Displaced Chadian women and men in Gouroukoun site gathering on the occasion of the performance of a female genital mutilation. Several girls, most of them 11 years old, were mutilated on those days. Gouroukoun site, Eastern Chad.

FEMALE GENITAL MUTILATION & ASYLUM IN THE EUROPEAN UNION

A Statistical Update (August 2018)[1,2]

Female genital mutilation (FGM) includes all procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons.[3] As in previous versions, this Too Much Pain report shows that a **sizable number** of women and girls applying for asylum in the EU **come from FGM-practising countries,**[4] and that **many of them are potentially affected by FGM**. This report aims to highlight the need to develop the necessary EU and national policies and tools to **prevent** FGM among communities from FGM-practising countries, as well as to **address the specific vulnerabilities** of asylum-seekers and refugees who are **survivors** of FGM.

FGM as a human rights violation

FGM is an internationally recognized **violation of the human rights of women and girls.** The practice 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. Consequently, the practice of FGM is considered as a criminal act in all EU Member States. Harmful practices in breach of international human rights law and standards cannot be justified on the basis of historical, traditional, religious or cultural grounds.

FGM as a form of persecution

FGM is a form of **gender-based violence,** which inflicts severe harm, both mental and physical, and amounts to persecution.[5] Like torture, FGM involves the deliberate infliction of severe pain and suffering. Yet, the consequences of FGM continue beyond the initial procedure, in the vast majority of cases throughout a woman's life. FGM survivors may sustain 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, notably post-traumatic stress disorder as well as negative consequences for female sexual health. Further, FGM can be linked to increased risk for intimate partner violence.

A woman or girl **who has already undergone the practice** before she seeks asylum may still have a well-founded fear of future persecution. She may fear being subjected to another form of FGM and/or suffer particularly serious long-term consequences of the initial procedure. Where the persecution suffered was particularly atrocious, and the woman or girl is experiencing ongoing and traumatic psychological effects, return to the country of origin may also be intolerable[6]. In addition, a girl or woman subjected to FGM in her youth can later undergo a re-excision or re-infibulation at the time of her marriage or childbirth. The genuine fear of the risk of FGM for female children of a survivor should be considered as well.

A girl or woman seeking asylum because she has been forced to undergo, or is likely to be subjected to, FGM **can therefore qualify for international protection.**

FGM and asylum in the EU

How many female asylum-seekers from FGM-practising countries?

In 2017, **66,000 women and girls from FGM-practising countries** sought asylum in the EU. This represents a drop compared to the 2013-2016 period, which showed a steady increase (Graph 1). However, this drop can be explained by the sharp decrease in the total number of asylum applications between 2016 and 2017 (from about 1,206,500 to 650,000).

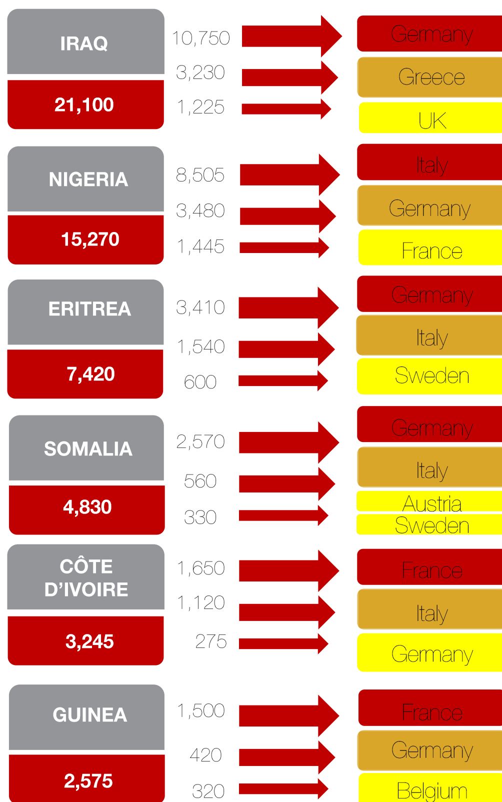
Nevertheless, **the share of women and girls applicants from FGM-practising countries as part of the total number of applicants has been increasing between 2013 and 2017** (from 6 to 9% of all applicants and from 19 to 28% of female applicants respectively).

From which FGM-practising countries?

In 2017, the top FGM-practising countries of origin for female asylum-seekers were **Iraq** (about 21,100 applications)**, Nigeria** (15,200), **Eritrea** (7,400) **and Somalia** (4,800) (Graph 2**).** These countries have **consistently featured as top FGM-practising countries of origin** for female asylum-seekers between 2013 and 2017, although in different orders. Over the period, female applicants from these four countries have represented **over two thirds of the total number of female applicants from FGM-practising countries.**

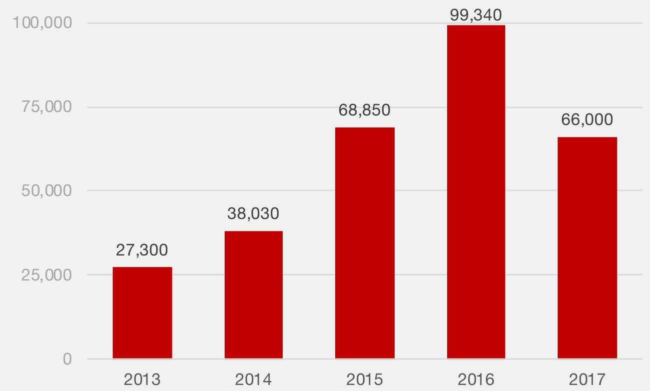
Côte d'Ivoire ranked fifth in 2017, totally about 5% of all female applications from FGM-practising countries that year, with more than 3,200 applications. In fact, applications by female asylum-seekers from Côte d'Ivoire have been increasing steadily since 2013, when they were only 660.

These figures should not hide the fact that **prevalence rates in these FGM-practising countries vary widely**, as highlighted in this report, including in Graph 5.

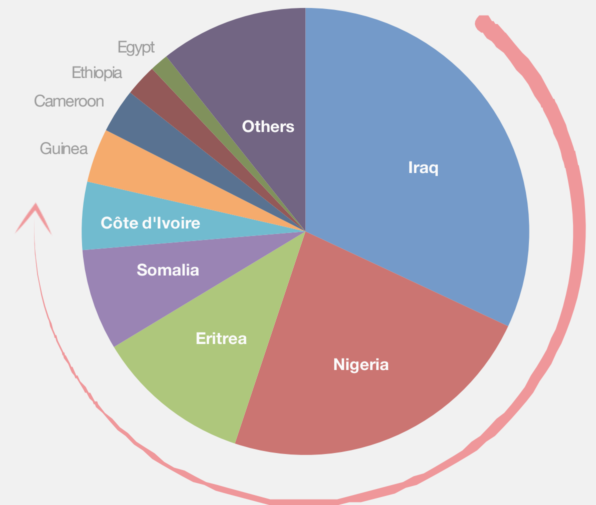


Graph 4: Destination countries of female asylum-seekers from FGM-practising countries, by country of origin

Graph 1: Number of female asylum-seekers from FGM-practising countries



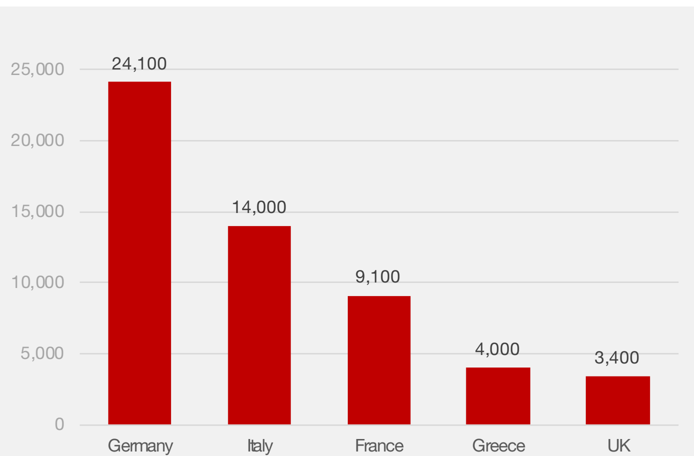
Graph 2: Top 10 FGM-practising countries of origin for female asylum-seekers (2017)



Where do they seek asylum?

In 2017, these women and girls applied for asylum mainly in **Germany, Italy, France, Greece and the UK** (Graph 3).

Iraqi, Eritrean and **Somalian** female applicants went mainly to Germany. **Nigerians** applied mainly in Italy, while Côte d'Ivoire and Guinean girls and women sought asylum mainly in France. (Graph 4).



Graph 3: Main EU countries of destination for female asylum-seekers from FGM-practising countries

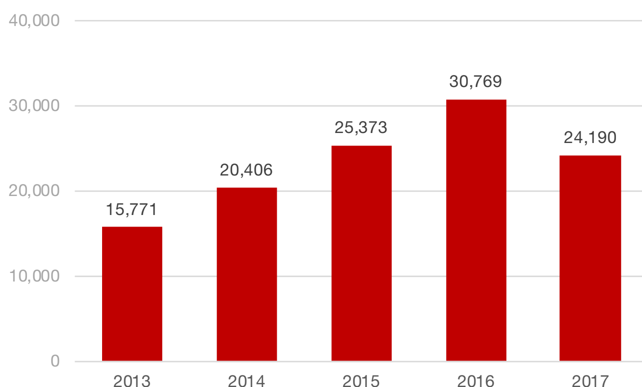
How many female asylum-seekers potentially affected by FGM?

Overall, it is estimated that **over 24,000 women and girls could potentially have already been affected by FGM** at the time of their asylum application in the EU **in 2017** (Graph 5). This amounts to an average **prevalence rate of about 37%** for female applicants coming from FGM-practising countries, although this figure is likely to actually be higher.

This rate represents **an increase compared** to the estimated prevalence rate observed in **2016 (about 31%)** but a decrease compared to previous years (about 37% in 2015, 54% in 2014, 58% in 2013) (based on Graph 6). These divergences are **linked to the profiles of arrivals**. In particular, they have to be read together with the respective shares of female applicants from the top four countries of origin (Eritrea and Somalia have high prevalence rates, while Iraq and Nigeria have low ones), as well as the prevalence rate of the country ranking fifth.

How many asylum claims on grounds of FGM?

Data collection proves particularly difficult. Breakdowns of claims by grounds for application are rarely available. Even when they are, claims on grounds of FGM are often only registered as part of the larger group of gender-related claims. In addition, several grounds are often invoked in FGM-related cases. **Belgium**, one of the few countries that do collect specific data, can however be used as an illustration. In 2015, the country received **609 asylum claims on grounds of FGM** out of a total of 3,545 claims from girls and women from FGM-practising countries, i.e. about **17%**.



Graph 6: Estimated number of female asylum-seekers potentially affected by FGM (2017)

Graph 5: Estimated number of female asylum-seekers potentially affected by FGM (2017)

Country of Origin	Female applicants*	Prevalence rate**	Estimated number of female asylum-seekers potentially affected by FGM***
Benin	110	9 %	10
Burkina Faso	175	76 %	133
Cameroon	2,105	1 %	29
Central African Rep.	235	24 %	57
Chad	250	38 %	96
Côte d'Ivoire	3,245	37 %	1,191
Djibouti	105	93 %	98
Egypt	885	87 %	772
Eritrea	7,420	83 %	6,159
Ethiopia	1,520	65 %	991
Gambia	570	75 %	427
Ghana	840	4 %	32
Guinea	2,575	97 %	2,493
Guinea-Bissau	75	45 %	34
Iraq	21,100	8 %	1,709
Kenya	325	21 %	68
Liberia	90	50 %	45
Mali	815	83 %	674
Mauritania	255	67 %	170
Niger	60	2 %	1
Nigeria	15,270	18 %	2,810
Senegal	630	23 %	148
Sierra Leone	490	90 %	439
Somalia	4,830	98 %	4,729
Sudan	870	87 %	753
Tanzania	100	10 %	10
Togo	250	5 %	12
Uganda	275	1 %	4
Yemen	530	19 %	98
Total	66,000		24,190

* Eurostat annual data, extracted on 4 April 2018.
** UNICEF, *Percentage of girls and women aged 15-49 years who have undergone FGM*, available at: https://data.unicef.org/wp-content/uploads/2015/12/FGMC-Women-prevalence-database_Feb-2018.xlsx. Actual prevalence rates are likely to be higher.
*** The estimates are calculated by multiplying the number of female applicants from FGM-practising countries by the corresponding prevalence rate.

The way forward

Statistical data is necessary to develop evidence-based policies. Consequently, EU Member States need to establish or strengthen **systematic data collection on FGM and asylum in the EU**. This could include recording asylum applications and decisions in a way that enables to single out FGM-related cases. As a prerequisite, a common methodology would be necessary.

The **existing legal framework applicable in the EU** includes important provisions for asylum-seekers at risk or victims of FGM. In particular, the Council of Europe Convention on preventing and combating violence against women and domestic violence (also known as the **Istanbul Convention**)[7] notably requires its Parties to recognize gender-based violence as a ground to grant international protection, to ensure a gender-sensitive interpretation of the 1951 Convention relating to the Status of Refugees, and to develop gender-sensitive reception conditions and asylum procedures. However, as of June 2018, the EU and 11 EU Member States still need to ratify the Istanbul Convention. In addition, the EU's **Common European Asylum System** (CEAS), and in particular the Asylum Procedures, Qualification and Reception Conditions Directives, include important provisions for asylum-seekers victims or at risk of FGM. This includes the recognition of FGM as a ground to receive international protection, and a recognition of asylum-seekers who are victims or at risk of FGM as vulnerable. EU rules on asylum need to be thoroughly implemented throughout the EU. The **CEAS reform** is providing an opportunity to strengthen these provisions, also keeping in mind that FGM survivors would be negatively affected by more restrictive asylum systems.

FGM-related cases are complex, especially when it comes to credibility assessment, which can be impaired by a lack of knowledge of FGM and because of age, gender and culture insensitivity. It is therefore key to strengthen the capacity of authorities who are likely to be in contact with asylum-seekers (e.g. case-workers, interpreters, lawyers, and reception staff) who are victims or at risk of FGM, through relevant **awareness-raising and training activities**. This includes ensuring that asylum authorities are fully aware of the provisions of international and EU law instruments of relevance for FGM-related cases at all stages of the asylum procedure. Awareness-raising and training activities would also focus on age, gender and diversity sensitivity, as well as on the impact of trauma and violence on vulnerability and on the credibility assessment. **Existing tools** such as UNHCR's Guidelines on Gender-related Persecution,[8] UNHCR's Guidance Note on Refugee Claims relating to Female Genital Mutilation,[8] EASO's Training Module on Gender, Gender Identity and Sexual Orientation,[9] End FGM European Network's Guide on FGM in EU Asylum Directives[10] and the United to End FGM platform[11] can prove particularly useful.

In that context, harmonized **Country of Origin Information (COI)** throughout the EU has a key role in ensuring that asylum authorities can adjudicate FGM-related claims in an informed and harmonized manner. EU Member States and EASO need to work on enhancing the **gender, age and culture-sensitive nature of COI**. This includes ensuring that COI consistently focuses on forms of potential or real harm or persecution to women and girls and COI assesses the prevalence rate of FGM without qualifying any type of FGM as a lighter form of mutilation. On that basis, FGM-related concerns should also be taken into account when making use of the **"safe country" concepts and when assessing availability of "internal protection".**[12]

In a complementary manner, **EU Member States need to develop country- and community-tailored prevention and protection responses** aiming to end FGM and provide support to affected women and girls. Prevention can include reaching out to and working in **partnership with affected communities** both in countries of origin and in the EU and **awareness raising among relevant actors** (e.g. school teachers, health professionals, social workers and child protection officers) on the risk of FGM being performed on girls going back to their country of origin during the summer holiday. Ending FGM involves changing gender and social norms of practicing communities both in the countries of origin and within Europe. Protection involves the establishment of **relevant and comprehensive medical services**, which would include gynecologists, midwives, psychologists and sexologists, to address the specific needs of refugee girls and women who live with the long-lasting physical, sexual and mental consequences of FGM in a way that is socially, linguistically and culturally sensitive. This includes the need for special medical attention for survivors in reproductive age, as, for each childbirth, trained midwife and medical personnel is required. The United to End FGM platform can prove to be a useful tool in that context.

[1] For previous editions, see UNHCR, *Too Much Pain – A statistical overview*, available at: http://www.unhcr.org/protection/women/531880249/pain-female-genital-mutilation-asylum-europe-an-union-statistical-overview.html and UNHCR, Too Much Pain – A statistical update (March 2014), available at: http://www.unhcr.org/protection/women/53187f379/pain-statistical-update-march-2014.html.

[2] This report uses Eurostat's annual data on "*Asylum and first time applicants by citizenship, age and sex*", migr_asyappctza.

[3] See WHO, *Female Genital Mutilation*, available at: http://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation.

[4] FGM-practising countries are to be understood as Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Côte d'Ivoire, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Iraq, Kenya, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Somalia, Sudan, Tanzania, Togo, Uganda, and Yemen. This is based on the statistical information published by UNICEF: UNICEF, Percentage of girls and women aged 15-49 years who have undergone FGM, available at: https://data.unicef.org/wp-content/uploads/2015/12/FGMC-Women-prevalence-database_Feb-2018.xlsx.

[5] UN High Commissioner for Refugees, *Guidance Note on Refugee Claims relating to Female Genital Mutilation*, May 2009, available at http://www.refworld.org/docid/4a0c28492.html.

[6] Ibid.

[7] Council of Europe, *Council of Europe Convention on preventing and combating violence against women and domestic violence*, Istanbul, 2011, available at: http://www.coe.int/en/web/conventions/full-list/-/conventions/rms/090000168008482e.

[8] UN High Commissioner for Refugees, *Guidelines on International Protection: Gender-related persecution within the context of Article 1A(2) of the 1951 Convention and/or its 1967 Protocol relating to the Status of Refugees*, May 2002, available at: http://www.unhcr.org/publications/legal/3d58ddef4/guidelines-international-protection-1-gender-related-persecution-context.html.

[9] This training is not publicly available but accessible online for trainers and trainees.

[10] *EndFGM European Network, FGM in EU Asylum Directives on Qualification, Procedures and Reception Conditions*, March 2016, available at: http://tinyurl.com/z8jfawd.

[11] The United to End FGM platform, to which UNHCR contributed as a partner, is a European web-based knowledge platform on FGM to serve as an EU-wide multilingual resource and education center, which will provide easily accessible and culturally appropriate information and support to professionals from diverse backgrounds across the EU with the aim to effectively deliver victim support, raise awareness on FGM, and protect women and girls living with or at risk of FGM. It is available at: uefgm.org.

[12] See also *End FGM European Network, Female genital mutilation and international protection: Towards a human rights-based and gender-sensitive Common European Asylum System*, November 2016, available at: http://www.endfgm.eu/resources/end-fgm-network/female-genital-mutilation-and-international-protection-towards-a-human-rights-based-and-gender-sensitive-common-european-asylum-system-2016/.