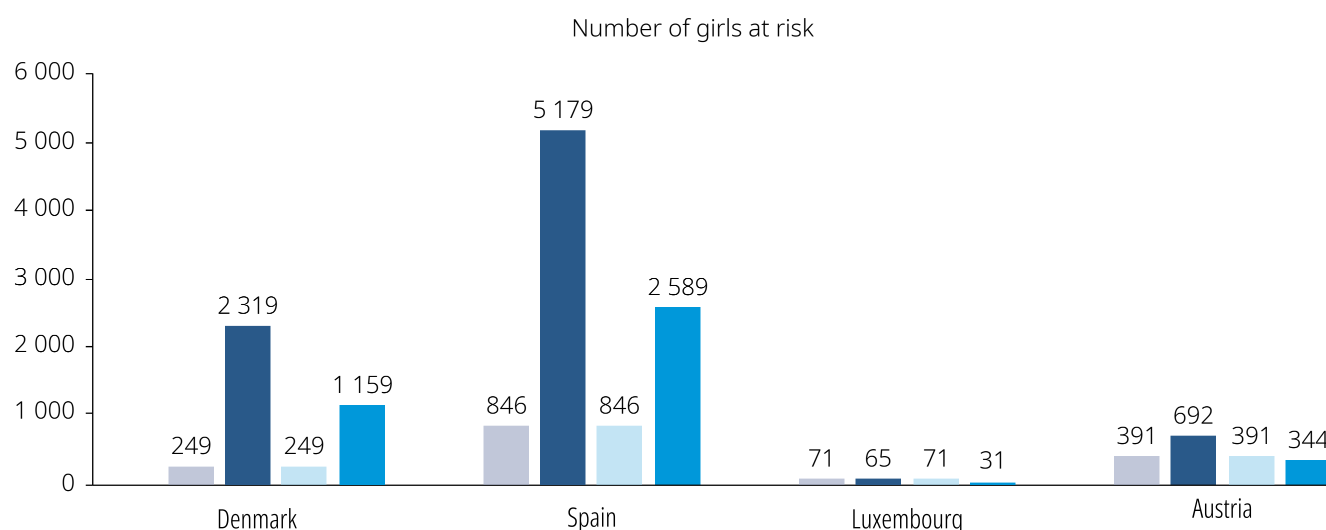
Since 2012, the European Institute for Gender Equality (EIGE) has mapped the situation of female genital mutilation (FGM) in the European Union, identified good practices to tackle it and developed a methodology to estimate the number of women and girls at risk. This common methodology was originally presented in 2015, pilot tested in three Member States (EIGE, 2015), further refined and applied to an additional six Member States (EIGE, 2018).

The overall objective of this report is to support the European institutions and all EU Member States by providing more accurate qualitative and quantitative information on FGM and its risks among girls, taking into account new patterns of migration. To achieve this, EIGE's 2018 methodology was applied to four additional Member States: Denmark, Spain, Luxembourg and Austria.

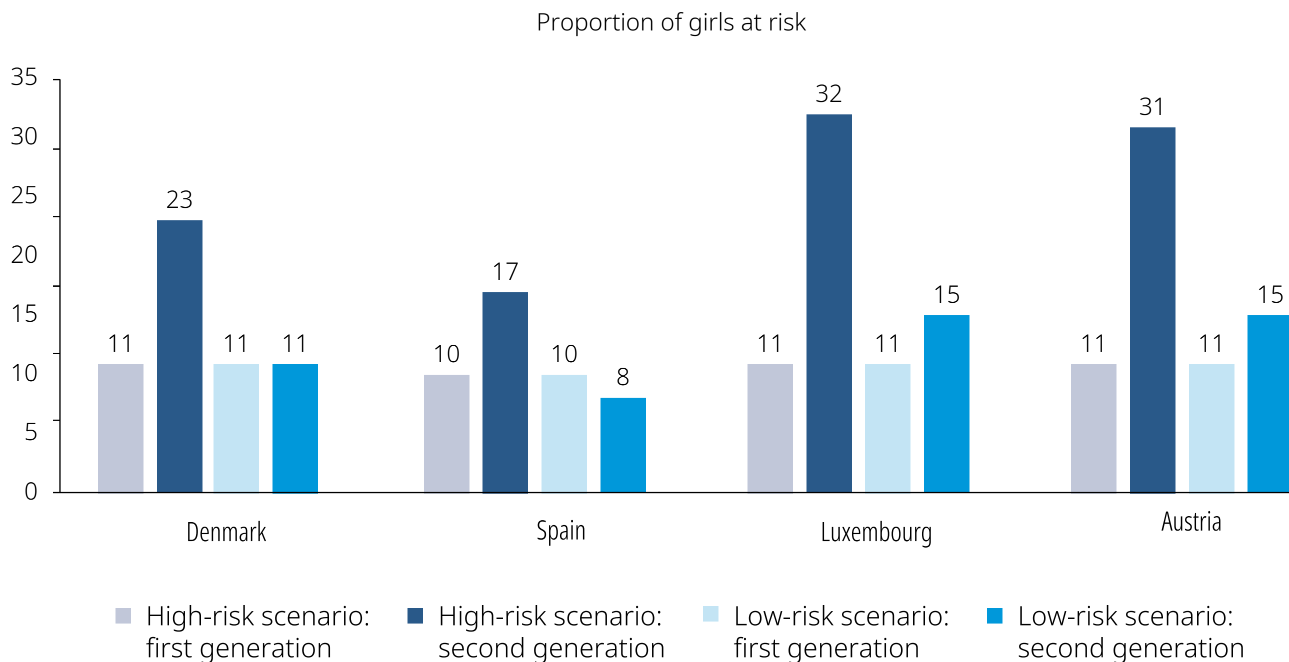
This study also examined FGM-related policies and legislation from mid 2017 to mid 2020.

When calculating the estimated number and proportion of girls at risk of FGM, two scenarios are presented. The **high-risk scenario** is the highest boundary of the estimated number of girls at risk of FGM. This scenario assumes that the process of migration and acculturation (3) has had no effect on FGM prevalence for both first- and second-generation migrants. The **low-risk scenario** assumes that the process of migration and acculturation has had an effect on FGM prevalence among first-generation migrants and that FGM risk remains among second-generation migrants, albeit at a lower level. The risk estimations are presented for both scenarios and for first- and second-generation migrants in Figure 1.

Figure 1. Number and proportion of girls (aged 0–18 years) at risk of FGM in Denmark (2019), Spain (2018), Luxembourg (2019) and Austria (2019)



(3) 'Acculturation can be defined as a culture learning process experienced by individuals who are exposed to a new culture or ethnic group' (Balls Organista et al., 2010).



Overall, this study found the following:

- The **prevalence of FGM in the countries of origin or communities drives the expected risk** of FGM. The size of the communities from the country of origin does not necessarily translate into greater risk. Therefore, the absolute number of girls at risk must be read together with prevalence.
- The risk of FGM is less pronounced when a woman or girl is in Europe. However, the **risk of FGM is higher any time an unmarried girl returns to her country of origin**.
- The four Member States in this study (DK, ES, LU, AT) **explicitly criminalise FGM and apply the principle of extraterritoriality**.
- **Asylum procedures across the four Member States do not fully serve the needs of women and girls** who have undergone FGM.
- **FGM is perceived by affected communities in this study as being a cultural tradition rather than a religious tradition.** Individuals consulted tended to agree that FGM is a harmful practice.
- **Effectively engaging communities by breaking down cultural barriers is a challenge in Denmark, Spain, Luxembourg and Austria.** This is a necessary step in tackling FGM by gaining a strong understanding of the cultures and perceptions in the affected communities.

This study identified key FGM legislation and policies at the EU and national levels from 2017 to 2020. At the EU level, this study found the following:

- Key developments since 2017 include the **introduction of the new Pact on Migration and Asylum and the EU strategy on victims' rights** (2020–2025). In 2017, the EU **signed the Istanbul Convention**, although it is yet to accede to the convention.
- Further developments include the **European Parliament resolution** on zero tolerance for FGM, another resolution on an EU strategy to put an end to FGM around the world and the **European Commission's gender equality strategy** (2020–2025), which includes specific actions to end FGM.
- The EU has stated its intention to **combat FGM globally** through the action plans on human

rights and democracy (2020–2024), and gender equality and women's empowerment in external relations (2021–2025 gender action plan III), as well as through the 'Spotlight' initiative, in partnership with the United Nations.

At national level, this study found the following:

- **FGM is criminalised in all 27 Member States of the EU** (EU-27) and the United Kingdom. In 21 countries (20 Member States and the United Kingdom), criminal laws make explicit reference to FGM or 'mutilation'. Seven Member States have general criminal legislation that can be used to prosecute FGM (BG, CZ, LV, HU, PL, SI, SK).
- **Overall, 25 Member States apply the principle of extraterritoriality** in criminal law (all of the EU-27, excluding BG and CZ).
- **A few Member States include an explicit mention of FGM or mutilation in their child protection laws** (ES, FR, LU AT, FI).
- **Eight countries** (seven Member States and the United Kingdom) **have legal or professional obligations for doctors and other professionals to report FGM** (BE, DE, DK, FR, MT, NL, SE, UK).
- **Six Member States explicitly recognise the risk of FGM as a ground for asylum** and have introduced appropriate legislation (BE, DK, EL, FR, HU, PT).
- **Overall, 20 countries** (19 Member States and the United Kingdom) **have enacted national action plans with a specific FGM focus or mention FGM in a broader strategy to combat gender-based violence**. Three Member States have a national action plan on gender-based violence more generally, but these do not mention FGM specifically (DK, LT, AT). Five Member States do not have a current national action plan on FGM or to combat gender-based violence more generally (DE, LV, MT, PL, SI).

1. Legislation and policies to tackle female genital mutilation at European and national levels

1.1. European level

This section provides an overview of recent legislation and policy designed to combat female genital mutilation (FGM) at EU level, from mid 2017 to mid 2020. This overview is a follow-up to the 2018 report of the European Institute for Gender Equality (EIGE) *Estimation of girls at risk of female genital mutilation in the European Union*.

1.1.1. Enhancing prevention and strengthening protection

Since mid 2017, the EU has financed various transnational projects and issued grants under the **rights, equality and citizenship programme** (4) that combat violence against women and children, with an emphasis on eliminating FGM. For example, the 4-year framework operating grant for the End FGM European Network 'Ensuring a European coordinated, human rights and children's rights-based approach to eliminate FGM' began in 2018 to support the implementation of anti-FGM instruments.

In September 2020, the European Commission adopted a new **Pact on Migration and Asylum** (5), replacing the Common European Asylum System. The pact includes various legislative and non-legislative instruments to promote coherent approaches to migration and asylum across the EU. The instruments of the pact include provisions that facilitate efforts to combat forms of gender-based violence, including FGM. More specifically, the pact states that the specific needs of applicants who have experienced gender-based violence should be considered during the asylum procedure. It aims to establish protection safeguards for vulnerable asylum seekers, including women who have undergone FGM, through the provision of medical support, legal support, counselling and psychosocial care (6).

The **action plan on integration and inclusion** (7) encourages Member States to promote the healthcare services available to migrants and to provide training to healthcare workers to meet the needs of specific migrant groups affected by forms of trauma and gender-based violence. Similarly, the new Screening Regulation (8) provides that third-country nationals must receive timely and adequate support in view of their physical and mental health.

(4) European Union (2013), Regulation (EU) No 1381/2013 of the European Parliament and of the Council of 17 December 2013 establishing a rights, equality and citizenship programme for the period 2014 to 2020, OJ L 354, 28.12.2013 (https://eur-lex.europa.eu/legal-content/EN/TXT/?qid=1397223391719&uri=CELEX:32013R1381).

(5) European Commission (2020), 'Migration and asylum package: New Pact on Migration and Asylum documents adopted on 23 September 2020' (https://ec.europa.eu/info/publications/migration-and-asylum-package-new-pact-migration-and-asylum-documents-adopted-23-september-2020_en).

(6) European Commission (2021), 'Questions and answers about female genital mutilation (FGM)', (https://ec.europa.eu/commission/presscorner/detail/en/QANDA_21_402).

(7) European Commission (2020), Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions – Action plan on integration and inclusion 2021-2027, COM(2020) 758 final, 24.11.2020 (https://ec.europa.eu/home-affairs/sites/homeaffairs/files/pdf/action_plan_on_integration_and_inclusion_2021-2027.pdf).

(8) European Parliament (2020), 'Screening of third-country nations at the EU's external borders', EU Legislation in Progress Briefing (https://www.europarl.europa.eu/RegData/etudes/BRIE/2020/659346/EPRS_BRI(2020)659346_EN.pdf).

1.1.2. Enhancing the legal framework to tackle female genital mutilation

In 2014, the Council of Europe Convention on preventing and combating violence against women and domestic violence (the **Istanbul Convention**) came into force ([9]). The convention is a legally binding instrument for those Member States that have ratified it and is dedicated to combating all forms of violence against women, including FGM.

Article 38 of the Istanbul Convention expects parties to the convention to enforce legislative measures to criminalise acts of FGM. The convention also includes monitoring mechanisms to facilitate the effective implementation of its provisions.

The accession of the EU to the Istanbul Convention would represent the adoption of a multifaceted legislative framework to prevent, prosecute and eliminate acts of violence against women. In 2015, the European Commission developed a roadmap on a possible EU accession to the Istanbul Convention, following which the EU adopted **two decisions on the signing of the Istanbul Convention** in May 2017. Council Decision (EU) (2017/865) ([10]) on judicial cooperation facilitates the establishment of minimum EU rules related to the definition of criminal offences and sanctions of particularly serious crime with a cross-border dimension (under which FGM would fall). Council Decision (EU) (2017/866) ([11]) on asylum and *non-refoulement* concerns certain articles of the Istanbul Convention, specifically Article 60 (recognition of gender-based asylum claims) and Article 61 (adherence to the principle of *non-refoulement*, as it relates to violence against women).

Following the adoption of these two Council decisions, the EU signed the Istanbul Convention in June 2017. However, it has not yet acceded to the Convention.

The 2018 European Parliament **resolution on zero tolerance for female genital mutilation** ([12]) urges Member States and the Commission to mainstream the prevention of FGM in all sectors, including health, asylum, child protection and justice. It encourages Member States to develop national strategies to tackle FGM and to train relevant actors (medical professionals, social workers, law enforcement, religious leaders) on the detection, prevention and prosecution of FGM. Finally, it urges all EU Member States to ratify the Istanbul Convention. In 2020, the European Parliament adopted the **resolution on an EU strategy to put an end to female genital mutilation around the world** ([13]), reaffirming the EU's commitment to combating and eliminating FGM. The resolution calls on the Commission and Member States to allocate adequate funding in future EU budgets (internal and external) to support anti-FGM initiatives led by community-based organisations. It also urges the Commission to review the 2013 communication 'Towards the elimination of FGM' to increase EU-led efforts to combat the practice worldwide ([14]).

([9]) Council of Europe (2011), *Council of Europe Convention on preventing and combating violence against women and domestic violence*, Council of Europe Treaty Series, No 210, Istanbul (https://rm.coe.int/168008482e).

([10]) European Union (2017), Council Decision (EU) (2017/865) of 11 May 2017 on the signing, on behalf of the EU, of the Council of Europe Convention on preventing and combating violence against women and domestic violence with regard to matters related to judicial cooperation in criminal matters, OJ L 131, 20.5.2017, p. 11–12.

([11]) European Union (2017), Council Decision (EU) (2017/866) of 11 May 2017 on the signing, on behalf of the EU, of the Council of Europe Convention on preventing and combating violence against women and domestic violence with regard to asylum and *non-refoulement*, OJ L 131, 20.5.2017, p. 13–14.

([12]) European Parliament (2018), European Parliament resolution of 7 February 2018 on zero tolerance for female genital mutilation (2019/2936(RSP)) (https://www.europarl.europa.eu/doceo/document/TA-8-2018-0033_EN.html).

([13]) European Parliament (2020), Motion for a resolution to wind up the debates on the statements by the Council and the Commission pursuant to Rule 132(2) of the Rules of Procedure on an EU strategy to put an end to female genital mutilation around the world (2019/2988(RSP)) (https://www.europarl.europa.eu/doceo/document/B-9-2020-0090_EN.html).

([14]) European Parliament (2020), European Parliament resolution of 12 February 2020 on an EU strategy to put an end to female genital mutilation around the world (2019/2988(RSP)) (https://www.europarl.europa.eu/doceo/document/TA-9-2020-0031_EN.html).

The European Commission's **2020–2025 gender equality strategy** ([15]) was adopted in March 2020 and includes specific actions to end FGM and other forms of gender-based violence by, inter alia, presenting a victims' rights strategy to support victims of gender-based violence and establishing an EU network on the prevention of gender-based violence and domestic violence. The gender equality strategy also encourages the EU's accession to the Istanbul Convention. If the EU's full accession remains blocked, the Commission intends to propose measures in 2021 to achieve the objectives outlined in the convention. In particular, it plans to expand the list of harmonised 'Eurocrimes' outlined in Article 83(1) of the Treaty on the Functioning of the European Union to include FGM.

In June 2020, the European Commission adopted its first-ever **EU strategy on victims' rights (2020–2025)** ([16]). The core objective of the strategy is to ensure that victims of crime can fully enjoy their rights across the EU, which have been outlined in the Victims' Rights Directive (2012/29/EU). The strategy adopts a two-strand approach, which includes the empowerment of victims of crime and working collaboratively across the EU to ensure that victims' rights are upheld. The strategy pays attention to the needs of victims of gender-based violence, which include women and girls who have experienced FGM. The victims' rights strategy will help to combat and eliminate FGM by fostering safe environments in which victims can report crime; improving protection safeguards for vulnerable victims; strengthening coordination among relevant actors and professionals; and strengthening victims' rights at the international level.

1.1.3. Global action

In 2017, the Council of Europe Committee of Ministers adopted the **Declaration on the need to intensify efforts to prevent and combat FGM and forced marriage** in Europe ([17]). The declaration reaffirms the willingness of the Council to work alongside the EU and intergovernmental organisations to eliminate and prevent FGM in Europe and beyond. Similarly, the prevention of violence against women, including harmful practices such as FGM, is a strategic objective in the Council's 2018–2023 gender equality strategy.

In September 2018, the EU partnered with the UN to launch the **Spotlight Initiative**, the largest targeted global effort to end violence against women and girls, including FGM ([18]). In a joint statement issued in 2018, the European Commission outlined the initiative's goal to end FGM globally by 2030.

In 2020, the European Parliament **resolution on an EU strategy to put an end to female genital mutilation around the world** ([19]) was adopted, reaffirming the need for the EU to combat FGM globally. Article 15 of the resolution urges Member States to encourage third countries to adopt anti-FGM legislation, whereas Article 17 encourages the Commission to make development assistance for third countries contingent on their progress in combating FGM.

([15]) European Commission (2020), Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions – A Union of equality: Gender equality strategy, COM(2020) 152 final, 5.3.2020 (https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX %3A52020DC0152).

([16]) European Commission (2021), 'Protecting victims' rights' (https://ec.europa.eu/info/policies/justice-and-fundamental-rights/criminal-justice/protecting-victims-rights_en).

([17]) Council of Europe (2017), *Declaration of the Committee of Ministers on the need to intensify the efforts to prevent and combat female genital mutilation and forced marriage in Europe including a guide to good and promising practices aimed at preventing and combating female genital mutilation and forced marriage*, Council of Europe, Strasbourg (https://rm.coe.int/female-genital-mutilation-and-forced-marriage/16807baf8f).

([18]) Spotlight Initiative (2021), 'Leaving no one behind', (https://www.spotlightinitiative.org/).

([19]) European Parliament (2020), European Parliament resolution of 12 February 2020 on an EU strategy to put an end to female genital mutilation around the world (2019/2988(RSP)) (https://www.europarl.europa.eu/doceo/document/TA-9-2020-0031_EN.html).

The EU's commitment to mainstreaming FGM elimination efforts in external action measures is outlined in the **action plan on human rights and democracy for 2020–2024**, issued on 25 March 2020 ([20]). The action plan reaffirms the EU's commitment to 'advocat[ing] for the elimination, prevention and protection from sexual and gender-based violence, including harmful norms and practices such as female genital mutilation'.

On 25 November 2020, the **EU action plan on gender equality and women's empowerment in external relations** (**2021–2025 gender action plan III (GAP III)**) ([21]) was launched. GAP III lists FGM as a core issue that threatens the achievement of gender equality in a global context. It includes initiatives to enhance the capacity of women's and girls' rights organisations, and encourage international collaboration between governments and local authorities to promote gender equality in policymaking and implementation.

1.2. National level

1.2.1. Criminalising female genital mutilation

FGM is criminalised either through criminal law or the penal code in all 27 EU Member States (EU-27) and the United Kingdom. **In 21 countries in this review (20 Member States and the United Kingdom), criminal laws make explicit reference to FGM or 'mutilation'**. In two Member States that make reference to 'mutilation', there are additional draft changes to the penal code to explicitly reference FGM, but these have not yet been passed (RO, FI).

Seven Member States have general criminal legislation that can be used to prosecute FGM (BG, CZ, LV, HU, PL, SI, SK). In these countries, FGM may fall under acts such as bodily harm or loss of an organ. However, this poses challenges and creates some ambiguity, as the varying definitions raise questions about whether or not all types of FGM are covered or how it might be penalised. The findings of this study provide a map of the EU Member States and the United Kingdom, which have specific criminal law provisions on FGM or 'mutilation'.

Five Member States have introduced **legal developments since 2017** (EL, LU, AT, RO, FI).

In 2018, **Greece** introduced Law 4531/2018 ([22]) in response to its ratification of the Istanbul Convention. This law added Article 315B to the Penal Code ([23]), which states that individuals who persuade a woman to undergo FGM will be punished with a prison sentence. In 2018, **Luxembourg** introduced the Law of 20 July 2018 implementing the Istanbul Convention ([24]), outlawing FGM in the Penal Code. Similarly, as part of its measures to implement the provisions of the Istanbul Convention, **Romania** introduced amendments to two of its laws in 2018: Law No 178/2018 introduced the concept of gender-based violence to include the genital mutilation of women in Law No 202.2002 on equal opportunities and treatment between women and men ([25]); and Law No 174/2018 amended Law No 217/2003 on preventing and combating

([20]) European Commission (2020), Joint Communication to the European Parliament and the Council – EU action plan on human rights and democracy 2020–2024, JOIN(2020) 5 final, 25.3.2020 (https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A52020JC0005).

([21]) European Commission (2021), 'Gender equality and women's rights worldwide (2021-25 action plan)' (https://ec.europa.eu/info/law/better-regulation/have-your-say/initiatives/12240-EU-Action-Plan-of-Gender-equality-and-women-s-empowerment-in-external-relations-for-2021-2025-).

([22]) Law 4531/2018 – Ratification of the Convention of the Council of Europe (Istanbul Convention) for the prevention and tackling of violence against women (https://www.e-nomothesia.gr/oikogeneia/nomos-4531-2018-phek-62a-5-4-2018.html).

([23]) Law 4619/2019 – Ratification of the Penal Code (https://www.e-nomothesia.gr/kat-kodikes-nomothesias/nomos-4619-2019-phek-95a-11-6-2019.html).

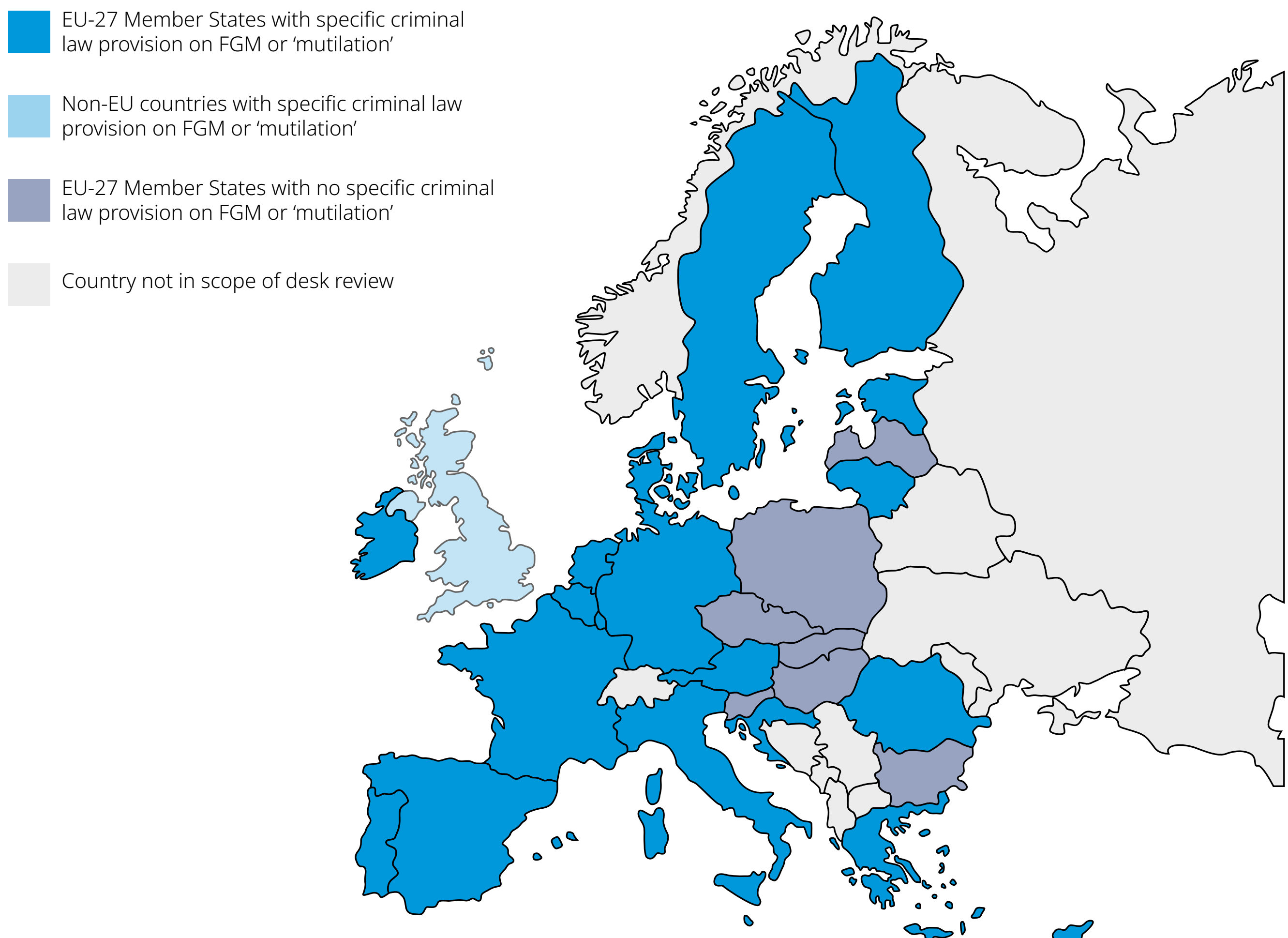
([24]) Law of 20 July 2018 approving the Council of Europe Convention on preventing and combating violence against women and domestic violence (http://legilux.public.lu/eli/etat/leg/loi/2018/07/20/a631/jo).

([25]) Law No 178/2018 amending and supplementing Law No 202/2002 on equal opportunities and treatment between women and men (https://lege5.ro/Gratuit/gi4dqojygyyq/legea-nr-178-2018-pentru-modificarea-si-completarea-legii-nr-202-2002-privind-egalitatea-de-sanse-si-de-tratament-intre-femei-si-barbati).

family violence, by stating that custom, culture, religion, tradition or 'honour' cannot be considered justification for any acts of violence against women and men ([26]). In 2020, Romania drafted a law to amend the Criminal Code to introduce an explicit offence for FGM; however, this has not yet been passed.

In **Austria**, an amendment to the Criminal Code in 2020 introduced a reference to FGM under the offence of bodily harm with severe and sustainable adverse effects ([27]). The provision criminalises 'mutilation or any other form of harm to the genitalia, that is able to cause sustainable negative effects to the sexual experience'. In 2020, the Parliament of **Finland** voted to clarify Finland's laws on FGM. The vote called on the government to explicitly outlaw FGM in the Criminal Code, and to establish clear punitive measures to prevent and combat the practice. Although no specific legislation has been adopted, the parliament voted in favour of drafting a separate law to outlaw FGM. During the 2020 parliamentary term, the parliament considered the necessary bills to explicitly prohibit the practice in the Criminal Code ([28]).

Figure 2. Map of EU Member States and other countries with specific criminal law provisions on FGM or 'mutilation' (mid 2017 to mid 2020)



([26]) Law No 174/2018 amending and supplementing Law No 217/2003 for preventing and combating family violence (http://legislatie.just.ro/Public/DetaliiDocumentAfis/202718).
([27]) § 85 of the Austrian Criminal Code (https://www.legislationline.org/download/id/8548/file/Austria_CC_1974_am122019_de.pdf).
([28]) Orjala, A. (2020), 'Parliament voted: the task of female genital mutilation to be punished even more clearly', yle, 6 November 2020 (https://yle.fi/uutiset/3-11634102).

Table 1 shows the time frames for the introduction of specific criminal legislation relevant to FGM in the EU-27 and the United Kingdom. 'Specific criminal legislation' covers situations in which Member States have an explicit reference to FGM or mutilation ([29]) in their national criminal codes and/or have adopted legislative acts dedicated to FGM (FGM-specific legislation).

Table 1. EU Member States and the United Kingdom with specific criminal law provisions on FGM or 'mutilation'

Periods covered	EU Member States
July 1982 to February 2012	Sweden (1982), Netherlands (1993), Lithuania (2000), Belgium (2001), Austria (2001) (*), France (2002), Denmark (2003), Spain (2003), Cyprus (2003), United Kingdom (2003), Italy (2006)
March 2012 to June 2014	Ireland (2012), Germany (2013), Croatia (2013), Malta (2014)
July 2014 to July 2017	Romania (2014) (*) (**), Portugal (2015), Finland (2015) (**), Estonia (2017)
August 2017 to May 2020	Greece (2018), Luxembourg (2018)

(*) Amendments to criminal law have also been introduced after this date.
(**) Draft proposals to change criminal law have been introduced after this date but have not yet been adopted.
NB: The periods covered refer to the first instance of specific reference to FGM or 'mutilation'.

1.2.2. Monitoring female genital mutilation in the legal system

There is **insufficient information** available in Member States to monitor FGM-related **court cases**, prosecutions and protection orders. This could be due to a number of factors. For instance, there may be a lack of specific national legal or policy framework requiring the relevant authorities to collect this information, even in Member States with specific criminal legislation on FGM. Member States with more limited numbers of migrants from FGM-practising countries may not consider FGM a priority and may not collect any relevant information at all (EIGE, 2018).

Fewer than half of all Member States monitor and/or publish ad hoc information on the number of judicial investigations, court cases, prosecutions and/or protection orders concerning FGM. The lack of data in countries such as Ireland and Italy, which have FGM-specific acts, highlights a gap in monitoring the enforcement of such legislation. Table 2 presents the data available from Member States.

([29]) Despite some countries making specific reference to mutilation in their national criminal codes, this terminology is considered quite general.

Table 2. Available data on FGM-related court cases, prosecutions and protection orders (mid 2017 to mid 2020)

Member State or United Kingdom	Available data
BE	Information on FGM has been recorded since 2017 in the judicial system under two separate codes – code 43K for FGM (Article 409 of the Penal Code) and code 43L for other sexual mutilations. *Source:* College of the Public Prosecutor's Office (2017), *Circular COL 6/2017– Joint Circular Letter from the Minister of Justice and the Board of Prosecutors General regarding the investigation and prosecution policy on honour-related violence, female genital mutilation, forced marriages and legal cohabitation* (https://igvm-iefh.belgium.be/sites/default/files/downloads/col06_2017_col_fr.pdf). **2017 to mid 2019: eight cases of FGM recorded in correctional facilities under code 43K** *Source:* Belgian Federal Police (http://www.stat.policefederale.be/assets/pdf/crimestat/nationaal/rapport_2019_trim4_nat_belgique_fr.pdf).
DK	**Since mid 2017, there has been one court case regarding FGM** (*).
DE	**Three convictions related to Article 226 of the Penal Code on FGM (two in 2017 and one in 2018).** *Source:* Federal Office of Statistics (Destatis), 'Statistisches Bundesamt' (https://www.destatis.de/EN/Home/_node.html).
EE	**Zero registered crimes related to FGM as of the end of 2019.** *Source:* Ministry of Justice (2020), 'Kuritegevus Eestis 2019' (https://www.kriminaalpoliitika.ee/kuritegevuse-statistika/).
IE	**2019: one court case leading to two convictions** of carrying out FGM on a child. *Source:* End FGM European Network (2019), 'Couple convicted of FGM – Ireland', 29 November 2019 (https://www.endfgm.eu/news-en-events/press-releases/couple-convicted-of-fgm-ireland/).
ES	**Four FGM-related provincial court cases and one central court case identified between 2017 and 2019.** *Source*: General Council of the Judiciary.
FR	**2018: five cases reported by the French Office for the Protection of Refugees and Stateless Persons (OFPRA) to the public prosecutor regarding dangerous situations on French territory in relation to domestic and/or sexual violence, human trafficking, forced marriage or FGM.** *Source:* OFPRA (2018), *Á l'Écoute du Monde – Rapport d'activité 2018*, OFPRA, Fontenay-sous-Bois, France (https://ofpra.gouv.fr/sites/default/files/atoms/files/rapport_dactivite_2018.pdf.pdf).
HR	The Ministry of Justice and the national registration system (eSpis) have collected data on court cases based on Article 116 on FGM since 2013 (when it was included in the Criminal Code). However, data are not publicly available.
PT	**2016: one court case but charges were dropped.** *Source:* Group of Experts on Action against Violence against Women and Domestic Violence (2019).
SE	**2019: 39 reported offences** regarding crimes against the Act on the prohibition of female genital mutilation. Of the 34 that were investigated, none were prosecuted. **2018: 38 reported offences.** *Source:* Crime statistics from the Swedish National Council for Crime Prevention.
UK	**2018–2019: Two defendants prosecuted for FGM – one was convicted and the other acquitted.** This was the first successful FGM conviction in England and Wales. *Source*: Crown Prosecution Service. **Mid 2017 to the end of 2019: 265 applications for FGM protection orders, 402 FGM protection order disposals, and 221 FGM protection order cases concluded.** *Source:* Ministry of Justice (2019) (**).

(*) Information was requested by Statistics Denmark from the Danish court system and was shared with this study. These data are not regularly collated or published.
(**) 'Female Genital Mutilation Protection Orders offer a legal means to protect and safeguard victims and potential victims of FGM. The orders are granted by a court and are unique to each case. They contain conditions to protect a victim or potential victim from FGM. This could include, for example, surrendering a passport to prevent the person at risk from being taken abroad for FGM or requirements that no one arranges for FGM to be performed on the person being protected' (UK government, n.d.).

Available data may point towards **limited legal enforcement** of the FGM-related legal provisions in place. For instance, despite having a dedicated FGM act in Sweden, all of the reported FGM offences in 2019 were closed without prosecution. Belgium seems to be the exception to the policy pattern. The Circular by the College of the Public Prosecutor's Office and the Minister of Justice relating to the policy of investigation and prosecution of violence related to honour, FGM, and forced legal marriages and cohabitations (COL 06/2017) ([30]) sets out binding guidelines on a common police and judicial approach across the country.

1.2.3. Prosecuting female genital mutilation committed abroad

In the majority of Member States (excluding Bulgaria and Czechia), the **principle of extraterritoriality** is applied in criminal law, meaning that it is possible for Member States to prosecute individuals for crimes committed abroad. In 2018 and 2019, respectively, Luxembourg and Greece introduced this principle into their penal codes. In Greece, however, the principle of extraterritoriality is not applicable if FGM is not punishable in the country in which it was committed ([31]).

1.2.4. Child protection provisions

In most Member States, FGM-related child protection falls under general child protection provisions or the country's criminal law. Five Member States include an **explicit mention** of FGM or mutilation in their child protection laws. These include Spain (Organic Act 1/1996; Law 14/2010 in Catalonia; and Law 12/2008 in Valencia) ([32]), France (Law No 2018-703, 2018) ([33]), Luxembourg (Act on Children and Family Assistance, 2008) ([34]), Austria (National Children and Youth Services Law 2020) ([35]) and Finland (Child Welfare Act, 2013) ([36]).

Although other Member States may lack FGM-specific child protection laws, some countries have relevant **policy instruments** to support practitioners in safeguarding child welfare (the Netherlands, Northern Ireland in the United Kingdom, Romania). For example, the Netherlands' Model Reporting Code (Domestic Violence and Child Abuse) (2013, revisions implemented in 2019) sets out guidance for professionals in responding to early signs of mistreatment at home ([37]). In Romania, Governmental Decision No 49/2011 establishes a common methodological framework for professionals in the field of child and family protection and social assistance and other professionals who come into direct contact with children, in

([30]) Openbaar Ministerie (n.d.), Omzendbrief COL 06/2017 – Gemeenschappelijke omzendbrief van de Minister van Justitie en het College van Procureurs-generaal betreffende het opsporings- en vervolgingsbeleid inzake eergerelateerd geweld, vrouwelijke genitale verminkingen, gedwongen huwelijken en wettelijke samenwoningen (http://intact-association.org/images/COLNL/COL06_2017_COL_NL.pdf).

([31]) See Articles 5–11 Law 4619/2019 – Ratification of the Penal Code (https://www.e-nomothesia.gr/kat-kodikes-nomothesias/nomos-4619-2019-phek-95a-11-6-2019.html).

([32]) Organic Act 1/1996 establishes the 'superior interest of minors' in situations of risk or lack of protection, requiring autonomous communities to intercede. Catalonia and Valencia are the only regions in Spain that refer to FGM in their own regulations. Law 14/2010 of 27 May on the rights and opportunities in childhood and adolescence (https://www.boe.es/buscar/act.php?id=BOE-A-2010-10213&p=20100602&tn=1). Law of the Valencian Community 12/2008 of 3 July on the integral protection of childhood and adolescence (https://www.boe.es/buscar/act.php?id=BOE-A-2008-14050&p=20151231&tn=1#ar-9).

([33]) Law No 2018-703 of 3 August 2018 strengthening the fight against sexual and gender-based violence (https://www.legifrance.gouv.fr/loda/id/JORFTEXT000037284450/).

([34]) Article 2 of Act of 16 December 2008 on Children and Family Assistance (http://data.legilux.public.lu/file/eli-etat-leg-memorial-2008-192-fr-pdf.pdf).

([35]) Section 1a of § 37 of the National Children and Youth Services Law, (https://www.ris.bka.gv.at/Dokumente/Bundesnormen/NOR40218041/NOR40218041.pdf).

([36]) Law No 417/2007, Child Welfare Act (https://www.finlex.fi/en/laki/kaannokset/2007/en20070417_20131292.pdf).

([37]) Model Reporting Code (Domestic Violence and Child Abuse). (https://www.government.nl/documents/reports/2013/03/14/model-reporting-code-domestic-violence-and-child-abuse).

accordance with legislation [38]. The document defines sexual abuse of children as including genital mutilation. A few Member States have established specific monitoring mechanisms for child protection in relation to FGM (FR, LU, AT, FI).

1.2.5. Asylum provisions

Although FGM could be incorporated into the general legal provisions on asylum and/or subsidiary protection of all Member States, only **six have explicitly recognised the risk of FGM as a ground for asylum** and introduced the appropriate legislation (BE, DK, EL, FR, HU, PT). Of these six, Belgium and Greece have introduced FGM-specific asylum legal provisions since mid 2017.

Despite not having FGM-specific asylum legal provisions in place, some Member States (IT, CY) and the United Kingdom have nevertheless made efforts to incorporate **gender-sensitive procedures** into their asylum processes, particularly in transposing the provisions of Directive 2013/33/EU. For example, Article 9KΓ of Cyprus's Refugee Law (2016) explicitly mentions women who have experienced FGM as an example of people who have experienced psychological, physical or sexual violence, and who should therefore be considered vulnerable in reception centres [39].

Data on asylum applications linked to FGM are very limited across Member States. Even where data are available on asylum claims, broken down by justification, FGM is often included in the wider category of gender-related claims (UNHCR, 2018). Judicial evidence on the number of FGM-based asylum applications is available in some Member States (ES, AT, RO).

1.2.6. Professional obligations to report FGM

Article 28 of the Istanbul Convention encourages state parties to ensure that confidentiality rules do not constitute a barrier to **reporting** if professionals have reasonable grounds to believe that a serious act of violence has occurred / will occur. This means, for example, that national legislation should allow for professionals in healthcare, education and other sectors to report suspected cases of FGM.

There is significant variation between Member States in relation to professional obligations to report FGM. The following Member States have either **professional or explicit legal obligations to report FGM** for doctors and other professionals: Denmark [40], Germany [41], Ireland [42], France [43], Italy [44], Malta [45], the

[38] Governmental Decision No 49/2011 covered the approval of the framework methodology for the multidisciplinary prevention and intervention units and networks on cases of violence against children and domestic violence and of the methodology of multidisciplinary and interinstitutional intervention for children who have been exploited or are at risk of labour exploitation and human trafficking, as well as Romanian migrant child victims of other acts of violence in the territories of other states.
[39] Refugee Law of 2000 (L. 6(I)/2000) (amended 2016) (http://www.refworld.org/docid/4a71aac22.html).
[40] The Social Services Act of 2005 obliges public professionals to report suspected cases to authorities if a girl is at risk of FGM.
[41] Children and Youth Services (Assistance for Children and Adolescents), Article 8: Participation of Children and Young People: Articles 8a, 8b and 4 (1990).
[42] Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012 (http://www.irishstatutebook.ie/eli/2012/act/24/enacted/en/html).
[43] Article 226-14 of the Penal Code (https://www.legifrance.gouv.fr/affichCode.do;jsessionid=90CA4DACFB6001CB2B6ADFB8CF4C53D4.tplgfr33s_3?idSectionTA=LEGISCTA000006181756&cidTexte=LEGITEXT000006070719&dateTexte=20200527).
[44] Associazione Italiana Donne Per Lo Sviluppo and End FGM European Network note that all public officers or any person responsible for the delivery of a public service have the duty to report a criminal offence through Articles 361, 362 and 365 of the Italian Penal Code. See Associazione Italiana Donne Per Lo Sviluppo and End FGM European Network, *Joint Shadow Report – Italy* (https://rm.coe.int/aidos-end-fgm-eu-joint-shadow-report-italy/16808eaaa6).
[45] Addition of Article 251E to the Criminal Code, Cap. 9. (2014).

Netherlands ([46]), Portugal ([47]), Finland ([48]) and Sweden ([49]). This also applies to the United Kingdom ([50]). In Belgium, professionals have an obligation to assist in relation to FGM, with reporting the case to the authorities being a last resort ([51]). In Spain ([52]), Luxembourg ([53]) and Austria ([54]), professionals are obliged to report any crime including bodily harm to the authorities, but the legal provisions do not explicitly mention FGM. The scope of obligations and nature of enforcement varies between countries. In Germany, youth welfare agency professionals must act if they strongly suspect that a girl is at risk of FGM. However, there are no specific sanctions for these professionals for not reporting a girl who is at risk of FGM. In Malta, by contrast, failing to help an individual at risk of FGM is criminalised by a fine or prison, regardless of any duty of confidentiality.

1.2.7. Other policies to tackle FGM

The extent to which Member States have enacted policies to combat FGM has varied in recent years. Overall, 20 countries (19 Member States and the United Kingdom) have enacted **national action plans** with a specific FGM focus or that mention FGM in a broader strategy to combat gender-based violence ([55]). Three Member States have a national action plan on gender-based violence more generally, but these do not mention FGM specifically (DK, LT, AT). Five Member States do not have a current national action plan on FGM or to combat gender-based violence more generally (DE, LV, MT, PL, SI).

In 13 countries ([56]), national governments, agencies or civil society organisations have produced guidance for professionals on how to deal with FGM. In 2017, Ireland's Department of Children

([46]) Mandatory Reporting Code (Domestic Violence and Child Abuse) (1.7.2013) (https://www.rijksoverheid.nl/documenten/rapporten/2017/01/09/basismodel-meldcode-huiselijk-geweld-en-kindermishandeling).
([47]) Article 242 of the Code of Criminal Procedures notes that health professionals, social workers, teachers, police officers and civil servants must report evidence of a crime they encounter in the course of their work (https://dre.pt/web/guest/legislacao-consolidada/-/lc/139876418/202011060833/73862075/element/diploma#73862075). Specific reporting mechanisms concerning crimes committed against children are outlined in Law No 147/99 (https://dre.pt/application/dir/pdf1s/1999/09/204A00/61156132.pdf).
([48]) Section 25.1 of the Child Welfare Act states that the duty to notify overrules confidentiality regulations in cases of ill-treatment of a child or in other situations in which the child's welfare is threatened. Ministry of Social Affairs and Health (2012), *The action plan for the prevention of circumcision of girls and women 2012–2016*, Publications of Ministry of Social Affairs and Health, Helsinki, p. 18, cited in Finnish League for Human Rights (*ihmisoikeuslitto*) and End FGM European Network, *Joint Shadow Report – Finland* (https://rm.coe.int/flhr-end-fgm-eu-joint-shadow-report-finland/16807c8920).
([49]) Punishable under Section 23 of the Penal Code as part of the 1998/1999 Female Genital Mutilation Act (http://www.notisum.se/rnp/sls/lag/19620700.htm#K2P5).
([50]) Serious Crime Act 2015 (http://www.legislation.gov.uk/ukpga/2015/9/part/5/crossheading/female-genital-mutilation).
([51]) Loi du 18 juin 2018 (https://www.etaamb.be/fr/loi-du-18-juin-2018_n2018013796.html).
([52]) Professionals must report any criminal offence to the public prosecutor or the police (Articles 262 and 355 of the Criminal Procedure Law). Professionals who detect a situation of abuse, risk or possible neglect of a minor, an offence against sexual freedom and trafficking in human beings or exploitation of minors must notify the authorities or the public prosecutor (Article 13 of Law 26/2015 of 26 July on the amendments of the protection system for children and adolescents). However, Article 13 of Law 26/2015 does not specifically mention FGM.
([53]) Public officers and other professionals are obliged to report any legitimate suspicion of crime or physical abuse to the law enforcement authorities (Article 23 of the Code of Criminal Proceedings, 2011). When minors are concerned, the obligation is applicable to all professionals and also private individuals. Doctors must inform authorities if they find that a patient has been subjected to ill treatment and report any identified crimes against minors (Articles 12 and 59 of the Code of Medical Ethics, 2013). However, these are general provisions that are not specific to FGM.
([54]) Medical doctors are obliged to report to the authorities if there are reasonable grounds for suspecting that a patient has been victim of grievous bodily harm under Section 54(4) of the amendment of the Physicians Law, which came into effect in October 2019. However, there must be no such obligation if the report would contradict the express will of the patient (provided that there is no immediate danger to the patient) or if the report would impair the relationship of trust and therefore the professional activity between the medical doctor and the patient.
([55]) The 20 countries (19 Member States and the United Kingdom) that have enacted national action plans with an FGM focus or that mention FGM in a broader strategy to tackle gender-based violence are Belgium, Bulgaria, Croatia, Cyprus, Czechia, Estonia, Finland, France, Greece, Hungary, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Romania, Slovakia, Spain, Sweden and the United Kingdom. FGM is not explicitly mentioned in the national action plans of Denmark, Lithuania and Austria. There is no relevant action plan in Germany, Latvia, Malta, Portugal or Slovenia.
([56]) Austria, Belgium, France, Germany, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Slovakia, Spain, Sweden and the United Kingdom.

and Youth Affairs issued national guidance for the protection and welfare of children. This guidance targets professionals and social service stakeholders who interact with children and can help to detect and respond to abuse, including FGM.

Countries rarely provide **specific budgets for tackling FGM**, which instead falls under the funding of other programmes. In Spain, for example, FGM measures fall under the 2018–2022 national agreement against gender-based violence. The national agreement was enacted by the Government Delegation against Gender Violence and operates on a budget of EUR 1 billion for the 5-year period.

Table 3 presents the main Member State policy initiatives to tackle FGM and gaps in this area between mid 2017 and mid 2020.

Table 3. Overview of Member State policy initiatives to tackle FGM (mid 2017 to mid 2020)

Member State or United Kingdom	Most recent national plan that mentions FGM	Most recent national plan on gender-based violence more generally that does not mention FGM	Period covered	Issuing authority
BE	National action plan to combat all forms of gender-based violence		2015–2019	Institute for the Equality of Women and Men, with the support of outside experts and an interdepartmental group
BG	National programme for prevention of violence against children and child abuse		2017–2020	State Agency for Child Protection
CZ	Action plan for the prevention of domestic and gender-based violence		2019–2022	Office of the Government of Czechia
DK		Action plan for the prevention of psychological and physical violence in intimate relationships	2019–2022	Ministry for Foreign Affairs
DE	No relevant national plan			
EE	Violence prevention strategy		2015–2020	Ministry of Justice
IE	National strategy for women and girls 2017–2020: creating a better society for all		2017–2020	Department of Justice and Equality
EL	National action plan on gender equality 2016–2020		2016–2020	General Secretariat for Gender Equality
ES	National agreement against gender-based violence		2018–2022	Government Delegation against Gender Violence
FR	National plan of action to eradicate female genital mutilation		2019 onwards	Secretary of State for Gender Equality and the Fight against Discrimination
HR	National policy for gender equality		2019–2022	Office for Gender Equality
IT	National strategic plan on male violence against women		2017–2020	Council of Ministers
CY	National action plan on gender equality		2019–2023	Ministry of Justice and Public Works
LV	No relevant national plan			

Member State or United Kingdom	Most recent national plan that mentions FGM	Most recent national plan on gender-based violence more generally that does not mention FGM	Period covered	Issuing authority
LT		National programme for the prevention and assistance of victims of domestic violence for 2014–2020	2014–2020	Government of the Republic of Lithuania
LU	Multiyear plan 'Emotional and sexual health'		2019 and also in the framework of the 2013 national programme for the promotion of emotional and sexual health (*)	Ministry of Health (lead); Ministry of Equality between Women and Men; Ministry of Education, Children and Youth; Ministry of Family Affairs and Integration
HU	Government resolution on the national strategy to promote equality between women and men		2010–2021	Government of Hungary
MT	No relevant national plan			
NL	'Violence does not belong anywhere': programme for tackling domestic violence and child abuse		2018–2021	Ministry of Health, Welfare and Sports; Ministry of Justice and Security; Ministry of Education, Culture and Science
AT		Action plan for women's health – 40 measures for the health of women in Austria	2017 onwards	Ministry of Health; Ministry of Education and Women's Affairs
PL	No relevant national plan			
PT	National strategy for equality and non-discrimination (**)		2018–2030	Council of Ministers
RO	National strategy for the promotion of equal opportunities and treatment for women and men and preventing and combating domestic violence		2018–2021	National Agency for Equal Opportunities between Women and Men
SI	No relevant national plan			
SK	National action plan for the prevention and elimination of violence against women		2014–2019	Government of the Slovak Republic
FI	Action plan for the prevention of female genital mutilation		2019 onwards	National Institute for Health and Welfare; Ministry of Social Affairs and Health
SE	National action plan to combat female genital mutilation		2018 onwards	Ministry of Health and Social Affairs
UK	Ending violence against women and girls		2016–2020	Home Office

(*) A new national action plan was published in September 2020.
(**) The strategy includes an action plan for the prevention and combating of violence against women and domestic violence (2018–2021). This includes the strategic objective to prevent and combat harmful traditional practices, including FGM.
NB: In Member States with multiple strategies, the most relevant is shown.

Of the 20 countries with national action plans that mention FGM, four have FGM-specific action plans (BE, FR, FI, SE). Table 4 gives an overview of the policy areas covered in these FGM-specific action plans.

Table 4. Member States with FGM-specific national policies and the policy areas covered (mid 2017 to mid 2020)

Member State	Health	Education	Engaging men	Engaging migrant communities	Migration and asylum	Awareness raising	Other policy areas
BE	✓	✓			✓	✓	• Not applicable
FR	✓	✓				✓	• Strengthen collaboration across sectors
SE	✓	✓	✓	✓	✓	✓	• More effective law enforcement • Strengthen and publish data on FGM
FI	✓	✓		✓	✓	✓	• Anticipatory intervention from social welfare authorities • More effective law enforcement

All four Member States focus on health policy, promoting education, and awareness-raising initiatives in their national action plans. Of the Member States with FGM-specific national policies, Sweden alone explicitly focuses on engaging men in eradicating FGM at national level. In terms of migration, two Member States (FI, SE) engage migrant communities through national policies, and three Member States (BE, FI, SE) include migration and asylum-focused initiatives in their national action plans.

2. Female genital mutilation risk estimation in Denmark

2.1. Female migrant population aged 0–18 years originating from female genital mutilation-practising countries

2.1.1. Migrant population

In 2019, there were 12 462 migrant girls (aged 0–18 years) in Denmark originating from FGM-practising countries. Of these, 82 % were second generation. Of the total number of girls aged 0–18 years, 48 % were aged 0–9 years and 52 % were aged 10–18 years. Girls in both age groups were much more likely to be second generation (0–9 years, 86 %; 10–18 years, 79 %).

Table 5. Age distribution of the female migrant population (aged 0–18 years) in Denmark originating from FGM-practising countries (2019)

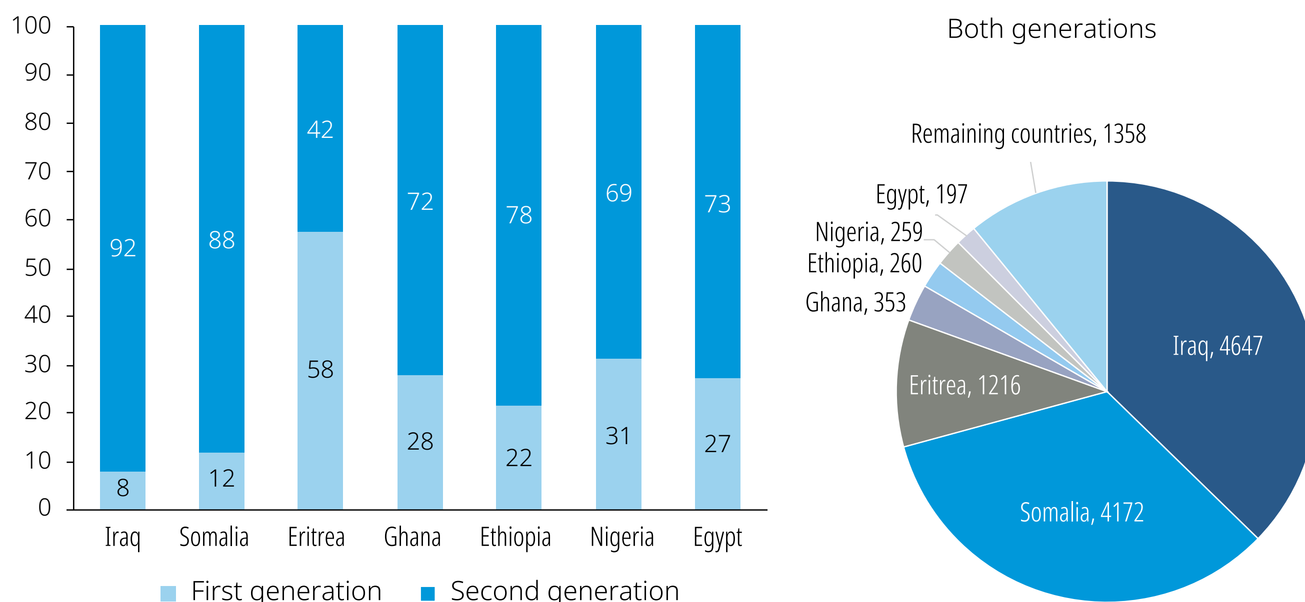
Age group	First generation	Second generation	Total (%)	Percentage first generation	Percentage second generation
0–9 years	848	5 158	**6 006 (48)**	14	86
10–18 years	1 345	5 111	**6 456 (52)**	21	79
Total	**2 193**	**10 269**	**12 462 (100)**	**18**	**82**

NB: From publicly available data from StatBank Denmark, information was extracted for female migrants aged 0–18 years with a country of origin that is among the 30 FGM-practising countries and with either Danish or foreign citizenship. The number includes refugees. In Danish statistics, the terms ‘immigrant’ and ‘descendant’ are used rather than ‘first generation’ and ‘second generation’. Accordingly, ‘immigrant’ refers to someone born in a foreign country (their country of origin), whereas ‘descendant’ refers to someone born in Denmark. A person is classified as having Danish origin if they have at least one parent who is a Danish citizen and was born in Denmark. By definition, neither immigrants nor descendants can have a parent who is a Danish citizen and was born in Denmark.
Source: Statistics are based on the civil registration system (CPR) from which Statistics Denmark receives daily data. The statistics are disseminated in Statistics Denmark’s Statbank and in news from Statistics Denmark (in Danish only). The population statistics are typically a quarterly inventory of the resident population in Denmark; however, because of coronavirus disease 2019, the number of deaths is disseminated on a weekly basis by date of death, age group and region. The data presented are those available as of 1 January 2020. See Annex 2 for detailed data.

The seven FGM-practising countries most represented in terms of first- and second-generation girls in 2019 are displayed in Figure 3.

Information on the region of origin within the country of origin of the girls (or their mothers) was unavailable. There may be a high risk of bias when applying national prevalence rates to migrant populations living in Denmark from countries with large variations in their regional prevalence rates.

Figure 3. Percentage and number of girls (aged 0–18 years) living in Denmark, by generation and seven most-represented countries of origin (2019)



NB: From left to right, the countries are presented in descending order of the size of their communities in Denmark (with Iraq being the highest and Egypt being the lowest). However, they are shown on the same scale to enable percentage comparisons by generation.
Source: Statistics Denmark: StatBank Denmark. See Annex 2 for detailed data.

2.1.2. Irregular migration

There are no official data available on the number of irregular migrants living in Denmark. Grey literature from a research unit at the Rockwool Foundation estimated the number of undocumented immigrants in Denmark between 2008 and 2018, based on Danish police data concerning people preliminarily charged with staying and/or working in Denmark illegally (Larsen and Skaksen, 2019). The report states that, in 2018, a total of 2 491 people were preliminarily charged with illegal stay, with the average age being 34.1 years. Of these, 614 (24.6 %) were women. Only three of the 30 FGM-practising countries were listed for 2018 – Iraq (4.5 %), Nigeria (3.9 %) and Somalia (3.0 %). These data were not used in the FGM risk estimation, as they are concerned solely with those who were apprehended or charged with illegal stay.

2.1.3. Asylum seekers and refugees

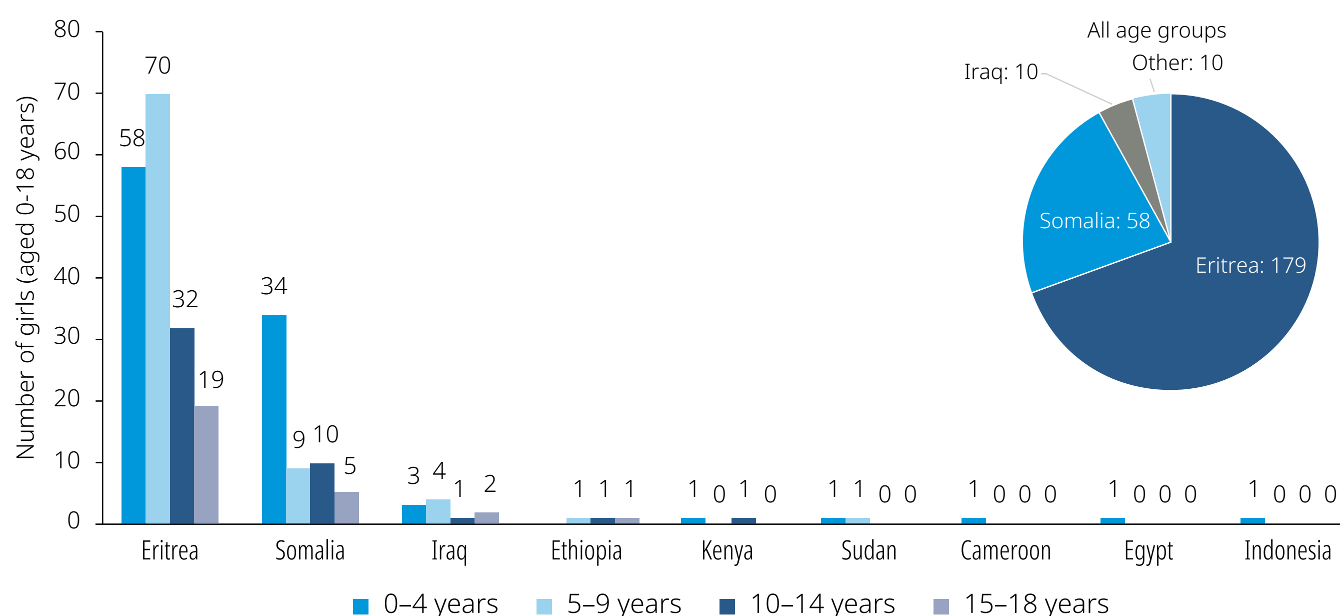
Publicly available data from StatBank Denmark provide information on female asylum seekers aged 0–19 years (only 5-year age intervals are available) with citizenship of one of the 30 FGM-practising countries. The total number of asylum applications includes all people who have applied for asylum in Denmark, and therefore includes people who have returned to a safe non-EU country, or have been transferred or retransferred to another EU Member State under the Dublin Regulation ([57]), and disappearances and withdrawals during the preliminary asylum procedure.

The data do not provide country of origin breakdowns for these asylum seekers but rather indicate citizenship, as the country of origin is not registered until the asylum seeker has been

([57]) In September 2020, the European Commission presented a new proposal for a regulation on asylum and migration management that would replace the Dublin Regulation. For further information, see European Commission (2020), Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions on a new Pact on Migration and Asylum, COM(2020) 609 final, 23.9.2020 (https://ec.europa.eu/info/sites/info/files/1_en_act_part1_v7_1.pdf).

granted a residence permit. Data are not disaggregated by first generation and second generation. Statistics Denmark are currently restructuring their database on refugees / asylum seekers, and, although more detailed data may be available in the future, the national statistical bodies confirm that no other data are currently available.

Figure 4. Asylum-seeking girls (aged 0–18 years) in Denmark, by age and citizenship (2019) (*n* = 257)



NB: There were no documented asylum seekers from the remaining FGM-practising countries.
Source: Statistics Denmark: StatBank Denmark. Information from the Danish Immigration Service (*Udlændingeservice*). In order to include only girls aged up to and including 18 years, the number of girls in the range 15–18 years was approximated proportionally from data provided for girls aged 15–19 years. See Annex 2 for detailed data.

Publicly available data from StatBank Denmark also indicate the numbers of female asylum seekers, as described above, who were granted residence permits in Denmark in 2019 on the following grounds: (1) asylum, refugee status; (2) family reunification – the spouse or cohabiting partner of a refugee; (3) family reunification – minors related or linked to a refugee; (4) family reunification – other family members of a refugee. Although not permanent, residence permits can be extended. Once a person is granted asylum, they are counted in the above statistics for migrants. The caveats to these data are the same as those described above.

Publicly available data from 2019 also indicate numbers of migrants granted asylum in Denmark; Table 6 presents the numbers of female migrants granted asylum from six FGM-practising countries.

2.1.4. Other records collecting information on female genital mutilation

Statistics Denmark also had available data on the number of prosecutions and offences under the Danish Act against FGM. The data outline the number of prosecutions and convictions but provide no information on the country of origin or age of the victim. According to these statistics, there were three prosecutions in Denmark between 2010 and 2019, two of which led to a conviction in 2017 and one of which led to an acquittal in 2010.

Table 6. Number of female migrants granted asylum (aged 0–18 years), by country of citizenship (2019)

Country of citizenship	Age group				Total
	0–4 years	5–9 years	10–14 years	15–18 years	
Eritrea	76	116	79	31	302
Somalia	7	7	9	3	26
Iraq	2	3	1	1	7
Egypt	1	0	0	0	1
Ethiopia	0	0	0	1	1
Sudan	0	1	0	0	1
Total	**86**	**127**	**89**	**36**	**338**

NB: No girls were granted asylum from the remaining FGM-practising countries of origin. See Annex 2 for detailed data.
Source: Statistics Denmark: StatBank Denmark. Information from the Danish Immigration Service (Udlændingeservice). In order to include only girls aged up to and including 18 years, the number of girls in the range 15–18 years was approximated proportionally from data provided for girls aged 15–19 years.

2.2. Community views of female genital mutilation

Four focus group sessions took place in Denmark in October and November 2020, with a total of 16 participants. There were between three and five participants in each group, drawn from the four target groups outlined in the methodology (see Annex 2).

Most of the 16 participants were from Somalia (12). Other participants originated from Kurdistan (Iraq, 3; Iran, 1). Various ethnic groups from these countries were represented.

Table 7. Focus group participants – Denmark

Information	Focus group 1	Focus group 2	Focus group 3	Focus group 4
Number of participants	5	4	3	4
Countries represented	Somalia (5)	Somalia (4)	Somalia (3)	Iraq (3); Iran (1)
Sex of participants	Female	Female	Male	Female
Age range	30–44 years	22–32 years	Unknown (3)	27–56 years
Generation	First	Second	First	First
Religion	Muslim (5)	Muslim (4)	Muslim (3)	Muslim (3); Christian (1)

NB: Table A1 in Section A2.4 outlines the demographic profiles of the focus group participants.

2.2.1. Identity and attitudes to female genital mutilation

Participants across all focus groups and interviews **held negative views of the practice** of FGM, irrespective of its type. FGM was viewed by women and men as having numerous negative physical, sexual and emotional consequences for women who had undergone the practice.

Participants in all groups indicated that **attitudes to FGM were changing because people had a greater** awareness of its consequences. Awareness raising in the country of origin was deemed impactful, such as religious leaders preaching against the practice, and work by civil society organisations and the World Health Organization in Somalia over the past 20 years.

The general perception among all groups was that FGM was **no longer an issue in relation to marriageability**, nor was it something men expected or wanted in relation to marriage. However, all groups noted that **virginity** remains very important, as Islam forbids sex before marriage. This value is enacted through parents advising their children against premarital sex. Views were divided on whether it was worse for women to lose their virginity before marriage or it was equally bad for men.

2.2.2. Perceptions of the risk of female genital mutilation in the host country and beyond

Generally, **women and men both believed that FGM was an outdated practice** that had almost been abandoned and should be abandoned completely. However, there were differences between their beliefs regarding their countries of origin and their beliefs regarding Europe. Overall, participants believed that FGM was not practised in Denmark or elsewhere in Europe. Those who believed that FGM was practised in Denmark or elsewhere in Europe based this solely on rumours and suspicion.

The majority of participants from all groups believed that the practice was still conducted in some areas of their country of origin. The Somali women and men believed that the practice had almost been eradicated in larger cities but was still practised to some degree in rural areas, whereas the Kurdish women believed that it was still practised in villages in Kurdistan.

Although most participants believed that FGM continued in some areas in their country of origin, they did not think that second- or third-generation migrant women from Denmark would be at actual risk of undergoing FGM when visiting their parents' country of origin. However, **several second-generation Somali women stated that their mothers had warned them of the risk of FGM when visiting Somalia** and, together with other trusted family members, were careful to guard them on the trip.

2.2.3. Knowledge of female genital mutilation legislation and services among migrant communities

The focus groups held contrasting views on the legislation and services available in Denmark and in their countries of origin. All of the Somali men were aware that FGM was illegal in Denmark but disagreed on whether or not the practice was illegal in Somalia. Some of the first-generation Kurdish women believed that it was illegal in both Denmark and Kurdistan, whereas others were unaware of any legislation. The first-generation Somali women knew of the law in Denmark, noting that 'it is clearly forbidden'. They also believed that it was criminalised in Somalia but did not think that everyone abided by the law. Most of the second-generation Somali women knew that FGM was a criminal act in Denmark but views varied on its legal status in Somalia.

Views were divided on the services available and their usage. Several second-generation Somali women had heard of voluntary reconstructive surgery, such as deinfibulation, and generally believed that doctors should be better educated so that they could address it without stigma, alongside other health issues related to migrant groups.

The second-generation Somali women did not identify themselves as potential victims of FGM, and felt that there was a **stigma associated with FGM** specifically and with Somalis more generally in Denmark.

The participants had **limited engagement with the Danish healthcare system in relation to FGM**. First-generation Somali women believed that they could go and see their general practitioner with FGM-related issues, yet had rarely discussed the matter with their doctor because of language issues and the sensitive nature of the topic. Instead, the **women relied on their network in the community for counselling and support**. First- and second-generation Somali women recommended more educational talks in women's centres and emphasised that doctors should have both a medical and a cultural insight into sexual and reproductive health issues.

Some Somali men believed that women who had undergone FGM could go to their general practitioner or a gynaecologist for support. The **Kurdish women from Iraq had not been in contact with the Danish healthcare system in relation to undergoing FGM** (prior to coming to Denmark), despite all of them having lived in Denmark for 17–27 years, giving birth in Denmark and seeing gynaecologists for other matters. They explained that they had never discussed the matter with any health personnel in Denmark and observed that the doctors/midwives 'never asked'. They did not know about reconstructive surgery. A few women were certain of the degree to which they had been subject to FGM, and most women were interested in being examined and getting help with the FGM-related sexual issues they and their husbands had encountered. For some, it was the primary reason for participating in the study – they hoped to get help from a doctor with both the relevant medical knowledge and an insight into Kurdish culture.

2.2.4. Key figures and decision-making

Participants in all groups believed that **women, especially mothers and grandmothers, were the key decision-makers for FGM**. They gave examples of men speaking out against the practice, which in one instance had negatively affected the man's sexual relationship with his wife. Overall, the participants believed that it was the parents, especially the mothers, who had the final say, and, if older generations wanted to carry on the practice, parents were generally able to refuse.

2.2.5. Key factors for prevention of female genital mutilation and related sexual and reproductive issues

As women were often perceived to be the key decision-makers in relation to FGM, they were also seen as the key to attitude change, meaning that they had an obligation to educate men on the matter. However, Somali men believed that it was extremely important to involve everyone in civil society, as men needed to help to eradicate the misconception that men prefer women who have undergone FGM.

All of the women agreed that the **Danish healthcare system needed a more culturally sensitive approach to sexual and reproductive health issues among ethnic minorities** and that this was key to addressing the issues they face. Women also said that the focus should extend to all other sexual and reproductive health and rights issues faced by women.

2.3. Estimation of the number of girls at risk of female genital mutilation

2.3.1. Estimation of the number of girls at risk in the regular migrant population

In 2019, the number of girls (aged 0–18 years) at risk of FGM in Denmark was 2 568 (21 % of girls originating from FGM-practising countries) in the high-risk scenario, which assumes that girls originating from an FGM-practising country and living in an EU country face the same risk as if they had never migrated, and 1 408 (11 %) in the scenario that assumes that second-generation girls experience a lower risk of being subjected to FGM.

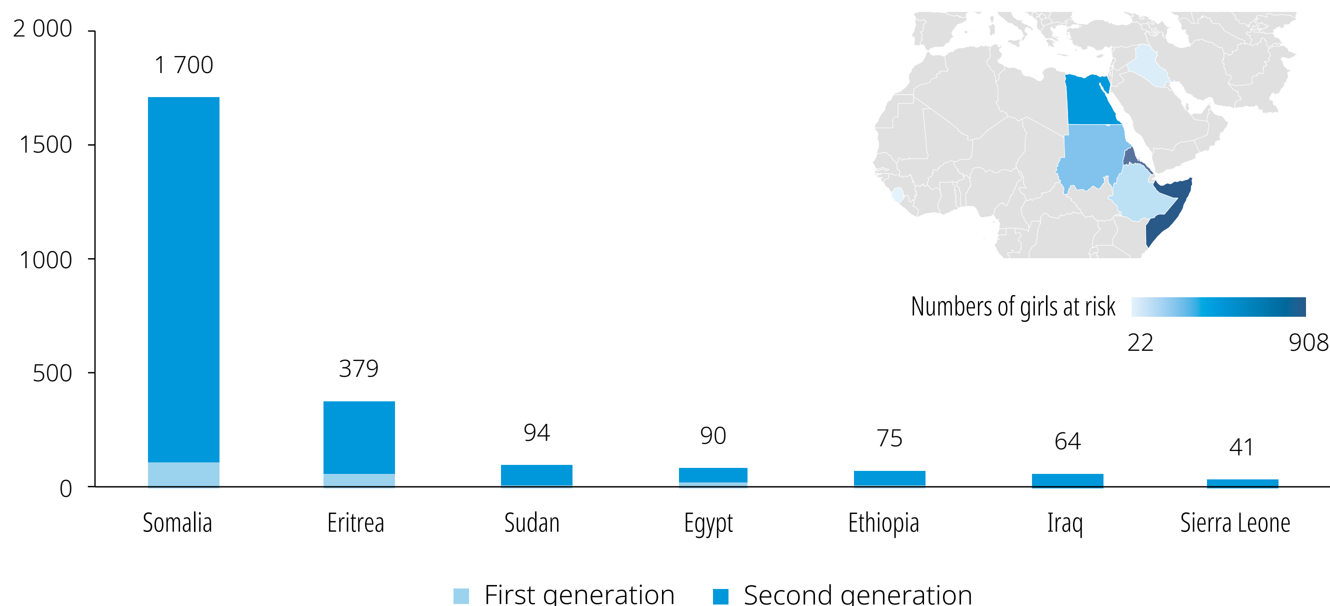
Table 8. Estimated number and percentage of girls (aged 0–18 years) living in Denmark who are at risk of FGM by high-risk and low-risk scenarios (2019)

Group	First generation	Second generation	Total
Number of girls (aged 0–18 years) originating from FGM-practising countries	2 193	10 269	**12 462**
Number (%) of girls at risk: high-risk scenario	249 (11 %)	2 319 (23 %)	**2 568 (21 %)**
Number (%) of girls at risk: low-risk scenario		1 159 (11 %)	**1 408 (11 %)**

NB: Data are available as of 1 January 2020. The estimates for first-generation girls at risk of FGM are the same in both the high-risk scenario and the low-risk scenario. In both scenarios, it is assumed that the process of migration and acculturation has had no effect on FGM prevalence. For second-generation girls, it is assumed that the process of migration and acculturation has had an effect on FGM prevalence, and this is reflected in the low-risk scenario estimates. See Annex 2 for detailed data.

In both scenarios, 11 % of first-generation girls were at risk. This is because, for each country of origin, the estimated rates of FGM for first-generation girls are the same in the high-risk and low-risk estimation scenarios ([58]). For second-generation girls, 23 % were at risk in the high-risk scenario and 11 % were at risk in the low-risk scenario.

Figure 5. High-risk scenario: estimated number of girls (aged 0–18 years) living in Denmark, at risk of FGM, by generation and most-represented countries of origin (2019)



NB: See Annex 2 for detailed data.

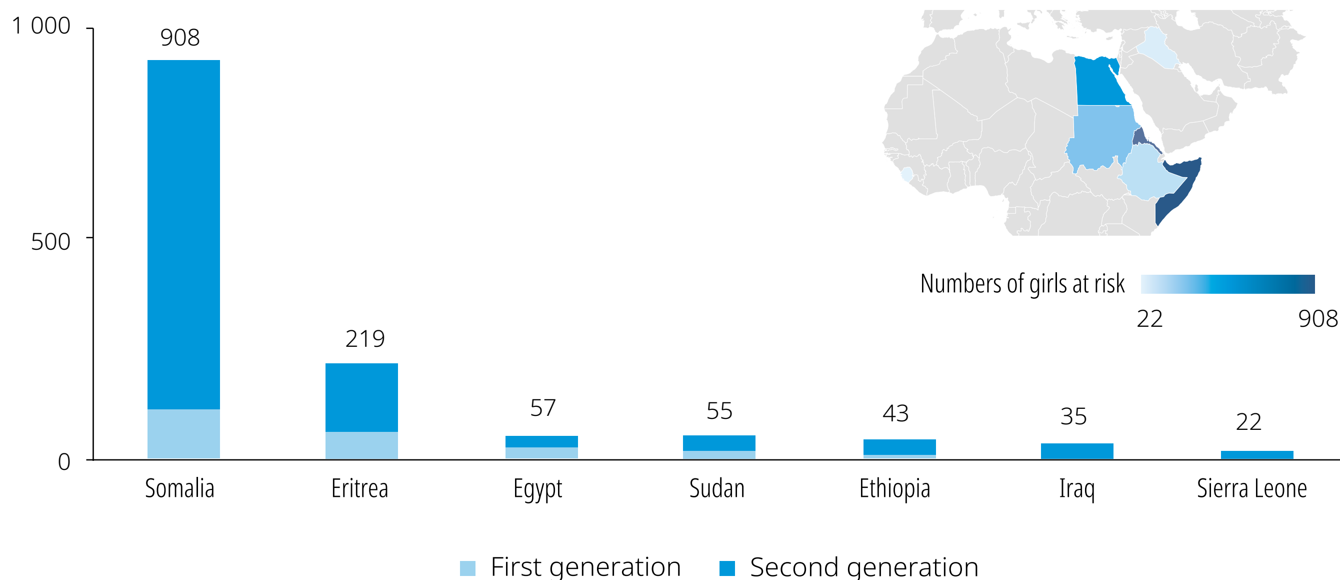
In 2019, the largest number of girls at risk (in the high-risk scenario) originated from Somalia, with 116 girls and 1 584 girls from the first-generation group and the second-generation group, respectively. This was followed by girls from Eritrea. Smaller groups of girls at risk

([58]) For example, for girls originating from Somalia, in the high-risk scenario 24.0 % of first-generation girls and 42.9 % of second-generation girls were estimated to be at risk. In the low-risk scenario, for first-generation girls the estimate is the same as in the high-risk scenario (24.0 %); however, the estimate for second-generation girls is lower (21.5 %) because the calculation takes migration and acculturation into account.

originated from Sudan, Egypt, Ethiopia, Iraq and Sierra Leone.

Countries of origin with a high prevalence and a large number of second-generation girls drive differences between the low-risk and high-risk scenarios. In Denmark, the difference between the estimated overall prevalence in the high-risk and low-risk scenarios is largely driven by the Somali and Eritrean second-generation girls, whose risk is halved in the low-risk scenario (see Figure 5 and Figure 6).

Figure 6. Low-risk scenario: estimated number of girls (aged 0–18 years) living in Denmark, at risk of FGM, by generation and most-represented countries of origin (2019)



NB: See Annex 2 for detailed data.

2.3.2. Estimation of the number of asylum-seeking and refugee girls at risk

A higher proportion of asylum-seeking girls (37 %) than refugee girls (25 %) were at risk of FGM, although both groups were at higher risk than the general group of girls (aged 0–18 years) originating from FGM-practising countries (21 %) ([59]).

Table 9. Estimated number and percentage of asylum-seeking girls and refugee girls (aged 0–18 years) at risk of FGM (*) (2019)

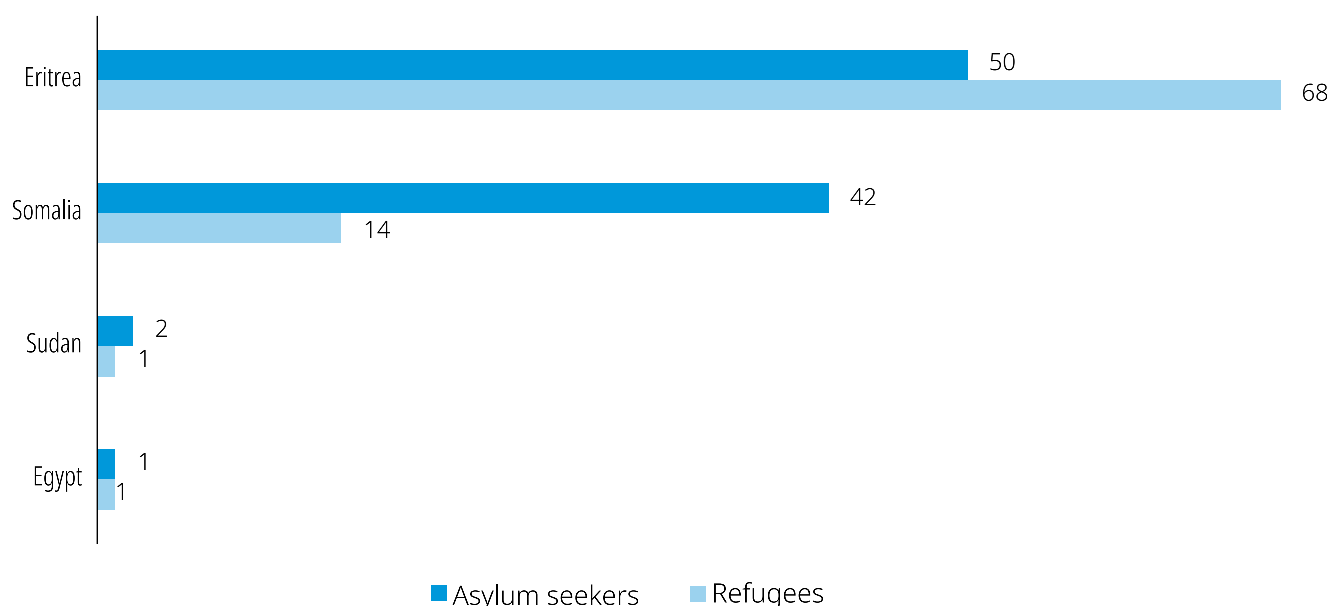
Group	Number of girls (aged 0–18 years) originating from FGM-practising countries	Number (%) of girls at risk: high-risk scenario
Asylum seekers	257	95 (37 %)
Refugees	338	84 (25 %)

(*) Only a high-risk scenario is possible.
NB: Refugee girls are included in the figures presented above on the overall number of girls living in Denmark from FGM-practising countries. See Annex 2 for detailed data.

([59]) Note that this figure relates to the high-risk scenario for first- and second-generation resident migrant girls at risk. The high-risk scenario is used for comparison, as estimates for asylum-seeking and refugee girls always refer to the high-risk scenario.

Asylum-seeking and refugee girls in Denmark at risk of FGM originate from four countries – Eritrea, Somalia, Sudan and Egypt – which roughly mirrors the patterns seen above for all girls (aged 0–18 years) living in Denmark who were at risk of FGM. However, among the 'regular' migrant population, Somalia was most represented in terms of girls at risk, and Eritrea was the second most-represented country of origin, whereas for both asylum seekers and refugees this pattern is reversed.

Figure 7. Estimated number of asylum-seeking and refugee girls (aged 0–18 years) living in Denmark, at risk of FGM, by most-represented countries of origin (2019)



NB: Only the high-risk scenario / first-generation calculation is possible for asylum seekers and refugees, as they are all foreign born. There were no asylum-seeking or refugee girls at risk from the other FGM-practising countries of origin. See Annex 2 for detailed data.

2.4. Tackling female genital mutilation: effective measures and challenges

The criminalization of FGM in Denmark in 2003 has been successful in turning the Somali community away from the practice. However, FGM has not been a priority area in recent years. Future action should be focused on prevention, awareness raising and training, as well as on helping FGM victims to tackle the consequences of FGM.

Stakeholder interview results indicate that diaspora groups, especially Somalis, played a significant role in communicating the law around FGM and educating their communities on the harmful consequences of FGM. This approach was highly successful and has led to a change of attitude and practice among many Somalis in Denmark, demonstrating the substantial impact of involving communities in providing education and raising awareness at the local level. Further legal and policy measures are detailed below.

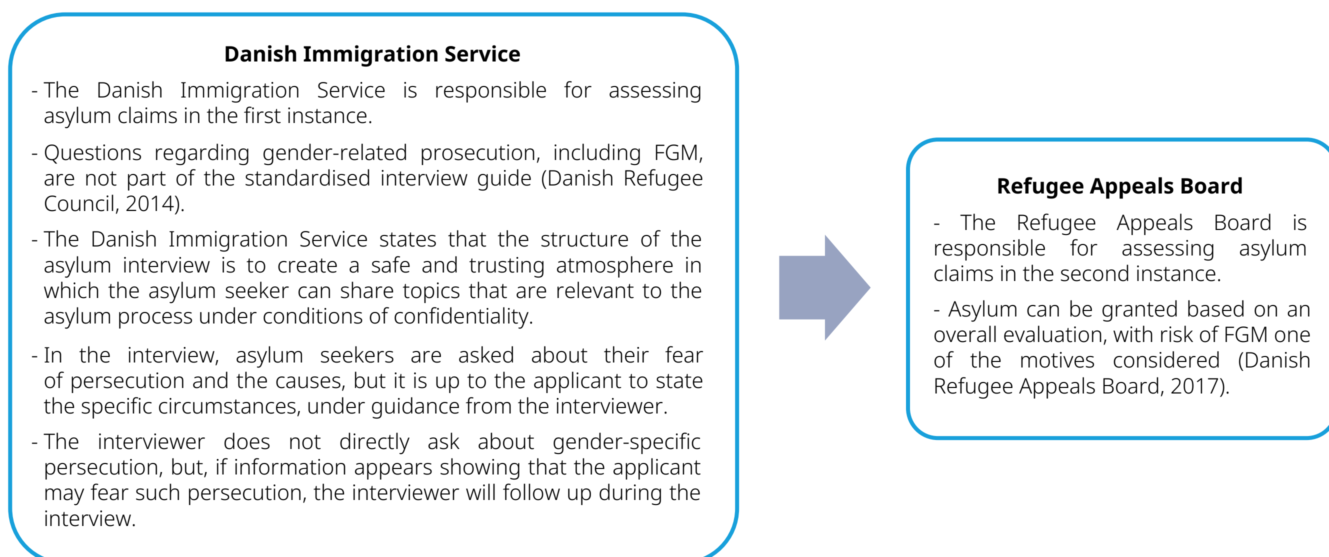
Prior to 2003, FGM was regarded as a criminal offence under the ordinary provisions against physical violence. In 2003, **FGM was made illegal under the Danish Criminal Code**. The law states that 'any Danish national or resident who with or without consent assaults the person of another by cutting or otherwise removing external female genitals in full or in part is liable for imprisonment for a term not exceeding six years' (Danish Criminal Code, 2010). The penalty applies to anyone who is complicit through incitement, advice or action – this includes parents and health personnel. The law also applies if the act is committed extraterritorially.

Although the **law has not led to many prosecutions (*n* = 3)**, the stakeholder interviews and focus group discussions indicate that it has a **preventive effect**, as parents fear prosecution or the loss of their residence permit. It also helps them to resist pressure from their families in their country of origin to carry out FGM.

Regarding **child protection provisions**, the Social Services Act of 2005 states that persons who have knowledge of someone who intends to have their daughters undergo FGM have an obligation to report it to the authorities. Public officials, such as doctors and midwives, have an enhanced reporting requirement (Section 153 of the Social Services Act (2017a)). The law also states that children can be removed from their home if inadequate treatment occurs, such as abuse, criminal behaviour or other social difficulties (Social Services Act, 2017b).

The interview results indicate that Denmark is generally known for its strict asylum system, which does not take in many refugees. The **asylum system** in Denmark has two stages, involving the Danish Immigration Service and the Danish Refugee Appeals Board, as shown in Figure 8.

Figure 8. Danish Immigration Service and Refugee Appeals Board



A case search was conducted using the terms 'gender-related prosecution' and 'FGM' on the publicly available search engine of the Refugee Appeals Board. There were 17 cases from 2019 to 2020, the majority concerning asylum seekers. Of the 17 cases identified, **13 were granted asylum** ([60]). In 2014, 12 cases related to FGM and Somalis were assessed by the board, with the rejection of asylum verified in eight cases and **asylum granted in four cases** ([61]). In 2018, the board was criticised by the UN Committee on the Rights of the Child for refusing to reassess an asylum case that claimed a Somali girl was at risk of FGM. However, the board rejected the criticism (Dagbladet Information, 2018).

([60]) Asylum was granted in seven instances in which the risk of FGM was claimed together with other aspects relevant to asylum. In one of these cases, the claim related to a risk of FGM to the daughter of a male Somali applicant was declined, but a residence permit was granted based on other grounds. When asylum was rejected, several reasons were given for rejecting the claim in relation to FGM: (1) the parents were viewed as resourceful enough to resist the societal pressure surrounding FGM; (2) the risk of FGM was found to be unspecific and unfounded; and (3) the fear of FGM was stated too late in the asylum process. In six other cases, the risk of FGM to applicants or their daughters was one of the reasons for granting a residence permit. In 10 cases, a residence permit was denied, and the risk of FGM to applicants or their daughters was deemed unfounded (Danish Refugee Appeals Board, 2018).

([61]) Several reasons were given for rejecting the claim in relation to FGM: (1) the fear of FGM was based on a presumption; (2) the parents were viewed as resourceful enough to reject the societal pressure surrounding FGM; and (3) the fear of FGM was stated too late in the asylum process.

In 2009, **a voluntary steering committee developed a national action plan** for the prevention of FGM in Denmark. The steering committee consisted of representatives from non-governmental organisations (NGOs) – Somali Women's society, the House of Women in Aarhus, the Intercultural Women's Society and the Danish Society against FGM ([62]) – as well as individuals working against FGM in Denmark. The action plan identified the following key priority areas: improve knowledge and guidance for ethnic minority groups on the consequences of FGM and develop role models among these groups who are willing to speak out against FGM; improve the public debate about the law against FGM, the opportunities for girls to seek counselling, and the possibility of free psychological support for girls and women who have undergone FGM; and establish procedures for the prevention of FGM and the examination of girls at risk of FGM, and legal proceedings for those guilty of practising FGM ([63]).

However, the national **plan was never implemented** by the Danish government. The interview results indicate that it may still be relevant to implement the action plan in Denmark, but a policy focus among Danish politicians is lacking. Since the publication of the action plan, the Danish Society against FGM is no longer in operation, and the national administrative effort against FGM now lies within the responsibility of the 98 Danish municipalities. A Danish study from 2018 concluded that there is a severe lack of initiatives to prevent and tackle FGM in Demark, compared with other Scandinavian countries and international recommendations (Christoffersen et al., 2018). The focus group discussions also indicate that bottom-up approaches and the involvement of civil society actors would be effective in further preventing FGM in Denmark.

More general action plans on gender-based violence exist in Denmark, although they are not directed towards FGM specifically. Since 2002, three national action plans have been developed, with the aim of improving efforts to combat intimate partner violence. In 2016, the Danish government implemented a national action plan to prevent honour-related crimes and negative social control (i.e. actions and sanctions that limit an individual's rights and behaviour, for example by restricting social relations, choice of partner and the right to bodily autonomy). Among other objectives, the action plan aims to develop aid schemes for young people and improve available treatment options for victims. It also aims to enhance professionals' skills and counselling options in the municipalities, as well as mobilising young people and increasing the focus on the rights of children and young people ([64]). The latest action plan was implemented by the Danish government in 2019 and focuses on preventing psychological and physical violence in intimate relationships ([65]). The action plan sets out initiatives related to honour-related crimes, conflicts and violence but makes no specific mention of FGM.

In the health sector, **FGM is part of the medical training of some Danish doctors and midwives**, although this training is not consistently available across all hospitals and is not a specific focus area in medical training programmes. Those receiving the training are made aware of the issue in case they see a patient who has been cut, for instance during labour. However, the interview and focus group results indicate that they may not be able to identify smaller cuts. Pregnant women who are infibulated are referred to an obstetrician and guided through the pregnancy with a special focus on potential complications. The women are offered the option of having the infibulation opened (deinfibulation) in the second

([62]) This organisation no longer exists.
([63]) 'Action plan against female genital mutilation' (https://ft.dk/samling/20091/almdel/suu/bilag/457/879655.pdf).
([64]) COWI A/S (2020), *National action plan for prevention of honour-related conflicts and negative social control – Evaluation report*, COWI A/S, Lyngby, Denmark (https://ec.europa.eu/migrant-integration/?action=media.download&uuid=43A21532-D13F-2059-93DF-B96AF042ED81).
([65]) Ministry of Foreign Affairs of Denmark (2019), *Action plan for the prevention of psychological and physical violence in intimate relationships*, Ministry of Foreign Affairs of Denmark, Copenhagen (https://um.dk/~/media/UM/Danish-site/Documents/Ligestilling/Publikationer/2019/Voldshandlingsplan %20UK %20 %20Web %20version %20 %20154351 %20E0006550011 %203Kpdf %20FINAL.pdf?la=da).

trimester, and if they do not wish to choose this option a birth plan is made. The general practitioner is informed of the anatomical changes during the birth registration ([66]). The Danish Health Authority does not recommend reinfibulation after a woman has given birth, and it is the duty of the healthcare professional to inform the woman about the health consequences of FGM, as well as its illegality in Denmark ([67]). The interview results indicate that reinfibulation after birth is a grey area – the law does not forbid a doctor from reinfibulating a woman if she asks for it and if it is viewed as being in her best interests. However, a doctor can decline to do so, for example if it goes against his or her ethics.

There is a **diagnosis code in the Danish health registry for FGM** (DZ907D: acquired damage to the genitals), in which doctors can register FGM discovered during childbirth. This code is used only for the Danish patient registries and is not used in relation to reporting to the authorities. The interview results indicate that the code is rarely used because of the low number of infibulated women of reproductive age and presenting during labour, and when diagnosis codes are not used regularly they tend to be forgotten. Therefore, it may not give a correct estimate of the number of women living with FGM in Denmark. For this report, it was not possible to obtain the number of registries using the diagnosis code.

2.5. Main findings

Table 10. FGM risk in Denmark in 2019: summary

High-risk scenario	In 2019, 12 462 girls aged 0–18 years originating from FGM-practising countries (born in the country of origin or in Denmark; or first and second generation) were residing in Denmark, of whom 2 568 were likely to be at risk of FGM. **Proportionally, 21 % of girls aged 0–18 years originating from FGM-practising countries (born in the country of origin or in Denmark) were at risk of FGM.**
	In 2019, there were 257 girls in Denmark seeking asylum from FGM-practising countries, of whom 95 (37 %) were estimated to be at risk of FGM. There were 338 refugee girls in Denmark in 2019, of whom 84 (25 %) were estimated to be at risk of FGM.
Low-risk scenario	In 2019, 12 462 girls aged 0–18 years originating from FGM-practising countries (born in the country of origin or in Denmark; or first and second generation) were residing in Denmark, of whom 1 408 were likely to be at risk of FGM. **Proportionally, 11 % of girls aged 0–18 years originating from FGM-practising countries (born in the country of origin or in Denmark) were at risk of FGM.**

- The criminalization of FGM in Denmark in 2003 has been successful in turning the Somali community away from the practice. However, FGM has not been a priority area in recent years. **Future action should be focused on prevention, awareness raising and training, as well as on helping FGM victims** to tackle the consequences of FGM.

- FGM has been **criminalised in Denmark since 2003,** but there have been few prosecutions. Nevertheless, its **criminalisation has reportedly had a preventive effect, with the Somali community in particular playing an active role in raising awareness** of the law against FGM and educating other minority groups about the harmful effects of the practice.

- There have been **limited measures to prevent FGM and protect girls at risk**, with **no national action plan** in place.

([66]) 'Revised appendix 4 on female genital mutilation' (https://www.sst.dk/-/media/Viden/Graviditet-og-f %C3 %B8dsel/Svangreomsorgen/Graviditet-og-kvindelig-omsk %C3 %A6ring/Revideret-bilag-4_Anbefalinger-for-svangreomsorgen_2013.ashx?la=da&hash=7356F54BE3129B1AC884FF254FE07C471F809E95).

([67]) Danish Health Authority (2019), 'Graviditet og kvindelig omskæring', 29 August 2019 (https://www.sst.dk/da/viden/graviditet-og-foedsel/svangreomsorgen/graviditet-og-kvindelig-omskaering).

- The interview results suggest that the **identification and reporting of FGM cases by medical professionals is limited in practice**, and focus group and interview participants suggested that doctors could be better educated on FGM.

- The focus groups and individual interviews conducted with both women and men in Denmark reveal a **pervasive negative attitude towards FGM**, recognising its adverse physical and psychological impacts. **The traditional importance of FGM as a prerequisite for marriage** among Somali and Kurdish communities in Denmark **was presented as having diminished**, although virginity was still seen as closely linked to marriageability.

- Most participants were **aware that FGM was illegal** in Denmark.

- Little was known to date about FGM practices among the Kurdish community. **The first-generation Kurdish women had less knowledge of the healthcare services available to them** than first-generation Somali women, and also expressed a stronger desire to be clinically examined to help them overcome sexual challenges encountered by themselves and their husbands as a result of FGM.

2.6. Recommendations

2.6.1. Train health professionals and implement a national registration system to record cases of female genital mutilation

Challenge. The Danish health registry has a diagnosis code for doctors to use to register FGM encountered during childbirth. However, the code is not used consistently, meaning that women might not receive the appropriate treatment and the Danish health registry may underestimate the numbers of women living with FGM in Denmark, hindering the development of prevention and protection policies and programmes.

Proposed action. Implement a mandatory requirement for all healthcare professionals to consistently register cases of FGM using the diagnosis code. This should be done anonymously to ensure the right to privacy and data protection of women who have experienced FGM. If possible (and with consent), data should be disaggregated by age, ethnicity, country of origin, generation and status of residence. Healthcare professionals should be systematically trained on mandatory recording requirements and on how to sensitively address sexual and reproductive health issues among minority groups, including FGM.

Potential stakeholders. Ministry of Health and municipalities.

2.6.2. Implement a national action plan on female genital mutilation

Challenge. Without a national framework to combat FGM and protect girls at risk, the municipalities in Denmark are responsible for initiatives at local level. However, only 10 % of municipalities have implemented specific action plans tackling FGM. A few municipalities offered written information on FGM to citizens or relevant professionals, or developed and implemented preventive initiatives, such as providing information on FGM to parents and families or outreach healthcare visits.

Proposed action. Adopt a national action plan to ensure that all municipalities communicate information on FGM and refer citizens at risk to professionals. The national action plan should be developed by the Ministry of Social Affairs. Affected communities, civil society organisations and local councils should be involved in developing and implementing local initiatives, thereby ensuring effective messaging and outreach on the harmful effects of FGM. Data on migrant populations in Denmark can identify the relevant communities to ensure that local initiatives appropriately consider specific cultural factors. Community members should be adequately compensated for their awareness-raising work.

Potential stakeholders. Ministry of Social Affairs and the Interior; the local councils of the 98 municipalities in Denmark; affected communities; and civil society organisations.

3. Female genital mutilation risk estimation in Spain

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

3.1.1. Migrant population

In 2018, there were 39 734 migrant girls (aged 0–18 years) in Spain originating from FGM-practising countries, 79 % of whom were second generation. Of the total number of girls aged 0–18 years, 59 % were aged 0–9 years and 41 % were aged 10–18 years. Nearly all girls aged 0–9 years were second generation (87 %), as were most girls aged 10–18 years (67 %).

Table 11. Age distribution of the female migrant population (aged 0–18 years) in Spain originating from FGM-practising countries (2018)

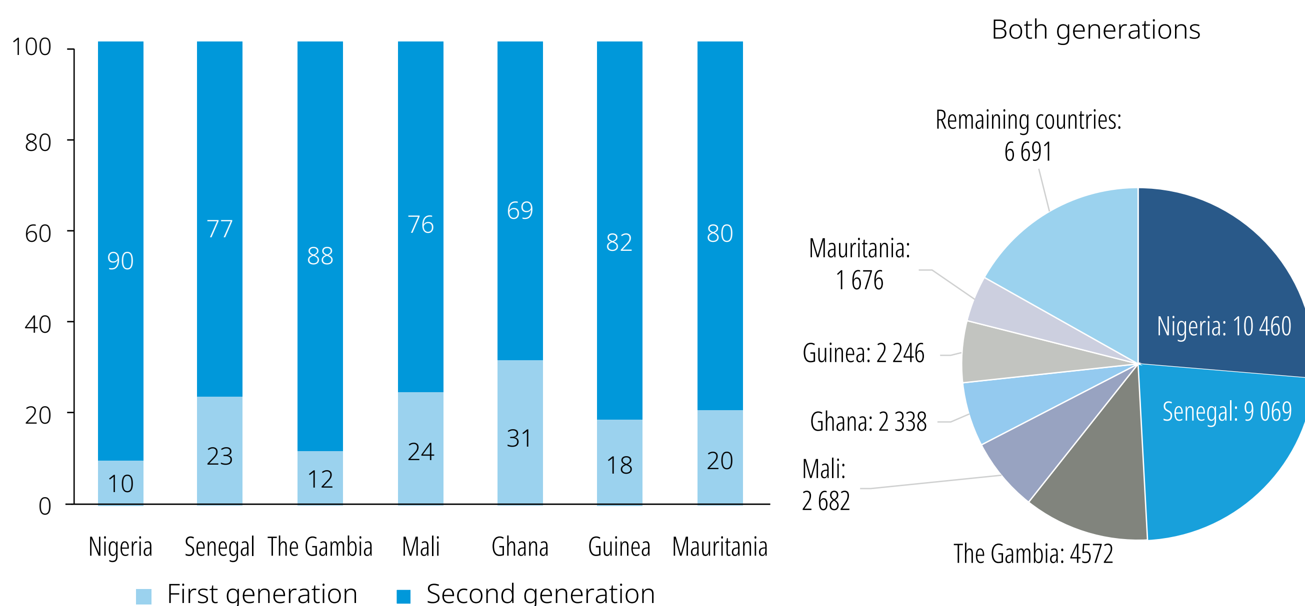
Age group	First generation	Second generation	Total (%)	Percentage in first generation	Percentage in second generation
0–9 years	2 998	20 300	23 298 (59)	13	87
10–18 years	5 504	10 932	16 436 (41)	33	67
Total	**8 502**	**31 232**	**39 734 (100)**	**21**	**79**

NB: Data are as of 1 January 2019. First-generation data are from the municipal register; second-generation data are from the Statistical Birth Bulletin.
Source: National Statistics Institute of Spain (INE). See Annex 2 for detailed data.

Data on second-generation girls are derived from the number of female live births to mothers originating from countries where FGM is documented, in the years 2000–2019, as this allows a calculation of the number of girls aged 0–18 years born to mothers from those countries. Use of these data assumes that all girls born in Spain to mothers from FGM-practising countries still live in Spain, and therefore there may be a slight overestimation.

The seven FGM-practising countries most represented in terms of first- and second-generation girls in 2018 were Nigeria (representing 26.3 % of the total population of girls in Spain aged 0–18 years originating from an FGM-practising country), Senegal (22.8 %), The Gambia (11.5 %), Mali (6.7 %), Guinea (5.7 %), Ghana (5.9 %) and Mauritania (4.2 %). The remaining countries of origin all represented 4 % or less. Nigeria and Senegal together represented 49.1 % of the total. Information on the region of origin within the country of origin of the girls (or their mothers) is unavailable. There may be a high risk of bias when applying national prevalence rates to migrant populations living in Spain from countries with large regional variations in their prevalence rates.

Figure 9. Percentage and number of girls (aged 0–18 years) living in Spain, by generation and the seven most-represented countries of origin (2018)



NB: From left to right, countries are presented in descending order of the size of their communities (with Nigeria being the largest and Mauritania the smallest). However, they are shown on the same scale to enable percentage comparisons by generation.
Source: National Statistics Institute of Spain (INE). See Annex 2 for detailed data.

3.1.2. Irregular migration

No official data are available on the number of irregular migrants living in Spain. Information from the market data and consumer information organisation Statistica (2020) states that over 32 000 irregular migrants entered Spain in 2019. The five most-represented countries of origin were Morocco (8 271), Guinea (5 124), Algeria (5 025), Mali (3 298) and Côte d'Ivoire (2 867). Of these, Morocco and Algeria are not classified as FGM-practising countries. As this information is not gender specific and its origin is unclear, these data were not used in the FGM risk estimation.

3.1.3. Asylum seekers and refugees

The Ministry of the Interior publishes detailed figures on asylum each year, including applicants for asylum by country of origin. In 2019, there were 118 446 asylum seekers, 53 816 of whom were women (Ministerio del Interior, Secretaría General Técnica, 2020). Among asylum seekers, the most-represented FGM-practising countries were Mali (1 247 applicants; 1.2 % aged 17 years and under), Guinea (991; 4.3 % aged 17 years and under) and Senegal (779; 1.7 % aged 17 years and under). There is no data set available that is disaggregated by country of origin, gender and age at the same time. In 2019, 1 659 people were given refugee status and granted the right of asylum (Ministerio del Interior, Secretaría General Técnica, 2020). Among these, the most-represented FGM-practising countries were Nigeria (35 people; 31.4 % aged 17 years and under) and Cameroon (31 people; 9.7 % aged 17 years and under). This information is also not disaggregated by country of origin, gender or age in the same data set.

The Ministry of the Interior also publishes monthly asylum data. From 1 January 2020 to 31 August 2020, 64 389 applications were submitted, of which 30 361 (47.1 %) were made by women and 11 627 (18.1 %) concerned applicants under the age of 17 years (Ministerio del Interior, Subsecretaría del Interior, 2020). Information about the countries of origin was not published, except information on the five most-represented countries of origin, none of which are among the 30 FGM-practising coun-

tries. No data are available on asylum granted on the grounds of FGM.

Disaggregated data on asylum seekers and refugees from the Ministry of the Interior were not made available.

3.1.4. Other records collecting information on female genital mutilation

The Centre for Judicial Documentation is a national registration system for monitoring judicial cases ([68]). It provides information on FGM-related investigations and cases. There have been three court cases since mid 2017: one in which extraterritoriality was applied for FGM conducted in Mauritania; and two in which FGM had been conducted in The Gambia and the defendants were acquitted. A further provincial court ruling in Catalonia adopted preventive measures by prohibiting the departure of three minors from the territory.

3.2. Community views of female genital mutilation

3.2.1. Overview of the focus group discussions

Four focus groups were held in Spain between 2 and 4 October 2020, with a total of 27 participants. There were between five and eight participants in each group, drawn from the four target groups outlined in the methodology (see Annex 2).

Most of the 27 focus group participants in Spain were originally from Senegal (17). Other participants originated from Guinea (2), Mali (2), Somalia (2), Nigeria (1), The Gambia (1) and Ethiopia (1). Various ethnic groups from these countries were represented.

Table 12. Focus group participants – Spain

Information	Focus group 1	Focus group 2	Focus group 3	Focus group 4
Number of participants	8	5	5	9
Countries represented	Senegal (8)	Senegal (5)	Guinea (1) Mali (1) Senegal (3)	Ethiopia (1) The Gambia (1) Guinea (1) Mali (1) Nigeria (1) Senegal (1) Somalia (2) Unknown (1)
Sex of participants	Female (8)	Female (2) Male (3)	Male (5)	Female (9)
Age range	27–41 years	18–24 years	33–47 years	25–54 years
Generation	First generation	Second generation	First generation	First generation
Religion	Muslim (8)	Muslim (4) Unknown (1)	Muslim (5)	Christian (2) Muslim (6) Unknown (1)

NB: Table A2 in Section A2.4 outlines the demographic profiles of the focus group participants.

([68]) Consejo General del Poder Judicial, 'Centro de Documentación Judicial' (http://www.poderjudicial.es/search/indexAN.jsp).

3.2.2. Identity and attitudes to female genital mutilation

Participants in all four focus groups held **negative attitudes to the practice of FGM**, particularly towards more severe forms of FGM involving infibulation. Two main reasons were given for these negative attitudes: the long-term physical damage caused by the practice (frequently mentioned); and the negative effect of FGM on women's sexual pleasure, and the associated discomfort and pain (mentioned in all four groups).

Participants in all four focus groups indicated that **social attitudes to FGM had changed** over the years, with those from Senegal observing that FGM was no longer performed as a community ceremony or ritual but was rather a more private practice because of fear of detection and punishment. Changing cultural attitudes and recent legislation have affected the prevalence of FGM in their communities, as well as factors such as socioeconomic status, access to formal education and ethnic group.

The concepts of **virginity** and **marriageability** were frequently mentioned by participants in all four groups. Second-generation Senegalese participants explained that the 'purity' and 'respectability' of girls were closely tied to their virginity: whether or not a woman was sexually active before marriage affected her 'marriageability'. Nevertheless, participants believed that these views had changed in their communities, with girls who had not undergone FGM still considered 'marriageable' provided that they were chaste. All four focus groups stated that, although older generations might still consider FGM to be 'natural' and traditional, younger generations had become more critical of the practice.

3.2.3. Perceptions of the risk of female genital mutilation in the host country and beyond

Participants in all focus groups noted that FGM was **not commonly practised in Spain**. Second-generation Senegalese participants stated that the practice was largely abandoned in Europe because of fear of punishment and changing cultural attitudes. Participants in the all-male group from FGM-practising communities argued that first-generation immigrants were more likely to experience and continue the practice than second- and third-generation immigrants. In all focus groups, participants felt that women and girls who had undergone FGM would be likely to hide it because of fear of shame and judgement in Spain.

3.2.4. Knowledge of female genital mutilation legislation and services among migrant communities

In most focus groups, participants were aware of anti-FGM campaigns and efforts in Europe but had not themselves been involved in such work. Second-generation women and men were unaware of ongoing anti-FGM advocacy work, which they attributed to the low prevalence of FGM in Spain. **Participants were unable to refer to any anti-FGM legislation in Spain but assumed that the practice was prohibited**, as it is in some of their countries of origin.

First-generation Senegalese participants had little awareness of the health services available, having only engaged with healthcare professionals during childbirth. First-generation women from hard-to-reach populations mentioned that **women often felt ashamed or judged by healthcare providers during childbirth if they had undergone FGM**. For this reason, participants felt that healthcare professionals should approach FGM with sensitivity. Among the focus group participants, first-generation men were least aware of the health services available in Spain for women and girls affected by FGM.

3.2.5. Factors encouraging female genital mutilation

According to participants, **tradition and religion were often used as justifications for upholding FGM**, although the practice was not a requirement in their religions.

Participants frequently stated that girls aged 12–15 **years** who had not undergone FGM were **at risk of experiencing the practice if they travelled to their countries of origin**, but others argued that this depended entirely on the beliefs of the family.

3.2.6. Key figures and decision-making

Participants held contrasting views on the key figures and decision-making structures relating to FGM. There was broad agreement that **men were complicit in the practice and must play a pivotal role in the elimination of FGM**. Other participants believed that mothers, grandmothers and other maternal figures were the core decision-makers and, as such, were primarily responsible for the continuation of the practice.

In all focus groups, 'elders' were considered to play a significant role in the decision-making around FGM.

3.3. Estimation of the number of girls at risk of female genital mutilation

3.3.1. Estimation of the number of girls at risk in the regular migrant population

In 2018, the number of girls (aged 0–18 years) at risk of FGM in Spain was 6 025 (15 % of girls originating from FGM-practising countries) in the high-risk scenario, and 3 435 (9 %) in the low-risk scenario.

Table 13. Estimated number and percentage of girls (aged 0–18 years) living in Spain who are at risk of FGM by high-risk and low-risk scenarios (2018)

	First generation	Second generation	Total
Number of girls (aged 0–18 years) originating from FGM-practising countries	8 502	31 232	**39 734**
Number (%) of girls at risk: high-risk scenario	846 (10 %)	5 179 (17 %)	**6 025 (15 %)**
Number (%) of girls at risk: low-risk scenario		2 589 (8 %)	**3 435 (9 %)**

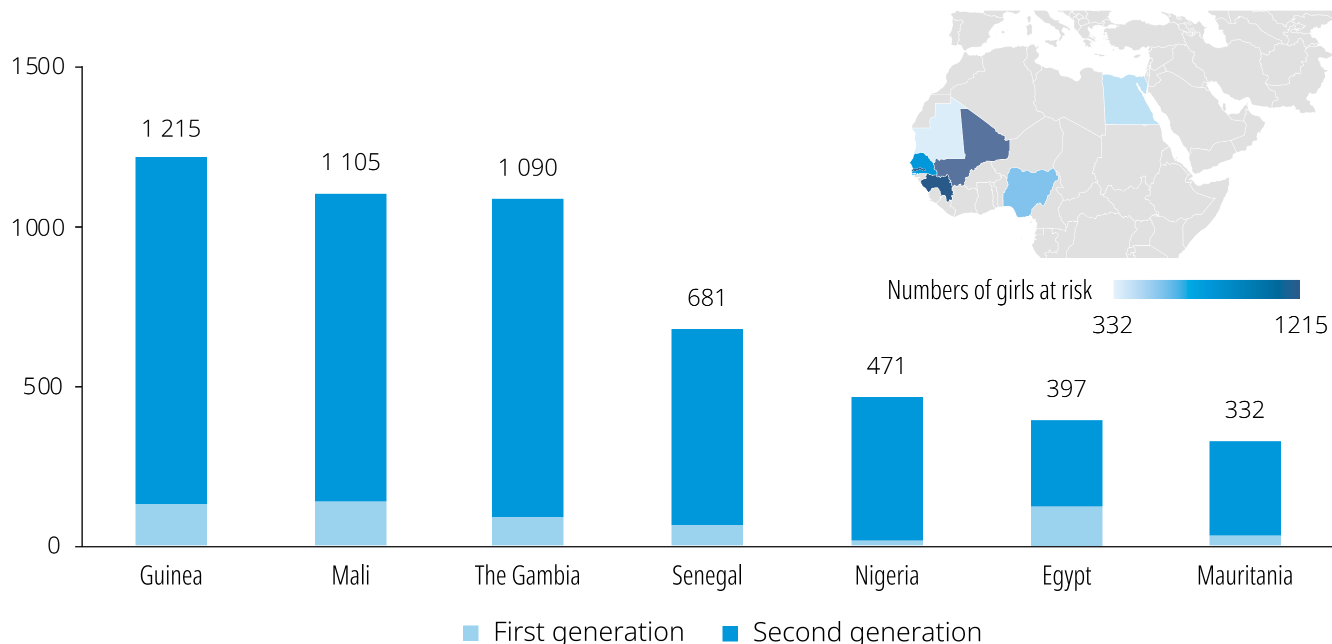
NB: See Annex 2 for detailed data.

In both scenarios, 10 % of first-generation girls were at risk. For second-generation girls, 17 % were at risk in the high-risk scenario and 8 % were at risk in the low-risk scenario.

In 2018, the largest number of girls at risk (in the high-risk scenario) originated from Guinea. In the high-risk scenario, 130 first-generation girls originating from Guinea were at risk and 5 179 second-generation girls originating from Guinea were at risk. This was followed by girls from Mali and The Gambia. Smaller groups of girls at risk originated from Senegal, Nigeria, Egypt, and Mauritania.

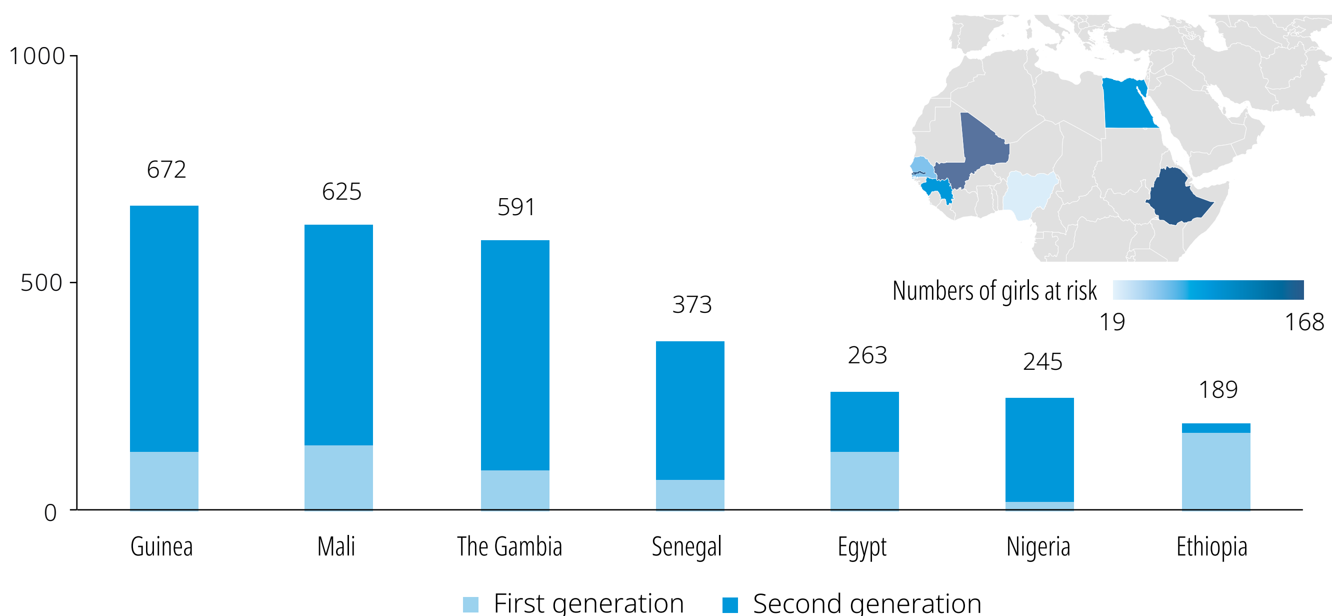
Countries of origin with a high prevalence and a large number of second-generation girls drive the differences between the low-risk and high-risk scenarios. In Spain, the difference between the estimated overall prevalence in the high-risk and low risk scenarios is largely driven by the Guinean and Malian second-generation girls, whose risk is almost halved in the low-risk scenario (see Figure 11).

Figure 10. High-risk scenario: estimated number of girls (aged 0–18 years) living in Spain, at risk of FGM, by generation and most-represented countries of origin (2018)



NB: The numbers above the bars are the total numbers of first- and second-generation girls in Spain for each country of origin. See Annex 2 for detailed data.

Figure 11. Low-risk scenario: estimated number of girls (aged 0–18 years) living in Spain, at risk of FGM, by generation and most-represented countries of origin (2018)



NB: The numbers above the bars are the total numbers of first- and second-generation girls in Spain for each country of origin. See Annex 2 for detailed data.

3.3.2. Estimation of the number of asylum-seeking and refugee girls at risk

Disaggregated data on asylum seekers and refugees were requested from the Ministry of the Interior; however, these data were not provided.

3.4. Tackling female genital mutilation: effective measures and challenges

Article 15 of the Spanish Constitution recognises personal integrity (physical and mental) as a fundamental right ([69]). **FGM is criminalised** ([70]) and is punishable with a sentence of imprisonment from 6 to 12 years. Organic Act 1/2014 of 13 March ([71]) sets up the principle of extraterritoriality, meaning that FGM is prosecuted if it is performed by a resident in Spain; if it is performed by a person with Spanish or foreign nationality in Spain or abroad; or if it is performed on an individual of Spanish nationality or with residence in the country, in Spain or abroad. Since mid 2017, there have been three court cases in which extraterritoriality has been taken into consideration (usually for family reunification) ([72]).

Article 158 of the **Civil Code** (modified by Organic Act 9/2000) **allows judges to adopt preventive measures in the case of imminent risk of FGM**, and a recent provincial court ruling in Catalonia (307/2017 10 July) prohibited the departure of three minors from the territory. Enforcement measures include retention of minors' passports and regular medical checks until they reach 18 years of age.

Article 149(2) allows the removal of parental authority (or equivalent) of a child aged between 4 years and 10 years, at the judge's discretion. Interview respondents suggested a multidisciplinary investigation of each case, but, in practice, this is complicated by a lack of resources and coordination, and insufficient knowledge and capacity.

Organic Act 1/1996 establishes the 'superior interest of minors' in situations of risk or lack of protection, requiring autonomous communities to intercede. Catalonia and Valencia are the only regions in Spain that make specific reference to FGM in their own regulations ([73]).

Spain's **State Pact against Gender-based Violence (2018–2022)** promotes the national coordination of public policies and recognises that the term 'gender-based violence' should be extended to all types of violence against women. It includes measures stipulating that FGM will be addressed through information campaigns, research, specific laws and training for health professionals ([74]).

In 2015, the **Common Protocol for a healthcare response to FGM** was developed by the Ministry of Health, Social Policy and Equality. It is the first national protocol to harmonise prevention, care and risk detection in the national health system. It notes that health and social services are best placed to approach families regarding FGM and sets out guidelines on how to intervene in common scenarios. However, training of health and social services professionals is not the competence of the aforementioned ministry and is provided at the regional level.

([69]) For further information, see Delegación del Gobierno para la Violencia de Género (2020), *La Mutilación Genital Femenina en España*, Ministerio de Igualdad, Madrid.

([70]) According to the modifications introduced by Organic Act 11/2003 on concrete measures in matters of public safety, domestic violence and social integration of foreigners. See Article 149(2) of the Criminal Code. The Criminal Code defines genital mutilation under Article 149(2): 'Whoever causes to another person a genital mutilation in any form shall be punished with a sentence of imprisonment from six to twelve years. Should the victim be a minor or incapacitated, the punishment of special barring from exercise of parental rights, guardianship, care, safekeeping or fostership shall be applicable for a term from four to ten years, should the Judge deem it appropriate in the interest of the minor or incapacitated person.' Aiding and abetting the commission of FGM is covered by Articles 28 and 29 of the Spanish Criminal Code.

([71]) Modifying Organic Act 6/1985 of 1 July, of judicial power in relation to universal justice.

([72]) Ruling 47/2018 of 2 February in Catalonia, Criminal Appeal No 257/2017 Resolution No 291/2017 in Andalusia, and Ruling 31/2019 of 15 November in Catalonia.

([73]) Catalonia: Law on the rights and opportunities in childhood and adolescence, 2010; Valencia: Law of the Valencian Community on the integral protection of childhood and adolescence, 2008.

([74]) Measure No 104.

Of the 17 autonomous communities, 12 have their own protocols or guides on FGM. Catalonia was the first to draw up a protocol (in 2002), as it historically had the highest percentage of migrants from FGM-practising areas.

Despite its importance, preventive work is often overlooked because of lack of time, coordination between different services and training, with professionals sometimes going directly to the police and judicial authorities rather than dealing directly with the family themselves (GIPE/PTP, 2018). Mangas (2017) and GIPE/PTP (2018) concluded that a balance must be found between FGM punishment and the possible stigma generated by such punishment.

At state level, two tools are important for FGM intervention: the knowledge, attitudes and practices questionnaires, and the preventive commitment (the FGM passport). First, the questionnaires were designed by the Interdisciplinary Group for the Prevention and Study of Harmful Traditional Practices of the Autonomous University of Barcelona ([75]). They measure the impact of actions on the ground, evaluate their effectiveness, identify areas for improvement, and explore changes across time and between groups. Second, the Transnational Observatory of Applied Research to New Strategies for Preventing FGM developed the 'FGM passport' tool ([76]) in 1998, which provides families with a stamped letter for the elders in their communities, stating the legal consequences of carrying out FGM in their country of origin. The Spanish Common Protocol includes a template for the FGM passport and is now used in most of the autonomous communities.

3.5. Main findings

Table 14. FGM risk in Spain in 2018: summary

High-risk scenario	In 2018, 39 734 girls aged 0–18 years originating from FGM-practising countries (born in the country of origin or in Spain; or first and second generation) were residing in Spain, of whom 6 025 were likely to be at risk of FGM. **Proportionally, 15 % of girls aged 0–18 years originating from FGM-practising countries (born in the country of origin or in Spain) were at risk of FGM.**
Low-risk scenario	In 2018, 39 734 girls aged 0–18 years originating from FGM-practising countries (born in the country of origin or in Spain; or first and second generation) were residing in Spain, of whom 3 435 were likely to be at risk of FGM. **Proportionally, 9 % of girls aged 0–18 years originating from FGM-practising countries (born in the country of origin or in Spain) were at risk of FGM.**

- Participants in all four focus groups held **negative attitudes towards the practice of FGM, particularly towards more severe forms of FGM** that involve infibulation (type III), and noted that **social attitudes to FGM had changed** over the years. They were largely **aware of anti-FGM campaigns and efforts in Europe but were unaware of anti-FGM legislation in Spain.**
- FGM is **criminalised in Spain and the principle of extraterritoriality applies** to this crime. Only two autonomous communities refer to FGM in their own child protection

([75]) Created in 2003, the group aims to implement a new strategy for tackling FGM based on research, awareness, prevention and empowerment. It seeks to protect the fundamental right to physical and mental integrity by reconciling this perspective with respect for traditions. The group consists of health and social sciences professionals.

([76]) Ministry of Health, Social Services and Equality (2015), *Common Protocol for a healthcare response to female genital mutilation (FGM)*, Ministry of Health, Social Services and Equality, Madrid (https://www.mscbs.gob.es/organizacion/sns/planCalidadSNS/pdf/equidad/A_Protocolo_comun_INGLES_(MGF).Accesible.pdf).

regulations ([77]). Legal provisions for asylum on the grounds of FGM are limited by the lack of specific mention of FGM in the legal asylum framework, with asylum applications based on FGM usually denied.

- **Policy measures and services to prevent FGM and protect girls at risk are evident at both national and regional levels**, particularly in the healthcare sector. At national level, Spain's national agreement on gender-based violence outlines measures on FGM, such as information campaigns and training for healthcare professionals. Less focus is placed on prevention efforts, probably because of lack of time and adequate training (including intercultural training) or policies targeting prevention and care. Such actions can result in stigmatisation and secondary victimisation.

3.6. Recommendations

3.6.1. Introduce female genital mutilation-specific provisions in regional child protection legislation across all of Spain

Challenge. Organic Act 1/1996 on the legal protection of children requires that public bodies intervene in situations of risk or lack of protection of minors. Only two autonomous communities in Spain explicitly recognise FGM in their regulations: Catalonia (Article 76 of Law 14/2010 of 27 May on the rights and opportunities in childhood and adolescence) and Valencia (Article 9(1) of Law of the Valencian Community 12/2008 of 3 July on the integral protection of childhood and adolescence).

Proposed action. National and regional legislatures should take steps to introduce amendments to existing legislation on child protection that explicitly recognise FGM. These amendments should contain specific provisions on professionals' reporting and disclosure obligations, including mandatory training to ensure a non-stigmatising and non-discriminatory approach. Relevant stakeholders should be consulted, particularly affected communities, including children and young people, to ensure that the provision(s) are comprehensive and address women's and girls' self-defined needs.

Potential stakeholders. National and regional legislatures of autonomous communities across Spain.

3.6.2. Strengthen the preventive work of health professionals

Challenge. Primary healthcare professionals often neglect preventive measures to combat FGM in favour of reporting suspected cases of FGM to authorities. Women and girls affected by FGM are thus at risk of secondary victimisation. Reporting obligations are alleged to result in girls undergoing FGM in their country of origin prior to coming to Spain, as well as barriers being created in accessing healthcare for women who have undergone FGM.

Proposed action. Primary healthcare professionals need to emphasise prevention of FGM. In line with the common protocol for healthcare response to FGM, healthcare professionals should inform families of the dangers of FGM in order to change cultural attitudes, and anticipate where patients are at risk of FGM (and refer them to the appropriate support services). The Ministry of Health and the autonomous communities should enhance the quality of prevention-related training for healthcare professionals to ensure that they are better sensitised to the needs of girls at risk of FGM and that they are appropriately skilled for prevention work.

Potential stakeholders. Ministry of Health and the autonomous communities.

([77]) In Spain, in situations of risk or lack of protection, public bodies responsible for the protection of minors are required to intervene (Organic Act 1/1996 on the legal protection of children). Catalonia and Valencia are the only regions in Spain that mention FGM in their own specific regulations. Catalonia: Law on the rights and opportunities in childhood and adolescence, 2010; Valencia: Law of the Valencian Community on the integral protection of childhood and adolescence, 2008.

4. Female genital mutilation risk estimation in Luxembourg

4.1. Female migrant population aged 0–18 years originating from female genital mutilation-practising countries

4.1.1. Migrant population

In 2019, there were 822 migrant girls (aged 0–18 years) in Luxembourg originating from FGM-practising countries. Of these, 24 % were second generation. Of the total number of girls aged 0–18 years, 53 % were aged 0–9 years and 47 % were aged 10–18 years. The majority of girls aged 0–9 years were first generation (55 %), and the vast majority of girls aged 10–18 years were first generation (98 %).

Data on second-generation girls were not available in Luxembourg statistics, and only data on foreign girls born in Luxembourg were available. This limitation implies an underestimation of the number of second-generation girls, because children of naturalised foreign-born parents or multiethnic couples are not included. As no data on births were available, the magnitude of the underestimation cannot be assessed ([78]).

Table 15. Age distribution of the female migrant population (aged 0–18 years) in Luxembourg originating from FGM-practising countries (2019)

Age group	First generation	Second generation	Total (%)	Percentage first generation	Percentage second generation
0–9 years	239	193	**432 (53)**	55	45
10–18 years	382	8	**390 (47)**	98	2
Total	**621**	**201**	**822 (100)**	**76**	**24**

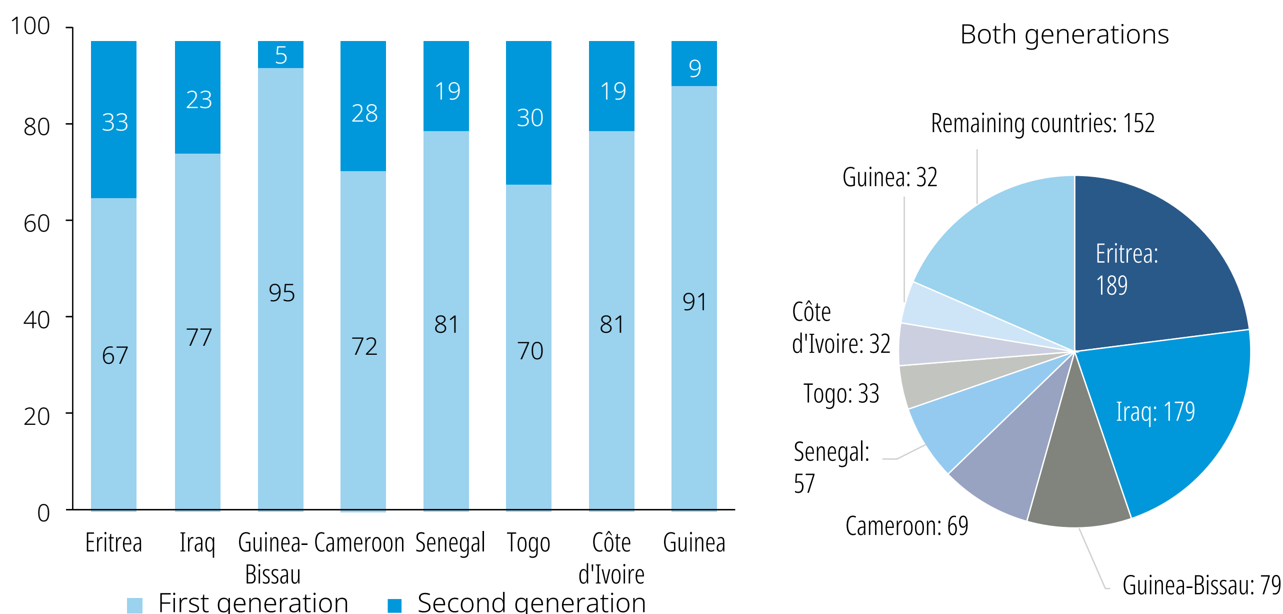
NB: No data available for female migrant population originating from Chad, Ghana, Niger or Uganda. No data available for second-generation girls from the 30 FGM-practising countries of origin. See Annex 2 for detailed data.
Source: Statistics are based on data on the numbers of girls aged 0–18 years by country of birth and age as of 1 January 2020 from the government statistics service of Luxembourg, STATEC.

The eight FGM-practising countries most represented among first- and second-generation girls in 2019 were Eritrea (representing 23.0 % of the total population of girls in Luxembourg aged 0–18 years originating from an FGM-practising country), Iraq (21.8 %), Guinea-Bissau (9.6 %), Cameroon (8.4 %), Senegal (6.9 %), Togo (4.0 %), Côte d'Ivoire (3.9 %) and Guinea (3.9 %). The remaining countries of origin represented approximately 18.5 %. Eritrea, Iraq and Guinea-Bissau together represented 55 % of the total.

Information on the region of origin within the country of origin of the girls (or their mothers) is unavailable. There may be a high risk of bias when applying national prevalence rates to migrant populations living in Luxembourg from countries that have large regional variations in prevalence rates.

([78]) In Austria, data on births by place of birth of the mother were available for a limited number of years, which enabled an estimation to be made of the extent of the underestimation, by using data on foreign girls born in the Member State. This was done by comparing data on foreign girls born in Austria with data on girls born from at least one foreign-born parent for the few years when both sets of data were available. As these data were not available in Luxembourg, no similar comparison could be made.

Figure 12. Percentage and number of girls (aged 0–18 years) living in Luxembourg, by generation and the eight most-represented countries of origin (2019)



NB: From left to right, the countries are presented in descending order of the size of their communities (with Eritrea being the largest and Côte d'Ivoire and Guinea being the smallest). 'G-B' indicates Guinea-Bissau and 'C d'I' indicates Côte d'Ivoire. Countries are shown on the same scale to enable percentage comparisons by generation.
Source: Statistics are based on data on the numbers of girls aged 0–18 years by country of birth and age in 2019 (as of 1 January 2020) from the government statistics service of Luxembourg, STATEC. See Annex 2 for detailed data.

4.1.2. Irregular migration

The Directorate of Immigration in the Ministry of Foreign and European Affairs provided data on irregular migration in Luxembourg. However, no estimation of the number of irregular migrant girls at risk of FGM was carried out, because of the partial nature of the data and extremely low numbers. The data indicate that, in 2019, only two migrant girls from Eritrea aged between 0 and 18 years were irregular migrants.

4.1.3. Asylum seekers and refugees

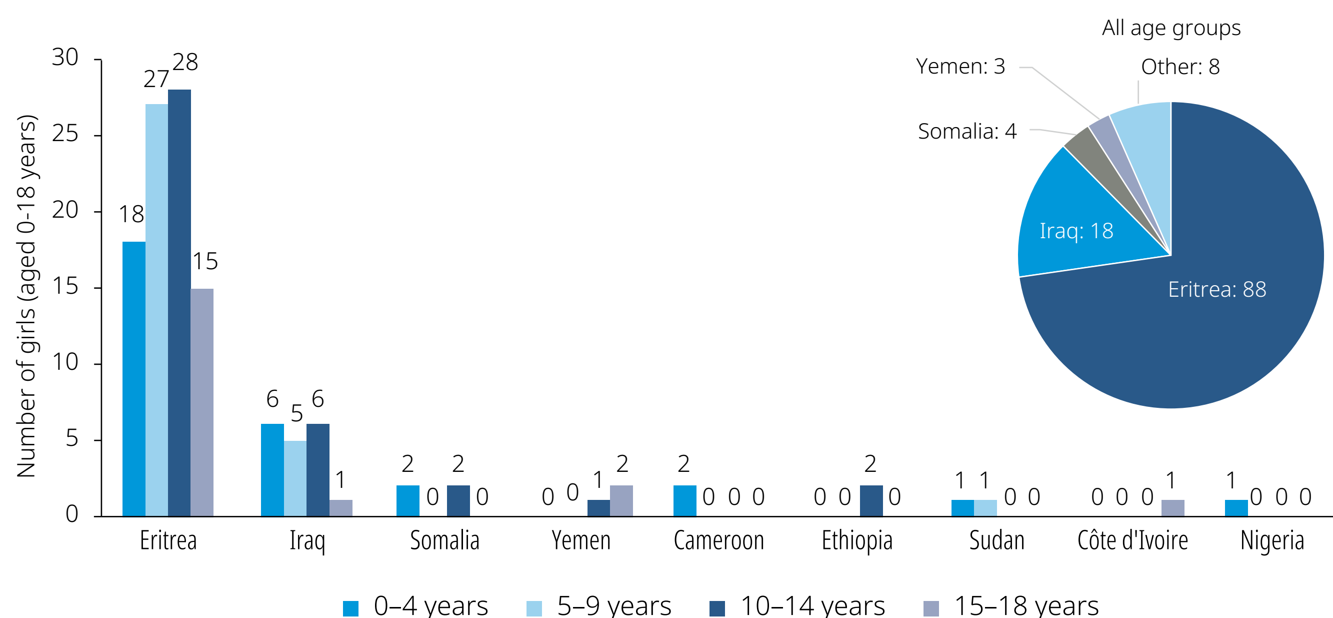
The Directorate of Immigration publishes monthly statistics on asylum applications. These statistics include information on the country of origin and the number of decisions made per year on the recognition of refugee status, granting of refugee status, refusal of international protection, withdrawals, transfer decision, inadmissibility, revocation of status and waivers.

In 2019, the Directorate of Immigration recorded 2 047 requests for asylum in Luxembourg ([79]). The publicly available statistics do not include the reasons for the asylum applications.

Data provided by the Directorate of Immigration on female asylum seekers aged 0–18 years by country of birth show that 121 girls from the 30 FGM-practising countries applied for asylum in Luxembourg in 2019. Of these, 88 girls (73 %) originated from Eritrea and 18 (15 %) originated from Iraq. The available data are not disaggregated by first and second generations.

([79]) Ministry of Foreign and European Affairs (2021), 'Statistics and publications' (https://maee.gouvernement.lu/en/directions-du-ministere/immigration/stats-et-publications.html).

Figure 13. Asylum-seeking girls (aged 0–18 years) in Luxembourg, by age and country of origin (2019)



NB: There were no documented asylum seekers from the remaining FGM-practising countries. Data for Luxembourg are available at 1-year intervals but presented here at 5-year intervals for consistency with Denmark, Spain and Austria.
Source: Information from the Directorate of Immigration, based on the number of asylum applicants who lodged an application in 2019. See Annex 2 for detailed data.

Table 16 presents the numbers of female migrants granted asylum in Luxembourg from six FGM-practising countries. Of the 74 girls who were granted asylum in 2019, 39 (53 %) originated from Eritrea and 24 (32 %) from Iraq.

Table 16. Number of female migrants granted asylum (aged 0–18 years) by country of birth (2019)

Country of birth	Age group				Total
	0–4 years	5–9 years	10–14 years	15–18 years	
Eritrea	25	9	3	2	**39**
Iraq	15	5	4	0	**24**
Egypt	1	1	0	2	**4**
Yemen	0	0	2	2	**4**
Ethiopia	2	0	0	0	**2**
Somalia	0	0	0	1	**1**
Total	43	15	9	7	**74**

NB: There were no girls granted asylum from the remaining FGM-practising countries of origin.
Source: Information from the Directorate of Immigration, based on the number of residence permits in the category 'International protection – Refugee status' delivered during 2019. See Annex 2 for detailed data.

4.1.4. Other records collecting information on female genital mutilation

The Ministry of Justice provides information on the number of prosecutions for FGM. This information shows that there have been no prosecutions for FGM committed against girls aged 0–18 years in Luxembourg.

4.2. Community views of female genital mutilation

4.2.1. Overview of the focus group discussions

Four focus group discussions were held in Luxembourg between 28 September and 10 October 2020, with a total of 25 participants. There were between 3 and 10 participants in each group, drawn from the four target groups outlined in the methodology (see Annex 2).

Most of the 25 focus group participants were from Eritrea (14). Other participants originated from Guinea-Bissau (9), Guinea Conakry (1) and Senegal (1). Various ethnic groups from these countries were represented.

Table 17. Focus group participants – Luxembourg

Information	Focus group 1	Focus group 2	Focus group 3	Focus group 4
Number of participants	5	10	3	7
Countries represented	Eritrea (5)	Eritrea (9) Guinea (1)	Guinea-Bissau (3)	Guinea-Bissau (6) Senegal (1)
Sex of participants	Male	Female	Male	Female
Age range	22–50 years	25–45 years	35–52 years	25–60 years
Generation	First	First	First	First
Religion	Christian (5)	Christian (9) Muslim (1)	Muslim (3)	Christian (1) Muslim (6)

NB: Table A3 in Section A2.4 outlines the demographic profiles of the focus group participants.

4.2.2. Identity and attitudes to female genital mutilation

Participants in all four focus groups agreed that the **practice and importance of FGM had gradually decreased in recent decades**. It had evolved from a systematic and obligatory practice to something more sporadic in their countries of origin, and was now believed to be performed more in rural and isolated areas than in urban areas. There was some disagreement about the reasons behind the practice, but most participants in all focus groups agreed that FGM was **more of a cultural issue than a religious issue**. Participants agreed that the practice was being abandoned as a result of more information and education on its consequences (particularly health concerns) and because it was illegal. Eritrean men mentioned that the Eritrean Army had played a significant role in diminishing the importance of the practice by taking a strong stance against it.

Both women and men in the focus groups believed that **having undergone FGM did not affect women's marriage prospects**. However, some women commented that virginity was still seen as important and a man might appreciate that a woman had been 'closed' as a symbol of this. The men explained that they would not want their women or daughters to undergo FGM because of the likelihood of pain and health problems. No blame was attached to women who had undergone FGM as children, and the men did not believe that a woman would be ashamed if she had been cut. However, some **women expressed feelings of shame when FGM was found** (e.g. in hospital) and at being unable to experience sexual pleasure. The men from Guinea-Bissau stated that they believed FGM was a traumatic experience for a woman that could be very difficult to talk about and necessitated psychological support.

Generational differences were evident, with some older participants maintaining that FGM had positive aspects and refusing to acknowledge any related health problems, and younger participants disagreeing.

4.2.3. Perceptions of the risk of female genital mutilation in the host country and beyond

Participants from all countries agreed that FGM was **not performed on girls living in Europe**. The participants agreed that there was no family pressure to perform FGM on their daughters, because they lived in Europe and it was widely known that it was banned there. None of the participants knew of anyone who had performed FGM on their daughters since living in Europe. A few participants mentioned that going back to the country of origin might change the situation, and there could be a risk of FGM when going back.

4.2.4. Knowledge of female genital mutilation legislation and services among migrant communities

Participants in all focus groups were aware that FGM was illegal in their countries of origin and in Luxembourg but were not always aware of extraterritorial jurisdiction in Luxembourg law.

The participants generally agreed that the health system in Luxembourg was very good and accessible but were unaware – and **had never been informed – of specific services** (e.g. reconstructive surgery) **available to women who had undergone FGM and who experienced related difficulties**. The women from Guinea-Bissau, who had been in the country longer than the Eritrean women, stated that they shared information informally among themselves about 'good' gynaecologists and doctors. Both women and men agreed that **information on such interventions and their accessibility was very important**.

4.2.5. Key risk factors for female genital mutilation

According to **most participants, there was no risk of anyone from their communities in Luxembourg performing FGM** on their daughters, because it was illegal and punishable in Europe.

Participants from Eritrea claimed that they would not perform FGM on their daughters even if they still lived in their country of origin and would certainly not do it in Europe. Some, however, were unsure and thought it **possible that very traditional or very religious people might go back to their country of origin to do it**, although they did not know any such people personally.

4.2.6. Key figures and decision-making

There was agreement among participants from all four focus groups that the **decision to carry out FGM on a girl was determined by women**. Nevertheless, some participants noted that family roles were changing and decisions were being shared more nowadays, and that it was important for fathers to refuse FGM for their daughters.

All participants agreed that, even if a father opposed FGM, the women would proceed if they had decided to do it and that this decision was made when the girl was born. Fathers do not intervene or even talk about FGM in certain cultures, or they may not even be aware that their daughter has undergone FGM.

4.3. Estimation of the number of girls at risk of female genital mutilation

4.3.1. Estimation of the number of girls at risk in the regular migrant population

In 2019, the number of girls (aged 0–18 years) at risk of FGM in Luxembourg was 136 (17 % of girls originating from FGM-practising countries) in the high-risk scenario and 102 (12 %) in the low-risk scenario.

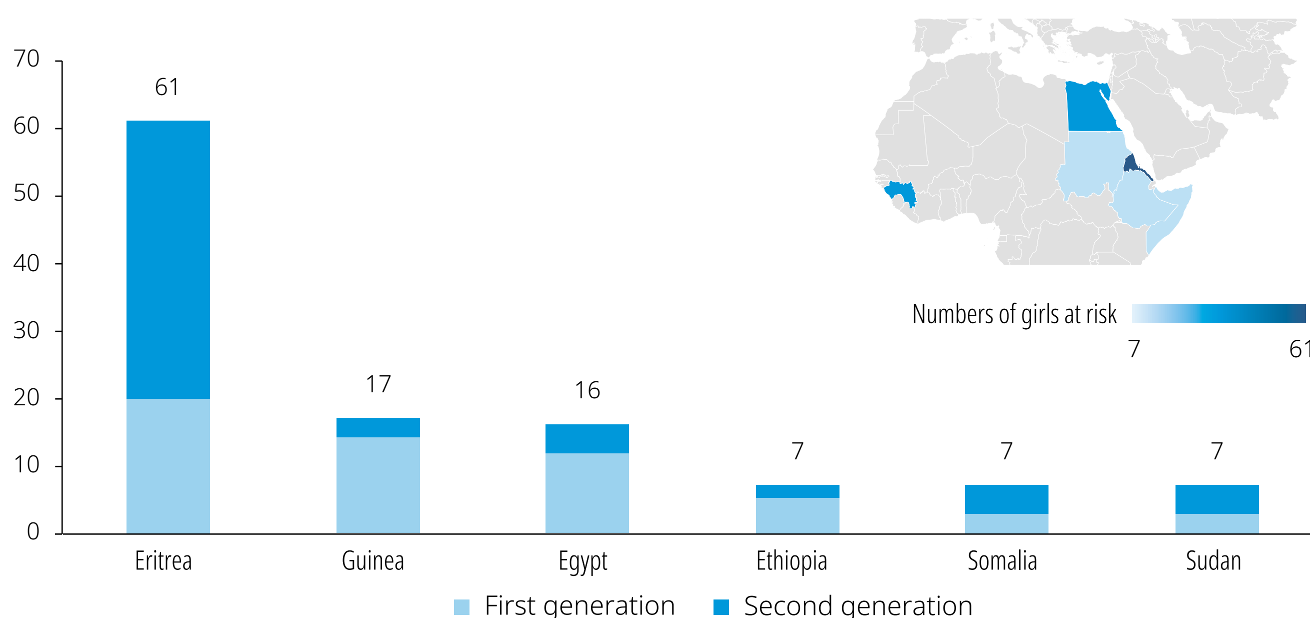
Table 18. Estimated number and percentage of girls (aged 0–18 years) living in Luxembourg who are at risk of FGM by high-risk and low-risk scenarios (2019)

	First generation	Second generation	Total
Number of girls (aged 0–18 years) originating from FGM-practising countries	621	201	**822**
Number (%) of girls at risk: high-risk scenario	71 (11 %)	65 (32 %)	**136 (17 %)**
Number (%) of girls at risk: low-risk scenario		31 (15 %)	**102 (12 %)**

NB: The estimates for first-generation girls at risk of FGM are the same in both the high-risk scenario and the low-risk scenario. In both scenarios, it is assumed that the process of migration and acculturation has had no effect on FGM prevalence. For second-generation girls, it is assumed that the process of migration and acculturation has had an effect on FGM prevalence, and this is reflected in the low-risk scenario estimates. See Annex 2 for detailed data.

In both scenarios, 11 % of first-generation girls were at risk. For second-generation girls, 32 % were at risk in the high-risk scenario and 15 % were at risk in the low-risk scenario.

Figure 14. High-risk scenario: estimated number of girls (aged 0–18 years) living in Luxembourg at risk of FGM, by generation and most-represented countries of origin (2019)

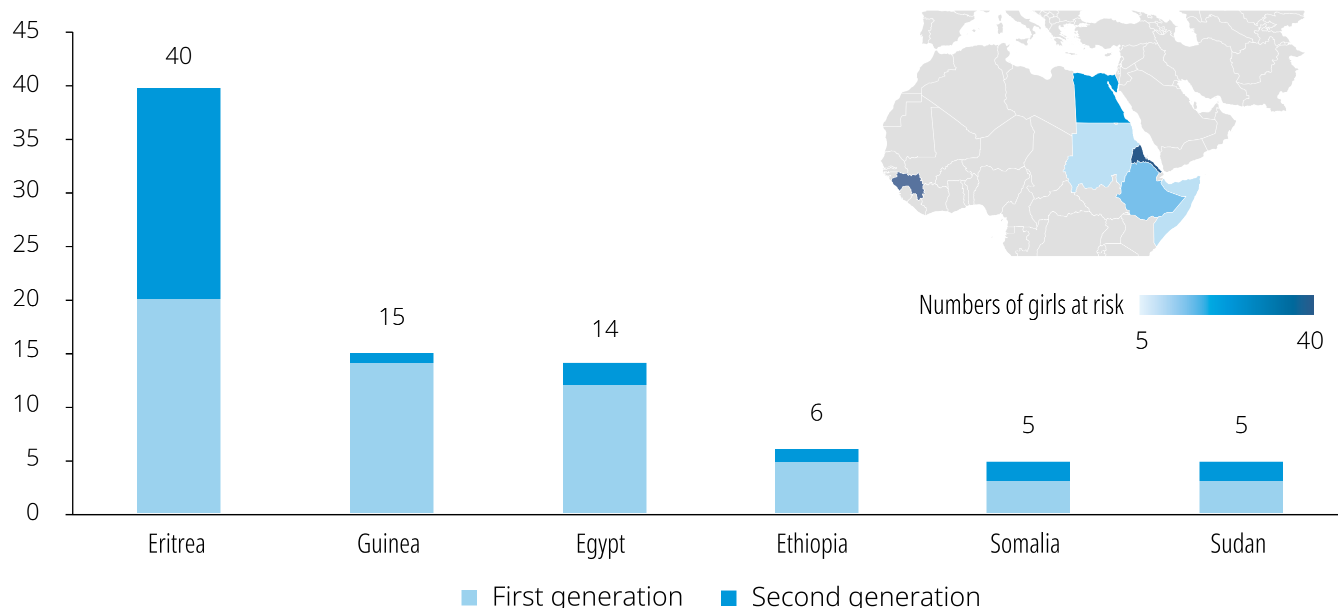


NB: Only the top six most-represented countries of origin are presented here, as there is a four-way tie for the seventh most-represented country. There were three girls estimated to be at risk from each of Côte d'Ivoire, Guinea-Bissau, Iraq and Senegal. See Annex 2 for detailed data.

In 2019, the largest number of girls at risk (in the high-risk scenario) originated from Eritrea, with 20 girls and 41 girls from the first-generation group and the second-generation group, respectively. This was followed by girls from Guinea and Egypt. Smaller groups of girls at risk originated from Ethiopia, Somalia and Sudan.

There is a smaller difference between the high-risk and low-risk scenarios for Luxembourg than for the other countries in the study (see Figure 15 for an illustration of the low-risk scenario).

Figure 15. Low-risk scenario: estimated number of girls (aged 0–18 years) living in Luxembourg, at risk of FGM, by generation and most-represented countries of origin (2019)



NB: See Annex 2 for detailed data.

4.3.2. Estimation of the number of asylum-seeking and refugee girls at risk

A higher proportion of refugee girls (28 %) than asylum-seeking girls (19 %) were at risk of FGM, although both groups were at a higher risk than the general group of girls (aged 0–18 years) originating from FGM-practising countries (17 %).

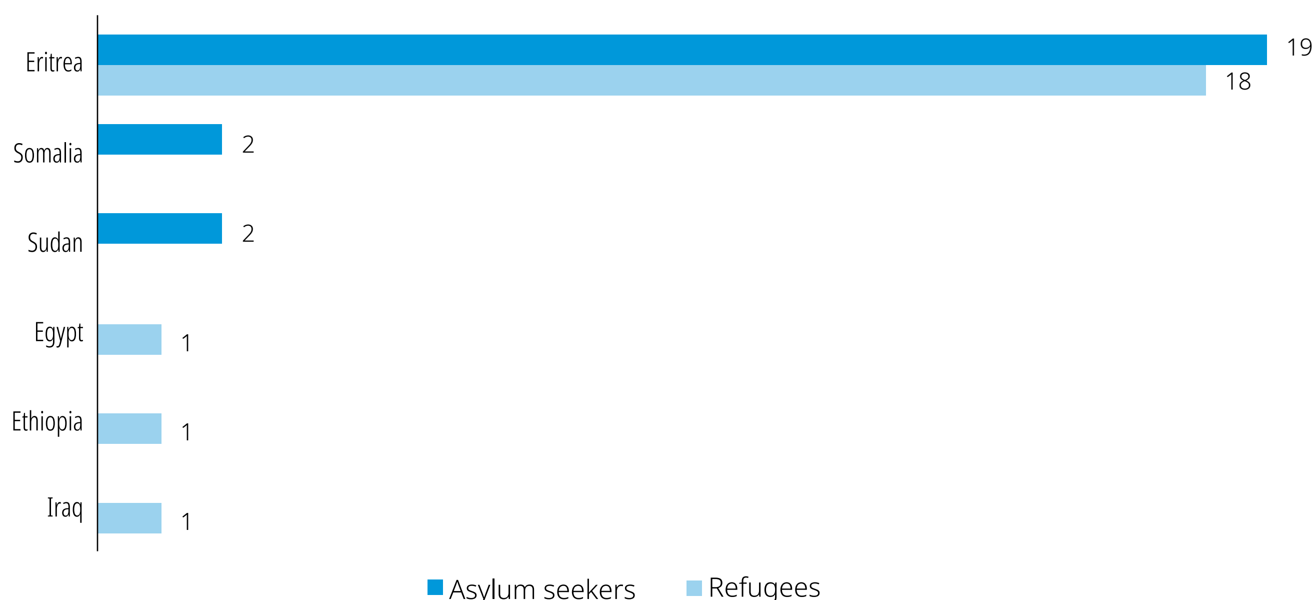
Table 19. Estimated number of asylum-seeking girls and refugee girls (aged 0–18 years) who are at risk of FGM (*) (2019)

Group	Number of girls (aged 0–18 years) originating from FGM-practising countries	Number (%) of girls at risk: high-risk scenario
Asylum seekers	121	23 (19 %)
Refugees	74	21 (28 %)

(*) Only a high-risk scenario is possible.
NB: See Annex 2 for detailed data.

The majority of asylum-seeking and refugee girls in Luxembourg at risk of FGM in 2019 originated from Eritrea, with a minority originating from five other countries of origin: Somalia, Sudan, Egypt, Ethiopia and Iraq. Similarly to the pattern for all girls (aged 0–18 years) living in Luxembourg who were at risk of FGM, Eritrea was most represented among asylum-seeking and refugee girls at risk in 2019. However, for the remaining countries of origin in the 'regular' migrant population, the number of girls at risk was significantly higher than the number of asylum-seeking and refugee girls at risk.

Figure 16. Estimated number of asylum-seeking and refugee girls (aged 0–18 years) living in Luxembourg, at risk of FGM, by most-represented countries of origin (2019)



NB: Only the high-risk scenario / first-generation calculation is possible for asylum seekers and refugees, as they are all foreign born. There were no asylum-seeking or refugee girls at risk from the other FGM-practising countries of origin. Data on asylum-seeking and refugee girls are not stocks but flows (i.e. the number of girls who lodged asylum applications or received permits in 2019). See Annex 2 for detailed data.

4.4. Tackling female genital mutilation: effective measures and challenges

Luxembourg's **legal framework** has explicitly prohibited FGM since 2008. The principle of extraterritoriality is also applied in its Criminal Code. The Law of 20 July 2018 implementing the Istanbul Convention ([80]) introduced Article 409*bis* into the Penal Code, which states that 'anyone who practises, facilitates or promotes the excision, infibulation or any other mutilation of all or part of the labia majora, labia minora or clitoris of a woman, with or without her consent, shall be punished by imprisonment for three to five years and a fine of EUR 500 to EUR 10 000' ([81]). This specific reference to FGM is in contrast to the previous Article 400 of the Penal Code, which related to the mutilation of any body part.

Luxembourg has child protection provisions in place with respect to FGM. The Law of 16 December 2008 on **child and family assistance** ([82]) sets out that the state, municipalities and assistance providers are obliged to ensure respect for the principles of dignity, value of the human person, non-discrimination and equal rights, particularly with regard to gender, race, and physical and mental resources. The law expressly prohibits all forms of physical and **sexual violence, inhuman and degrading treatment, and genital mutilation**.

Asylum provisions for reception conditions explicitly recognise victims of FGM. The Law of 18 December 2015 on international protec-

([80]) Law of 20 July 2018 approving the Council of Europe Convention on preventing and combating violence against women and domestic violence (http://legilux.public.lu/eli/etat/leg/loi/2018/07/20/a631/jo).
([81]) The modified law strengthened several articles of the Criminal Code prohibiting certain acts of violence, including deliberate assault or battery, by introducing aggravating circumstances and higher penalties (http://legilux.public.lu/eli/etat/leg/loi/2003/09/08/n1/jo).
([82]) http://legilux.public.lu/eli/etat/leg/loi/2008/12/16/n4/jo

tion and temporary protection ([83]) sets forth, in article 53(3), that 'account shall be taken of the specific situation of vulnerable persons', without making any specific reference to FGM. Furthermore, Article 15 of the Law of 18 December 2015 on international protection and temporary protection ([84]) sets out that 'the Director shall take into account the special reception needs of vulnerable persons … in particular **victims of female genital mutilation'**. However, one interviewee stated that, although victims of FGM are mentioned in the Law of 18 December 2015 as vulnerable persons, in practice this only means that the specific needs of asylum seekers must be taken into account during the asylum procedure and that asylum seekers must receive adequate assistance and support, including medical services. According to the interviewee, FGM-related concerns do not necessarily affect decisions on asylum seekers' applications for international protection.

Despite the legal framework in place, the concrete impact on the relevant migrant communities is unknown. One interviewee believed that there was very little case-law on this matter, given the difficulty of instituting legal proceedings against families. Similarly, another interviewee stated that no statistical data were collected in Luxembourg on the reasons given by asylum seekers, and the Directorate of Immigration did not disclose the basis on which international protection was granted to asylum seekers.

There appears to be **no clear or explicit government policy to tackle FGM in Luxembourg**. The Ministry of Equality between Women and Men (*Ministère de l'Egalité pour les Femmes et les Hommes* (MEGA)) published its new national action plan for equality between women and men in September 2020. Although the previous action plan (2015–2018) mentioned FGM in the context of the fight against violence against women, particularly the government's ratification of the Istanbul Convention, the new action plan makes no specific mention of FGM. Likewise, the national plan to promote emotional and sexual health contains measures and actions to prevent and combat sexual violence more broadly, yet contains only a brief mention of FGM in reference to the Law of 16 December 2008. There is a growing need for a policy framework, given the **recent increase in migrant populations** from countries in which FGM is prevalent.

Very little is known about the **social and health services** for women and girls subjected to FGM, or access to such services. The interview and focus group findings suggest that concrete services have yet to be put in place, although national actors have begun to promote the issue. Some initiatives exist to support the integration of migrant women and provide them with a safe space, but these do not explicitly focus on FGM. The interview findings suggest that these services are insufficiently known among newly arrived migrants and that further efforts are needed to coordinate and network services and promote their visibility.

Prevention efforts against FGM have been scarce, with one awareness-raising campaign having been organised by the City of Luxembourg (the country's capital) in partnership with civil society organisations ([85]). The campaign was first organised in 2011 and has since been repeated several times around the International Day against FGM (6 February). More recently, the National Reference Centre for Emotional and Sexual Health (CESAS) developed a guide on sex and sexuality for school students in Luxembourg, which mentions FGM issues. The guide was published in December 2020 and will be presented in schools by trained professionals ([86]).

The interview findings show that a lot remains to be done in Luxembourg and that **the issue**

([83]) http://legilux.public.lu/eli/etat/leg/loi/2015/12/18/n15/jo
([84]) () http://legilux.public.lu/eli/etat/leg/loi/2015/12/18/n16/jo
([85]) Organisations that contributed include *Conseil National des Femmes du Luxembourg* (CNFL), Initiativ Liewenszufank, Fondation Follerau, UN Children's Fund Luxembourg and *Programmes d'Aide et de Dévelopment Destinés aux Enfants du Monde* (PADEM).
([86]) 'Let's Talk about Sex!' can be ordered by email (letstalkaboutsex@cesas.lu).

of FGM is still quite new, as immigration from FGM-practising countries was virtually non-existent before 2015. The interviews showed a strong perception that little had been done, and more knowledge and training was needed, especially among professionals. The interviewees recognised that this responsibility was shared by various actors and thus required a joint strategy. They also observed **a lack of contact with and entry points into the relevant communities**, alongside a lack of knowledge of how to discuss potentially sensitive topics with those concerned. One interviewee noted the substantial cultural differences between the migrant communities and Luxembourgers, with time needed to sensitise the relevant communities and change mindsets. Anecdotal findings from the interviews suggest that immigration from countries in which FGM is prevalent has increased significantly in recent years, highlighting the need for strong FGM prevention efforts.

4.5. Main findings

Table 20. FGM risk in Luxembourg in 2019: summary

High-risk scenario	In 2019, 822 girls aged 0–18 years originating from FGM-practising countries (born in the country of origin or in Luxembourg; or first and second generation) were residing in Luxembourg, of whom 136 were likely to be at risk of FGM. **Proportionally, 17 % of girls aged 0–18 years originating from FGM-practising countries (born in the country of origin or in Luxembourg) were at risk of FGM.**
	In 2019, there were 121 girls seeking asylum from FGM-practising countries in Luxembourg, 23 (19 %) of whom were estimated to be at risk of FGM. In total, 74 girls received refugee status in Luxembourg in 2019, of whom 21 (28 %) were estimated to be at risk of FGM.
Low-risk scenario	In 2019, 822 girls aged 0–18 years originating from FGM-practising countries (born in the country of origin or in Luxembourg; or first and second generation) were residing in Luxembourg, 102 of whom were likely to be at risk of FGM. **Proportionally, 12 % of girls aged 0–18 years originating from FGM-practising countries (born in the country of origin or in Luxembourg) were at risk of FGM.**

- Focus group participants noted that **FGM was recognised as becoming increasingly less prevalent in their countries of origin, largely thanks to education and laws**. A few participants associated the practice with religion, with the majority asserting its cultural role and function.

- **Luxembourg criminalises FGM** in its Penal Code, and the principle of extraterritoriality applies. Although the focus group findings suggest that participants were aware that FGM had been banned by law both in their countries of origin and in Luxembourg, **participants were not always aware that the principle of extraterritoriality applied**.

- There are **FGM-specific legal provisions related to child protection and asylum reception conditions** in Luxembourg.

- However, unlike its predecessor, the new national action plan for equality between women and men does not refer to FGM specifically. Despite the legal framework, **few policies and services are in place to prevent FGM** and protect girls at risk.

4.6. Recommendations

4.6.1. Improve implementation of Luxembourg's existing law criminalising female genital mutilation

Challenge. There is a lack of awareness of the application of extraterritorial jurisdiction in Luxembourg law relating to FGM.

Proposed action. To fully implement the existing law, the Ministry of Justice, in consultation with MEGA, should carry out education campaigns and the dissemination of information to affected communities, including extraterritorial applicability. Such awareness-raising campaigns should ensure cultural and gender sensitivity, take a non-discriminatory approach, be accessible to communities and be translated into community languages.

Potential stakeholders. MEGA and the Ministry of Justice.

4.6.2. Improve data collection on and support provided to victims of female genital mutilation during the asylum procedure

Challenge. FGM-related concerns may not affect decisions on applications for international protection. Healthcare and psychological support is not systematically offered to asylum seekers and refugees. No statistical data are collected in Luxembourg on asylum seekers' reasons for their claims, and the Directorate of Immigration does not disclose the basis on which international protection is granted. This limits the monitoring of applications in which participants include risk of FGM as a reason for requesting asylum.

Proposed action. Asylum seekers and refugees should be clearly informed of the law in Luxembourg on FGM, and reception conditions should address the needs of FGM victims and women and girls at risk, for instance by ensuring the provision of necessary healthcare and psychological support. Data collection on the reasons given by asylum seekers and the basis on which international protection is granted would allow assessments of whether or not asylum decisions in Luxembourg take into consideration the risk of FGM.

Potential stakeholders. Ministry of Justice; Ministry of Health; Ministry of Foreign Affairs (asylum and immigration); MEGA; and National Reception Office (ONA).

4.6.3. Develop a national strategy on tackling female genital mutilation in Luxembourg

Challenge. Luxembourg has no explicit government policy to tackle FGM.

Proposed action. In the light of the recent increase in migrant populations from FGM-prevalent countries, such as Eritrea, a nationwide strategy is necessary to combat FGM. A working group comprising the relevant ministries, professional networks, civil society actors and community-based organisations should be created to discuss the current needs for addressing FGM in Luxembourg. Based on its findings, policymakers should develop a national strategy on FGM. The national strategy action plan should ideally be overseen by a single ministry, with adequate human and financial resources, and run for multiple years, with monitoring and evaluation delegated to an independent body. A national strategy should connect all political levels, coordinating at national, regional and municipal levels, as well as the different sectors relevant to tackling FGM. The strategy could be integrated into the existing national action plan for emotional and sexual health and could help to establish official coordination mechanisms between various ministries and key stakeholders (civil society organisations, community representatives, professionals).

Potential stakeholders. Ministry of Justice; Ministry of Health; Ministry of Education, Children and Youth; Ministry of Family Affairs and Integration; Ministry of Foreign Affairs (asylum and immigration); MEGA; and ONA. Given its recent work on guidance for school students on sex and sexuality, CESAS could play a key role in coordinating actions to tackle FGM in the long term.

4.6.4. Identify and reinforce existing services for migrant women or victims of gender-based violence and expand those services to victims of female genital mutilation in Luxembourg

Challenge. Very little is known about social and healthcare services for women and girls who are victims of FGM.

Proposed action. Existing social and healthcare services for migrant women and victims of gender-based violence should be mapped to identify gaps in services for victims of FGM. The engagement of migrant communities will be important in reinforcing existing services and addressing gaps, as well as in ensuring an adequate community referral system and network. Community outreach groups will ensure accurate assessment of service needs and dissemination of information on the existing services for migrant women or victims of FGM. Referral systems should allow for a holistic and integrated approach, linking different services (schools, social, health and legal services, etc.). Coordination with health professionals in gynaecological services of the four main hospital centres will ensure that women and girls get the right assistance and support.

Potential stakeholders. Ministry of the Interior; Ministry of Health; Ministry of Justice; Ministry of Social Affairs; medical, education and legal professionals; and civil society organisations.

4.6.5. Awareness-raising campaigns targeting recent migrant communities

Challenge. Immigration from FGM-practising countries has increased significantly in recent years, with greater numbers of women and girls affected by FGM in Luxembourg. This creates a need for stronger prevention and awareness-raising efforts targeting migrant communities.

Proposed action. Efforts to engage with migrant communities should be increased, together with adequate funding, to implement awareness-raising campaigns. These campaigns should be designed in cooperation with community members and use appropriate language and the most effective means of raising awareness in their communities. They should aim to target and engage with recent migrant communities, such as the Eritrean and Iraqi communities in Luxembourg, working with social assistants in the ONA and the Red Cross residential centres, as well as asylum seekers from the moment they arrive in Luxembourg. EIGE recommends that relevant professionals (e.g. at the ONA) discuss the criminalisation and risks of FGM with migrant communities.

Potential stakeholders. ONA and civil society organisations.

5. Female genital mutilation risk estimation in Austria

5.1. Female migrant population aged 0–18 years originating from female genital mutilation-practising countries

5.1.1. Migrant population

In 2019, there were 5 910 migrant girls (aged 0–18 years) in Austria originating from FGM-practising countries. Of these, 62 % were first generation and 38 % were second generation. Of the total number of girls aged 0–18 years, 54 % were aged 0–9 years and 46 % were aged 10–18 years. Girls aged 0–9 years were more likely to be second generation (61 %), but girls aged 10–18 years were more likely to be first generation (89 %).

Table 21. Age distribution of the female migrant population (aged 0–18 years) in Austria originating from FGM-practising countries (2019)

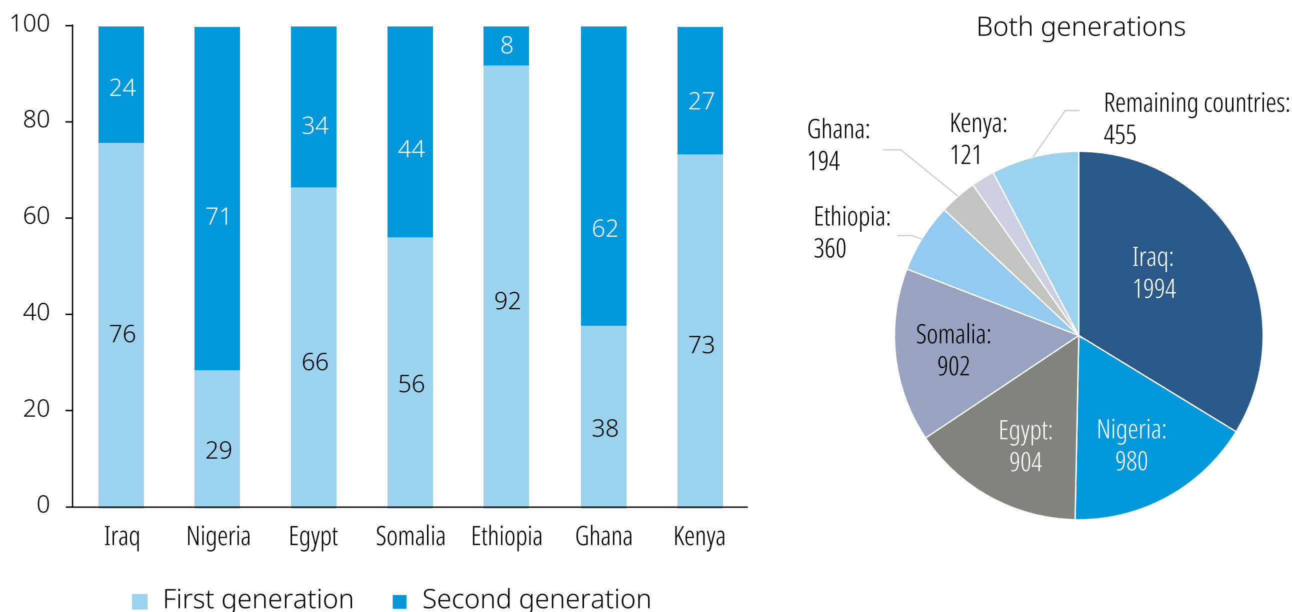
Age group	First generation	Second generation	Total (%)	Percentage first generation	Percentage second generation
0–9 years	1 238	1 945	**3 183 (54)**	39	61
10–18 years	2 429	298	**2 727 (46)**	89	11
Total	**3 667**	**2 243**	**5 910 (100)**	**62**	**38**

NB: Detailed data on the female migrant population (broken down by sex, age and generation) are available as of 1 January 2020 and are presented here. Data were taken from publicly available data from Statistics Austria. Information was extracted for female migrants aged 0–18 years with a country of origin that is among the 30 FGM-practising countries.
Source: Statistics Austria's Population Register (POPREG). See Annex 2 for detailed data.

As data on births of girls by place of birth of the mother were available only for a limited number of years, data on second-generation girls were derived from data on foreign girls born in Austria [87]. Using these data is likely to result in an underestimation: foreign girls born in Austria were compared with girls born to at least one foreign-born parent for the few years when both sets of data were available, and this comparison revealed that considering only foreign-born girls resulted in an underestimation of around 80 % (5 500–6 000) of the number of second-generation girls. Children of naturalised foreign-born parents or multi-ethnic couples are not accounted for in this estimation.

(87) In Austria, data on births by place of birth of the mother were available for a limited number of years, allowing a rough calculation of the extent of the underestimation that arises, by using data on foreign girls born in the Member State. This was done by comparing data on foreign girls born in Austria with data on girls born from at least one foreign-born parent for the few years when both sets of data were available.

Figure 17. Number and percentage of girls (aged 0–18 years) living in Austria, by generation and seven most-represented countries of origin (2019)



NB: From left to right, the countries are presented in descending order of the size of their communities (with Iraq having the largest and Kenya the smallest). However, they are shown on the same scale to enable percentage comparisons by generation.
Source: Statistics Austria's Population Register (POPREG). See Annex 2 for detailed data.

Information on the region of origin within the country of origin of the girls (or their mothers) is unavailable. There may be a high risk of bias when applying national prevalence rates to migrant populations living in Austria from countries with large regional variations in their prevalence rates.

The seven FGM-practising countries most represented in terms of first- and second-generation girls in 2019 were Iraq (representing 33.7 % of the total population of girls in Austria aged 0–18 years originating from an FGM-practising country), Nigeria (16.6 %), Egypt (15.3 %), Somalia (15.3 %), Ethiopia (6.1 %), Ghana (3.3 %) and Kenya (2.0 %). The remaining countries of origin all represented 7.7 % or less.

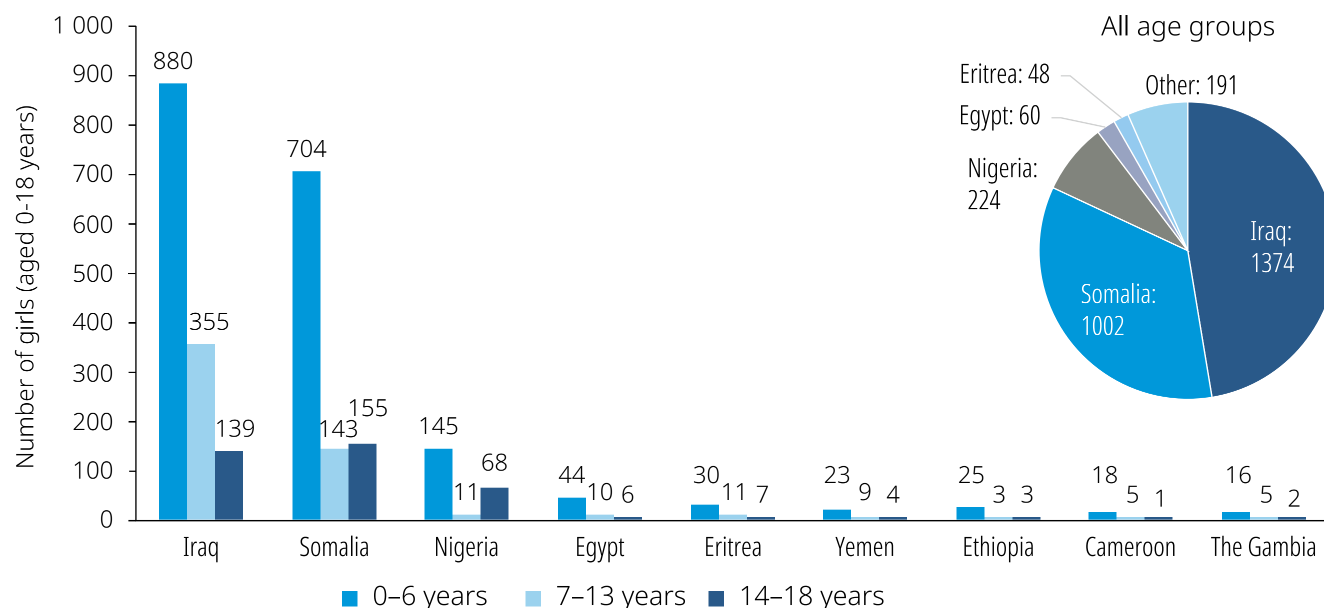
5.1.2. Irregular migration

No official data are available on the number of irregular migrants living in Austria.

5.1.3. Asylum seekers and refugees

Data from the Federal Ministry of the Interior's central registry of foreign nationals provides information on female asylum seekers aged 0–18 years in Austria, disaggregated by age and citizenship. These data count first and multiple applications, including children of applicants, from 2016 until the end of the first half of 2020.

Figure 18. Asylum-seeking girls (aged 0–18 years) in Austria, by age and citizenship (2016 to 30 June 2020)



NB: The countries included in 'Other' are (in numerical order) Yemen, Ethiopia, Cameroon, The Gambia, Sudan, Guinea, Côte d'Ivoire, Kenya, Sierra Leone, Ghana, Uganda, Benin, Togo, Mali, Burkina Faso, Central African Republic, Guinea-Bissau and Tanzania.
Source: Federal Ministry of the Interior central registry of foreign nationals (2020). In order to include only girls aged up to 18 years, the number of girls in the range 15–18 years was approximated proportionally from data provided on girls aged 15–19 years. See Annex 2 for detailed data.

From 2016 to 30 June 2020, most asylum-seeking girls aged 0–18 years originated from Iraq (1 374), Somalia (1 002) and Nigeria (224). In total, approximately 90 % of asylum-seeking girls in Austria originated from these three countries. Approximately 10 % of asylum-seeking girls aged 0–18 years in Austria originated from Egypt (2.1 %), Eritrea (1.7 %), Yemen (1.2 %), Ethiopia (1.1 %), Cameroon (0.8 %), The Gambia (0.8 %) and other countries [88]. There were no official data identified on the numbers of refugees or people granted asylum living in Austria.

5.1.4. Other records collecting information on female genital mutilation

Information on asylum cases processed in the Federal Administrative Court in Austria is available online. These data show that, to date, there have been 509 cases in the asylum court that mention FGM explicitly [89]. In some of these cases, FGM was a reason for granting asylum or a right to residence.

5.2. Community views of female genital mutilation

5.2.1. Overview of the focus group discussions

Four focus group discussions were held in Austria in October 2020, with a total of 35 participants. There were between 6 and 11 participants in each group, drawn from the four target groups outlined in the methodology (see Annex 2).

Most of the 35 focus group participants were from Egypt (26), with the remainder from Sudan (9).

[88] Including (in numerical order) Sudan, Guinea, Côte d'Ivoire, Kenya, Sierra Leone, Ghana, Uganda, Benin, Togo, Mali, Burkina Faso, Central African Republic, Guinea-Bissau and Tanzania.
[89] FGM-related cases that are granted asylum in the first instance are not made public. Federal Ministry for Digital and Economic Affairs (*Bundesministerium für Digitalisierung und Wirtschaftsstandort*) (2020), 'Austrian Legal Information System' (https://www.ris.bka.gv.at/Ergebnis.wxe?Suchworte=fgm %23&x=0&y=0&Abfrage=Gesamtabfrage).

Table 22. Focus group participants – Austria

Information	Focus group 1	Focus group 2	Focus group 3	Focus group 4
Number of participants	9	11	6	9
Countries represented	Egypt (9)	Egypt (11)	Egypt (6)	Sudan (9)
Sex of participants	Female	Female	Male	Female
Age range	26–57 years	18–24 years	18–60 years	32–57 years
Generation	First	Second	First and second	First
Religion	Muslim (9)	Muslim (11)	Muslim (6)	Muslim (9)

NB: A2.4 Table A4 outlines the demographic profiles of the focus group participants.

5.2.2. Identity and attitudes to female genital mutilation

All participants across the focus groups stated that **FGM was something that was done in the past** and mostly continued in rural areas, among less-educated people. Second-generation Egyptian participants had the clearest standpoint against FGM, connecting it with pain and inequality. First-generation women from Sudan had themselves experienced severe health issues and thus held strong opinions against FGM. First-generation women from Egypt were more ambivalent, with several having at least one daughter who had undergone FGM. This was similar to the standpoint of the Egyptian men, who had an ambivalent and partly favourable attitude to FGM.

Men in the focus groups tended to be more conservative and felt the need to uphold traditions that clash with the beliefs of the society in their country of residence. Sudanese women, for example, argued that, even though some men in their community questioned FGM, many men wanted to continue the practice.

Some Egyptian male participants argued that the fight against FGM in Austria was part of more general Islamophobia in Western society. They felt that Western society had **numerous prejudices about violence against women in Muslim societies** and a tendency to interfere in the affairs of Muslim people without knowing the needs of Muslim communities.

FGM was given a certain **sociocultural importance by all participants in terms of marriageability and control of sexuality**. Virginity was generally considered highly important in both Egyptian and Sudanese society, and FGM was seen as a 'protective measure' for upholding this ideal. Only some of the young second-generation women from Egypt questioned that social ideal.

5.2.3. Perceptions of the risk of female genital mutilation in the host country and beyond

Most participants in all focus groups believed that at least **some people in their communities in Europe had practised FGM** and, indeed, had travelled to their countries of origin for that purpose.

Participants agreed that women and girls who had not undergone FGM might be viewed negatively in Egyptian and Sudanese societies, especially in their countries of origin. Egyptian women with children, Sudanese women and Egyptian men all mentioned social pressure from family members in their home countries to have their daughters undergo FGM.

5.2.4. Knowledge of female genital mutilation legislation and services among migrant communities

Participants in all four focus groups were **generally aware of the existence of a law against FGM in Austria**, or at least assumed that there might be one. However, some were not aware that there was a law in Austria or in their country of origin. All participants were generally aware of organisations working against FGM in Austria.

Some participants argued that Austrians made a career of working against FGM, when it should be a job for community members. Such **community responsibility for awareness-raising campaigns would improve outcomes**, as it would be more widely accepted, especially by male community members.

All female participants reported **discrimination in the health sector** that reflected the discrimination some of them experience in daily life (due to wearing a hijab, etc.). Except in specialised clinics, these participants stated that they felt belittled by doctors at times, that they were not taken seriously or that they were even used to showcase FGM.

5.2.5. Key risk factors for female genital mutilation

One of the **central risks was the medicalisation of FGM in Egypt and the assumption that negative health consequences would be avoided if FGM was performed in a 'safe way'**. Generally, Egyptian participants in the first and third focus groups considered FGM riskier (in terms of health consequences) when done by traditional midwives but safe when performed by doctors.

5.2.6. Key figures and decision-making

Participants described **social pressure from their families in their countries of origin**, with a husband's female relatives playing a significant role in decision-making about FGM. However, both women and men considered men the most important decision-makers on FGM, as they held the power position in the family.

First-generation **women from Egypt reported that it was the decision of doctors** (who were considered the best and safest providers of FGM in Egypt) whether or not a girl 'needed' FGM. 'Needing FGM' appeared to relate to either masculine traits or childhood masturbation.

A middle-aged Sudanese woman mentioned that grandmothers could continue to push for FGM. She considered it necessary to 'be like our daughters, who are totally against it'. Sudanese women also stressed that it would help to focus on the men in the community, who are the decision-makers and need to learn about the dire consequences of FGM for women.

5.3. Estimation of the number of girls at risk of female genital mutilation

5.3.1. Estimation of the number of girls at risk in the regular migrant population

In 2019, the number of girls aged 0–18 years at risk of FGM in Austria was 1 083 (18 % of girls originating from FGM-practising countries) in the high-risk scenario and 735 (12 %) in the low-risk scenario.

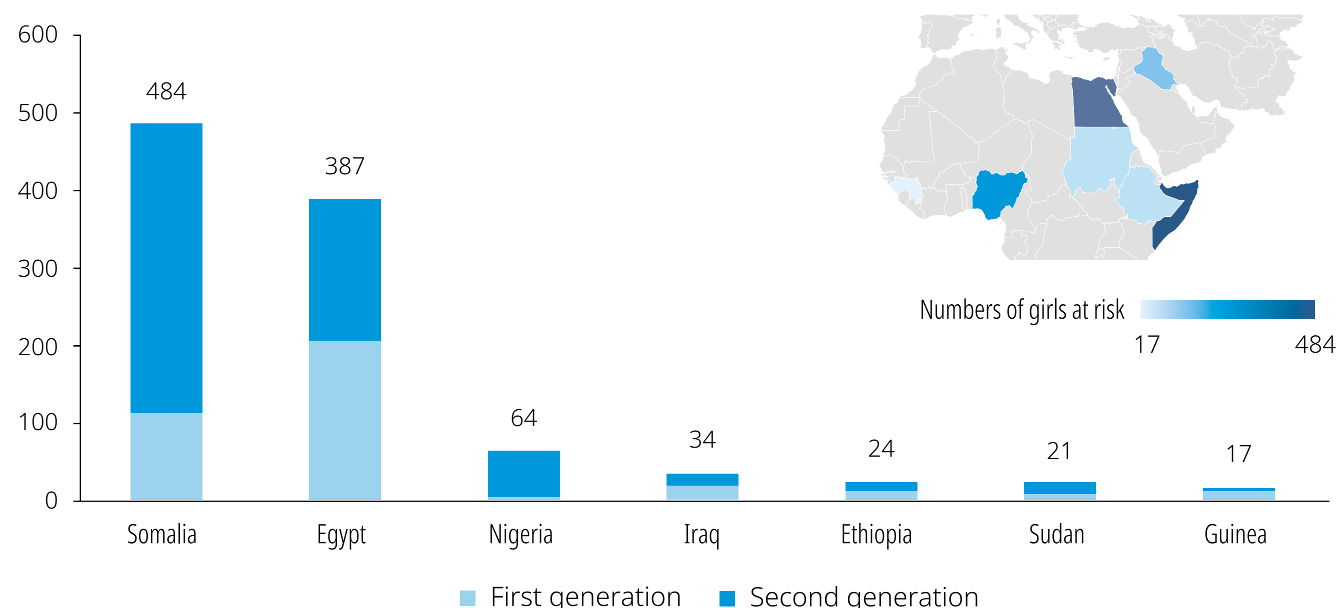
Table 23. Estimated number and percentage of girls (aged 0–18 years) living in Austria who are at risk of FGM by high-risk and low-risk scenarios (2019)

<table>
<tr><th></th><th>First generation</th><th>Second generation</th><th>Total</th></tr>
<tr><td>Number of girls (aged 0–18 years) originating from FGM countries</td><td>3 667</td><td>2 243</td><td>5 910</td></tr>
<tr><td>Number (%) of girls at risk: high-risk scenario</td><td rowspan="2">391 (11 %)</td><td>692 (31 %)</td><td>1 083 (18 %)</td></tr>
<tr><td>Number (%) of girls at risk: low-risk scenario</td><td>344 (15 %)</td><td>735 (12 %)</td></tr>
</table>

NB: See Annex 2 for detailed data. The estimates for first-generation girls at risk of FGM are the same in both the high-risk scenario and the low-risk scenario. In both scenarios, it is assumed that the process of migration and acculturation has had no effect on FGM prevalence. For second-generation girls, it is assumed that the process of migration and acculturation has had an effect on FGM prevalence, and this is reflected in the low-risk scenario estimates.

In both scenarios, 11 % of first-generation girls were at risk. For second-generation girls, 31 % were at risk in the high-risk scenario and 15 % in the low-risk scenario.

Figure 19. High-risk scenario: estimated number of girls (aged 0–18 years) living in Austria, at risk of FGM, by generation and most-represented countries of origin (2019)

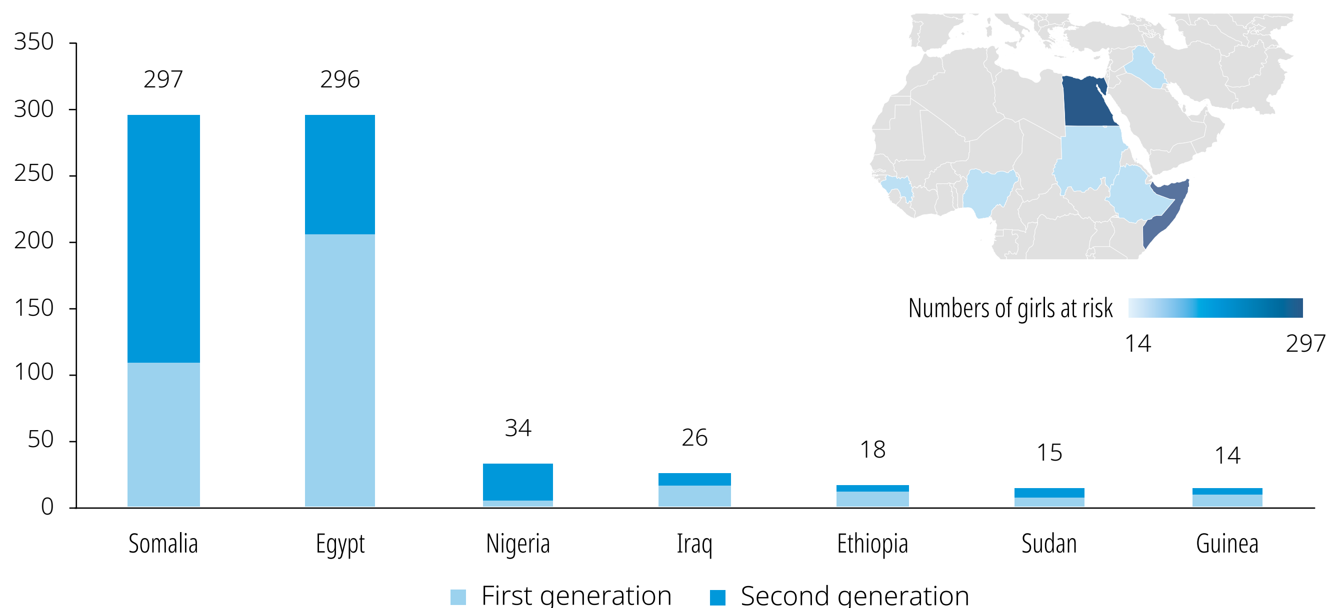


NB: See Annex 2 for detailed data.

In 2019, the largest number of girls at risk (in the high-risk scenario) originated from Somalia, with 374 girls and 110 girls from the first-generation group and the second-generation group, respectively. This was followed by girls from Egypt. Smaller groups of girls at risk originated from Nigeria, Iraq, Ethiopia, Sudan and Guinea.

Countries of origin with a high prevalence and a large number of second-generation girls drive differences between low-risk and high-risk scenarios. In the case of Austria, the difference between the estimated overall prevalence in the high-risk and low-risk scenarios is largely driven by the Somali and Egyptian second-generation girls (see Figure 19 and Figure 20).

Figure 20. Low-risk scenario: estimated number of girls (aged 0–18 years) living in Austria, at risk of FGM, by generation and most-represented countries of origin (2019)



NB: See Annex 2 for detailed data.

5.3.2. Estimation of the number of asylum-seeking girls at risk

In Austria, 2 899 asylum-seeking girls aged 0–18 years originated from countries that practice FGM, and 31 % (907) of asylum-seeking girls were at risk of FGM.

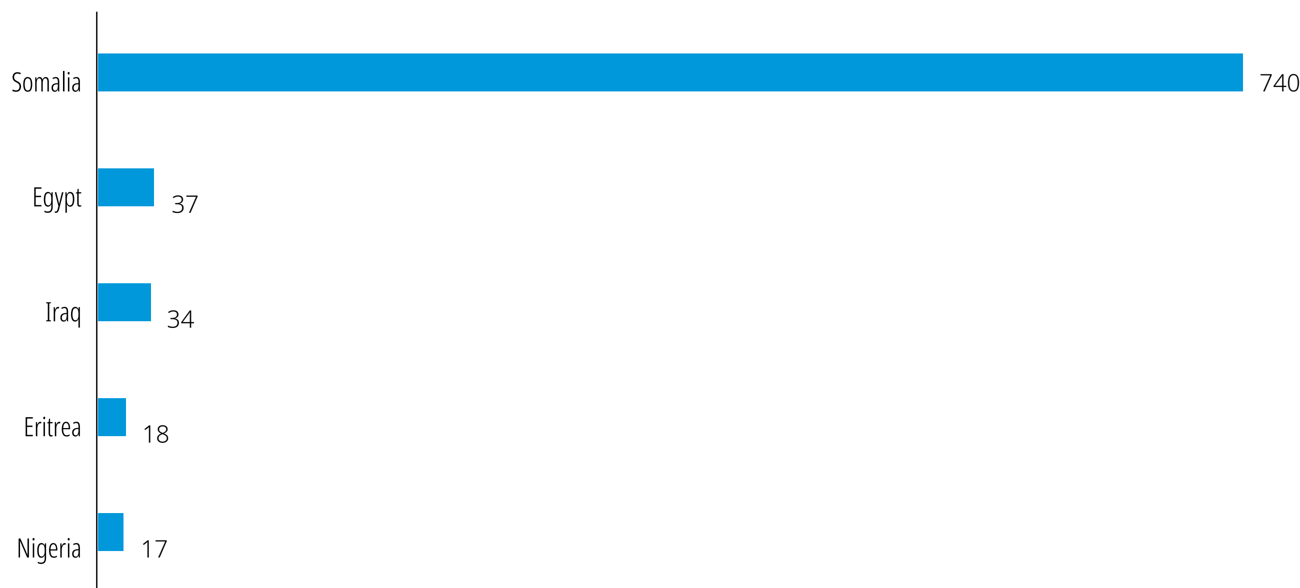
Asylum-seeking girls in Austria at risk of FGM originated from Somalia, Egypt, Iraq, Eritrea and Nigeria.

Table 24. Estimated number of asylum-seeking girls (aged 0–18 years) who are at risk of FGM (*) (2016 to 30 June 2020)

Group	Number of girls (aged 0–18 years) originating from FGM-practising countries	Number (%) of girls at risk: high-risk scenario
Asylum seekers	2 899	907 (31 %)

(*) Only a high-risk scenario is possible.
NB: See Annex 2 for detailed data.

Figure 21. Estimated number of asylum-seeking girls (aged 0–18 years) in Austria, at risk of FGM, by most-represented countries of origin (2016 to 30 June 2020)



NB: Only the high-risk scenario / first-generation calculation is possible for asylum seekers, as they are all foreign born. There were no asylum-seeking girls at risk from the remaining countries of origin. See Annex 2 for detailed data.

5.4. Tackling female genital mutilation: effective measures and challenges

Since 2001, the Penal Code has explicitly stated that no exemption from punishment can be obtained by consenting to genital mutilation. The principle of extraterritoriality is also applied, meaning that it is possible to prosecute individuals for crimes committed abroad. Following amendments in 2020, the Austrian Penal Code now states that a person cannot agree to genital mutilation and that carrying out FGM on others can be penalised with up to 10 years' imprisonment. **Recent amendments to the Physicians Law** came into effect in October 2019 and clarify that medical doctors are, in general, obliged to report a crime of bodily harm caused by an illegal act. The **National Children and Youth Services Law was amended in 2020** and states that, if the suspicion arises that a child whose mother is a victim of FGM is also in danger of undergoing FGM, the health institutions must immediately notify the local child and youth welfare office in writing ([90]). According to the interviews, this amendment to the youth welfare legislation is positive in that it now acknowledges that a mother with FGM increases the FGM risk to the child. Interviewees noted, however, that this law is insufficient, as there is a **lack of properly trained people to implement the law appropriately**. From 2020, FGM is also explicitly named as a separate qualifying offence of bodily harm with serious long-term consequences.

In Austria, only the five grounds of persecution outlined in the Geneva Convention (persecution based on race, religion, nationality, membership of a particular social group or political opinion) are recognised as **grounds for asylum**. In some cases, FGM was found to be a reason for granting asylum or subsidiary protection. The interviews suggested that there should be sensitivity training for clerks working on asylum cases featuring FGM.

In the stakeholder interviews, participants spoke about how **health-counselling centres provided services and wrote reports for asylum-seeking women**. Typically, it is social workers from refugee NGOs who refer women to health-counselling cen-

([90]) Section 1a of § 37 of the National Children and Youth Services Law (https://www.ris.bka.gv.at/Dokumente/Bundesnormen/NOR40218041/NOR40218041.pdf).

tres after highlighting the negative consequences of FGM. The women are then examined in one of the FGM clinics of the centres and informed about relevant medical procedures, including deinfibulation and reconstructive surgery. Afterwards, they need to be protected and cannot be returned to their home country. Participants in the stakeholder interviews said that the process of supporting asylum-seeking women affected by FGM could be simplified if asylum authorities raised the issue of FGM earlier. Interview participants suggested that training professionals working on asylum cases could increase their sensitivity to FGM. This would complement existing training of employees in the asylum authorities, which has increased knowledge of FGM.

The Viennese Women's Health Centre, FEM Süd, is the **first health-counselling body** in Austria targeting women from countries where FGM is prevalent. Vienna has three FGM clinics in hospitals: Medical Centre Ottakring, Vienna General Hospital and Medical Centre Landstraße. There is also an FGM clinic in the University Clinic Innsbruck (Tyrol).

The most recent **action plan, *Women's Health – 40 measures for the health of women in Austria*** ([91]), entered into force in 2017. Although the action plan does not explicitly mention FGM, it contains measures for violence prevention (among other areas) and for specific issues relevant to women with migrant backgrounds. Since January 2020, the **Directorate-General for Women and Equality and the Directorate-General for Integration** have been under the responsibility of the Ministry for Women and Integration at the Federal Chancellery. The work of both directorates-general is cross-cutting and complementary in relation to the issue of harmful traditional practices, including FGM.

The establishment of an **Austria-wide advisory structure for victims of FGM** (Austrian Red Cross and FEM Süd) is an important recent measure to combat and eliminate FGM in Austria. The advisory structure provides that contact points should be established in all nine federal provinces in Austria for women or girls affected by violence and who need support and advice. In early 2020, the Viennese programme for women's health published an online training programme on FGM for teachers and other educators, to ensure that they are better prepared to support girls in school settings in this respect ([92]).

Relevant women's organisations, other civil society organisations and health centres providing counselling, education and training, and sexual and reproductive health education to combat FGM include the African Women's Organisation in Austria, Bright Future, the Stop FGM platform, Aktion Regen, Diakonie, Caritas and the Austrian Red Cross.

A key challenge in Austria is the **funding of FGM projects** to improve their effectiveness. The Ministry for Women and Integration states that the budget for women's affairs and gender equality has been substantially increased in the past 3 years (by 43 % until 2021). However, the interview findings suggest that more sustainable funding would allow long-term continuous projects rather than short, expensive ones. In addition, the budget for women's affairs remains too low, following cuts in previous years. Working with these women requires more financial and human resources, as it **takes time and understanding to successfully reach the target population**. Counselling cannot be a one-off event but should rather provide constant personal contact and support. Services need to be easily accessible and adjusted to these women's needs, so that they feel comfortable attending relevant appointments and meetings.

Experts suggest that the **legislature needs to be (better) coordinated** with the affected communities and include their perspectives, with the community ideally providing suggestions as part of the legislation process.

([91]) Federal Ministry of Social Affairs, Health, Care and Consumer Protection (*Bundesministerium für Arbeit, Soziales, Gesundheit und Konsumentenschutz*) (2017), *Women's Health – 40 measures for the health of women in Austria*, Federal Ministry of Social Affairs, Health, Care and Consumer Protection, Vienna (https://www.sozialministerium.at/dam/jcr:9334268b-5282-4444-855e-e62391561895/aktionsplan_frauengesundheit.pdf).

([92]) https://stadtwienfgm.clickandlearn.at/Modul1/

5.5. Main findings

Table 25. FGM risk in Austria in 2019: summary

High-risk scenario	In 2019, 5 910 girls aged 0–18 years originating from FGM-practising countries (born in the country of origin or in Austria; or first and second generation) were residing in Austria, 1 083 of whom were likely to be at risk of FGM. **Proportionally, 18 % of girls aged 0–18 years originating from FGM-practising countries (born in the country of origin or in Austria) were at risk of FGM.**
	In 2019, there were 2 899 girls seeking asylum from FGM-practising countries in Austria, of whom 907 (31 %) were estimated to be at risk of FGM.
Low-risk scenario	In 2019, 5 910 girls aged 0–18 years originating from FGM-practising countries (born in the country of origin or in Austria; or first and second generation) were residing in Austria, 735 of whom were likely to be at risk of FGM. **Proportionally, 12 % of girls aged 0–18 years originating from FGM-practising countries (born in the country of origin or in Austria) were at risk of FGM.**

- Focus group participants observed that **FGM was becoming generally more redundant as a cultural practice, although they recognised its role in controlling the chastity of girls and promoting virginity** (and thus marriageability). Some focus group participants reflected on experiences of discrimination and perceived Islamophobia in Austrian society in the context of FGM. Female participants reported being belittled by doctors when seeking FGM-related assistance. Second-generation Egyptian participants had the clearest standpoint against FGM, connecting it with pain and inequality. Men tended to be more conservative and felt a need to uphold traditions that clashed with the beliefs of the host society.

- **FGM has always been criminalised.** There is a legal obligation for medical doctors to report a crime of bodily harm caused by an illegal act, which would entail reporting cases of FGM to the police. This has reportedly caused fear and resistance in the community, can lead to girls being left in their home countries to undergo FGM before coming to Austria, and can present women who have undergone FGM with barriers to seeking healthcare.

- **No national action plan in Austria explicitly refers to FGM, but there have been several initiatives to provide education and services to communities.** Such measures include provision of training for representatives of FGM-affected communities to become peer educators, counselling for women on FGM, stakeholder networking and cooperation, online training for teachers to support girls in schools, healthcare centres and dedicated clinics in hospitals.

5.6. Recommendations

5.6.1. Improve monitoring of reported female genital mutilation cases that result in prosecution and conviction

Challenge. FGM has always been a punishable criminal offence under the Austrian Penal Code. There is limited information on the number of cases and prosecutions involving FGM, and institutional actors and stakeholders have encountered difficulties in assessing the extent to which anti-FGM legislation has been enforced.

Proposed action. FGM cases and prosecutions should be better monitored to assess the extent to which legislation has been implemented, for example through the systematic collection of data on FGM cases reported, FGM-related prosecutions and convictions, and punitive measures imposed. This would help to assess the extent to which the criminalisation of FGM has been upheld by institutional actors.

Potential stakeholder. Federal Ministry of Justice.

5.6.2. Develop a national action plan and accompanying budget on female genital mutilation

Challenge. Austria has no national action plan that explicitly refers to FGM, relying instead on initiatives to provide education and services to FGM-affected communities. A lack of coordination between various actors at national level reduces the likelihood of anti-FGM programming achieving long-term results.

Proposed action. EIGE recommends that an interministerial working group should work collaboratively alongside professional networks and organisations to address FGM-related issues in Austria. The working group could comprise relevant federal ministries, community-based organisations led by women affected by the practice and supporting civil society organisations. Its findings should inform a multiyear national action plan, coordinated by a single ministry, with adequate human and financial resources, and monitored by an independent body. Harmonising efforts at national level could help to ensure that civil society organisations can access long-term sources of funding for anti-FGM initiatives.

Potential stakeholder. Federal Ministry for Women and Integration.

5.6.3. Improve training for professionals

Challenge. There is no definition of different institutions' responsibilities in the various stages of FGM prevention, detection and intervention. A lack of training and awareness among professionals can further alienate women and girls.

Proposed action. Training should be tailored for healthcare, law enforcement, asylum, child protection and education professionals who interact with women and girls at risk of FGM, to ensure that they can provide non-discriminatory support to women and girls from affected communities.

Potential stakeholders. Federal Ministry of Education, Science and Research; Federal Ministry for Women and Integration; Federal Ministry of Justice; and Federal Ministry of Social Affairs, Health, Care and Consumer Protection.

5.6.4. Improve trust between health practitioners and female genital mutilation-affected communities

Challenge. Since October 2019, an amendment to the Physicians Law requires medical doctors to report crimes of bodily harm caused by an illegal act. This can create fear among affected communities, discourage women and girls from seeking help from support services, and undermine trust between institutional actors and affected communities.

Proposed action. Healthcare professionals should prioritise respectful dialogue with their patients and, in cases of FGM risk, ensure a quick referral to specialist organisations and services. They should be trained on the law, FGM, ethical professional principles, and non-discriminatory medical and non-medical interventions. A risk assessment tool should be created for use by all professionals to ensure appropriate and evidence-based case-by-case analysis.

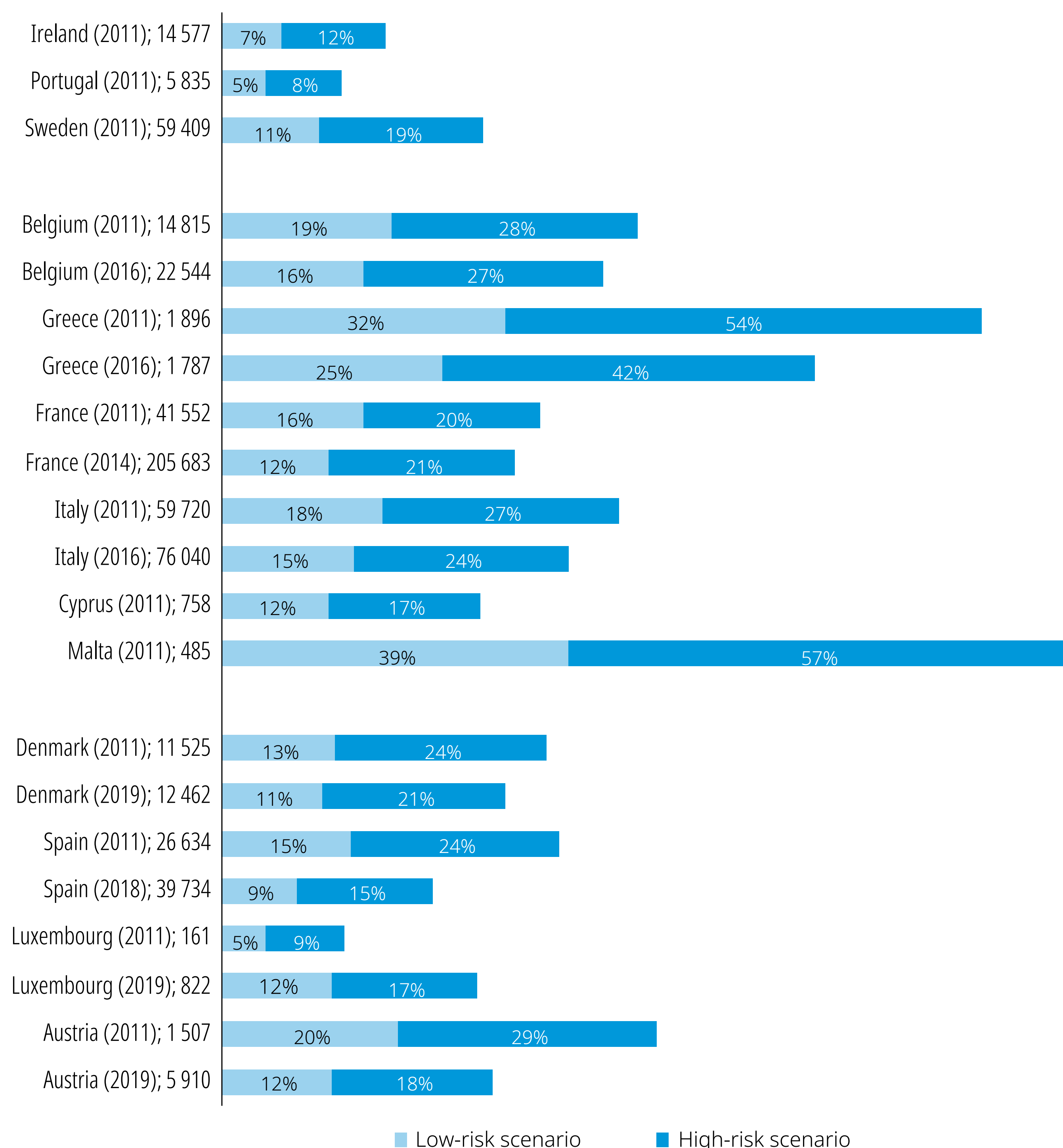
Potential stakeholders. Federal Ministry for Women and Integration; Federal Ministry of Justice; and Federal Ministry of Social Affairs, Health, Care and Consumer Protection.

6. Conclusions on the risk of female genital mutilation across the four Member States

6.1. Female genital mutilation risk estimations and community views of female genital mutilation have changed over time

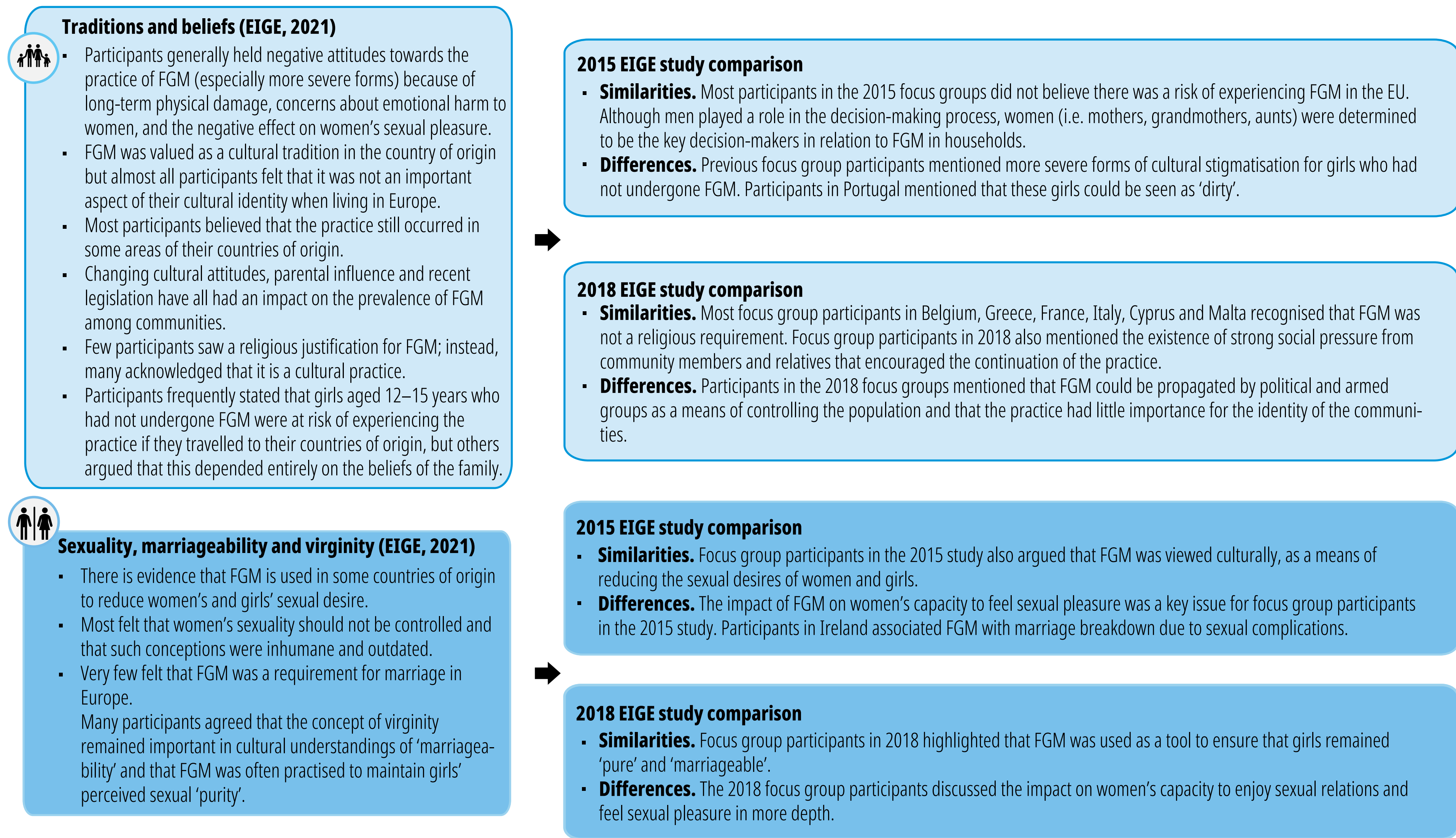
Figure 22 presents the estimates for girls at risk of FGM in the nine Member States of the previous study (EIGE, 2018) and the four Member States of the present study, for 2011 and the latest available year. The results indicate that, in 2011, the size of the female migrant population varied significantly across all Member States shown in Figure 22, ranging from 161 in Luxembourg to 59 720 in Italy. Luxembourg, Malta and Cyprus had the smallest populations of resident migrant girls, and the highest proportions of girls at risk were observed in Malta and Greece. The countries with the lowest proportions of girls at risk in 2011 were Portugal and Luxembourg. However, Italy and Sweden had the greatest numbers of girls at risk, demonstrating the importance of considering both the number and the proportion of girls at risk when interpreting risk estimation.

Figure 22. Estimated proportion of girls (aged 0–18 years) in the resident migrant population at risk of FGM in 13 Member States (2011 and latest available year)



NB: Data on Ireland, Portugal and Sweden are from EIGE's 2015 study; data on Belgium, Greece, France, Italy, Cyprus and Malta are from EIGE's 2018 study; and data on Denmark, Spain, Luxembourg and Austria are from the current study (EIGE 2021).

Figure 23. Focus group findings from current study (EIGE, 2021) compared with EIGE's 2018 and 2015 studies



Health consequences (EIGE, 2021)

- Participants in several focus groups noted that further awareness of ongoing health complications caused by FGM had changed cultural attitudes to the practice.
- Some participants, such as those from Guinea-Bissau in the Luxembourg focus group, had little awareness of associated health issues.
- Participants from Sudan in the Austria focus group were concerned by problems during childbirth.
- Senegalese, Somali and Kurdish participants highlighted sexual problems as a result of FGM.

2015 EIGE study comparison

- **Similarities.** Negative health impacts caused by FGM were universally considered a strong discouraging factor. Participants in 2015 recognised the physical and mental health repercussions of the practice.
- **Differences.** Focus group participants in 2015 mentioned different health risks caused by FGM, including the transmission of the human immunodeficiency virus (HIV).

2018 EIGE study comparison

- **Similarities.** Several focus group participants in 2018 were generally opposed to FGM because of the health consequences, pain and discomfort experienced by women and girls who had undergone the practice. Most women mentioned that health practitioners had demonstrated insensitive behaviour when dealing with FGM-related issues.
- **Differences.** Some focus group participants in 2018 argued that a decline in FGM was mainly to avoid existing health risks and deaths, not because of increased 'women's empowerment'.

Legislation and policy (EIGE, 2021)

- The practice and importance of FGM has gradually decreased in recent years and has become a more private practice because of fear of prosecution.
- Recent legislation has affected the prevalence of FGM among communities.
- There was generally higher awareness of the law in Denmark and Luxembourg than in Spain and Austria.
- In Luxembourg, there was little awareness of extraterritorial jurisdiction.
- Participants in Spain were unable to refer to any anti-FGM legislation.
- In Austria, some assumed that there was a law against FGM but were not certain.
- Most participants felt that the laws in their countries of origin were not enforced and FGM was performed in secret by doctors, midwives or traditional cutters.

2015 EIGE study comparison

- **Similarities.** In the 2015 study, focus group participants generally agreed that laws against FGM were positive and helped to combat the practice in Europe. Legislation had a protective element in some Member States, as parents could tell relatives in their countries of origin that they would be imprisoned if their daughters experienced FGM.
- **Differences.** In some focus groups in 2015, there appeared to be little awareness/knowledge that FGM was illegal or of the penalties for breaking the law in their respective Member States.

2018 EIGE study comparison

- **Similarities.** Participants in several Member States in 2018 noted that, where the law was enforced and participants were aware of arrests, there was a general consensus that it was extremely dangerous to practice FGM.
- **Differences.** In the 2018 study, researchers noted a possible bias in the perspectives of focus group participants, as some participants exhibited a fear of possible criminal consequences for expressing pro-FGM views.

6.2. The scale of female genital mutilation risk is driven by female genital mutilation-affected communities with high prevalence rates

FGM is a problem in all four Member States included in this study, albeit to varying extents. The overall size of the female migrant population from FGM-practising countries differs substantially between the four Member States. This study found that a high estimated number of girls at risk of FGM did not necessarily indicate a high percentage of girls at risk. **Proportions alone do not reflect the scale of the policy intervention necessary** to reach out to all girls at risk in a given country. As community size does not automatically correspond to a greater number of girls at risk, **there is no straightforward relationship between level of migration and FGM risk,** as illustrated in Table 26.

Table 26. Changes in the number of migrant girls from FGM-practising countries and in the absolute number and percentage of girls at risk over time

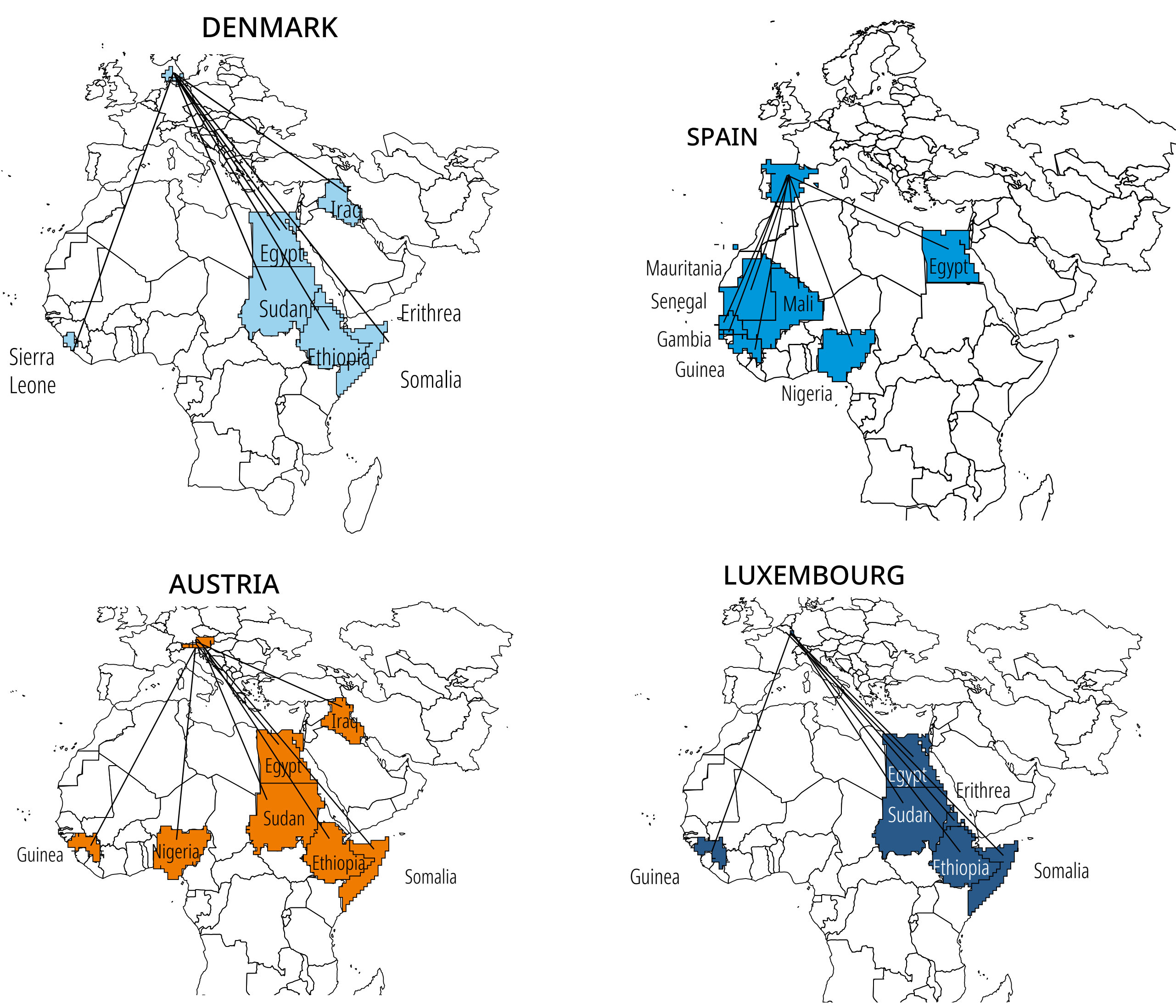
Member State	Change from 2011 to 2018 for Spain and 2019 for Denmark, Luxembourg and Austria			Driver of change in number of girls at risk
	Number of migrant girls from FGM practising countries	Absolute number of girls at risk	Percentage of girls at risk in the high risk scenario	
Denmark	↑	↓	↓	In both 2011 and 2019, the largest group of girls at risk of FGM was from Somalia, which has a high FGM prevalence rate of 97 %. In 2019, there were 224 fewer first-generation girls from Somalia in the resident migrant population than in 2011. The largest group of girls in the resident migrant population in 2011 and 2019 was from Iraq, which has a much lower prevalence rate of FGM (4 %).
Spain	↑	↓	↓	Spain has seen the largest increase in the number of girls from countries of origin with low prevalence rates of FGM: Senegal (21 %) and Nigeria (14 %). There was a decrease in the number of girls from countries with higher FGM prevalence rates, such as Egypt (70 %) and Ethiopia (47 %).
Luxembourg	↑	↑	↑	In 2011, the largest group of girls was from Cameroon, which has an FGM prevalence rate of 0.4 %. However, in 2019, the second largest group consisted of girls from Eritrea, which has a much higher prevalence rate (69 %).
Austria	↑	↑	↓	Between 2011 and 2019, the number of girls residing in Austria either increased or stayed the same for all countries of origin, except Tanzania. However, in 2011 the largest group of girls was from Ethiopia (FGM prevalence rate of 47 %), and in 2019 the largest group consisted of girls from Iraq, which has a much lower prevalence rate (4 %).

NB: FGM prevelance rates given in Table 26 are for girls aged 15–19 years. Throughout the table, ↑ refers to an increase over time and ↓ refers to a decrease over time.

This study has compared the seven **countries of origin with the largest numbers of migrant girls** residing in the four Member States and identified certain overlaps. Ghana, Iraq and Nigeria were in the top seven most-represented countries in three Member States. Iraq was the most-represented country of origin in two Member States (DK, AT), the highest of any country of origin.

The countries of origin of girls at risk also varied between Member States. In terms of **countries of origin with the largest numbers of girls at risk of FGM**, Egypt was in the top seven countries of origin for all four Member States, whereas Ethiopia, Somalia, Sudan and Guinea were in the top seven countries of origin for three Member States. Somalia accounted for the highest number of girls at risk in both Denmark and Austria. Guinea accounted for the highest number of girls at risk in Spain. Eritrea accounted for the highest number of girls at risk in Luxembourg. Figure 24 illustrates the most-represented countries of origin in terms of high FGM risk in each Member State. Countries in East Africa and north-east Africa, along with Guinea, were generally in the top seven countries of origin of girls at risk, whereas countries in West Africa tended to be less represented. Figure 24 also demonstrates that countries of origin of girls at risk varied by Member State, with Spain mostly receiving migrant girls from West Africa; Luxembourg and Denmark mainly receiving migrant girls from East Africa; and Austria having a more even spread.

Figure 24. Countries of origin with the largest numbers of migrant girls in Member States



NB: The countries in colour are in the top seven countries of origin of girls at risk of FGM calculations in the respective Member States. See Annex 2 for detailed data.

This information can inform policy design and implementation, for example adopting the most appropriate messages when engaging with affected communities. It requires the collection of reliable and comparable data regularly and over time. However, care needs to be taken in how data are collected, used and interpreted, to ensure that privacy concerns are respected and stigmatisation is avoided.

In summary, across the four Member States, the largest numbers of girls at risk of FGM originate from **Egypt, Ethiopia, Somalia, Sudan and Guinea-Bissau**. FGM prevalence in the countries of origin has a strong impact on the estimated number of girls at risk from these countries. **Policy interventions therefore need to be targeted** at the specific communities most affected by FGM.

6.3. Estimated risk for asylum-seeking girls and refugees differs from that for the general migrant population

Detailed and reliable data on **asylum seekers** were available in Denmark, Luxembourg and Austria. Information on **refugees** was available in Denmark and Luxembourg ([93]). In Denmark, Luxembourg and Austria, **asylum-seeking girls were at a higher estimated risk of FGM** than the general migrant population: 37 % of asylum-seeking girls were at risk in Denmark, compared with 21 % of the general migrant population (high-risk scenario), whereas 31 % of asylum-seeking girls were at risk in Austria, compared with 18 % of the general migrant population (high-risk scenario), and 19 % of asylum-seeking girls were at risk in Luxembourg, compared with 17 % of the general migrant population (high-risk scenario) ([94]). This highlights the importance of ensuring that **gender-sensitive asylum procedures** are in place to prevent FGM and protect girls at risk. This is particularly important in countries such as Luxembourg, where the number of asylum seekers from FGM-practising countries has increased in recent years.

In Denmark, in 2019 (the latest available year), recognised refugee girls were at lower estimated risk of FGM than girls seeking asylum, but at higher risk than the general migrant population (although refugees are included in the general migrant population data). In Luxembourg, in 2019, a higher proportion of recognised refugee girls than asylum-seeking girls (28 % and 19 %, respectively) were at risk of FGM, although both groups were at higher risk than the general migrant population according to the high-risk scenario (17 %).

6.4. Understanding the factors affecting the risk of female genital mutilation can better inform policymaking

The majority of those consulted for this study shared the view that **the risk of FGM was less pronounced while a woman or girl was in Europe**. However, there was consensus among first-generation migrant women (with the exception of Kurdish women) that until she married, **a girl was at increased risk any time she returned to her country of origin**. There was further agreement among focus group participants that, in the country of origin, having undergone FGM was an indicator of purity, linked to virginity. Once in the country of origin, the risk factors could multiply, and the **attitudes of and pressure exerted by family members** could be instrumental in determining whether or not a girl was at more risk of undergoing FGM.

Some focus group participants in Spain observed that the **risk was entirely family dependent**, whereas Austrian focus group participants noted that the husband's family, or indeed grandmothers (and other female

([93]) Disaggregated data on asylum seekers and migrants were not available for Spain.
([94]) Disaggregated data on asylum seekers and migrants were not available for Spain.

relatives, such as aunts), could be influential in deciding whether or not a girl underwent FGM. Egyptian participants in the Austrian focus groups stressed that the medicalisation of the practice meant that girls could be at risk when interacting with medical professionals. In Egypt, **a doctor can decide if FGM is 'needed'** for a girl, based on her having certain traits or exhibiting particular behaviours (e.g. childhood masturbation or 'masculine traits').

This study found that FGM was valued as a **cultural – rather than religious – tradition**. At the same time, however, several members of FGM-affected communities in the four Member States did not feel that the practice of FGM was intrinsically linked to their cultural identity. Some participants felt that abandoning the practice would be beneficial for their communities, because it would protect women and girls from experiencing physical and mental health issues. The cultural relevance of the practice was seen as contributing to the pattern of attitudes to migrant and Muslim communities, who reported encountering hostility in their countries of residence or when they believed that the practice represented a *sunna* ([95]). There was general agreement among first-generation women who had experienced FGM and among most men, who believed that the practice was damaging, caused enduring suffering and was not something they would want for their daughters. There were some exceptions to this viewpoint, notably among Sudanese women, who acknowledged the adverse impacts of the practice but would nevertheless continue, as many men consider it a prerequisite to marriage. Similarly, some Egyptian women saw the practice as necessary for girls exhibiting so-called excessive sexuality.

Migration, acculturation and education are powerful factors reducing the risk of FGM for girls living in Europe. Second-generation women (and men) who were consulted revealed that education is a key factor in changing attitudes to the practice and thus mitigating the risk. Second-generation Somali men in Denmark noted the depth of education among the Somali community in Denmark on the topic (including on the law), whereas second-generation Egyptian women in Austria highlighted the role of workshops and classes in helping to question 'old beliefs' about the practice.

6.5. Criminalising female genital mutilation has important effects on affected communities

The legal frameworks in the four Member States **explicitly criminalise FGM** and apply the **principle of extraterritoriality**. However, the impact of the principle on migrant communities is more difficult to define, with a lack of reported cases and prosecutions. In Spain and Austria, the criminalisation of FGM reportedly creates fear among FGM-affected communities, with potential revictimisation and harmful effects on family reunification. **Reporting obligations** for professionals encountering cases (or suspected cases) of FGM are not always applied in practice in all four Member States. In Denmark, professionals are not always able to identify FGM cases, which makes reporting to authorities difficult. Conversely, professionals in Spain report suspected cases of abuse to authorities and the public prosecutor, but at the cost of preventive work. This obligation has reportedly resulted in girls being left in their country of origin to undergo FGM before coming to Spain, as well as **creating barriers** to accessing healthcare for women who have undergone FGM. This study found a **need to improve asylum procedures** for women who apply for asylum on the grounds of FGM, by providing better training for staff working on asylum cases and integrating specific FGM-related questions into interview questionnaires.

National policies with a specific focus on FGM are limited in three of the four Member States. In Spain, 12 of the 17 autonomous communities have implemented their own protocols or guidelines on tackling FGM. A range of smaller-scale initiatives and services were identified across

([95]) A saying, tradition or practice of the Islamic Prophet Muhammad. Also referred to as 'female circumcision', it may consist of FGM type I or II.

Austria (and within Spain). Far fewer organisations work on this issue in Denmark and Luxembourg, where the issue of FGM is sometimes covered by more general services or by civil society organisations working with migrant communities. These efforts are often siloed and lack cooperation between different actors.

6.6. Challenges exist in reaching and engaging with affected communities

All participants across the four Member States felt that **raising awareness of FGM was very important**. Many felt that it was necessary to raise awareness of the negative health consequences of the practice, the related human rights issues and the sexual oppression of women. Others felt that the sensitisation of people in their countries of origin was important and that it was necessary for European institutions and campaigns to also work with community members in their countries of origin.

However, affected communities have differing views on the level of intervention that should exist to protect girls from FGM. Some focus group participants argued that EU interventions were necessary to protect the human rights of girls at risk of undergoing FGM, whereas others felt that private matters should not be the concern of EU institutions. Some argued that the EU's increased focus on combating FGM actually stemmed from the cultural belief that Muslim women were oppressed, and it could result in further discrimination.

Reaching out and engaging with affected communities is a common challenge across all four Member States. Either there are limited structures and organisations in place, or organisations work in silos and lack cooperation. Communities are seen to be **excluded from discussions and decision-making**, which makes the design of prevention and protection measures less effective. The interview findings highlight the need for more intercultural training for professionals across public services, to eliminate some of the barriers faced in engaging with communities. Breaking down such barriers requires time and regular contact with relevant communities to change mindsets. The lack of coordination between authorities and services working with affected communities can have a negative impact on their visibility and their ability to reach these communities.

7. Recommendations

7.1. Recommendations for EU institutions

7.1.1.1. The EU should accede to the Istanbul Convention or propose measures, within the limits of EU competence, to achieve the same objectives as the Convention

Challenge. The EU has not ratified the Istanbul Convention because of the reservations of some Member States.

Proposed action. If accession to the Istanbul Convention remains blocked, the European Commission should ensure that proposed legislative measures can achieve the same objectives as the Convention. The Commission announced its intention to implement the Convention in its 2020–2025 gender equality strategy.

Potential stakeholders. European Commission; the Council of the European Union; and the European Parliament.

7.1.1.2. Ensure that risks of FGM are addressed in the new Pact on Migration and Asylum

Challenge. The current EU proposal for a regulation on asylum and migration management (COM/2020/610 final) omits an approach for gender-based asylum claims.

Proposed action. This appears to be a missed opportunity to align the regulation with the Istanbul Convention, especially in the light of the Commission's commitment to the Convention. EIGE recommends that the new Pact on Asylum and Migration and related implementation tools are grounded in existing EU legal instruments protecting migrant and refugee women from FGM, recognising women and girls as a specific group at risk.

Potential stakeholders. European Commission; the Council of the European Union; and the European Parliament.

7.1.1.3. Increase the use of EU external action to prevent female genital mutilation outside the EU

Challenge. Unmarried women and girls may be at risk of FGM when returning to their countries of origin, indicating a lack of awareness of the consequences of FGM in some countries of origin.

Proposed action. It is important to conduct actions to prevent FGM in countries of origin (including raising awareness of the consequences of FGM and of the extraterritoriality principle of laws criminalising FGM) through training activities provided in partnership with affected communities. EIGE recommends that preventive actions should not only be conducted in the 30 countries where FGM has been officially documented through nationwide surveys, but also consider affected communities in several other countries in Africa, the Middle East, Asia and the Americas, where there is evidence of the presence of FGM. Messaging of preventive actions, including awareness raising, should be culturally sensitive and tailored to the audience. EIGE also recommends that the EU provide financial and technical assistance to existing local initiatives that specifically target this risk in the countries of origin through its external action, such as through the Spotlight Initiative.

Potential stakeholders. European Commission; the Council of the European Union; the European Parliament; the European Action Service; EU delegations in non-EU countries; and local initiatives targeting risk in countries of origin.

7.1.1.4. Strengthen efforts to combat racism and increase integration in Member States

Challenge. Integration is hindered by media representations of FGM as barbaric, with women and girls who have experienced FGM

more likely to feel shame and fear, creating barriers to accessing support, care and protection.

Proposed action. People of colour are subject to harassment and hate crimes in their country of residence, which is increasing in the wake of changing political contexts in Europe. EIGE recommends that implementation of the 2020–2025 gender equality strategy takes a non-discriminatory and intersectional approach and acknowledges the impact of stigmatisation and discrimination based on race or ethnicity when adopting measures aiming to tackle FGM. The EU should use the 2020–2025 anti-racism action plan to combat stigmatisation and discrimination experienced by diaspora communities across its Member States.

Potential stakeholders. European Commission; the Council of the European Union; and the European Parliament.

7.1.1.5. Facilitate the exchange of good practices between Member States in tackling FGM

Challenge. There is a lack of opportunities for professionals and experts working on FGM to exchange good practices, which limits Member States' opportunities to learn from these.

Proposed action. EU institutions should host events and support platforms and mutual learning as a means of sharing promising practices to tackle FGM. EU funding programmes should allocate sufficient resources to the implementation of measures tackling FGM, paying particular attention to pilot projects. Long-term EU funding is needed to support the establishment, maintenance and update of transnational projects and consortia across Member States. EU funding should not only invest in new ideas but also scale up existing success stories.

Potential stakeholders. European Commission; Council of the European Union; European Parliament; EU agencies; national governments; and competent national authorities.

7.2. Recommendations for all Member States

7.2.1. Legislative recommendations

7.2.1.1. All EU Member States should criminalise female genital mutilation and related acts, in line with Article 38 of the Istanbul Convention

Challenge. Criminalisation and the definition of FGM vary between Member States. An absence of specific legislation criminalising FGM creates legal ambiguity on the types of FGM covered and penalties. It can also result in a lack of adequate policies and funding.

Proposed action. EIGE recommends that all EU Member States should criminalise FGM and acts surrounding it, in line with Article 38 of the Istanbul Convention. EIGE also recommends that all Member States should fully implement the Victims' Rights Directive. Both of these actions should be supplemented with appropriate training, and protection and prevention policies.

7.2.1.2. Prosecute female genital mutilation that has been perpetrated abroad

Challenge. The principle of extraterritoriality applies in the criminal law of most Member States, but their dual criminality condition is not in line with Article 44(3) of the Istanbul Convention.

Proposed action. EIGE recommends that all Member States apply the extraterritoriality principle as a central position in efforts to tackle FGM. The broad adoption of this principle will require bilateral efforts between countries to disclose the information necessary for prosecution and exchange best practice and data. Community representatives should be engaged in all cooperation efforts.

Potential stakeholders. National parliaments and governments; ministries of justice; and ministries of foreign affairs.

7.2.1.3. Apply gender-sensitive and anti-racist asylum procedures that are tailored to the needs of applicants who have undergone or are at risk of female genital mutilation

Challenge. Many Member States lack specific asylum procedures for vulnerable asylum seekers and migrants who are at risk of FGM or who have undergone FGM.

Proposed action. EIGE recommends that Member States ensure that asylum applications can be made on the grounds of FGM, that women and girls are made aware of this possibility before lodging their application, and that the entire asylum process is sensitive to the needs of applicants who have undergone or are at risk of FGM.

Potential stakeholders. National parliaments; ministries of the interior or of asylum; and migration and asylum authorities.

7.2.1.4. Improve enforcement of female genital mutilation-related legislation

Challenge. Data on FGM-related court cases, prosecutions and protection orders suggest limited enforcement of existing FGM-related legal provisions.

Proposed action. EIGE recommends that Member States strengthen their prosecution of cases of FGM and the implementation and enforcement of protection orders. This can be achieved through awareness raising among FGM-affected communities, adequate sensitivity training for law enforcement officials and professionals who encounter FGM cases, and clarifying potential reporting obligations for professionals.

Potential stakeholders. Ministries of justice; ministries of the interior; and national parliaments.

7.2.1.5. Monitor the impact of female genital mutilation-related legislation and policy

Challenge. The lack of data on the enforcement of FGM-specific legislation highlights a gap in enforcement monitoring that prevents meaningful evaluation of Member States' responses to FGM.

Proposed action. EIGE recommends that Member States implement monitoring mechanisms that allow oversight of the enforcement of relevant legislation in practice, particularly in terms of criminal legislation (progress of FGM cases through the police and judicial sectors), asylum legislation and recording policies. This requires adequate data collection (see recommendations on data collection).

Potential stakeholders. Ministries of justice; ministries of the interior; and national parliaments.

7.2.2. Prevention and protection policies and services

7.2.2.1. Address the gender dimension of female genital mutilation in all related measures

Challenge. In many countries, national legislation and policies tackling violence against women are formulated in a gender-neutral manner, leading to a lack of recognition of the gender dimension of FGM as a form of violence.

Proposed action. The Explanatory Report to the Istanbul Convention highlights that the gendered nature of FGM requires related criminal offences to break with the principle of gender neutrality. Member States are encouraged to use policy and awareness-raising efforts to define FGM as required by the Istanbul Convention ([96]). Relevant law and policy, such as national

([96]) See Article 13 of the Istanbul Convention on awareness raising: Council of Europe (2011), *Explanatory Report to the Council of Europe Convention on preventing and combating violence against women and domestic violence*, Council of Europe Treaty Series, No 210, Istanbul (https://rm.coe.int/16800d383a).

strategies tackling violence against women and FGM, should recognise the gender dimension of FGM.

Potential stakeholders. National governments and parliaments; and public administrations.

7.2.2.2. Adopt a national action plan that includes female genital mutilation

Challenge. Only four Member States have enacted national action plans with a specific FGM focus, whereas 18 Member States and the United Kingdom mention FGM in a broader strategy to combat gender-based violence.

Proposed action. EIGE recommends that Member States without an existing national action plan on FGM adopt a plan and accompanying budget.

National governments should create a working group with relevant ministries, professional networks, civil society actors, community-based organisations and FGM-affected communities, to establish the measures needed to better tackle FGM and create an action plan. The following sectors should be covered in the plan: healthcare, education, migration, law enforcement and asylum. Interventions should reflect an intersectional and non-discriminatory approach. National action plans should ideally run for multiple years, have adequate human and financial resources, and be monitored by an independent body.

Potential stakeholders. National governments; ministries of equality and health; professional networks; civil society actors; community-based organisations; and FGM-affected communities.

7.2.2.3. Involve female genital mutilation-affected communities in the creation and implementation of policies

Challenge. Member States struggle to break down language and cultural barriers and build trust, which they need to do if efforts to tackle FGM are to be culturally sensitive and effective.

Proposed action. FGM-affected communities must be involved in policymaking if they are to be truly engaged. Findings from this study noted the importance of ensuring community involvement throughout the policy life cycle.

Potential stakeholders. National authorities and relevant communities.

7.2.2.4. Ensure access to comprehensive support services

Challenge. Women who have undergone FGM can require multiple specialist services (as can women and girls at risk), but a lack of awareness of support services persists and services may not be sensitive to gender and culture.

Proposed action. Member States must work to remove barriers and improve the uptake and delivery of a range of services for women and girls who have undergone or are at risk of FGM. EIGE recommends that Member States ensure access to a range of comprehensive services offering holistic care and assistance, delivered by professionals trained in gender-sensitive and culturally sensitive approaches who are non-judgemental, non-discriminatory and non-stigmatising, and with a strong referral system between services.

Potential stakeholders. National, regional and local authorities.

7.2.2.5. Provide adequate funding for specialised organisations and projects

Challenge. Civil society and community-based organisations working to tackle FGM do not always have sustainable long-term funding for their work.

Proposed action. Shifting attitudes to FGM in affected communities is a long-term process that requires long-term investment. Member States should provide strong support and adequate funding for civil society and community-based organisations that work with affected communities to reduce incidences of FGM.

Potential stakeholders. National governments, parliaments and competent authorities; and civil society and community-based organisations.

7.2.3. Improve data collection and increase knowledge

7.2.3.1. Update the list of countries where female genital mutilation is practised as new evidence and data become available from other countries and regions

Challenge. Risk estimations, policies and legislation depend on an accurate list of all countries and ethnic communities where FGM is practised; otherwise, they overlook some FGM-affected communities.

Proposed action. Member States should work with EIGE to update the list of countries and communities. National governments should be aware of the updated list of countries where FGM is practised as new evidence and data become available from other countries and regions.

Potential stakeholder. National governments and EIGE.

7.2.3.2. Undertake regular female genital mutilation risk estimations

Challenge. Without regular risk estimations, the problem of FGM remains invisible.

Proposed action. All Member States should carry out regular risk estimation to generate comparable data across Member States, support EU-level FGM-specific initiatives, harmonise approaches across countries and ensure that policymaking is evidence based. Member States can adopt EIGE's methodology to generate information that can help them to develop or improve national approaches to tackling FGM.

Potential stakeholders. National statistical authorities and national equality bodies.

7.2.3.3. Improve the availability of quantitative data on all migrants including specific data on the female migrant population

Challenge. Necessary data on resident migrants, asylum seekers and irregular/undocumented migrants, by generation, are not always available for carrying out risk estimations.

Proposed action. Member States should harmonise the terminology attached to data on migrants and collect data disaggregated by age, sex, country and region of birth, generation (first or second, based on country of birth), mother's and father's country of birth, 1-year age intervals, age on arrival and number of years since migration.

Member States should collect the following data on the female migrant population: the number of female resident migrants (aged 0–18 years) from FGM-affected countries by generation of birth; the number of female asylum seekers from FGM-affected countries; and the number of female live births to mothers from FGM-affected countries. Member States should collect and publish the following data: the number of cases reported to the police related to FGM; the number of women and girls recognised as refugees on FGM-related grounds; and the number of women and girls living with the consequences of FGM in the national territory. These data should be accompanied by data collected through other administrative sources, such as the number of child protection orders related to FGM and healthcare data on patients presenting with FGM. Member States should also try to collect data on irregular/undocumented migrants by working in partnership with organisations providing services to them. A range of public services (particularly health and child protection) should collect data on girls and women who have undergone FGM, and should establish and maintain national registries of such cases.

Potential stakeholders. National statistical authorities; ministries of health; and child protection authorities.

7.2.3.4. Ensure comparable data on female genital mutilation are available and shared between Member States

Challenge. The quality of data on FGM and migration varies significantly between Member States, with limited funding available to pilot data collection and sharing. Differences in data collection complicate the comparability of key metrics relevant to FGM across the EU and prevent data comparisons between Member States.

Proposed action. Member States should share data on FGM in order to provide a strong basis for collaboration in the EU, underpin the sharing of good practices and promote the development of common standards to tackle FGM at national level. Governments should work towards collecting data that are comparable across Member States and find ways of sharing anonymised data on FGM that adhere to the General Data Protection Regulation and other data protection legislation. Funding should be allocated (at EU or Member State level) to pilot data collection and sharing initiatives.

Potential stakeholders. National governments; competent ministries; and statistical offices.

7.2.4. Improve awareness raising and communication in communities

7.2.4.1. Prevent female genital mutilation through the education system

Challenge. Attitudes to changing traditions and values vary among FGM-affected communities, with women and girls from these communities still at high risk of FGM. The education system fails to address stereotypical gender social norms, improve children's and families' knowledge of FGM and thus reduce the prevalence of FGM in communities.

Proposed action. Education should be prioritised, with initiatives covering the risks to mental and physical health (including sexual health), and legislation and policies addressing FGM (including the application of the extraterritoriality principle) and gender equality. Education should target all children and their families, including affected communities. Education initiatives should also signpost children and families to relevant support services and community initiatives. They should be non-discriminatory, non-racist and ideally delivered by community members in specialised organisations who have a culturally sensitive understanding of FGM.

Potential stakeholders. Competent national authorities and community-based organisations.

7.2.4.2. Ensure culturally sensitive outreach to communities

Challenge. Outreach activities that are not culturally sensitive have a limited impact among affected communities.

Proposed action. Successful communication strategies and community engagement require an understanding of the affected community's cultural values and priorities.

Awareness-raising campaigns and other communication strategies should be culturally sensitive and accessible in terms of language needs of the target community. For example, messages should place greater focus on the various health implications for women and girls who have undergone FGM and should discuss tradition, the notion of honour and the perceived importance of virginity for marriageability. The human rights and gender dimension of the practice should be present in all communication strategies in a culturally sensitive manner.

Potential stakeholders. Competent national authorities and community-based organisations.

7.2.4.3. Address misconceptions about religion, cultural identity and female genital mutilation

Challenge. Although FGM is perceived by affected communities as being a cultural and/or traditional practice, authorities, policymakers and wider communities in countries of residence may still perceive FGM as primarily a religious issue.

Proposed action. Raising awareness among authorities and policymakers of the fact that FGM is perceived by affected communities as primarily a cultural or traditional practice will serve to debunk damaging misconceptions and ensure that actions to tackle FGM are appropriately targeted. Communication strategies should focus on correcting this misconception where it exists, and religious and community leaders should be engaged to speak against FGM, given their influential position in the community.

Potential stakeholders. Competent national authorities and community-based organisations.

7.2.4.4. Create safe spaces for community discussions

Challenge. Safe discussions help individuals and communities to take ownership of the discourse and facilitate behavioural change, yet barriers to openly discussing FGM persist for some individuals and communities.

Proposed action. Communication strategies in communities should encourage confidential and culturally sensitive discussions of FGM. Cultural mediators and facilitators from participant communities should be involved, alongside interpreters.

Potential stakeholders. Competent national authorities; community-based organisations; and NGOs.

7.2.4.5. Engage men

Challenge. Men have a role in family and community structures in reinforcing gendered power dynamics yet are not systematically engaged in actions tackling FGM.

Proposed action. EIGE recommends that Member States work to increase men's knowledge of the impact of FGM and damaging gender power dynamics through awareness-raising initiatives. National authorities could support community organisers to develop platforms for dialogue to engage men in their communities. Member States should engage with men who are anti-FGM ambassadors in diaspora communities and invite them to join the White Ribbon Campaign to show their opposition to FGM and other forms of gender-based violence.

Potential stakeholders. National authorities; specifically relevant ministries; and agencies under which community initiatives are implemented.

7.2.5. Training and strengthening professional response

7.2.5.1. Strengthen professional capacity

Challenge. Gaps in training on gender-based violence and FGM, together with cultural taboos, can stunt communication between professionals and women from FGM-affected communities, reducing the quality of care and services provided.

Proposed action. Professionals across the healthcare, education, police, judicial and migration sectors should receive specialised training on FGM, as well as on important contextual factors to ensure cultural sensitivity, non-discrimination and non-racism. Member States should also develop guidelines for all relevant professions to promote a cohesive approach to early identification of women who have experienced FGM, including prevention, protection, prosecution and integrated policies.

Potential stakeholders. National governments, particularly relevant ministries and agencies responsible for establishing professional training and workplace standards and guidance.

7.2.5.2. Align the implementation of asylum provisions with the UN High Commissioner for Refugees Guidance Note on female genital mutilation and systematically train asylum professionals

Challenge. Interpretations of national asylum law are not always in line with the international protection standards laid out in the UN High Commissioner for Refugees (UNHCR) Guidance

Note on Refugee Claims relating to FGM. There are gaps in asylum case workers' awareness of the needs of asylum applicants who have experienced FGM.

Proposed action. Culture-, gender- and age-sensitive training is needed for asylum case workers to develop a more sensitive and proactive approach, particularly if applicants may not be able to address these issues themselves. Member States should ensure that the interpretation of national asylum law is in line with the international protection standards laid out in the UNHCR Guidance Note on Refugee Claims relating to FGM. Asylum seekers should be able to request asylum personnel of their preferred sex and be provided with information relevant to their rights during their asylum procedure, in addition to healthcare access and other relevant services for the duration of their claim.

Potential stakeholders. National governments, particularly relevant ministries and agencies responsible for immigration and asylum.

7.2.6. Strengthening cooperation between Member States (and countries of origin)

7.2.6.1. Improve monitoring of departure and re-entry between EU Member States and countries of origin of female genital mutilation-affected communities

Challenge. Women and girls at risk of FGM (and their families) may travel through transit countries in the EU as a means of returning to their country of origin to undergo FGM.

Proposed action. Cooperation between Member States should include collaboration during external border controls, such as at airports. This can take the form of awareness-raising initiatives at border controls, including training for border guards on non-discrimination and monitoring. Such provisions must be accompanied by clear legislation and data protection procedures if they are to avoid stigmatisation and racial profiling of groups. Any interventions related to prevention should be applied on a case-by-case basis and based on clear intelligence and identified risks.

Potential stakeholders. National governments; ministries of the interior; and competent border authorities.

7.2.6.2. Improve Member State responses to asylum claims on the grounds of female genital mutilation through the new Pact on Migration and Asylum

Challenge. FGM-related asylum claims are often rejected for reasons that lack gender and cultural sensitivity or sound knowledge of FGM. Asylum procedures (interview questions, access to specialist care) do not consistently meet the needs of women and girls seeking asylum on the grounds of FGM, even those from high-risk areas.

Proposed action. Member States should ensure sufficient access to specialised services and that FGM-specific questions are included during the asylum application process. Applicants should be provided with relevant information (including the right to request asylum personnel of the preferred sex, and that FGM is one of the grounds on which to request asylum), and all asylum officers, including interpreters, should be trained on FGM and all forms of gender-based violence.

Potential stakeholders. National governments; and competent national authorities.

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Annexes

Annex 1. Methodology to estimate the number of girls at risk of female genital mutilation

EIGE established a common methodology to estimate the number of girls at risk of FGM in the European Union. The original methodology was developed in 2015, pilot-tested in the same year in three Member States: Ireland, Portugal and Sweden (EIGE, 2015). The methodology was then further refined in EIGE's 2018 study, and applied in six further Member States: Belgium, Cyprus, France, Greece, Italy and Malta (EIGE, 2018). A step-by-step guide is available describing in detail how to implement the methodology (EIGE, 2018).

Figure A1. EIGE step-by-step methodology summary (EIGE, 2019)

Source: EIGE (2018)

A1.1. Quantitative component

The quantitative component of EIGE's methodology entailed collecting the necessary quantitative data for estimating the number of girls aged 0–18 at risk of FGM in the four Member States and applying EIGE's 2018 methodology to calculate these estimates.

The methodology calculates 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:

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

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 or have reached 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 or have reached the national median age of FGM occurrence in country *c*;

- p_c is the national prevalence rate of FGM in country of origin *c;*

- $m_{c=first}$ is the migration and acculturation factor for the first generation, which estimates how FGM prevalence differs between first-generation migrants and the population of the country of origin *c*. $m_{c=first}$ could range from 0, in the case of no impact of migration and acculturation on the risk (i.e. higher risk), to 1, in case of full impact of migration and acculturation on the risk (i.e. no risk);

- $m_{c=second}$ is the migration and acculturation factor for the second generation, which estimates how FGM prevalence differs between second-generation migrants and the population of the country of origin *c*. $m_{c=second}$ could range from 0, in the case of no impact of migration and acculturation on the risk (i.e. higher risk), to 1, in case of full impact of migration and acculturation on the risk (i.e. no risk).

The calculation required a range of data, both from the four Member States studied and FGM-practising countries ('countries of origin'). More specifically, main data and metadata were collected on the following indicators:

Destination countries (Denmark, Spain, Luxembourg and Austria):

- Female migrant population (aged 0–18) from FGM-practising countries (based on birth and/or citizenship), for first and second-generation migrants;

- Female live births to mothers from FGM-practising countries;

- Female asylum seekers and refugees from FGM-practising countries.

Country of origin data:

- National FGM prevalence rates for women/girls aged 15–19. This is the youngest group of adults considered to be in 'final cut status', i.e. either having undergone FGM or no longer at risk of FGM;

- National age of typical FGM occurrence for women/girls aged 15–19.

Destination country data were collected, disaggregated by sex, country of origin of migrants, citizenship and generation. The main sources for destination country data were national statistical institutes, ministries, birth registration organisations, and border and immigration agencies. In most cases, not all of the requested data were available and a number of 'proxies' were used (e.g. live birth data). The most updated data at country level were requested, from the most recent year available. Alongside this, data were collected from 2011, to allow for comparisons to be made with other countries for which estimates have been previously calculated (the last European population census took place in 2011 and therefore provides comparable data on relevant female migrant population across the four EU Member States).

Country of origin data were extracted from the Demographic and Health Survey (DHS) and the Multiple Indicator Cluster Survey (MICS), which provide information on the prevalence of FGM in the 30 countries where this practice has been documented ([97]).

Following the EIGE methodology, two estimates of the number of girls at risk of FGM were produced:

- **High estimate of FGM risk** assumes that the process of migration and acculturation has had no effect on FGM prevalence for both first and second-generation migrants. Therefore, the values of *mc=first* and *mc=second* are set to 0. This hypothetical scenario yields the highest boundary of estimated number of girls (high-risk scenario);

- **Low estimate of FGM risk** assumes that the process of migration and acculturation has had an effect on FGM prevalence among first-gen-

([97]) Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Côte d'Ivoire, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Ghana, Guinea, GuineaBissau, Indonesia, Iraq, Kenya, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Somalia, Sudan, Togo, Uganda, Tanzania and Yemen.

eration migrants and that FGM risk remains, albeit at a lower level, among second-generation migrants. Here, the value of *mc=first* is set to 0 but the value of *mc=second* is set to 0.5.

A1.2. Qualitative component

As outlined in Step 1 of EIGE's Step-by-Step Guide (EIGE, 2018), the study team conducted an extensive desk review of the policy and legal framework on FGM across Denmark, Spain, Luxembourg and Austria from mid-2017 to mid-2020. To gather information on the latest legislative and policy developments, as well as identify the strengths and weaknesses of existing approaches, three or four interviews were conducted with national stakeholders in Denmark, Spain, Luxembourg and Austria. National stakeholders included government representatives, academics, legal experts, and civil society representatives.

As outlined in Steps 8–13 of EIGE's methodology (EIGE, 2019), four focus groups took place in each of the four Member States with migrant communities from FGM-practising countries. These focus groups sought to evaluate attitudes to the practice in FGM-affected communities across the Member States in question, and to probe the factors influencing the formation of those attitudes (considering the influence of migration in the transmission of attitudes and behaviours around FGM within communities and across generations). The focus groups also gathered feedback on the effectiveness of national prevention/protection services and assessed levels of awareness of legislation and available services.

Target communities were defined for each focus group to gain a better understanding of these issues across different age, ethnic communities, generations, and gender:

- **Focus group 1:** women >25 years, who have daughters at risk (first generation);
- **Focus group 2:** young women aged 18–25 (second generation);
- **Focus group 3:** men aged 25–60 years (first and second generation);
- **Focus group 4:** women from hard to reach populations or recent migrants (first generation) > 18 years.

This approach draws on a range of perspectives and allowed the study team to assess whether, for example, the views of women and girls differ from those of men, and the extent to which generation plays a role in shaping attitudes to FGM. As well as collecting and analysing a range of perspectives from established ethnic communities, this approach ensured that feedback was collected from an additional community – those relatively newly arrived (newly migrated) to the Member States. Three key factors were taken into consideration when defining the migrant communities to consult: FGM prevalence; overall size of the community in the Member State; and the level of existing research on the community (in order that this research might generate new information on a less studied community). In terms of practical implementation, the final composition of focus groups did at times slightly differ from the demographic composition outlined above, due to the nature of migrant populations in certain Member States.

Further to the focus groups, the study team held two virtual experience-sharing meetings attended by government and civil society representatives, academics and other national stakeholder.

The purpose of these meetings was to exchange experiences from the four Member States, to discuss challenges faced in their countries, and to share good practices and initiatives so as to support their efforts in preventing FGM and protecting girls at risk.

- The first meeting focused on engaging communities in the design and implementation of measures to prevent FGM and ensuring cooperation between different actors working on the issue.
- The second meeting focused on the sensitivity of asylum procedures to women and girls who have undergone, or are at risk of, FGM, and the importance of clear professional reporting obligations which adequately served the needs of the girls, women and communities which they endeavour to serve.

A1.3. Comparison of methodological approaches from this study with earlier EIGE estimation studies

A1.3.1. Qualitative component

For the qualitative data collection, this study encountered certain challenges that were not applicable in EIGE's previous studies. This was a result of the COVID-19 pandemic, which took place throughout the research period, and the ensuing protection measures that were put in place in each country. This was the main methodological difference with respect to the qualitative component across the studies.

A1.3.2. Quantitative component

EIGE's 2015 and 2018 studies reported similar issues and challenges for the quantitative data collection regarding availability of data. These included the lack of data on irregular migrants, regions of origin and ethnicity. All three studies also encountered the need to use proxies to overcome gaps in the data when calculating estimates, particularly regarding second-generation migrants and the alternative use of data on births. An additional challenge encountered during the study which was not applicable in EIGE's previous studies was the delay in response from some public authorities for requested data, where COVID-19 reduced capacity in the relevant institutions holding the data.

A1.4. Demographic profiles of focus group participants

Table A1. The demographic profiles of focus group participants in Denmark

	Focus group discussion 1: *Women > 25 with daughters at risk from FGM-practising countries (first generation)*	**Focus group discussion 2:** *Women >18 years from FGM-practising countries (second generation)*	**Individual interviews 1:** *Men aged 25–60 from FGM-affected communities*	**Individual interviews 2:** *Hard to reach populations (first generation)*
Number of participants	5	4	3	4
Countries of origin represented [98]	Somalia (5)	Somalia (4)	Somalia (3)	Iraq (3) Iran (1)
Sex of participants	Female	Female	Male	Female
Age range	30–44	22–32	Unknown (3)	27–56
Generation	First	Second	First	First
Average residence (number of months) and previous residence in other countries	Average residence in Demark: 23 years and 4 months. 2 years in UK (1 participant)	Average residence in Denmark: 23 years and 6 months. 8 years in Somalia (1 participant)	Average residence in Denmark: 27 years and 7 months.	Average residence in Denmark: 16 years and 8 months (3 participants). 8 months (1 participant)
Number of second-generation participants who have lived in their parents' country of birth	N/A	1	N/A	N/A

[98] This is the country of birth of first-generation migrants (FGM-practising countries), or country of birth of parents of second-generation migrants (FGM-practising countries). Here, someone is second generation if they were not born in an FGM-practising country but have at least one parent born in an FGM-practising country.

	Focus group discussion 1: *Women > 25 with daughters at risk from FGM-practising countries (first generation)*	**Focus group discussion 2:** *Women >18 years from FGM-practising countries (second generation)*	**Individual interviews 1:** *Men aged 25–60 from FGM-affected communities*	**Individual interviews 2:** *Hard to reach populations (first generation)*
Civil status of participants:	Divorced (4) Married (1)	Married (2) Single (1) In a relationship (1)	Married (3)	Married (2) Divorced (1) Engaged (1)
Number of participants with/ without children	Children (5)	Children (1) No children (3)	Children (3)	Children (3) No children (1)
Religion	Muslim (5)	Muslim (4)	Muslim (3)	Muslim (3) Christian (1)
Ethnic groups (if available)	N/A	N/A	N/A	Kurdish (4)
Level of education	High school (2) Middle school (3)	Bachelor's degree (3) Master's degree (1)		
(For first generation) Shortest and longest amount of time residing in Denmark (years)	20 – 27	N/A	25–32	5–27
(For first generation) Shortest and longest amount of time residing in another European Member State	2 years (UK)	N/A	N/A	8 months (1 participant)
Date of session	5 November 2020	9 November 2020	9–14 November 2020	23 October – 3 November 2020

Table A2. The demographic profiles of focus group participants in Spain

	Focus group discussion 1: *Women > 25 with daughters at risk from FGM-practising countries (first generation)*	**Focus group discussion 2:** *Young people aged 18–25 from FGM-practising countries (second generation)*	**Focus group discussion 3:** *Men aged 25–60 from FGM-affected communities*	**Focus group discussion 4:** *Hard to reach populations (first generation)*
Number of participants	8	5	5	9
Countries of origin represented (99)	Senegal (8)	Senegal (5)	Guinea (1) Mali (1) Senegal (3)	Ethiopia (1) The Gambia (1) Guinea (1) Mali (1) Nigeria (1) Senegal (2) Somalia (1) Unknown (1)

(99) This is the country of birth of first-generation migrants (FGM-practising countries) or country of birth of parents of second-generation migrants (FGM-practising countries). Here, someone is second generation if they are not born in an FGM-practising country but have at least one parent born in an FGM-practising country.

	Focus group discussion 1: *Women > 25 with daughters at risk from FGM-practising countries (first generation)*	**Focus group discussion 2:** *Young people aged 18–25 from FGM-practising countries (second generation)*	**Focus group discussion 3:** *Men aged 25–60 from FGM-affected communities*	**Focus group discussion 4:** *Hard to reach populations (first generation)*
Sex of participants	Female (8)	Female (2) Male (3)	Male (5)	Female (9)
Age range	27–41	18–24	33–47	25–54
Generation	First generation	Second generation	First generation	First generation
Average residence (number of months) and previous residence in other countries	12–14 years (2) 3–4 years (2) 1 year (2) <20 years (2)	16–20 years (2) 5–7 years (2) NA (1)	12–17 years (3) 10–11 years (2)	2 years (3) 4 years (2) 8 years (1) 12–14 years (2) Unknown (1)
Number of second-generation participants who have lived in their parents' country of birth	No second-generation participants	2 participants lived in Senegal for a period of time	No second-generation participants	No second-generation participants
Civil status of participants	Married (4) Unmarried (4)	Single (5)	Married (2) Unmarried (3)	Married (5) Unmarried (3) Unknown (1)
Number of participants with/ without children	Children (8)	No children (5)	Children (3) No Children (2)	Children (6) No children (2) Unknown (1)
Religion	Muslim (8)	Muslim (4) Prefer not to say (1)	Muslim (5)	Christian (2) Muslim (6) Unknown (1)
Ethnic groups	Wolof (2) Soninke (1) Sose (1) Prefer not to say (4)	Serere (1) Wolof (1) Prefer not to say (3)	Guinea: Fula (1) Mali: Soninke (1) Senegal: Serere (1), Sose (1), Wolof (1)	Ethiopia (1) – Amhara/ Oromo The Gambia (1) – Mandinka Guinea (1) – Fula Mali (1) – Soninke Nigeria (1) – Igbo Senegal (2) – Fula and Unknown Somalia (2) – Ashraf, Isaaq
Level of education	No formal education (2) Primary (1) Secondary (2) University level (3)	Primary (1) Secondary (1) N/A (3)	Primary (3) Secondary (2)	No formal education (2) Primary (1) Secondary (2) University level (3) Prefer not to say (1)
(For first generation) Shortest and longest amount of time residing in Spain	Few months- 24 years	N/A	10 – 17 years	2 – 14 years
(For first generation) Shortest and longest amount of time residing in another European Member State	Shortest time (few months) Longest time (1 year and a half)	N/A	Shortest time (3 months) Longest time (2 years)	Shortest time (4 years) Longest time (4 years)
Date of session	2 October 2020	3 October 2020	3 October 2020	4 October 2020

Table A3. The demographic profiles of focus group participants in Luxembourg

	Focus group discussion 1: *Men from hard to reach or recent migrants >18 years (first generation)*	**Focus group discussion 2:** *Women from hard to reach or recent migrants >18 years (first generation)*	**Focus group discussion 3:** *Men aged 25–60 years from FGM-practising countries (first generation)*	**Focus group discussion 4:** *Women >25 years, who have daughters at risk from FGM-practising countries (first generation)*
Number of participants	5	10	3	7
Countries of origin represented ([100])	Eritrea (5)	Eritrea (9) Guinea (1)	Guinea-Bissau (3)	Guinea-Bissau (6) Senegal (1)
Sex of participants	Male	Female	Male	Female
Age range	22–50	25–45	35–52	25–60
Generation	First	First	First	First
Average residence (number of months) and previous residence in other countries	38 months Previous residence in Italy for some	16 months	Approx. 15 years Previous residence in Portugal for some	Approx. 7 years Previous residence in Portugal for some
Number of second-generation participants who have lived in their parents' country of birth	N/A	N/A	N/A	N/A
Civil status of participants:	Married (2) Single (1) Prefer not to say (2)	Married (6) Single (1) Divorced (1) Prefer not to say (2)	Married (2) Divorced (1)	Married (5) Single (1) Prefer not to say (1)
Number of participants with/without children	With children (2), without children (3)	With children (8), without children (2)	With children (3)	With children (5), without children (1), unknown (1)
Religion	Christian (5)	Christian (9), Muslim (1)	Muslim (3)	Christian (1), Muslim (6)
Ethnic groups (if available)	Tigrinya (5)	Eritrea: Tigrinya (9) Guinea: Fulani (1)	Fulani (1) Mandinka (1) Prefer not to say (1)	Guinea Bissau: N/A (6) Senegal: Peul (1)
Level of education	Prefer not to say (5)	Higher education (1) Prefer not to say (9)	Prefer not to say (3)	Prefer not to say (7)
(For first generation) Shortest and longest amount of time residing in Luxembourg	2 years; 5 years	Less than 1 year; 2 years	Minimum 10 years; 20 years	3–4 years; 12 years
(For first generation) Shortest and longest amount of time residing in another European Member State	A few months in the Netherlands; 1 year in Italy	No	10 years in Portugal	Several years in Portugal
Date of session	28 September 2020	1 October 2020	3 October 2020	10 October 2020

([100]) This is the country of birth of first-generation migrants (FGM-practising countries), or country of birth of parents of second-generation migrants (FGM-practising countries). Here, someone is second generation if they were not born in an FGM-practising country but have at least one parent born in an FGM-practising country.

Table A4. The demographic profiles of focus group participants in Austria

	Focus group discussion 1: *Women >25 years, who have daughters at risk (first generation)*	**Focus group discussion 2:** *Women >18 years (second generation)*	**Focus group discussion 3:** *Men aged 25–60 years (first and second generation)*	**Focus group discussion 4:** *Women from hard to reach or recent migrants >25 years (first generation)*
Number of participants	9	11	6 (including 1 participant who left early)	9
Countries of origin represented ([101])	Egypt (9)	Egypt (11)	Egypt (6)	Sudan (9)
Sex of participants	Female	Female	Male	Female
Age range	26 – 57 years	18 – 24 years	18 – 60 years	32 – 57 years
Generation	First	Second	First and second	First
Average residence (number of months) and previous residence in other countries	20 years 4 months in Austria 25 years in Egypt	4 participants lived between 12 months and 7 years in Egypt as children, but were born in Austria	Born in Austria and never lived abroad (1) born in Egypt (5) and lived in Austria in average 22,5 years	On average 19 years in Austria
Number of second-generation participants who have lived in their parents' country of birth	0	4	0	N/A
Civil status of participants:	Married (9)	Married (1) Unmarried (10)	Married (4) Unmarried (2)	Married (8) Divorced (1)
Number of participants with/ without children	With children (9)	With children (1) Without Children (10)	With children (3) Without children (2) N/A (1)	With children (9)
Religion	Muslim (9)	Muslim (11)	Muslim (6)	Muslim (9)
Ethnic groups (if available)	N/A	N/A	N/A	N/A
Level of education	Higher secondary school (2) College degree (5) University degree (2)	High school diploma (7) Social work degree (1) University degree (3)	High school diploma (1) University degree (3) Unknown (2)	4 years of school (1) High school diploma (1) University degree (7)
(For first generation) Shortest and longest amount of time residing in Austria	Shortest: 6 years Longest: 31 years	N/A	Shortest: unknown Longest: 30 years	Shortest: 2,5 years Longest: 40 years
(For first generation) Shortest and longest amount of time residing in another European Member State	N/A	N/A	N/A	N/A
Date of session	12 October 2020	10 October 2020	4 October 2020	3 October 2020

([101]) This is the country of birth of first-generation migrants (FGM-practising countries), or country of birth of parents of second-generation migrants (FGM-practising countries). Here, someone is second generation if they are not born in an FGM-practising country but have at least one parent born in an FGM-practising country.

Annex 2. Data tables on the female migrant population at risk

Table A5. Prevalence rate and median age of FGM in countries of origin (2020)

Country of origin	FGM prevalence rate	Median age of FGM
Benin	2.4	10.0
Burkina Faso	57.7	7.0
Cameroon	0.4	11.0
Central African Republic	17.9	14.0
Chad	31.8	12.0
Côte d'Ivoire	27.4	8.0
Djibouti	89.5	10.0
Egypt	69.6	12.0
Eritrea	68.8	5.0
Ethiopia	47.1	9.0
Gambia	75.0	6.0
Ghana	1.5	3.0
Guinea	91.7	11.0
Guinea-Bissau	14.9	8.0
Indonesia	49.0	2.0
Iraq	3.5	8.0
Kenya	11.4	13.0
Liberia	27.6	16.0
Mali	86.2	6.0
Mauritania	62.5	5.0
Niger	1.4	6.0
Nigeria	13.7	5.0
Senegal	21.4	5.0
Sierra Leone	64.3	16.0
Somalia	96.7	9.0
Sudan	81.7	10.0
Togo	1.4	11.0
Uganda	1.0	17.0
Tanzania, United Republic of	4.7	17.0
Yemen	16.4	0.0
Maldives	1.0	3.0

Source: EIGE, 2021. Reference date 2020.

Table A6. Female migrant population at risk in Denmark (2019)

Country of origin	Total number of girls in Denmark from this country of origin	Total number of girls in DK (aged 0–18) below typical age of cutting from this country of origin			National FGM prevalence rate for the 15–19 age group	No. of girls at risk	
		First generation	Second generation	Total		Min.	Max.
Benin	5	0	3	3	2.4	0	0
Burkina Faso	3	1	1	2	57.7	1	1
Cameroon	157	31	100	131	0.4	0	1
Central African Republic	7	2	2	4	17.9	0	1
Chad	3	1	1	2	31.8	0	1
Côte d'Ivoire	96	3	44	47	27.4	7	13
Djibouti	13	0	9	9	89.5	4	8
Egypt	197	36	93	129	69.6	57	90
Eritrea	1216	86	465	551	68.8	219	379
Ethiopia	260	24	136	160	47.1	43	75
Gambia	119	3	37	40	75	16	30
Ghana	353	7	76	83	1.5	1	1
Guinea	20	2	11	13	91.7	7	12
Guinea-Bissau	22	3	10	13	14.9	1	2
Indonesia	132	0	30	30	49	7	15
Iraq	4647	140	1690	1830	3.5	35	64
Kenya	132	38	64	102	11.4	8	12
Liberia	18	1	16	17	27.6	2	5
Mali	9	0	4	4	86.2	2	3
Mauritania	3	0	0	0	62.5	0	0
Niger	1	0	1	1	1.4	0	0
Nigeria	259	11	78	89	13.7	7	12
Senegal	30	1	9	10	21.4	1	2
Sierra Leone	64	5	58	63	64.3	22	41
Somalia	4172	120	1638	1758	96.7	908	1700
Sudan	191	19	96	115	81.7	55	94
Togo	14	1	10	11	1.4	0	0
Uganda	193	50	134	184	1	2	2
Tanzania, United Republic of	91	15	69	84	4.7	3	4
Yemen	35	1	1	2	16.4	0	0
Maldives	0	0	0	0	1	0	0
Total	12462	601	4886	5487	N/A	1408	2568

Source: Statistics Denmark. Reference date 01.01.2020

Table A7. Female migrant population at risk in Spain (2018)

Country of origin	Total number of girls in Spain from this country of origin	Total number of girls in ES (aged 0–18) below typical age of cutting from this country of origin			National FGM prevalence rate for the 15–19 age group	No. of girls at risk	
		First generation	Second generation	Total		Min.	Max.
Benin	70	3	36	39	2.4	0	1
Burkina Faso	200	12	63	75	57.7	25	43
Cameroon	1080	87	641	728	0.4	1	3
Central African Republic	45	8	34	42	17.9	4	8
Chad	18	2	14	16	31.8	3	5
Côte d'Ivoire	635	50	350	400	27.4	62	110
Djibouti	10	0	4	4	89.5	2	4
Egypt	793	186	384	570	69.6	263	397
Eritrea	19	1	3	4	68.8	2	3
Ethiopia	1499	356	88	444	47.1	189	209
Gambia	4572	121	1332	1453	75	591	1090
Ghana	2338	52	522	574	1.5	5	9
Guinea	2246	142	1183	1325	91.7	672	1215
Guinea-Bissau	762	27	360	387	14.9	31	58
Indonesia	293	15	52	67	49	20	33
Iraq	293	52	91	143	3.5	4	5
Kenya	198	37	125	162	11.4	11	18
Liberia	102	5	87	92	27.6	13	25
Mali	2682	168	1114	1282	86.2	625	1105
Mauritania	1676	56	475	531	62.5	183	332
Niger	73	2	18	20	1.4	0	0
Nigeria	10460	142	3299	3441	13.7	245	471
Senegal	9069	305	2878	3183	21.4	373	681
Sierra Leone	203	12	167	179	64.3	62	115
Somalia	69	4	28	32	96.7	18	31
Sudan	120	11	51	62	81.7	30	51
Togo	78	5	49	54	1.4	0	1
Uganda	37	9	28	37	1	0	0
Tanzania, United Republic of	52	8	42	50	4.7	1	2
Yemen	40	0	3	3	16.4	0	0
Maldives	2	0	1	1	1	0	0
Total	39734	1878	13522	15400	N/A	3435	6025

Source: National Institute of Statistics Spain (INE). Reference date 01.01.2019

Table A8. Female migrant population at risk in Luxembourg (2019)

Country of origin	Total number of girls in Luxembourg from this country of origin	Total number of girls in LU (aged 0–18) below typical age of cutting from this country of origin			National FGM prevalence rate for the 15–19 age group	No. of girls at risk	
		First generation	Second generation	Total		Min.	Max.
Benin	3	1	2	3	2.4	0	0
Burkina Faso	5	3	0	3	57.7	2	2
Cameroon	69	14	19	33	0.4	0	0
Central African Republic	2	2	0	2	17.9	0	0
Chad	0	0	0	0	31.8	0	0
Côte d'Ivoire	32	6	5	11	27.4	3	3
Djibouti	1	0	0	0	89.5	0	0
Egypt	28	17	6	23	69.6	14	16
Eritrea	189	29	59	88	68.8	40	61
Ethiopia	29	10	4	14	47.1	6	7
Gambia	5	1	0	1	75	1	1
Ghana	0	0	0	0	1.5	0	0
Guinea	32	15	3	18	91.7	15	17
Guinea-Bissau	79	13	4	17	14.9	2	3
Indonesia	4	1	0	1	49	0	0
Iraq	179	43	42	85	3.5	3	3
Kenya	14	10	1	11	11.4	1	1
Liberia	3	0	2	2	27.6	0	1
Mali	2	0	1	1	86.2	0	1
Mauritania	1	1	0	1	62.5	1	1
Niger	4	0	4	4	1.4	0	0
Nigeria	23	1	6	7	13.7	0	1
Senegal	57	9	6	15	21.4	3	3
Sierra Leone	1	1	0	1	64.3	1	1
Somalia	9	3	4	7	96.7	5	7
Sudan	12	4	5	9	81.7	5	7
Togo	33	10	8	18	1.4	0	0
Uganda	0	0	0	0	1	0	0
Tanzania, United Republic of	2	2	0	2	4.7	0	0
Yemen	4	0	0	0	16.4	0	0
Maldives	0	0	0	0	1	0	0
Total	822	196	181	377	N/A	102	136

Source: National Institute of Statistics and Economic Studies of the Grand Duchy of Luxembourg (STATEC). Reference date 01.01.2020

Table A9. Female migrant population at risk in Austria (2019)

Country of origin	Total number of girls in Austria from this country of origin	Total number of girls in AT (aged 0–18) below typical age of cutting from this country of origin			National FGM prevalence rate for the 15–19 age group	No. of girls at risk	
		First generation	Second generation	Total		Min.	Max.
Benin	4	1	3	4	2.4	0	0
Burkina Faso	11	1	2	3	57.7	2	2
Cameroon	89	15	42	57	0.4	0	0
Central African Republic	1	1	0	1	17.9	0	0
Chad	0	0	0	0	31.8	0	0
Côte d'Ivoire	24	3	9	12	27.4	2	3
Djibouti	1	1	0	1	89.5	1	1
Egypt	904	296	260	556	69.6	296	387
Eritrea	26	1	12	13	68.8	5	9
Ethiopia	360	25	25	50	47.1	18	24
Gambia	49	5	11	16	75	8	12
Ghana	194	2	38	40	1.5	0	1
Guinea	38	12	7	19	91.7	14	17
Guinea-Bissau	1	0	0	0	14.9	0	0
Indonesia	87	6	6	12	49	4	6
Iraq	1994	508	455	963	3.5	26	34
Kenya	121	56	32	88	11.4	8	10
Liberia	2	1	0	1	27.6	0	0
Mali	4	0	2	2	86.2	1	2
Mauritania	0	0	0	0	62.5	0	0
Niger	3	1	0	1	1.4	0	0
Nigeria	980	40	426	466	13.7	34	64
Senegal	7	0	4	4	21.4	0	1
Sierra Leone	8	4	4	8	64.3	4	5
Somalia	902	114	386	500	96.7	297	484
Sudan	39	11	15	26	81.7	15	21
Togo	11	4	5	9	1.4	0	0
Uganda	40	27	11	38	1	0	0
Tanzania, United Republic of	1	0	1	1	4.7	0	0
Yemen	9	0	3	3	16.4	0	0
Maldives	0	0	0	0	1	0	0
Total	5910	1135	1759	2894	N/A	735	1083

Source: Statistics Austria. Reference date 01.01.2020

Table A10. Denmark female asylum-seeking population at risk (2019)

Country of origin	Total number of asylum-seeking girls in Denmark from this country of origin	No. of asylum-seeking girls below the typical age of cutting	National FGM prevalence rate in the 15–19 age group	No. of asylum-seeking girls at risk
Benin	0	0	2.4	0
Burkina Faso	0	0	57.7	0
Cameroon	1	1	0.4	0
Central African Republic	0	0	17.9	0
Chad	0	0	31.8	0
Côte d'Ivoire	0	0	27.4	0
Djibouti	0	0	89.5	0
Egypt	1	1	69.6	1
Eritrea	179	72	68.8	50
Ethiopia	3	1	47.1	0
Gambia	0	0	75	0
Ghana	0	0	1.5	0
Guinea	0	0	91.7	0
Guinea-Bissau	0	0	14.9	0
Indonesia	1	0	49	0
Iraq	10	6	3.5	0
Kenya	2	2	11.4	0
Liberia	0	0	27.6	0
Mali	0	0	86.2	0
Mauritania	0	0	62.5	0
Niger	0	0	1.4	0
Nigeria	0	0	13.7	0
Senegal	0	0	21.4	0
Sierra Leone	0	0	64.3	0
Somalia	58	43	96.7	42
Sudan	2	2	81.7	2
Togo	0	0	1.4	0
Uganda	0	0	1	0
Tanzania, United Republic of	0	0	4.7	0
Yemen	0	0	16.4	0
Maldives	0	0	1	0
All countries of origin	257	128	N/A	95

Source: Statistics Denmark. Reference date 2019.

Table A11. Luxembourg female asylum-seeking population at risk (2019)

Country of origin	Total number of asylum-seeking girls in Luxembourg from this country of origin	No. of asylum-seeking girls below the typical age of cutting	National FGM prevalence rate in the 15–19 age group	No. of asylum-seeking girls at risk
Benin	0	0	2.4	0
Burkina Faso	0	0	57.7	0
Cameroon	2	2	0.4	0
Central African Republic	0	0	17.9	0
Chad	0	0	31.8	0
Côte d’Ivoire	1	0	27.4	0
Djibouti	0	0	89.5	0
Egypt	0	0	69.6	0
Eritrea	88	28	68.8	19
Ethiopia	2	0	47.1	0
Gambia	0	0	75	0
Ghana	0	0	1.5	0
Guinea	0	0	91.7	0
Guinea-Bissau	0	0	14.9	0
Indonesia	0	0	49	0
Iraq	18	10	3.5	0
Kenya	0	0	11.4	0
Liberia	0	0	27.6	0
Mali	0	0	86.2	0
Mauritania	0	0	62.5	0
Niger	0	0	1.4	0
Nigeria	1	1	13.7	0
Senegal	0	0	21.4	0
Sierra Leone	0	0	64.3	0
Somalia	4	2	96.7	2
Sudan	2	2	81.7	2
Togo	0	0	1.4	0
Uganda	0	0	1	0
Tanzania, United Republic of	0	0	4.7	0
Yemen	3	0	16.4	0
Maldives	0	0	1	0
All countries of origin	121	45	N/A	23

Source: National Institute of Statistics and Economic Studies of the Grand Duchy of Luxembourg (STATEC). Reference date 2019.

Table A12. Austria female asylum-seeking population at risk (2019)

Country of origin	Total number of asylum-seeking girls in Austria from this country of origin	No. of asylum-seeking girls below the typical age of cutting	National FGM prevalence rate in the 15–19 age group	No. of asylum-seeking girls at risk
Benin	3	3	2.4	0
Burkina Faso	1	1	57.7	1
Cameroon	24	22	0.4	0
Central African Republic	1	1	17.9	0
Chad	0	0	31.8	0
Côte d'Ivoire	8	7	27.4	2
Djibouti	0	0	89.5	0
Egypt	60	53	69.6	37
Eritrea	48	26	68.8	18
Ethiopia	31	26	47.1	12
Gambia	23	16	75	12
Ghana	4	2	1.5	0
Guinea	15	12	91.7	11
Guinea-Bissau	1	0	14.9	0
Indonesia	0	0	49	0
Iraq	1374	981	3.5	34
Kenya	6	6	11.4	1
Liberia	0	0	27.6	0
Mali	2	2	86.2	2
Mauritania	0	0	62.5	0
Niger	0	0	1.4	0
Nigeria	224	124	13.7	17
Senegal	0	0	21.4	0
Sierra Leone	5	5	64.3	3
Somalia	1002	765	96.7	740
Sudan	23	19	81.7	16
Togo	3	3	1.4	0
Uganda	4	4	1	0
Tanzania, United Republic of	1	1	4.7	0
Yemen	36	3	16.4	1
Maldives	0	0	1	0
All countries of origin	2899	2082	N/A	907

Source: Statistics Austria. Reference date: 01.01.2016 – 30.06.2020. Note that table refers to first and multiple applications for asylum including asylum-seekers' children.

Table A13. Denmark female refugee population at risk (2019)

Country of origin	Total number of refugee girls in Denmark from this country of origin	No. of refugee girls who are below the typical age of cutting	National FGM prevalence rate in the 15–19 age group	No. of refugee girls at risk
Benin	0	0	2.4	0
Burkina Faso	0	0	57.7	0
Cameroon	0	0	0.4	0
Central African Republic	0	0	17.9	0
Chad	0	0	31.8	0
Côte d’Ivoire	0	0	27.4	0
Djibouti	0	0	89.5	0
Egypt	1	1	69.6	1
Eritrea	302	99	68.8	68
Ethiopia	1	0	47.1	0
Gambia	0	0	75	0
Ghana	0	0	1.5	0
Guinea	0	0	91.7	0
Guinea-Bissau	0	0	14.9	0
Indonesia	0	0	49	0
Iraq	7	4	3.5	0
Kenya	0	0	11.4	0
Liberia	0	0	27.6	0
Mali	0	0	86.2	0
Mauritania	0	0	62.5	0
Niger	0	0	1.4	0
Nigeria	0	0	13.7	0
Senegal	0	0	21.4	0
Sierra Leone	0	0	64.3	0
Somalia	26	14	96.7	14
Sudan	1	1	81.7	1
Togo	0	0	1.4	0
Uganda	0	0	1	0
Tanzania, United Republic of	0	0	4.7	0
Yemen	0	0	16.4	0
Maldives	0	0	1	0
All countries of origin	338	119	N/A	84

Source: Statistics Denmark. Reference date 2019.

Table A14. Luxembourg female refugee population at risk (2019)

Country of origin	Total number of refugee girls in Luxembourg from this country of origin	No. of refugee girls who are below the typical age of cutting	National FGM prevalence rate in the 15–19 age group	No. of refugee girls at risk
Benin	0	0	2.4	0
Burkina Faso	0	0	57.7	0
Cameroon	0	0	0.4	0
Central African Republic	0	0	17.9	0
Chad	0	0	31.8	0
Côte d'Ivoire	0	0	27.4	0
Djibouti	0	0	89.5	0
Egypt	4	2	69.6	1
Eritrea	39	26	68.8	18
Ethiopia	2	2	47.1	1
Gambia	0	0	75	0
Ghana	0	0	1.5	0
Guinea	0	0	91.7	0
Guinea-Bissau	0	0	14.9	0
Indonesia	0	0	49	0
Iraq	24	19	3.5	1
Kenya	0	0	11.4	0
Liberia	0	0	27.6	0
Mali	0	0	86.2	0
Mauritania	0	0	62.5	0
Niger	0	0	1.4	0
Nigeria	0	0	13.7	0
Senegal	0	0	21.4	0
Sierra Leone	0	0	64.3	0
Somalia	1	0	96.7	0
Sudan	0	0	81.7	0
Togo	0	0	1.4	0
Uganda	0	0	1	0
Tanzania, United Republic of	0	0	4.7	0
Yemen	4	0	16.4	0
Maldives	0	0	1	0
All countries of origin	74	49	N/A	21

Source: National Institute of Statistics and Economic Studies of the Grand Duchy of Luxembourg (STATEC). Reference date 2019.

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