Acknowledgements

The UNHCR Bureau for Europe wishes to acknowledge the contribution of three interns with UNHCR in 2012 to the preparation of this statistical overview. Marie Schirmmeister made the idea of this statistical study possible by assembling the first set of data, which Sheun Olaoshebikan then further developed. Special thanks go to Hannah West for the preparation of the final tables and graphs and the initial analysis of the data presented in this publication.
Introduction

Female genital mutilation (FGM) includes procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons. This harmful traditional practice is most common in the western, eastern, and north-eastern regions of Africa; in some countries in Asia and the Middle East; and among migrant and refugee communities from these areas in Europe, Australia, New Zealand, Canada and the United States of America. FGM is recognized internationally as a violation of the human rights of girls and women. The practice also violates a person’s rights to health, security and physical integrity; the right to be free from torture and cruel, inhuman or degrading treatment; and the right to life when the procedure results in death. The practice of FGM is also considered as a criminal act in all EU Member States.

This statistical overview has been prepared on the occasion of the European Institute for Gender Equality (EIGE) study on FGM in the European Union and Croatia. Little is known about FGM in the European Union in general, and this statement holds true about FGM and asylum more specifically. In light of the recognized need for country- and community-tailored responses, this study provides some of the statistical evidence needed to advance the discussion on the necessary policies and tools to address the specific vulnerabilities of female asylum-seekers with FGM in the asylum system on the one hand, and of refugee girls and women living with FGM and integrating in EU Member States on the other hand. In addition, in the absence of statistical data on asylum claims relating to this harmful traditional practice, this document also provides estimates that draw attention to the specific needs for international protection girls (and their parents) as well as women may raise in relation to FGM.

Female genital mutilations must be seen as child abuse and mistreatment.

Christine Flamand, Belgian lawyer, Intact (NGO).

UNHCR hopes this study will further encourage EU Member States to gather more systematic qualitative and quantitative data on this little-researched aspect of the asylum system, with the support of Eurostat, in order to provide timely, complete and sex-disaggregated statistical data.

It is also hoped that the study will encourage EU Member States and the European Asylum Support Office (EASO) to develop training material in the European Asylum Curriculum (EAC) and enhance the gender-sensitive nature of Country of Origin Information (COI) to strengthen the capacity of the asylum authorities to adjudicate claims relating to FGM. This study also aims to encourage the European Commission in considering the need for interpretative guidelines on FGM and asylum that would support Member States to further harmonize national practices in line with the spirit of the Common European Asylum System (CEAS). At the level of the national asylum authorities, the hope is for this report to help raise the awareness of individual staff members regarding FGM and its relevance to their responsibilities, be it as health practitioners, interviewers, decision-makers, policy-makers or managers.

It is a matter of principle that women are free and equal.

Ayaan Hirsi Ali, Somali refugee in the Netherlands.

Last but not least, UNHCR also hopes that this study will encourage policy-makers at EU, state and regional levels and service providers to fully include asylum-seeking as well as refugee girls and women in their comprehensive and multi-disciplinary action plans for the abandonment of FGM in the European Union in line with the recent UN General Assembly Resolution.1

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Methodology

For the purpose of this study, FGM-practising countries of origin include Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Congo, Côte d’Ivoire, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Somalia, Sudan, Tanzania, Togo, Uganda, and Yemen. Given the recent arrival of these female asylum-seekers in the EU, it was deemed methodologically appropriate to use the FGM prevalence rates from the national survey data on FGM prevalence in the countries of origin for this study. Given the lack of comparable data on FGM practices in Iraq, a key country of origin in the asylum systems of the EU, Iraq has not been included in this study.

The statistics in this document were compiled between October and December 2012 using the data available in Eurostat for the four year period 2008 to 2011. Data on asylum applications for 2012 were unfortunately too incomplete to allow the inclusion of a fifth year in this study.

Methodological decisions also had to be made to address some of the constraints linked to the nature of Eurostat data. The category “New Asylum Applicant”, i.e. excluding repeat applications and double-counting of individuals, has been used as much as possible in the preparation of the data set out in this study. However the category “Asylum Applicant” also had to be resorted to where the lack of disaggregated data between new and repeat applications made it impossible to have a full and comprehensive view of the phenomenon.

Likewise, Eurostat does not record whether the women and girls under statistical study are principal or secondary applicants making it more difficult to analyze the issues at hand.

Of note too, data in Eurostat is not consistently available for the appeal stage; as such this study only looks at first instance applications and decisions.

The estimates in the last section of this study on the number of applications raising FGM issues are calculated on the basis of the data recorded by the Belgian asylum authority and Eurostat statistics.

Content

Focusing on girls and women from FGM-practising countries of origin who seek asylum in the EU, this statistical study seeks to provide answers to the six following questions:

1. Where do they seek asylum in the EU? – This first set of data provides an overview of the destination countries for the approximately 20,000 women and girls who seek asylum from practising countries of origin in the EU every year.

2. Where do they come from? – This set of data in turn focuses on the countries of origin of these 20,000 girls and women, and looks at the different patterns of applications in the main asylum countries.

3. Where do they settle in the EU? – This set examines where girls and women from FGM-practising countries of origin granted international protection settle and integrate in the EU.

4. What is the FGM prevalence rate? – This set identifies the estimated FGM prevalence rate among female asylum-seekers in the EU, and constitutes a direct contribution to the EIGE study on FGM in the EU and Croatia.

5. Where do these girls settle in the EU? – The following set seeks to estimate the number of refugee girls from practising countries of origin who settle every year in EU Member States following the grant of international protection or other form of national status, and who should be fully incorporated into prevention, prosecution and protection responses to end FGM in the Diasporas of the EU.

6. How many asylum claims relate to FGM? – In the absence of disaggregated data collected by the EU asylum authorities on the grounds for international protection in general, and FGM in particular, the last set of data seeks to provide estimates of the number of asylum claims on FGM grounds the top destination asylum countries may handle every year.

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2 This study uses the concepts of (FGM-) practising and FGM-risk (in the tables) countries interchangeably.

3 The World Health Organisation (WHO) notes that there are only anecdotal reports on FGM in the Democratic Republic of Congo, and that the figure of 5% mentioned in a WHO publication in 1997 was a questionable estimate (available at: http://who.int/dph/hrh/).

4 This national survey data is part of the Demographic and Health Surveys (DHS) published by Macro, or the Multiple Cluster Indicator Surveys (MICS), published by UNICEF; available at: http://dhsprogram.com.

5 FGM prevalence data for Iraq became available in 2013, too late to be taken into account in this publication. Based on Multiple Cluster Indicator Surveys (MICS) in 2011, the FGM prevalence rate for Iraq is estimated at 8.1% but rises to 42.8% in the Kurdistan Region (Suleimaniya: 54.3%; Erbil: 57.5%; Kirkuk: 19.9%). Source: Iraq - Multiple Indicator Cluster Survey, 2011, Final Report, Central Statistics Organization, Kurdistan Regional Statistics Office, Ministry of Health, UNICEF, September 2012, available at: http://dhsprogram.com.
Around 20,000 women and girls seek asylum from FGM-practising countries of origin in the EU every year. This number has remained relatively constant between 2008 (18,110) and 2011 (19,565), despite the total number of female applicants having increased from 65,125 in 2008 to 93,350 in 2011. This is due mostly to the general reduction in asylum claims from Somalia; Somali women and girls represented about 20% of all female applicants in 2011, down from 27.8% in 2008.8

In absolute numbers, France (4,210), Italy (3,095), Sweden (2,610), the United Kingdom (2,410), Belgium (1,930), Germany (1,720), and the Netherlands (1,545) were the main countries of asylum for these women and girls in 2011.7 Between 2008 and 2011, all these EU Member States have experienced an increase in the total number of asylum claims from females from practising countries, apart from the Netherlands and Sweden.8

Over the four year period, Finland, France, Greece, Ireland, the Netherlands, Spain, Sweden, and the United Kingdom, all received an average of over 20% of female applicants from practising countries of origin. Within this time frame, the United Kingdom stands out having experienced an increase in the percentage of females from practising countries of origin seeking asylum, from 19.5% to 27.4%. As for Belgium and Germany, on average over 10% of all female applicants in these two States come from practising countries of origin.

On the other hand, Malta and Italy are the two Member States with the highest proportion of female asylum applicants from practising countries of origin out of the total female applicants. In Malta, the percentage of females from practising countries seeking asylum was more than 90% for the years 2008, 2009 and 2011.9 In Italy, 10,270 applications from females from practising countries of origin were received between 2008 and 2011; an average of 66% of all female applicants over the four year period.

6 This data has been calculated using “Asylum Applicant” in Eurostat rather than “New Asylum Applicant” (i.e. excluding repeat applications) which had too many missing data and provided for an extremely incomplete picture. The same basis has been used for tables and graphs 1 to 1.2.

7 Table 1: Geographical distribution of female applicants from FGM-practising countries of origin (CoO) in the EU 27 Member States. The percentage of females applying for asylum from FGM-practising CoO for the years 2008-2011 has been calculated by identifying the number of females from FGM-practising CoO as a proportion of the total number of females applying for asylum. Countries with a significant percentage of female applications from FGM-practising CoO have been highlighted.

8 See Graph 1.2.

9 By contrast, in 2010, the proportion was only 42.8%, due most certainly to the considerably lower level of applications received from women in Malta that year. Over the four year period, Malta received a total of 1,075 female applicants from FGM-practising countries of origin.
Table 1: Geographical Distribution of Female Applicants from FGM-risk Countries of Origin in EU 27 (2008-2011)

<table>
<thead>
<tr>
<th>EU Member State</th>
<th>Total Number of Females Applying for Asylum</th>
<th>Females from FGM-risk Countries of Origin</th>
<th>Percentage of Females from FGM-risk Countries of Origin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>4,255</td>
<td>4,855</td>
<td>3,260</td>
</tr>
<tr>
<td>Belgium</td>
<td>5,540</td>
<td>8,080</td>
<td>9,555</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>175</td>
<td>160</td>
<td>165</td>
</tr>
<tr>
<td>Cyprus</td>
<td>1,075</td>
<td>1,085</td>
<td>1,045</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>485</td>
<td>410</td>
<td>245</td>
</tr>
<tr>
<td>Denmark</td>
<td>550</td>
<td>885</td>
<td>1,215</td>
</tr>
<tr>
<td>Estonia</td>
<td>5</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Finland</td>
<td>815</td>
<td>1,470</td>
<td>1,080</td>
</tr>
<tr>
<td>France</td>
<td>15,455</td>
<td>17,320</td>
<td>19,375</td>
</tr>
<tr>
<td>Germany</td>
<td>8,500</td>
<td>10,995</td>
<td>17,770</td>
</tr>
<tr>
<td>Greece</td>
<td>1,625</td>
<td>2,515</td>
<td>1,590</td>
</tr>
<tr>
<td>Hungary</td>
<td>670</td>
<td>1,110</td>
<td>315</td>
</tr>
<tr>
<td>Ireland</td>
<td>1,400</td>
<td>930</td>
<td>665</td>
</tr>
<tr>
<td>Italy</td>
<td>4,400</td>
<td>4,530</td>
<td>2,560</td>
</tr>
<tr>
<td>Latvia</td>
<td>15</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>Lithuania</td>
<td>180</td>
<td>130</td>
<td>140</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>160</td>
<td>140</td>
<td>245</td>
</tr>
<tr>
<td>Malta</td>
<td>320</td>
<td>440</td>
<td>35</td>
</tr>
<tr>
<td>Netherlands</td>
<td>5,200</td>
<td>5,445</td>
<td>6,070</td>
</tr>
<tr>
<td>Poland</td>
<td>4,065</td>
<td>4,675</td>
<td>3,025</td>
</tr>
<tr>
<td>Portugal</td>
<td>50</td>
<td>35</td>
<td>40</td>
</tr>
<tr>
<td>Romania</td>
<td>105</td>
<td>105</td>
<td>120</td>
</tr>
<tr>
<td>Slovakia</td>
<td>85</td>
<td>95</td>
<td>65</td>
</tr>
<tr>
<td>Slovenia</td>
<td>35</td>
<td>40</td>
<td>50</td>
</tr>
<tr>
<td>Spain</td>
<td>1,415</td>
<td>880</td>
<td>800</td>
</tr>
<tr>
<td>Sweden</td>
<td>8,545</td>
<td>8,495</td>
<td>12,050</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>:</td>
<td>11,735</td>
<td>8,590</td>
</tr>
<tr>
<td>EU (total)</td>
<td>65,125</td>
<td>86,685</td>
<td>90,095</td>
</tr>
</tbody>
</table>

Notes:
- FGM-risk countries of origin: Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Congo, Cote d'Ivoire, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Somalia, Sudan, Tanzania, Togo, Uganda, Yemen
- Only EU MS with significant number of female asylum applicants from FGM-risk CoO are highlighted. Colours represent the percentage of female applicants out of total female applicants from FGM-risk CoO: Red for 50% or more; Orange for 20% or more; and Yellow for 10% or more
- (1) These EU totals exclude the UK whose numbers were unavailable in Eurostat.
- (2) All numbers are rounded by Eurostat. EU totals do not match the sum of individual EU-27 states.
- (*) represents no data available

TOO MUCH PAIN - Female Genital Mutilation & Asylum in the European Union
A Statistical Overview
Map: Female applicants from FGM-practising countries of origin in EU 27
Some preliminary comments

The sheer number of women and girls from FGM-practising countries in the asylum reception systems of the top destination countries in the EU is likely to lead to FGM-specific issues being raised in that context, be it in relation to primary health, reproductive health or psychological problems during the asylum procedure or later when settling and integrating in EU Member States. The section on FGM prevalence among female asylum-seekers in the EU Member States addresses FGM in the context of the asylum reception conditions more in depth, while two other sections focus more specifically on the integration of refugee girls and women and the prevention efforts necessary to ensure that these girls live free of FGM.

Notwithstanding the constraints posed by the lack of disaggregated data in Eurostat between principal and secondary applicants, and based on the sheer number of female applicants from FGM-practising countries of origin in the top countries of asylum, it is reasonable to assume that some of these women and girls may raise gender-specific issues in their applications and statements to the asylum authorities, including FGM-related issues.

Professionals working with asylum-seekers and refugees face multiple challenges, including: linguistic differences; pressures of finite time; inadequate cultural awareness; and deficient expertise. Co-ordinated inter-agency training is key for all professionals working with affected communities, enabling them to provide effective and culturally sensitive support to those affected and to protect children by being sensitised to warning signs.

The different individual backgrounds and past experiences of women and girls from FGM-practising countries of origin will require specific gender, age and social awareness by staff and consequently tailored training to carry out the credibility assessment and the examination of the substantive issues arising in these applications. These in turn will require adjusted Country of Origin Information (COI) to document the situation in the different countries of origin these women and girls come from, as opposed to the countries of origin of applicants in general. For instance, while the total number of asylum claims from Nigeria is negligible, when considered through the “FGM lens”,

Nigeria becomes the top country of origin for these women and girls. Likewise, asylum adjudicators are also likely to need tailored COI to address the specific facts and country conditions these women and girls may refer to in their claims. To continue with the example of Nigeria, while male applicants tend to raise ethnic and religion-related issues, Nigerian women and girls may raise in addition gender-specific, including FGM-related, issues. Likewise, the issue of ‘safe countries of origin’ also takes a new dimension when considered through the “FGM lens”.

The next section provides disaggregated data on the countries of origin of these women and girls for the top asylum countries in the EU and, as such, provides a tool to further refine this analysis at the level of individual Member States. The study is also a useful evidence basis for the further development of the European Asylum Curriculum, which needs to reflect the specific issues raised by FGM as part of general efforts to enhance training material on gender-related claims. It is also hoped that the statistical data in this report will also encourage EASO to further support Member States through the provision of gender-specific COI, including on FGM.


2. Where do they come from?

In 2011, woman and girl asylum-seekers from FGM-practising countries of origin came mainly from Nigeria (3,835), Somalia (3,340), Eritrea (2,215), Guinea (1,965), and Cote d’Ivoire (955). Nigerian and Somali female applicants represent 21% and 18% of all female applicants respectively.

Tables 2a, Graph 2b and Tables 2.1 to 2.7 show the geographical distribution of female applicants from the top 18 FGM-practising countries in the EU 27 Member States between 2008 and 2011. Just under half of all the female claimants from Nigeria applied for asylum in Italy, followed by the United Kingdom and France (Table 2.1). Sweden was the primary destination of asylum for Somali female applicants, followed by the Netherlands (Table 2.2). Sweden was also the asylum country for the majority of female applicants from Eritrea, while Belgium and France recorded the majority of Guinean and Ivorian female claimants.

The number of female applicants from Somalia has dramatically decreased from 5,190 in 2008 to 3,340 in 2011, while the number of Guinean female applicants has increased fivefold from 380 to 1,965, and the number of Ivorian women has almost tripled from 350 to 955.


Table 2a: Top 18 FGM-Risk Countries of Origin for Female Applicants in 2011

<table>
<thead>
<tr>
<th>FGM-practising Country of Origin</th>
<th>Total Nbr of Female Applicants from Practising Country</th>
<th>% out of Total Female Applicants from All FGM-Practising Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Nigeria</td>
<td>3,835</td>
<td>21.19%</td>
</tr>
<tr>
<td>2 Somalia</td>
<td>3,340</td>
<td>18.45%</td>
</tr>
<tr>
<td>3 Eritrea</td>
<td>2,215</td>
<td>12.24%</td>
</tr>
<tr>
<td>4 Guinea</td>
<td>1,965</td>
<td>10.86%</td>
</tr>
<tr>
<td>5 Cote d’Ivoire</td>
<td>955</td>
<td>5.28%</td>
</tr>
<tr>
<td>6 Ethiopia</td>
<td>685</td>
<td>3.78%</td>
</tr>
<tr>
<td>7 Congo</td>
<td>520</td>
<td>2.87%</td>
</tr>
<tr>
<td>8 Mali</td>
<td>515</td>
<td>2.85%</td>
</tr>
<tr>
<td>9 Cameroon</td>
<td>495</td>
<td>2.73%</td>
</tr>
<tr>
<td>10 Ghana</td>
<td>435</td>
<td>2.40%</td>
</tr>
<tr>
<td>11 Sudan</td>
<td>375</td>
<td>2.07%</td>
</tr>
<tr>
<td>12 Egypt</td>
<td>350</td>
<td>1.93%</td>
</tr>
<tr>
<td>13 Uganda</td>
<td>330</td>
<td>1.82%</td>
</tr>
<tr>
<td>14 Gambia</td>
<td>305</td>
<td>1.69%</td>
</tr>
<tr>
<td>15 Kenya</td>
<td>300</td>
<td>1.66%</td>
</tr>
<tr>
<td>16 Senegal</td>
<td>265</td>
<td>1.46%</td>
</tr>
<tr>
<td>17 Sierra Leone</td>
<td>250</td>
<td>1.38%</td>
</tr>
<tr>
<td>18 Mauritania</td>
<td>240</td>
<td>1.33%</td>
</tr>
</tbody>
</table>

10 Table 2a shows the top 16 FGM-practising CoO for female applicants in the EU 27 Member States in 2011. For each FGM-practising CoO the number of female applicants has been calculated as a percentage of the total number of female applicants to the EU 27 Member States.

11 The countries receiving a significant number of applications from FGM-practising CoO are marked in red, orange or yellow, based on the average over the four year period.
Graph 2b: Geographical Distribution of Female Applicants from Top 10 FGM-risk Countries (2011)
### Table 2.1: Top 1: Female Applicants from Nigeria in EU 27

<table>
<thead>
<tr>
<th>EU Member State</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belgium</td>
<td>20</td>
<td>40</td>
<td>35</td>
<td>60</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>:</td>
<td>:</td>
<td>:</td>
<td>0</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>10</td>
<td>15</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Denmark</td>
<td>:</td>
<td>:</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Germany</td>
<td>200</td>
<td>305</td>
<td>260</td>
<td>295</td>
</tr>
<tr>
<td>Estonia</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Ireland</td>
<td>485</td>
<td>245</td>
<td>175</td>
<td>90</td>
</tr>
<tr>
<td>Greece</td>
<td>:</td>
<td>:</td>
<td>:</td>
<td>150</td>
</tr>
<tr>
<td>Spain</td>
<td>:</td>
<td>:</td>
<td>125</td>
<td>140</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>:</td>
<td>:</td>
<td>:</td>
<td>0</td>
</tr>
<tr>
<td>Hungary</td>
<td>:</td>
<td>:</td>
<td>:</td>
<td>0</td>
</tr>
<tr>
<td>Malta</td>
<td>50</td>
<td>70</td>
<td>0</td>
<td>75</td>
</tr>
<tr>
<td>Netherlands</td>
<td>35</td>
<td>55</td>
<td>45</td>
<td>45</td>
</tr>
<tr>
<td>Austria</td>
<td>:</td>
<td>:</td>
<td>:</td>
<td>:</td>
</tr>
<tr>
<td>Poland</td>
<td>5</td>
<td>5</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Portugal</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>:</td>
</tr>
<tr>
<td>Romania</td>
<td>:</td>
<td>:</td>
<td>:</td>
<td>0</td>
</tr>
<tr>
<td>Slovenia</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Slovakia</td>
<td>:</td>
<td>:</td>
<td>:</td>
<td>0</td>
</tr>
<tr>
<td>Finland</td>
<td>:</td>
<td>:</td>
<td>:</td>
<td>:</td>
</tr>
<tr>
<td>Sweden</td>
<td>50</td>
<td>60</td>
<td>65</td>
<td>95</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>485</td>
<td>385</td>
<td>555</td>
<td>545</td>
</tr>
<tr>
<td>EU (total)</td>
<td>3,090</td>
<td>2,920</td>
<td>2,375</td>
<td>3,835</td>
</tr>
</tbody>
</table>

### Table 2.2: Top 2: Female Applicants from Somalia in EU 27

<table>
<thead>
<tr>
<th>EU Member State</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belgium</td>
<td>40</td>
<td>45</td>
<td>80</td>
<td>175</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>:</td>
<td>:</td>
<td>:</td>
<td>5</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Denmark</td>
<td>:</td>
<td>:</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>Germany</td>
<td>65</td>
<td>130</td>
<td>515</td>
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### Table 2.5: Top 5: Female Applicants from Cote d’Ivoire in EU 27

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### Table 2.6: Top 6: Female Applicants from Ethiopia in EU 27

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Some preliminary comments

The above data further refine the preliminary comments in the previous section regarding the top asylum countries for all female applicants from FGM-practising countries by providing a breakdown of these countries of origin. The following data are therefore meant as a tool for Member States to further focus the capacity of their respective COI Units or COI Researchers on the relevant key FGM-practising countries of origin. The data could also be useful to EASO in its support role with regards COI, including when developing the Common COI Portal, organizing COI Workshops, and gathering COI on specific topics, to enhance their gender-sensitivity in general and incorporate FGM more specifically.

As is the case for all asylum claims, each top destination country receives applications from a different set of countries of origin allowing for further specialization of both the COI Units and the adjudicators in the respective asylum authorities. Harmful traditional practices, and FGM in particular, are not a uniform phenomenon across the various FGM-practising countries of origin; the contextual circumstances of each country of origin, including its laws and their application, the social mores and the changes in behaviour vary, notwithstanding the personal background of the applicant herself, including her age, gender, ethnic origin, social status and place of residence. As such the issues raised in their claims by these women and girl applicants are likely to be of a different nature and require the examination of specific issues depending on the conditions in the FGM-practising countries of origin.

Table 2.7: Geographical Distribution of Female Applicants from FGM-risk Countries of Origin in EU 27 (2011)

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3. Where do they settle in the EU?

Over the four year period under study (2008-2011), the number of female asylum-seekers from FGM-practising countries of origin granted international protection in the EU 27 increased from 1,380 to 1,950. The majority of these women and girls came from Somalia (1,690), Eritrea (795), and Nigeria (595). Recognition rates seem to indicate that 14 EU Member States granted international protection to female refugees from FGM-practising countries during the same period: the United Kingdom, France, Sweden, Germany, the Netherlands, Austria, Belgium, Italy, and to a lesser degree Ireland, Romania, Greece, the Czech Republic, Finland and Cyprus.

The United Kingdom offered protection to the largest number of women and girls from FGM-practising countries of origin (2,525) i.e. to over 600 a year (from 685 in 2008 to 640 in 2011); these came mainly from Somalia, Eritrea and Nigeria.

France in turn granted international protection to 1,775 women and girls, of whom the majority came from Guinea, Mali and Congo. The number of females receiving international protection in France increased from 345 to 485 between 2008 and 2011. Sweden then came third, followed by Germany and the Netherlands. From the top 7 EU Member States that received women and girls seeking asylum from FGM-practising countries of origin, Italy provided international protection to the smallest number of females (75 between 2008 and 2011); more than Belgium and Italy. Graph 3 provides an overview of recognition rates for female asylum-seekers from FGM-practising countries of origin in the top seven EU destination countries between 2008 and 2011.

Even if the law exists and that multiple actions to improve prevention [against FGM] are conducted, disarray amongst professionals confronted with this problem remains enormous.

Even if the law exists and that multiple actions to improve prevention [against FGM] are conducted, disarray amongst professionals confronted with this problem remains enormous.

Fabienne Richard, midwife-referent, GAMS Belgium, and researcher at the Department of Public Health, Institute of Tropical Medicine in Antwerp.

Table 3.1: Number of Females Granted International Protection in EU 27

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12 See Table 3.1. 13 See Table 3.2. 14 See Table 3.3. 15 See Table 3.4. 16 See Table 3.5. 17 See Table 3.6. 18 See Table 3.7. 19 See Table 3.8. 20 See Table 3.9.
Some preliminary comments

This section provides detailed data on the EU Member States in which refugee women and girls from FGM practising countries reside, as well as information about their respective countries of origin. The data in this set aim at raising awareness on these refugee women and girls who live in EU Member States with very specific long-lasting physical, sexual and mental health problems resulting from FGM. Social, linguistic, religious and cultural barriers may hinder the access of these refugee women and girls to specialist health and support services. It is thus hoped that this data, with its breakdown by countries of origin, will encourage the tailored and targeted design of initiatives aimed at supporting the integration of refugee women and girls in the key destination EU Member States.

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Graph 3: Recognition Rate for Females from FGM-risk Countries in Top EU 7 Member States
### Table 3.4: Sweden

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### Table 3.6: Netherlands

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<td>TOTAL</td>
<td>40</td>
<td>35</td>
<td>20</td>
<td>5</td>
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</table>
4. What is the FGM prevalence rate?

The study estimates that 8,809 female asylum applicants aged 14-64 may have been affected by FGM in 2011, i.e. 61% of the total 14,440 girls and women from the same age group who sought asylum in the EU 27 Member States from FGM-practising countries of origin that year. The majority of these were aged 18 to 34. Based on the FGM prevalence rate in the countries of origin, Somali, Eritrean and Guinean girls and women seeking asylum in the EU were likely to be the most affected by FGM.

The social worker to whom I explained my story said, “Excuse me, but what are you talking about?”. For a moment I was speechless, I could not understand how as a social worker she didn’t know about excision. She is supposed to “help” me and she does not even know what I am talking about; it was useless to continue telling her my story.

Teliwel Diallo, anti-FGM activist in Guinea, refugee in Belgium.

While female applicants from FGM-practising countries represented 20% of all women and girls seeking asylum in the EU in 2011, as outlined in the first section of this study, the estimated proportion of women and girls aged 14-64 potentially affected by FGM out of the total number of female asylum applicants is 9.1%.

---

Table 4.1: Estimated Number of Female Asylum-Seekers Aged 14-64 Potentially Affected by FGM

<table>
<thead>
<tr>
<th>FGM-risk Country of Origin</th>
<th>Age</th>
<th>Total No of Female Applicants Aged 14-64</th>
<th>FGM Prevalence Rate</th>
<th>Estimated No of Female Applicants Aged 14-64 Potentially Affected by FGM</th>
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<tbody>
<tr>
<td></td>
<td>14-17</td>
<td>18-34</td>
<td>35-64</td>
<td></td>
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<td>Cameroon</td>
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<td>425</td>
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<td>70</td>
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<td>Congo</td>
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<td>430</td>
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<td>1,275</td>
<td>385</td>
<td>1,825</td>
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<td>Ethiopia</td>
<td>70</td>
<td>450</td>
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<td>580</td>
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<td>Kenya</td>
<td>15</td>
<td>175</td>
<td>70</td>
<td>260</td>
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<td>Somalia</td>
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<td>1,765</td>
<td>490</td>
<td>2,465</td>
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<td>Uganda</td>
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<td>270</td>
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<td>60</td>
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<td>Egypt</td>
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<td>140</td>
<td>75</td>
<td>230</td>
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<td>Sudan</td>
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<td>Benin</td>
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<td>20</td>
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<td>85</td>
<td>340</td>
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<td>Guinea</td>
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<td>Sierra Leone</td>
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<td>140</td>
<td>10</td>
<td>175</td>
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<td>Togo</td>
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<td>110</td>
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<td>Yemen</td>
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<td>35</td>
<td>25</td>
<td>65</td>
</tr>
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<td>TOTAL</td>
<td>915</td>
<td>10,730</td>
<td>2,385</td>
<td>14,030</td>
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</table>

* The FGM-prevalence rates are derived from national survey data (the Demographic and Health Surveys (DHS) published by Macro, or the Multiple Cluster Indicator Surveys (MICS), published by UNICEF), available at: http://www.who.int/reproductivehealth/topics/fgm/prevalence/en/index.html

(c) The World Health organization (WHO) notes that there are only anecdotal reports on FGM in the Democratic Republic of Congo.
In absolute numbers, the top five asylum countries with the highest estimated number of female applicants aged 14-64 likely to be affected by FGM in 2011 were **Sweden, France, Italy, the United Kingdom** and **Belgium**. Looking at the proportion these girls and women potentially affected by FGM may represent out of the total number of female applicants from FGM-practising countries of origin in each Member State, the **Netherlands, Austria and Malta** then join this group of top Member States.

According to this estimate, over 50% of all female applicants from FGM-practising countries of origin in **Austria, Malta, Belgium, France, Germany** and the **United Kingdom** were potentially affected by FGM in 2011, and they came mostly from **Somalia, Guinea and Eritrea**.

"All the women usually try to avoid being examined in that area because they don’t feel comfortable. Especially those who are newcomers because of the language they have to have a third person as an interpreter or the husband."

In **Sweden**, 1,716 female applicants between the ages of 14 and 64 are likely to be affected by FGM i.e. 85.4% of the total female applicants from FGM-practising countries of origin in **Sweden**. The majority of these were **Somali** women and girls (estimated at 964).

In the **Netherlands**, it is estimated that 798 female asylum-seekers are likely to be affected by FGM, representing 80.6% of the total female applicants aged 14-64 from FGM-practising countries. The majority of these are from **Somalia** (an estimated 387 girls and women).

### Table 4.2: Estimated Number of Female Applicants Aged 14-64 Potentially Affected by FGM in EU 27 Member States (2011)

<table>
<thead>
<tr>
<th>EU Member State</th>
<th>Total Female Applicants Aged 14 to 64 from FGM-risk Countries</th>
<th>Estimated Nbr of Female Applicants Aged 14 to 64 Potentially Affected by FGM</th>
<th>Estimated % of Female Applicants Aged 14-64 Potentially Affected by FGM out of the Total Female Applicants from FGM-risk Countries</th>
<th>Estimated % of Female Applicants Aged 14-64 Potentially Affected by FGM out of Total Female Applicants</th>
</tr>
</thead>
<tbody>
<tr>
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<td>2,010</td>
<td>1,716</td>
<td>85.4%</td>
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<td>France</td>
<td>2,820</td>
<td>1,597</td>
<td>56.6%</td>
<td>11.06%</td>
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<td>2,665</td>
<td>1,092</td>
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<tr>
<td>UK</td>
<td>1,830</td>
<td>1,085</td>
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<tr>
<td>Belgium</td>
<td>1,380</td>
<td>945</td>
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<td>Netherlands</td>
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<td>798</td>
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<td>Germany</td>
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<td>Greece</td>
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<td>156</td>
<td>39.5%</td>
<td>1.08%</td>
</tr>
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<td>81</td>
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<td>0.56%</td>
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<tr>
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<td>0.0%</td>
<td>0.00%</td>
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<td>EU TOTAL</td>
<td>14,440</td>
<td>8,809</td>
<td></td>
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</table>

* Data for these countries is based on “Asylum Applicant” not “New Asylum Applicant” as this information was not available in Eurostat.
Some preliminary comments

The EU asylum acquis requires that the special needs of vulnerable asylum-seekers be taken into account, including needs arising from torture. Like torture, FGM involves the deliberate infliction of severe pain and suffering, and the pain inflicted by FGM does not stop with the initial procedure, but often continues as on-going torture throughout a woman’s life.26

The data in this study are aimed at further supporting Member States enhance the capacity of their respective reception systems to identify and meet the specific needs of the women and girl asylum-seekers living with FGM and its long-lasting consequences, including chronic pain, chronic pelvic infections, infection of the reproductive system, repetitive trauma at delivery and obstetric complications, as well as several emotional and psychological disturbances, most prominently post-traumatic stress disorder.

This section provides statistical data on the FGM prevalence amongst female asylum-seekers in the 27 EU Member States. It is designed in support of policy makers’ efforts to ensure that the specific needs of this group of women and girls are effectively addressed. Awareness raising and training on FGM amongst health practitioners, in the asylum centres and the areas where asylum-seekers live in the community, are necessary so that the girls and women affected by FGM can be identified and appropriately taken care of and have a safe space where they can discuss FGM-related issues. Likewise, guardians who look after the well-being and best interests of children would also need to be sensitized to these issues. More specifically, training ethnic minority health workers from FGM-practising countries could also contribute to enhancing the response capacity of asylum reception systems in EU Member States in this field. In States where the specialist medical expertise required to address FGM is not available in the health units present in or servicing asylum reception centres, tailored responses could include, for instance, the establishment of referral mechanisms to the national health sector with expertise in FGM.

The European Commission could also play a useful role in facilitating exchanges of information and best practices between health practitioners in Members States where such expertise has been developed over the years on the one hand, and “newcomers” to the issue on the other.

The map shows the areas where FGM is practised, and since this can vary markedly in different parts of any country, no national boundaries are shown.

Data at the sub-national level are not available for Zambia. Due to a discrepancy between the regional divisions used by DHS and the one adopted by DevInfo, it was not possible to include data at the sub-national level for Yemen.

Map: Prevalence of female genital mutilation in Africa and Yemen (women aged 15-49)

Sources: MICS, DHS and other national surveys, 1997–2006
Map developed by UNICEF, 2007
This section also provides more insights into the FGM prevalence rates amongst each national group of female asylum-seekers from FGM-practising countries of origin. The purpose here is to provide statistical tools to raise the awareness of asylum practitioners to the potential specific needs of women and girls from the respective FGM-practising countries, starting from the registration and screening phase. The data can also be used to raise the awareness of FGM amongst health practitioners in the asylum reception centres. For instance, if 30% of all Nigerian female applicants in Sweden are potentially already affected by FGM at the time of their arrival in the EU, registration and other staff have at hand a useful indicator to identify specific vulnerabilities and needs, and where relevant apply the necessary safeguards for persons with vulnerabilities.

Refugee girls and women may not come uniformly from a country of origin and may, depending on the political, religious, ethnic, social and other conditions, come from some regions in particular, where the FGM prevalence might be even higher than the national average. For instance, while the national FGM prevalence in Gambia is 78.3%, the highest prevalence rises to 99%. Many refugee women and girls from Gambia are Mandinka, Fulas and Serahule, amongst whom FGM is more common. It is thus hoped that this study will encourage health practitioners as well as registration staff and decision-makers in the asylum system to further enhance their understanding of the practice of FGM amongst the various national, ethnic and religious groups who seek asylum in their respective Member States.

The statistical data will also be useful to raise the awareness of interviewers and decision-makers to the specific vulnerabilities of this group of applicants. Although the scientific research addressing the psychological consequences of FGM is limited, documented psychological consequences include feelings of low-esteem, post-traumatic stress disorder, anxiety, depression and memory loss, which would need to be taken into account by decision-makers who examine cases that involve women and girls from FGM-practising countries of origin, in particular when assessing the credibility of the material facts of their claims.

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27 Refer to Inter-Agency, Eliminating Female Genital Mutilation. An Interagency Statement, February 2008, p. 5, for a map showing the prevalence of FGM in Africa and Yemen, and highlighting at times markedly varied differences within one country, available at: http://www.unhcr.org/refworld/docid/47dc8a6e2.html

---

<table>
<thead>
<tr>
<th>FGM-risk CoO</th>
<th>Total Female Applicants Aged 14 to 64</th>
<th>FGM Prevalence Rate</th>
<th>Estimated Nbr of Female Applicants Aged 14 to 64 Potentially Affected by FGM</th>
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<th>Estimated Nbr of Female Applicants Aged 14 to 64 Potentially Affected by FGM</th>
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### Table 4.5: Top 3: Italy

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<th>Total Female Applicants Aged 14 to 64</th>
<th>FGM Prevalence Rate</th>
<th>Estimated Nbr of Female Applicants Aged 14 to 64 Potentially Affected by FGM</th>
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<tr>
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### Table 4.6: Top 4: United Kingdom

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<th>Total Female Applicants Aged 14 to 64</th>
<th>FGM Prevalence Rate</th>
<th>Estimated Nbr of Female Applicants Aged 14 to 64 Potentially Affected by FGM</th>
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### Table 4.7: Top 5: Belgium

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<th>FGM Prevalence Rate</th>
<th>Estimated Nbr of Female Applicants Aged 14 to 64 Potentially Affected by FGM</th>
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<tr>
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### Table 4.8: Top 6: The Netherlands

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<th>Total Female Applicants Aged 14 to 64</th>
<th>FGM Prevalence Rate</th>
<th>Estimated Nbr of Female Applicants Aged 14 to 64 Potentially Affected by FGM</th>
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<tr>
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<tr>
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<tr>
<td>Mali</td>
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<td>85.2%</td>
<td>0</td>
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<tr>
<td>Ghana</td>
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<td>3.8%</td>
<td>0</td>
</tr>
<tr>
<td>Sudan</td>
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<td>90.0%</td>
<td>36</td>
</tr>
<tr>
<td>Egypt</td>
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<tr>
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<tr>
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</tr>
<tr>
<td>Central African Republic</td>
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<td>0</td>
</tr>
<tr>
<td>Chad</td>
<td>0</td>
<td>44.9%</td>
<td>0</td>
</tr>
<tr>
<td>Djibouti</td>
<td>0</td>
<td>93.1%</td>
<td>0</td>
</tr>
<tr>
<td>Guinea-Bissau</td>
<td>0</td>
<td>44.5%</td>
<td>0</td>
</tr>
<tr>
<td>Kenya</td>
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<td>27.1%</td>
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### Table 4.9: Top 7: Germany

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<th>FGM-risk CoO</th>
<th>Total Female Applicants Aged 14 to 64</th>
<th>FGM Prevalence Rate</th>
<th>Estimated Nbr of Female Applicants Aged 14 to 64 Potentially Affected by FGM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nigeria</td>
<td>195</td>
<td>29.6%</td>
<td>58</td>
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<tr>
<td>Somalia</td>
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<td>97.9%</td>
<td>215</td>
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<tr>
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<td>88.7%</td>
<td>173</td>
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<td>Guinea</td>
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<td>95.6%</td>
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</tr>
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<td></td>
</tr>
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<td>Mali</td>
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<td>Sudan</td>
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<td>90.0%</td>
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</tr>
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<td>72.2%</td>
<td>0</td>
</tr>
<tr>
<td>Sierra Leone</td>
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<td>94.0%</td>
<td>14</td>
</tr>
<tr>
<td>Benin</td>
<td>5</td>
<td>12.9%</td>
<td>1</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>5</td>
<td>72.5%</td>
<td>4</td>
</tr>
<tr>
<td>Central African Republic</td>
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<td>25.7%</td>
<td>0</td>
</tr>
<tr>
<td>Chad</td>
<td>0</td>
<td>44.9%</td>
<td>0</td>
</tr>
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<td>Djibouti</td>
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<td>0</td>
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<td>0</td>
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<tr>
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<tr>
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<td>58.2%</td>
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</tr>
<tr>
<td>Niger</td>
<td>0</td>
<td>2.2%</td>
<td>0</td>
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<tr>
<td>Tanzania</td>
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<td>14.6%</td>
<td>0</td>
</tr>
<tr>
<td>Togo</td>
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</tr>
<tr>
<td>Yemen</td>
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<tr>
<td>TOTAL</td>
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</table>
5. Where do these girls settle in the EU?

The age at which FGM is performed varies. In some areas it is carried out during infancy (as early as a couple of days after birth), in others during childhood, at the time of marriage, during a woman’s first pregnancy or after the birth of her first child. The most typical age is between infancy and age 15. Data in this section therefore focuses on the girls under 14 of age who seek asylum in the EU.

Over 3,000 (3,665) girls aged under 14 sought asylum in the EU in 2011, out of a total of 20,000 women and girls from FGM-practising countries.

Researchers estimate that there are 3,000-4,000 new FGM cases in the UK every year.

Over the four year period under study, the number of girls under 14 seeking asylum in the EU almost doubled (from 1,905 in 2008 to 3,665 in 2011) due in particular to significant increases in girl claimants from Guinea (tenfold jump to 455), Mali and to a lesser extent from Nigeria and Eritrea. Within this timeframe, France received the most applications followed by the Netherlands and Sweden.

Table 5.1: Total Girls Under 14 Seeking Asylum from FGM-risk Countries of Origin

<table>
<thead>
<tr>
<th>EU Member State</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
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<td>Austria</td>
<td>:</td>
<td>:</td>
<td>:</td>
<td>:</td>
</tr>
<tr>
<td>Belgium</td>
<td>70</td>
<td>150</td>
<td>180</td>
<td>300</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>:</td>
<td>:</td>
<td>:</td>
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<tr>
<td>Cyprus</td>
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<td>0</td>
<td>5</td>
<td>10</td>
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<tr>
<td>Czech Republic</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
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<td>:</td>
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<td>15</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Finland</td>
<td>:</td>
<td>:</td>
<td>:</td>
<td>:</td>
</tr>
<tr>
<td>France</td>
<td>:</td>
<td>725</td>
<td>890</td>
<td>1,115</td>
</tr>
<tr>
<td>Germany</td>
<td>245</td>
<td>275</td>
<td>345</td>
<td>380</td>
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<tr>
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<td>:</td>
<td>:</td>
<td>0</td>
</tr>
<tr>
<td>Hungary</td>
<td>:</td>
<td>:</td>
<td>:</td>
<td>:</td>
</tr>
<tr>
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<td>230</td>
<td>155</td>
<td>120</td>
<td>70</td>
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<tr>
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<td>0</td>
<td>0</td>
</tr>
<tr>
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<td>25</td>
<td>0</td>
<td>40</td>
</tr>
<tr>
<td>Netherlands</td>
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<td>920</td>
<td>315</td>
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<td>5</td>
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<tr>
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<td>590</td>
<td>515</td>
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<tr>
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<td>395</td>
<td>435</td>
<td>460</td>
<td>435</td>
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<td>TOTAL</td>
<td>1,905</td>
<td>2,975</td>
<td>3,595</td>
<td>3,665</td>
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</table>

28 In line with the assumptions made for the EIGE study, it was assumed that despite the varying practices regarding the ages at which FGM is practised in the countries of origin, girls under the age of 14 may still be intact at the time of their arrival in Europe.

29 Table 5.1 shows the number of girls under the age of 14 from FGM-practising CoO that sought asylum in the EU 27 Member States for the years 2008-2011. The countries receiving the most significant numbers of applications from girls under 14 are highlighted based on an average over the four year period: red for over 1,000; orange over 500; and yellow over 200.
<table>
<thead>
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<th>EU Member State</th>
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<th>2010</th>
<th>2011</th>
</tr>
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<td>30</td>
<td>35</td>
<td>40</td>
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<tr>
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<td>180</td>
<td>300</td>
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<td>5</td>
<td>5</td>
<td>5</td>
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<tr>
<td>Cyprus</td>
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<td>0</td>
<td>0</td>
<td>0</td>
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<td>515</td>
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<td>435</td>
<td>460</td>
<td>435</td>
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<tr>
<td>TOTAL</td>
<td>1,905</td>
<td>2,975</td>
<td>3,595</td>
<td>3,665</td>
</tr>
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</table>

Table 5.2: Number of Girl Beneficiaries of International Protection from FGM-risk Countries of Origin in each EU Member State
### Table 5.3: Number of Girl Beneficiaries of International Protection from FGM-risk Countries of Origin in the EU

<table>
<thead>
<tr>
<th>Year</th>
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<th>2010</th>
<th>2011</th>
</tr>
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<td><strong>FGM-Risk Country</strong></td>
<td><strong>Total Girls under 14 Seeking Asylum in EU 27 MS</strong></td>
<td><strong>Recognition Rate for Under-14 Girls (%)</strong></td>
<td><strong>Girls under 14 with International Protection</strong></td>
<td><strong>Total Decisions/ Positive Decisions</strong></td>
</tr>
<tr>
<td><strong>Nigeria</strong></td>
<td>355</td>
<td>11%</td>
<td>25</td>
<td>355</td>
</tr>
<tr>
<td><strong>Somalia</strong></td>
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<td>33%</td>
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<td><strong>Sierra Leone</strong></td>
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<td>5</td>
<td>45</td>
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<td><strong>Tanzania</strong></td>
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<td>5</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Togo</strong></td>
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<td>0%</td>
<td>25</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Uganda</strong></td>
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<td>5</td>
<td>25</td>
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<tr>
<td><strong>Yemen</strong></td>
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<td>40</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>1,905</td>
<td>170</td>
<td>2,975</td>
<td>130</td>
</tr>
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</table>

**Notes:**
1. Recognition rate based on final decisions not first decisions; 2. For 2008 and 2009, figures exclude Austria, Bulgaria, Denmark, Finland, France, Greece, Hungary, Luxembourg, Romania, Slovakia and Spain; 3. For 2010, figures exclude Austria, Bulgaria, Finland, France, Greece, Hungary, Luxembourg, and Romania; 4. For 2011, figures exclude Austria, Finland, Hungary and Slovakia

These countries are excluded as no data was available in Eurostat based on “New Asylum Applicant”. Red represents applications over 1000; Orange over 500; Yellow over 250. Green represents FGM-risk countries of origin with over 40 girls granted international protection in EU-27.
Over the same period, the number of these girls receiving international protection at first instance increased from 179 in 2008 to 325 in 2011, which amounts to a recognition rate at first instance of less than 10% (8.8%). The figures suggest that between 2008 and 2011, ten EU Member States only granted international protection to girls under the age of 14 from FGM-practising countries of origin, up from just four Member States in 2008. The United Kingdom has provided protection to the highest number of these girls, 500 in total, since 2008. This is more than three times as many provided by any other EU 27 Member State and over half of the EU total for the four years. The United Kingdom is followed by France, Germany and Sweden.

Girl asylum-seekers under 14 from FGM-practising countries are from Somalia, Nigeria and Guinea (of note is the fact that Eritrea comes fourth only for this group). Over the four year period under study, 210 girls from Somalia were granted international protection i.e. 23% of the total girls from FGM-practising countries of origin with international protection in the EU. Girl asylum-seekers under 14 from Nigeria (in the UK) were the second largest group, followed by Gambia (in the UK) and Mali (in France).

The United Kingdom granted international protection to more than half of the girls from Nigeria and Somalia and all the girls from Gambia from 2008-2011. The geographical distribution of girls under 14 from FGM-practising countries of origin to the top six EU Member States, United Kingdom, France, Germany, Sweden, Austria and the Netherlands, during this period can be viewed in tables 10.1 to 10.6.

---

30 Table 5.2 provides an overview of the distribution of applications from girls under 14 in the EU 27 and the number of girls receiving international protection in each country for the years 2008-2011. The recognition rate has been calculated using the total number of positive decisions as a percentage of the total decisions for each FGM-practising CoO in each Member State. Positive decisions include Refugee Status, Subsidiary Protection and Humanitarian Status. Graph 5 shows the geographical distribution of girls under 14 with international protection in the top 10 EU asylum countries.

31 All the figures are based on new applications not total applications.

32 See Table 5.3: The recognition rate for girls under 14 for each FGM-practising CoO has been calculated using the same method as outlined in table 5.2. FGM-practising CoO with over 1,000 applications are highlighted in red, over 500 in orange; and over 200 in yellow.

33 Table 5.3 highlights in green the FGM-practising CoO where international protection was granted to over 40 girls.
Some preliminary comments

The lack of disaggregated data in Eurostat between principle and secondary applicants unfortunately limits any in-depth analysis in this section. The questions as to whether child-sensitive asylum procedures gave these girls the opportunity to claim international protection on their own separate grounds, or whether FGM featured as a consideration when a Best Interest Assessment and/or Determination was carried out,34 or whether the determining authorities used a child-sensitive interpretation of the refugee definition and of serious harm will remain unanswered. This study though provides a platform for further discussions and exchanges on these important aspects of child asylum claims.

Female genital mutilation is a deeply entrenched tradition within communities and their social, economic and political structures. The pressure to subject girls to FGM comes from families and communities both in the countries of origin and in Europe. The practice itself is cross-border in nature, being performed in a variety of countries. In light of the current discussions within the EU regarding the need for comprehensive and integrated approaches for the abandonment of FGM, it was felt necessary for this statistical study to also look at the number of potentially intact refugee girls from FGM-practising countries who settle every year in communities throughout the EU.

Knowledge is currently not available on the (potential) changes of behaviour by members of the Diasporas from FGM-practising countries in the EU. Research is needed to better understand how FGM practices are affected by migration and exile, including forced displacement, and by contact with communities where FGM is not practised and considered a criminal act punishable by law.

As such, the set of data provided in this study does not purport to reach any conclusions. Its aim is merely to draw the attention of policy-makers to the number of refugee girls from FGM-practising countries living in communities in the EU whose rights, including the right to live intact from FGM, need to be factored in the policies and actions devised by the European Union and its Member States to prevent FGM. The tables in this section are also intended to support community-tailored and appropriate prevention and protection responses by providing more details regarding these refugee girls.

34 UNHCR, Field Handbook for the Implementation of UNHCR BID Guidelines, November 2011, available at: http://www.unhcr.org/refworld/docid/4e4a5757d.html; "...individual casework with children at risk, including unaccompanied and separated children, must be based on an assessment of protection needs with recommendations for interventions and referrals. UNHCR’s assessment tool for protection of individual children is referred to as a Best Interests Assessment (BIA). A BIA is essential before any action affecting an individual child of concern to UNHCR is taken, unless a BID is required. [...] Best interests determination (BID) describes the formal process with strict procedural safeguards designed to determine the child's best interests for particularly important decisions that affect him or her", pages 7-8.
6. How many asylum claims relate to FGM?

In the absence of disaggregated data collected by the EU asylum authorities on the grounds for international protection in general, and FGM in particular, this section seeks to provide estimates of the number of asylum claims on FGM grounds the top destination asylum countries may handle every year.

Belgium has been gathering data on gender-based claims, including FGM, since 2008. Table 6.1 shows the number of FGM-based decisions. The study has therefore used this unique data to try and approximate what the number of FGM-related claims could be in other EU Member States where that data is not collected.

Based on the number of FGM-related claims over the four year period under study, the study has averaged the four annual percentages of FGM-related decisions out of the total applications by female applicants from FGM-practising Countries of Origin.36 Using a process of extrapolation these percentages have been applied to the top 6 destination EU Member States for female applicants from FGM-practising countries to estimate the number of FGM-related claims that could have been handled by these Member States in 2011. These findings can be viewed in tables 6.2-6.7.36

---

### Table 6.1: Number of FGM-Based Decisions for Females in Belgium (2008-2011)

<table>
<thead>
<tr>
<th>Year</th>
<th>FGM-Risk CoO Nbr of Female Applicants</th>
<th>Nbr of FGM-based Decisions</th>
<th>% of FGM-based decisions from female applicants</th>
<th>Nbr of Female Applicants</th>
<th>Nbr of FGM-based Decisions</th>
<th>% of FGM-based decisions from female applicants</th>
<th>Nbr of Female Applicants</th>
<th>Nbr of FGM-based Decisions</th>
<th>% of FGM-based decisions from female applicants</th>
<th>Nbr of Female Applicants</th>
<th>Nbr of FGM-based Decisions</th>
<th>% of FGM-based decisions from female applicants</th>
<th>Nbr of Female Applicants</th>
<th>Nbr of FGM-based Decisions</th>
<th>% of FGM-based decisions from female applicants</th>
<th>Nbr of Female Applicants</th>
<th>Nbr of FGM-based Decisions</th>
<th>% of FGM-based decisions from female applicants</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>Nigeria</td>
<td>20</td>
<td>1</td>
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<td>40</td>
<td>15%</td>
<td>35</td>
<td>5</td>
<td>14%</td>
<td>60</td>
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<td>20%</td>
<td></td>
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<tr>
<td></td>
<td>Somalia</td>
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<td>45</td>
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<td>10%</td>
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<td></td>
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<tr>
<td></td>
<td>Guinea</td>
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<td>103</td>
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<td>525</td>
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<td>30%</td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cote d’Ivoire</td>
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<td>25%</td>
<td>15</td>
<td>33%</td>
<td>45</td>
<td>5</td>
<td>11%</td>
<td>90</td>
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<tr>
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<td>20</td>
<td>6</td>
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<td>28%</td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gambia</td>
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<td>5</td>
<td>4</td>
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<tr>
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<td>27%</td>
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<td>20%</td>
<td></td>
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<td></td>
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<tr>
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<td>Djibouti</td>
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<td>1</td>
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<td>20</td>
<td>10%</td>
<td>25</td>
<td>3</td>
<td>12%</td>
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<td>Tanzania</td>
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<td>15</td>
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<td>TOTAL</td>
<td>585</td>
<td>150</td>
<td>840</td>
<td>154</td>
<td>1,045</td>
<td>179</td>
<td>1,605</td>
<td>21%</td>
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</tr>
</tbody>
</table>

* For Uganda and Tanzania the average % is calculated for 3 years of data

---

36 See Table 6.1. These percentages (marked in red in Table 6.1) have been calculated by applying the number of FGM-based decisions made by Belgium to the total number of female applicants received from each FGM-practising country.

36 The estimates have been calculated by applying the four-year average percentages of FGM-based decisions in Belgium (marked in yellow on Table 6.1) to the number of female applications for each FGM-practising CoO in these top 6 EU Member States. The estimates are limited to 18 of the FGM-practising CoO due to the constraint of an average over a four year period. Where data was only available for three years (Tanzania and Uganda) this has been marked in the table. The colours in Tables 6.2 to 6.7 represent the FGM-practising CoO with the 3 highest estimates of FGM-based decisions.
The results based on this methodology seem to indicate that in 2011 France may potentially have handled an estimated 670 FGM-related claims, mostly by female applicants from Guinea, the largest number of such claims in the EU. Italy would come second with an estimated 375 FGM-related claims, the majority of these by females from Nigeria.

“I dream of blood. It’s an abuse. I just want [my daughter] Aisha to be able to grow up stronger than I am. We have no choice about it in our country. I did not understand that I had rights until I came to the UK.”


Graph 6.8 provides an overview of the estimated number of FGM-related claims made as a proportion of the total number of female applications received from 18 FGM-practising countries of origin in the top 7 destination countries for this group of applicants in 2011. Using this methodology, Belgium would have the second highest percentage of FGM-related claims (after France) i.e. 22.4% of all decisions on applications from females from FGM-practising countries of origin, the majority of these being from Guinea. Third would be the United Kingdom with an estimated 364 decisions, mostly by female asylum-seekers from Gambia.

### Table 6.2: Estimated Number of FGM-Based Decisions in France

<table>
<thead>
<tr>
<th>FGM-risk CoO</th>
<th>Total Nbr of Female Applicants from FGM-risk Countries of Origin</th>
<th>% of FGM-based Decisions in Belgium</th>
<th>Estimated Nbr of FGM-based Decisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nigeria</td>
<td>445</td>
<td>14%</td>
<td>62</td>
</tr>
<tr>
<td>Somalia</td>
<td>170</td>
<td>10%</td>
<td>17</td>
</tr>
<tr>
<td>Guinea</td>
<td>860</td>
<td>30%</td>
<td>258</td>
</tr>
<tr>
<td>Côte d’Ivoire</td>
<td>580</td>
<td>20%</td>
<td>116</td>
</tr>
<tr>
<td>Cameroon</td>
<td>95</td>
<td>5%</td>
<td>5</td>
</tr>
<tr>
<td>Sudan</td>
<td>80</td>
<td>28%</td>
<td>22</td>
</tr>
<tr>
<td>Gambia</td>
<td>15</td>
<td>40%</td>
<td>6</td>
</tr>
<tr>
<td>Senegal</td>
<td>115</td>
<td>16%</td>
<td>18</td>
</tr>
<tr>
<td>Mauritania</td>
<td>220</td>
<td>55%</td>
<td>121</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>20</td>
<td>20%</td>
<td>4</td>
</tr>
<tr>
<td>Djibouti</td>
<td>15</td>
<td>14%</td>
<td>2</td>
</tr>
<tr>
<td>Kenya</td>
<td>10</td>
<td>37%</td>
<td>4</td>
</tr>
<tr>
<td>Liberia</td>
<td>10</td>
<td>38%</td>
<td>4</td>
</tr>
<tr>
<td>Niger</td>
<td>10</td>
<td>16%</td>
<td>2</td>
</tr>
<tr>
<td>Tanzania</td>
<td>0</td>
<td>16%</td>
<td>0</td>
</tr>
<tr>
<td>Togo</td>
<td>40</td>
<td>7%</td>
<td>3</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>40</td>
<td>61%</td>
<td>24</td>
</tr>
<tr>
<td>Uganda</td>
<td>10</td>
<td>17%</td>
<td>2</td>
</tr>
<tr>
<td>TOTAL</td>
<td>2,736</td>
<td>20%</td>
<td>670</td>
</tr>
</tbody>
</table>

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37 See table 6.2.
38 See Table 6.3.
Some preliminary comments

The EU asylum acquis requires States to take into account the gender dimension of claims when examining applications for asylum, in particular the individual background of the applicant which includes his or her gender when assessing the facts and circumstances of the application, as well as the gender-specific nature of acts of persecution, and the gender-related aspects of the reasons for persecution. As such, the identification of potential gender-specific elements in an asylum claim is an important and necessary step in the examination of applications.

The estimates of FGM-related claims in this section are unlikely to represent the actual numbers of such applications those six Member States actually handled in 2011. The estimates are calculated from a small sample of cases with the potential risk of distortion. Likewise, a variety of factors may also be relevant in this regard which cannot be taken into consideration in this statistical study, such as the differences between the profiles of cases received by different Member States. In addition, and unlike in Belgium, the FGM-related aspects of the claims may not have been investigated and considered in full and/or may have been discarded as irrelevant early in the examination of the case, and the claim finally decided on other grounds. As such, these estimates are intended as working tools rather than set figures. UNHCR hopes that these estimates will encourage Member States to collect data on FGM-related claims and/or decisions to provide the necessary evidence needed to better understand these complex and potentially large numbers of claims.

Aissata, a young woman from Mali who has a 2-year-old daughter.

I come from a village in Mali where excisions are always practised. My sister had a daughter and when the baby was not even 2 years old, she was mutilated. When I was four months pregnant and my doctor told me it was a little girl, I was scared for her and ran away to France. I didn’t want my daughter to undergo what they did to me when I was young.

Table 6.3: Estimated Number of FGM-Based Decisions in Italy

<table>
<thead>
<tr>
<th>FGM-risk CoO</th>
<th>Total Nbr of Female Applicants from FGM-risk Countries of Origin</th>
<th>% of FGM-based Decisions in Belgium</th>
<th>Estimated Nbr of FGM-based Decisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nigeria</td>
<td>1,870</td>
<td>14%</td>
<td>262</td>
</tr>
<tr>
<td>Somalia</td>
<td>215</td>
<td>10%</td>
<td>22</td>
</tr>
<tr>
<td>Guinea</td>
<td>20</td>
<td>30%</td>
<td>6</td>
</tr>
<tr>
<td>Côte d’Ivoire</td>
<td>100</td>
<td>20%</td>
<td>20</td>
</tr>
<tr>
<td>Cameroon</td>
<td>35</td>
<td>5%</td>
<td>2</td>
</tr>
<tr>
<td>Sudan</td>
<td>60</td>
<td>28%</td>
<td>17</td>
</tr>
<tr>
<td>Gambia</td>
<td>5</td>
<td>40%</td>
<td>2</td>
</tr>
<tr>
<td>Senegal</td>
<td>35</td>
<td>16%</td>
<td>6</td>
</tr>
<tr>
<td>Mauritania</td>
<td>10</td>
<td>55%</td>
<td>6</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>10</td>
<td>20%</td>
<td>2</td>
</tr>
<tr>
<td>Djibouti</td>
<td>0</td>
<td>14%</td>
<td>0</td>
</tr>
<tr>
<td>Kenya</td>
<td>15</td>
<td>37%</td>
<td>6</td>
</tr>
<tr>
<td>Liberia</td>
<td>15</td>
<td>38%</td>
<td>6</td>
</tr>
<tr>
<td>Niger</td>
<td>20</td>
<td>16%</td>
<td>3</td>
</tr>
<tr>
<td>Tanzania</td>
<td>5</td>
<td>16%</td>
<td>1</td>
</tr>
<tr>
<td>Togo</td>
<td>10</td>
<td>7%</td>
<td>1</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>25</td>
<td>61%</td>
<td>15</td>
</tr>
<tr>
<td>Uganda</td>
<td>5</td>
<td>17%</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>2,455</td>
<td></td>
<td>375</td>
</tr>
</tbody>
</table>

40 EU Qualification Directive (Recast), Art. 9(2)(f).
41 EU Qualification Directive (Recast), Art. 10(1)(d).
Asylum claims on FGM grounds are particularly complex and involve a growing variety of profiles at risk. In addition to the women and men activists persecuted for their opinions and commitment to end FGM in their countries of origin (political opinion) and/or their perceived threat to religious beliefs (religion), EU Member States have also been receiving claims from:

- girls and women who seek protection from FGM whether they come directly from FGM-practising countries or have lived most of their lives in the EU and face return at the time the claim is lodged;
- girls and women who have already been subjected to FGM and seek protection from re-excision for instance or infibulation, defibulation or reinfibulation, upon marriage or at child birth;
- girls and women who may suffer from a continuous form of harm and/or for whom there may be compelling reasons to seek protection arising from that past persecution;
- parents claiming international protection to protect their (baby) daughters from FGM;
- women who are under pressure from their families and communities but refuse to become excisers in light of the growing awareness generated by anti-FGM campaigns in countries of origin;
- women who had been subjected to FGM, have accessed reconstructive surgery (often while in the EU) and who fear being cut again upon return for instance at the time of marriage.

These claims often give rise to additional considerations involving fear linked to early and forced marriage and domestic violence. The UNHCR Guidance Note on Refugee Claims relating to Female Genital Mutilation provides guidance on the adjudication of these claims.\(^{42}\)

### Table 6.4: Estimated Number of FGM-Based Decisions in the United Kingdom

<table>
<thead>
<tr>
<th>FGM-risk CoO</th>
<th>Total Nbr of Female Applicants from FGM-risk Countries of Origin</th>
<th>% of FGM-based Decisions in Belgium</th>
<th>Estimated Nbr of FGM-based Decisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nigeria</td>
<td>545</td>
<td>14%</td>
<td>76</td>
</tr>
<tr>
<td>Somalia</td>
<td>325</td>
<td>10%</td>
<td>33</td>
</tr>
<tr>
<td>Guinea</td>
<td>30</td>
<td>30%</td>
<td>9</td>
</tr>
<tr>
<td>Côte d’Ivoire</td>
<td>65</td>
<td>20%</td>
<td>13</td>
</tr>
<tr>
<td>Cameroon</td>
<td>45</td>
<td>5%</td>
<td>2</td>
</tr>
<tr>
<td>Sudan</td>
<td>110</td>
<td>28%</td>
<td>31</td>
</tr>
<tr>
<td>Gambia</td>
<td>235</td>
<td>40%</td>
<td>94</td>
</tr>
<tr>
<td>Senegal</td>
<td>15</td>
<td>16%</td>
<td>2</td>
</tr>
<tr>
<td>Mauritania</td>
<td>0</td>
<td>55%</td>
<td>0</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>0</td>
<td>20%</td>
<td>0</td>
</tr>
<tr>
<td>Djibouti</td>
<td>0</td>
<td>14%</td>
<td>0</td>
</tr>
<tr>
<td>Kenya</td>
<td>75</td>
<td>37%</td>
<td>28</td>
</tr>
<tr>
<td>Liberia</td>
<td>10</td>
<td>38%</td>
<td>4</td>
</tr>
<tr>
<td>Niger</td>
<td>0</td>
<td>16%</td>
<td>0</td>
</tr>
<tr>
<td>Tanzania</td>
<td>25</td>
<td>16%</td>
<td>4</td>
</tr>
<tr>
<td>Togo</td>
<td>5</td>
<td>7%</td>
<td>0</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>65</td>
<td>61%</td>
<td>40</td>
</tr>
<tr>
<td>Uganda</td>
<td>165</td>
<td>17%</td>
<td>28</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1,715</td>
<td></td>
<td>364</td>
</tr>
</tbody>
</table>

---

\(^{42}\) UNHCR, Guidance Note on Refugee Claims relating to Female Genital Mutilation, May 2009, available at: http://www.unhcr.org/refworld/docid/4a0c284b0.html
In the light of the not-so-negligible number of women and girls applicants from FGM-practising countries of origin and the potential hundreds of asylum claims on grounds of FGM every year in the EU, these estimates tend to indicate the need for guidelines to harmonize and support the practice of decision-makers in the asylum authorities of Member States when FGM-related issues are raised by applicants, and enhanced provision of information to applicants from FGM-practising countries or origin.

These estimates combined with the complexities, shame and stigma arising from FGM claims also point to the need for specific training to enhance the quality of the adjudication of gender-based claims in general and claims related to FGM in particular, and to capacitate interviewers with the skills necessary to create an environment conducive to disclosure.

“For asylum claims based on FGM, there is still much to be done to take into account the girls or women who flee their countries.”

These estimates would also tend to indicate the need for gender-sensitive and gender-specific Country of Origin Information (COI) to document the situation in the countries of origin of these women and girls generally speaking and more specifically the practice of FGM. Workshops of COI researchers could also help address the need for expertise and exchange of information on gender-sensitive COI.

On all the above three accounts, EASO, in its support to Member States, could play an important role to fill these gaps.

When international protection is granted to protect girls from FGM, the monitoring of the continued physical integrity of these girls through regular medical check-ups has sparked a debate on the need for protection- and child-sensitive operational approaches as well as greater legal clarity on the basis for such mandatory check-ups and what would happen should the girl be subjected to FGM. UNHCR hopes that this study will encourage the EU institutions, EU Member States and EASO to engage into much-needed information exchange, debate and policy clarification on this issue.

Table 6.5: Estimated Number of FGM-Based Decisions in Sweden

<table>
<thead>
<tr>
<th>FGM-risk CoO</th>
<th>Total Nbr of Female Applicants from FGM-risk Countries of Origin</th>
<th>% of FGM-based Decisions in Belgium</th>
<th>Estimated Nbr of FGM-based Decisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nigeria</td>
<td>95</td>
<td>14%</td>
<td>13</td>
</tr>
<tr>
<td>Somalia</td>
<td>1,235</td>
<td>10%</td>
<td>130</td>
</tr>
<tr>
<td>Guinea</td>
<td>15</td>
<td>30%</td>
<td>5</td>
</tr>
<tr>
<td>Côte d’Ivoire</td>
<td>10</td>
<td>20%</td>
<td>2</td>
</tr>
<tr>
<td>Cameroon</td>
<td>15</td>
<td>5%</td>
<td>1</td>
</tr>
<tr>
<td>Sudan</td>
<td>30</td>
<td>28%</td>
<td>8</td>
</tr>
<tr>
<td>Gambia</td>
<td>10</td>
<td>40%</td>
<td>4</td>
</tr>
<tr>
<td>Senegal</td>
<td>0</td>
<td>16%</td>
<td>0</td>
</tr>
<tr>
<td>Mauritania</td>
<td>0</td>
<td>55%</td>
<td>0</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>0</td>
<td>20%</td>
<td>0</td>
</tr>
<tr>
<td>Djibouti</td>
<td>5</td>
<td>14%</td>
<td>1</td>
</tr>
<tr>
<td>Kenya</td>
<td>30</td>
<td>37%</td>
<td>11</td>
</tr>
<tr>
<td>Liberia</td>
<td>10</td>
<td>38%</td>
<td>4</td>
</tr>
<tr>
<td>Niger</td>
<td>0</td>
<td>16%</td>
<td>0</td>
</tr>
<tr>
<td>Tanzania</td>
<td>10</td>
<td>16%</td>
<td>2</td>
</tr>
<tr>
<td>Togo</td>
<td>0</td>
<td>7%</td>
<td>0</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>15</td>
<td>61%</td>
<td>9</td>
</tr>
<tr>
<td>Uganda</td>
<td>40</td>
<td>17%</td>
<td>7</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1,580</td>
<td></td>
<td>196</td>
</tr>
</tbody>
</table>
### Table 6.6: Estimated Number of FGM-Based Decisions in Germany

<table>
<thead>
<tr>
<th>FGM-risk CoO</th>
<th>Total Nbr of Female Applicants from FGM-risk Countries of Origin</th>
<th>% of FGM-based Decisions in Belgium</th>
<th>Estimated Nbr of FGM-based Decisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nigeria</td>
<td>295</td>
<td>14%</td>
<td>41</td>
</tr>
<tr>
<td>Somalia</td>
<td>335</td>
<td>10%</td>
<td>34</td>
</tr>
<tr>
<td>Guinea</td>
<td>65</td>
<td>30%</td>
<td>20</td>
</tr>
<tr>
<td>Côte d’Ivoire</td>
<td>25</td>
<td>20%</td>
<td>5</td>
</tr>
<tr>
<td>Cameroon</td>
<td>75</td>
<td>5%</td>
<td>4</td>
</tr>
<tr>
<td>Sudan</td>
<td>5</td>
<td>28%</td>
<td>1</td>
</tr>
<tr>
<td>Gambia</td>
<td>30</td>
<td>40%</td>
<td>12</td>
</tr>
<tr>
<td>Senegal</td>
<td>10</td>
<td>16%</td>
<td>2</td>
</tr>
<tr>
<td>Mauritania</td>
<td>0</td>
<td>55%</td>
<td>0</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>10</td>
<td>20%</td>
<td>2</td>
</tr>
<tr>
<td>Djibouti</td>
<td>0</td>
<td>14%</td>
<td>0</td>
</tr>
<tr>
<td>Kenya</td>
<td>120</td>
<td>37%</td>
<td>44</td>
</tr>
<tr>
<td>Liberia</td>
<td>0</td>
<td>38%</td>
<td>0</td>
</tr>
<tr>
<td>Niger</td>
<td>0</td>
<td>16%</td>
<td>0</td>
</tr>
<tr>
<td>Tanzania</td>
<td>0</td>
<td>16%</td>
<td>0</td>
</tr>
<tr>
<td>Togo</td>
<td>25</td>
<td>7%</td>
<td>2</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>20</td>
<td>61%</td>
<td>12</td>
</tr>
<tr>
<td>Uganda</td>
<td>30</td>
<td>17%</td>
<td>5</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1,045</td>
<td></td>
<td>184</td>
</tr>
</tbody>
</table>

### Table 6.7: Estimated Number of FGM-Based Decisions in the Netherlands

<table>
<thead>
<tr>
<th>FGM-risk CoO</th>
<th>Total Nbr of Female Applicants from FGM-risk Countries of Origin</th>
<th>% of FGM-based Decisions in Belgium</th>
<th>Estimated Nbr of FGM-based Decisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nigeria</td>
<td>45</td>
<td>14%</td>
<td>6</td>
</tr>
<tr>
<td>Somalia</td>
<td>625</td>
<td>10%</td>
<td>63</td>
</tr>
<tr>
<td>Guinea</td>
<td>120</td>
<td>30%</td>
<td>36</td>
</tr>
<tr>
<td>Côte d’Ivoire</td>
<td>25</td>
<td>20%</td>
<td>5</td>
</tr>
<tr>
<td>Cameroon</td>
<td>5</td>
<td>5%</td>
<td>0</td>
</tr>
<tr>
<td>Sudan</td>
<td>55</td>
<td>28%</td>
<td>15</td>
</tr>
<tr>
<td>Gambia</td>
<td>5</td>
<td>40%</td>
<td>2</td>
</tr>
<tr>
<td>Senegal</td>
<td>0</td>
<td>16%</td>
<td>0</td>
</tr>
<tr>
<td>Mauritania</td>
<td>0</td>
<td>55%</td>
<td>0</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>0</td>
<td>20%</td>
<td>0</td>
</tr>
<tr>
<td>Djibouti</td>
<td>0</td>
<td>14%</td>
<td>0</td>
</tr>
<tr>
<td>Kenya</td>
<td>0</td>
<td>37%</td>
<td>0</td>
</tr>
<tr>
<td>Liberia</td>
<td>5</td>
<td>38%</td>
<td>2</td>
</tr>
<tr>
<td>Niger</td>
<td>0</td>
<td>16%</td>
<td>0</td>
</tr>
<tr>
<td>Tanzania</td>
<td>5</td>
<td>16%</td>
<td>1</td>
</tr>
<tr>
<td>Togo</td>
<td>5</td>
<td>7%</td>
<td>0</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>55</td>
<td>61%</td>
<td>34</td>
</tr>
<tr>
<td>Uganda</td>
<td>55</td>
<td>17%</td>
<td>9</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1,005</td>
<td></td>
<td>173</td>
</tr>
</tbody>
</table>
Graph 6.8: Estimated Proportion of FGM-related Claims to Total Number of Female Applicants from 18 FGM-risk Countries in Top 7 Asylum EU Member States (2011)

* Only the total number of female applications from 18 FGM-risk Countries is calculated as these are the countries for which Belgium has made decisions based on FGM for 3 or 4 consecutive years between 2008-2011

* FGM-risk Countries include: Nigeria, Somalia, Guinea, Côte D’Ivoire, Cameroon, Sudan, Gambia, Senegal, Mauritania, Burkina Faso, Djibouti, Kenya, Liberia, Niger, Tanzania, Togo, Sierra Leone and Uganda