

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

## Step-by-step guide



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

Step-by-step guide

This step-by-step guide was developed within the framework of the study on the estimation of the number of women and girls at risk of female genital mutilation (FGM) in selected EU Member States. It was commissioned by the European Institute for Gender Equality (EIGE) and coordinated by Jurgita Pečiūrienė with the support of Ligia Nobrega and Thérèse Murphy. The study was carried out by Yellow Window, represented by researchers Lut Mergaert, Catarina Arnaut, Marja Exterkate, Siobán O'Brien Green, Sofia Strid and Els Leye.

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## Abbreviations

<b>CSO</b>	Civil Society Organisation
<b>DHS</b>	Demographic and Health Survey
<b>EC</b>	European Commission
<b>EIGE</b>	European Institute for Gender Equality
<b>EU</b>	European Union
<b>Eurostat</b>	The Statistical Office of the European Union
<b>FGM</b>	Female Genital Mutilation
<b>MICS</b>	Multiple Indicator Cluster Survey
<b>Unicef</b>	United Nations Children's Fund
<b>WHO</b>	World Health Organisation





# Contents

<b>Introduction</b> .....	<b>7</b>
<b>Methodological approach to estimate FGM risk in the EU: a step-by-step guide</b> ...	<b>9</b>
1. State of the art .....	9
2. Quantitative component .....	10
2.1. Countries of origin (countries where FGM is commonly practised) .....	10
2.2. Countries of destination (EU Member States) .....	11
3. Qualitative component .....	14
4. FGM risk estimation .....	17
5. Plan the next FGM risk estimation .....	21
Possible indicators of trends in FGM risk .....	21
Reflections and further research .....	21
<b>Bibliography</b> .....	<b>25</b>
<b>Annexes</b> .....	<b>27</b>
<b>Annex 1.</b> Glossary .....	27
<b>Annex 2.</b> Checklist for estimating FGM risk in the EU .....	30
<b>Annex 3.</b> List of countries where FGM is documented; respective national FGM prevalence rates and median age of FGM (as of 21 August 2014) .....	31
<b>Annex 4.</b> Guidelines on quantitative data collection to estimate FGM risk .....	33
<b>Annex 5.</b> Suggestions to organise focus group discussions .....	38

# Introduction







## Introduction

Female genital mutilation (FGM) refers to all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons (WHO, 2008). The European Commission (EC) is committed to contributing to the elimination of this phenomenon. Recent efforts include a study to map the current situation and trends of FGM in twenty-eight EU Member States<sup>(1)</sup>, followed by a communication to the European Parliament and the European Council<sup>(2)</sup>. Both the study and the communication were launched in 2013.

The European Commission's communication 'Towards the elimination of female genital mutilation' has defined the better understanding of this harmful practice in the EU as one of its objectives. To achieve this goal, the European Commission asked the European Institute for Gender Equality (EIGE) 'to develop a common methodology and indicators to measure the prevalence of FGM, to estimate the number of women and girls at risk of being mutilated and the number of women affected by FGM in the EU' (European Commission, 2013). In order to contribute to the implementation of the latter actions, EIGE launched a study in 2014 to develop a methodological approach to estimate FGM risk in the EU. This process included a literature review, consultation of experts and a pilot test. As a starting point, the most recent methodological approaches for estimating FGM risk in EU countries were reviewed and, based on the

experience gained, a methodology was developed. The methodological approach was revised by 23 experts before and after being tested in three EU Member States: Ireland, Portugal and Sweden<sup>(3)</sup>. Based on these pilot studies and on the experts' feedback, the methodological approach was adjusted.

This step-by-step guide is the final result of the study: *Estimation of girls at risk of female genital mutilation in the European Union*<sup>(4)</sup>. It sets out the minimum requirements for estimating FGM risk, as well as suggestions to enhance the quality and accuracy of the assessment. The guide aims to be a practical support for those appointed to the task to estimate the risk of FGM in a region or a country within the EU. At the same time, by offering a common methodological framework to estimate FGM risk in the EU, EIGE wants to contribute to the production of comparable and up-to-date data across EU Member States. Estimations of FGM risk provide relevant input to EU Member States' policy makers to continue their work towards the prevention of FGM and the protection of girls from being subjected to this harmful practice.

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- (1) EIGE (2013). *Female genital mutilation in the European Union and Croatia — Report*.
  - (2) European Commission (2013). *Communication to the European Parliament and the Council — Towards the elimination of female genital mutilation* (COM(2013) 833 final).

- (3) More information about the pilot studies can be found in EIGE's report entitled *Estimation of girls at risk of female genital mutilation in the European Union* (2015).
- (4) For a full understanding of the methodological options presented in this step-by-step guide, please consult the report entitled *Estimation of girls at risk of female genital mutilation in the European Union* (EIGE, 2015).

# Methodological approach to estimate FGM risk in the EU: a step-by-step guide





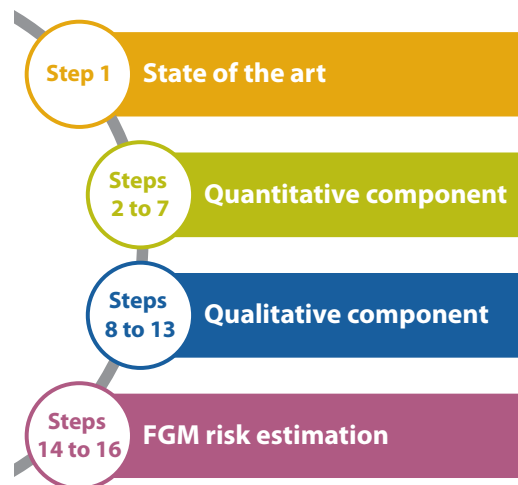
# Methodological approach to estimate FGM risk in the EU: a step-by-step guide

The methodology to estimate FGM risk includes a quantitative and a qualitative component. Combining both components provides a more accurate and comprehensive picture than the one obtained through quantitative or qualitative analysis alone.

Although the listed steps follow a logical order, the quantitative and qualitative parts of the research can be performed simultaneously or one after the other.

FGM risk estimations need to be repeated regularly in order to monitor trends and the impact of policies. If based on census data, they are usually done every 10 years, with a few possible exceptions. Those countries that have a population register can carry out FGM risk (and prevalence) assessment more frequently.

A checklist to estimate FGM risk in the EU can be found in Annex 2.



## 1. State of the art

As a starting point, it is advisable to conduct a (web-based) search to gather information on recent research focusing on FGM prevalence and risk in the country and on the influence of migration and acculturation on attitudes and behaviours towards FGM. In order to obtain a comprehensive picture of the literature available, it is recommended to examine documentation

written in English and in the official language(s) of the country. Other languages can be considered as well. For this purpose, national native-speaking researchers might have to be involved. In addition, it is important to be well informed about the current FGM legal and policy frameworks in the EU Member States.

1

**Review existing knowledge** about FGM prevalence and risk, as well as about the influence of migration and acculturation on attitudes and behaviours towards FGM (in English and in the official language(s) of the EU Member State). Consider reviewing the existing legal and policy framework in the country.

## 2. Quantitative component

Different types of data are required to estimate the number of women and girls at risk of FGM in an EU Member State. These data relate to the countries of origin (i.e. countries where FGM is commonly practised and for which national prevalence rates are documented) and to the countries of destination (i.e. an EU Member State).

### 2.1 Countries of origin (countries where FGM is commonly practised)

For most countries where FGM is commonly practised, its prevalence has been estimated based on large-scale, national and representative household surveys, which include modules on FGM. National survey data in these

countries originate from demographic and health surveys (DHS) published by ICF International, and from multiple indicator cluster surveys (MICS) published by Unicef (<http://www.measuredhs.com/Publications/Publications-by-Country.cfm> and [http://www.childinfo.org/mics\\_available.html](http://www.childinfo.org/mics_available.html)). These are the most widely recognised and referenced sources of information about FGM. Nevertheless, there is evidence that FGM is also practised in South East Asia and amongst Kurdish populations. Despite the fact that data sources for the latter may not be as reliable as MICS or DHS, robust prevalence research results will hopefully become available in the future, allowing the inclusion of these communities in FGM risk estimations in the EU.

## 2

**Review the most recent DHS and MICS reports to collect information on national prevalence rates and age of FGM for the age cohort 15–19.** In case the EU Member State collects information on the region of origin (or ethnicity) of the migrant population, gather information about the regional (or ethnic) prevalence rates for the age cohort 15–19 in the countries of origin. A brief explanation about each variable is provided below.

#### National prevalence rates for the 15–19 age cohort

Using national prevalence levels for the age cohort 15–19 to estimate the number of girls at risk overestimates the true risk for girls from countries where FGM prevalence has declined in recent years (most recent FGM prevalence data indicate a decline in a vast majority of countries). As suggested by Yoder (2011) and Unicef (2013), using prevalence figures for women in the 15–19 age cohort (i.e. the group of youngest adults considered to be in ‘final cut status’, i.e. either having undergone FGM or no longer at risk of FGM) in the country of origin is believed to yield a more precise FGM risk estimation.

#### Age of FGM for women in the 15–19 age cohort

Among women, data on age of FGM are likely to be imprecise, as recall bias can be presumed to affect responses from girls and women who underwent FGM procedure when they were very young. Data on age of FGM are used for women in the youngest age cohort (15–19) (Unicef, 2013). In case data on the age of cutting

for women in the 15–19 age cohort are not available, age of FGM for women aged 15–49 is to be used.

#### Regional prevalence rates for the 15–19 age cohort

Data on FGM prevalence rates disaggregated by region are available for all 29 countries in which FGM is documented<sup>(5)</sup>. In most countries of origin (20 countries, see Annex 3), the variance in FGM prevalence between different geographical regions is 50 % or more. The region of origin can therefore be considered an important determinant for FGM risk estimations. The migrant population residing in an EU Member State may or may not be representative of the population in the country of origin regarding age and region. However, not all EU Member States collect information on the region of origin for the migrant population. Check whether the EU Member State gathers this information because it will enhance the accuracy of any FGM risk estimation. For comparability reasons, be aware that the list of regions needs to coincide with those mentioned in DHS and MICS reports.

(5) The list of all the countries in which FGM is documented is provided in Annex 3.



### Ethnicity prevalence rates

FGM prevalence rates disaggregated by ethnicity are currently available for 11 countries of origin. Some EU Member States gather information about the ethnicity of its migrant population, and such data will enhance

the accuracy of the estimation. For comparability reasons, be aware that the list of ethnicities needs to coincide with those mentioned in DHS and MICS reports.

## 3

**Calculate the median age of FGM** for each country where FGM is commonly practised.

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

- firstly, the ‘unknown’ cases are proportionately redistributed over the age categories;
- secondly, the highest boundary of the age group in which 50 % falls is selected as the median age.

### 2.2 Countries of destination (EU Member States)

Different types of data are needed to estimate the risk of FGM. However, they are not necessarily collected by the same institution or easily accessible. The population groups about which information is needed for estimating FGM risk in the countries of destination are: female migrant population, asylum seekers, refugees and irregular migrants. Other datasets that can be considered are: female live births and FGM-specific records that include information on girls aged 0–18 (e.g. medical/hospital, child protection, asylum, judicial and police records).

### Reference year

The reference year for collecting data should be the most recent year for which all datasets are available. For some EU Member States, this is likely to be the year of the most recent population census. For others, there may be more up-to-date data (e.g. through population registers).

An EU-wide census took place in 2011, which strived for an output harmonisation in order to establish more comparable data between Member States (including migration history). In the 2011 censuses, information on the ‘place of birth’ (country) of an individual was (to be) collected according to the place of usual residence of the mother at the time of birth; or, if not available, the place where the birth took place. All countries where FGM is commonly practised are enumerated in the list provided in the statistical office of the European Union’s explanatory notes on EU legislation on the 2011 population and housing censuses (Eurostat, 2011) (which means that data broken down by country of birth are available).

As censuses are conducted every 10 years, the next census will take place in 2021. The advantage of using the most recent census year as the reference year for FGM risk (and prevalence) studies in the EU is that the results produced are easily comparable across Member States.

## 4

**Identify the institutions holding data necessary for estimating FGM risk.** An explanation about the required variables to be collected is provided below.

### Female migrant population

Data for the female migrant population aged 0–18 in an EU Member State, originating from countries where FGM is commonly practised, need to be disaggregated referring to the reference:

- by country of origin, one-year age group<sup>(6)</sup>, first and second generation;
- if available, by region of origin, e.g. region, county or city of birth;
- if available, by residence region in the country of destination (EU Member State).

A possible source of information for requesting these data from may be the national statistical office.

### Female asylum seekers, refugees and irregular migrants

Data for female asylum seekers, refugees and irregular migrants aged 0–18 in an EU Member State, originating from countries where FGM is practised, need to be disaggregated referring to the reference year and subsequent years (if data are available):

- by country of origin, one-year age group, first and second generation;
- if available, by region of origin, e.g. region, county or city of birth.

Possible sources of information for requesting these data may be the national border and immigration services, as well as refugee centres.

### Female live births

Data for female live births in an EU Member State to mothers originating from countries where FGM is documented need to be disaggregated referring to the reference year and subsequent years (if data are available):

- by country of origin of the mother;
- if available, by region of origin of the mother, e.g. region, county or city of birth;
- if available, by region in the country of destination where the birth took place or usual residence of the mother (EU Member State).

Possible sources for requesting these data may be the central birth registration office or the national statistical office.

### Other sources where records with FGM data for girls aged 0–18 are kept

These records may refer to FGM or risk of FGM among girls under the age of 18 with parents originating from an 'FGM risk country' and currently living in an EU Member State, referring to the reference year and subsequent years (if data are available). These data may be collected through different organisations where relevant records are kept.

## 5

**Draft guidelines to be sent to the identified institutions holding data**, explaining the study and its objectives, the data to be collected and the level of disaggregation of data, as well as other specificities related to data collection.

An example of guidelines can be found in Annex 4. These were developed and used within the framework of the *Study on the estimation of girls at risk of FGM in the EU* (EIGE, 2014). It is recommended to include a glossary to ensure a common understanding of the variables on which data are to be collected. The guidelines should be kept short and simple and without unnecessary

complications. The advice here is to be specific about what you are looking for, and why.

When making a request for data, it is important to summarise it in a language appropriate to the institution and to refer to the guidelines for a more specific and detailed description of the request.

6 Collecting data per one-year age group is very important to estimate FGM risk as the median age of cutting varies between countries of origin.



## 6

**Contact the institutions** that possess the data and indicate a deadline for the request to be fulfilled. **Follow up on the data collection** (i.e. call or e-mail the contact person regularly).

Allow sufficient time for collection of the requested data. Avoid summer and any other holiday periods to request the data. Otherwise, (major) delays can be expected. Be aware that fees may be charged for the requested data.

Several exchanges may be needed in order to obtain the sufficient level of data disaggregation as requested. It can also be expected that specific data processing by

the institution possessing the data may be required (for instance, readily accessible data might be broken down into different age groups than those requested).

For certain datasets, specific non-disclosure and confidentiality declarations may have to be signed in order to obtain the data.

## 7

After receiving the data, **conduct a 'quality control'** in order to confirm that all requested data have been provided and that the underlying definitions correspond to what was asked. Pay specific attention to the level of disaggregation of the data.

The quality control includes a check on completeness, consistency, and on whether data provided are in line with the definitions listed in the guidelines.

### 3. Qualitative component

In order to assess the influence of migration and acculturation (7) in the EU on attitudes and behaviours towards FGM, the methodological approach to estimate the number of girls at risk of undergoing FGM includes a qualitative component. The research team needs to

be aware of the particular characteristics of FGM as a research topic. It is a sensitive and taboo topic among the migrant communities living in the EU. This ought to be taken into consideration when designing, planning and implementing the methodology.

8

**Define the qualitative method(s) that are going to be used**, as well as specific objectives. Delineate the period for carrying out the qualitative component of the research.

Several qualitative methods can be used separately or in combination, such as focus group discussions (8), in-depth interviews, surveys and community-based participatory research. The choice of a method or a combination of methods will depend on the research question(s), the target group and its specificities.

not collide with important religious festivals or celebrations (e.g. Ramadan, religious holidays), school vacations and holiday periods. Avoid the evenings on which migrant communities most commonly go to religious gatherings (e.g. mosques, churches). Weekends may be a good choice for organising activities, although this may not suit parents with school-age children.

Make sure that the dates chosen for conducting your activities (e.g. interviews, focus group discussions) do

9

**Clearly define your target group(s).**

Based on your research question(s), the target group(s) may include: women and/or men of first and second generation originating from countries where FGM is commonly practised (9), women who have undergone FGM, religious and/or community leaders and professionals from different sectors (healthcare, protection, justice, asylum, etc.). You may consider defining quota

and criteria for your target group(s) based on variables, such as age, length of stay and level of education.

The criteria to participate in the activities (e.g. interviews, focus group discussions) need to be clearly formulated in order to optimise the recruitment process.

10

**Recruit participants** according to the criteria previously defined. Allow sufficient time for recruitment.

7 'Acculturation can be defined as a culture learning process experienced by individuals who are exposed to a new culture or ethnic group.' (Balls Organista, P., Marin G. and Chun K. M. (2010). 'Acculturation' in *The psychology of ethnic groups in the United States*. SAGE Publications, Inc. Available at: [http://www.sagepub.com/upm-data/30900\\_Chapter4.pdf](http://www.sagepub.com/upm-data/30900_Chapter4.pdf)).

8 Considering that the qualitative method chosen and the pilot tested in the study *Estimation of girls at risk of female genital mutilation in the European Union* was focus group discussions, detailed recommendations on how to organise and facilitate such groups are provided in Annex 5.

9 In case you consider organising focus group discussions, it is recommended to separate participants based on sex. The presence of someone of a different sex might have an adverse effect on the other participants.





Time is crucial for recruiting potential participants.

Trust is an important factor when it comes to recruiting participants to any kind of qualitative research, and maybe in particular when the researcher's position is different than that of the participants' with regard to ethnic, religious, cultural, class, gender or nationality background. This requires a certain level of openness from the researcher and other team members. Establishing trust will reduce suspicion regarding the purposes of the research and the use that will be made of the information that is shared. Besides involving key civil society organisations working with migrant communities in the recruitment of participants, people from the communities concerned can be extremely helpful in recruitment. The involvement of religious or community leaders might also be considered as they are influential in the communities.

Encouraging recruitment through word-of-mouth and the snowballing technique may prove effective, but it takes time to spread the word. A way to implement these techniques could be a coupon or a flyer with the researcher's contact details. Such coupons can be given to each recruited participant who can bring in others by distributing the coupon with the contact phone number and details to other potential participant(s).

Due to the particular characteristics and compositions of migrant communities, allow some flexibility in the application criteria and quota to the target group(s). Be aware that refusing participants might have adverse effects on others.

Foresee a budget to cover participants' expenses (e.g. travel, childcare) and as compensation for their collaboration.

## 11

### Plan and prepare the research activities (e.g. interviews, focus group discussions).

Prepare informed consent forms to be signed by the participants, ensuring anonymity and confidentiality (according to national legislation and research ethics), and get permission to use the information that will be collected. Other aspects can be taken into consideration, such as permission to use an audio recorder.

Be aware of the legal framework in force in the EU Member State where the research is taking place. The researcher(s) may be obliged by law to report any situation of (risk of) FGM in case they become aware of it. Establish a reporting procedure for such events.

Consider collecting and/or preparing informative materials about FGM and about the activities that are going to be organised (e.g. group discussions) to give to the participants. Gather information about possible referral routes for health, protection and legal and psychological support so that participants can be referred to specialised support if needed during or after the research. Be informed about the accessibility to these services and whether they are free of charge. This information should be provided to all participants.

Consider recruiting researchers, interviewers or facilitators who belong to and speak the native language(s) of the envisaged communities. This might reduce resistance from the participants and reduce bias in the research results. It is advisable that the researcher, interviewer or facilitator is the same sex as the participant(s).

As regards the content of the qualitative research to assess the influence of migration and acculturation towards FGM, the following determinants can be studied: age of FGM in a migration context, correlation between FGM and levels of education, and/or acculturation, and/or length of stay in the EU, and/or number of schooling years in the EU, FGM decision-makers in families, attitudes to marriage and relationships, reasons behind performing FGM, awareness of/exposure to campaigns against FGM, attitudes regarding sexuality, exposure to other cultures, access to services (health, social, etc.) and views regarding effectiveness of policy initiatives, among others.

Prepare the research instruments (e.g. discussion guide, interview checklist) taking into account the objectives, hypotheses and target group(s) of the study.

## 12

### **Pilot test and implement the research activities** (e.g. interviews, focus group discussions).

Pilot testing the methodology and respective instruments (e.g. questionnaire) are essential. Refine, amend and adapt the approach if necessary.

Ensure the participants are informed about the purposes of the study and the researchers' duty to report any intentions to subject a girl to FGM to the respective authorities according to the national legal framework. Be aware that this might bias your research results <sup>(10)</sup>.

Implement the research activities as planned, while allowing a certain degree of flexibility. Keep in mind the fact that cultural norms can differ. For instance, it cannot be assumed that agreed starting times will always be respected; mothers may bring their young children with them, etc.

## 13

### **Report on the qualitative research findings.**

The notes taken and/or the recordings are useful in drafting and analysing the information collected. If resources are available, consider transcribing the recordings and analyse them using specific software for qualitative and mixed-methods data analysis (e.g. MAXQDA, NVIVO).

It is recommended to make a report per individual group discussion or interview respectively, following the structure of the discussion or interview guide. Subsequently,

a report can be written bringing together the results of the qualitative research, theme by theme, answering the research questions, and, where relevant, supporting findings with quotes from the participants.

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10 Participants might share less information as they fear the legal consequences of admitting (their intentions) to subjecting a girl to FGM (or assisting someone to do it).



## 4. FGM risk estimation

After controlling the quality and statistical relevance of the data received (i.e. check on completeness, consistency and whether data provided are in line with the definitions listed in the guidelines) and carrying out the qualitative research component, FGM risk can be estimated. Due to the particular challenges related to FGM risk (and prevalence) assessment in the EU, the risk

estimation will be expressed in an interval (with a higher and a lower boundary), which allows consideration of any uncertainties that cannot be ruled out in the calculations.

### 14

#### Apply the 'extrapolation-of-FGM-practising-countries-prevalence data method'

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

$$x_c = a_c \times p_c$$

in which:

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

$a_c$  = first and second generation girls (originating from a particular country where FGM is documented) who, in the reference year (2011 for this study), had not yet reached the median age of cutting as customary in the particular country of origin;

$p_c$  = national prevalence rate of the age cohort 15–19 for that particular country (MICS divided by 100).

The example below represents a theoretical maximum number of girls who can be considered 'at risk of FGM'. In the example it is assumed that the probability of performing FGM procedure for a girl is the same as in the country of origin.

### Example

The median age of cutting in Ghana and in Somalia is 9 years. The national FGM prevalence rates (age cohort 15–19) for these two countries are 2 % (MICS, 2011) and 97 % (MICS, 2006), respectively. If the total number of girls (first and second generation) living in a certain EU Member State originating from these countries and aged under 9, amounts to 250 and 150 respectively, then the number of girls being at risk of FGM is calculated by multiplying the total number of girls by the prevalence rate of each country. We can then conclude that five girls originating from Ghana and 146 girls originating from Somalia and currently living in the EU are at risk of undergoing FGM.

$$x_{Ghana} = 250 \times 0.02$$

$$x_{Somalia} = 150 \times 0.97$$

$$x_{Ghana} = 5$$

$$x_{Somalia} = 146$$

## 15

## Introduce the migration and acculturation impact factor into your calculation.

A crucial element to be considered in an FGM risk estimation is the influence of migration and acculturation on attitudes and behaviour towards cutting girls. At the time of preparing this guide, the 'migration and acculturation impact factor' was represented as a binary variable expressed as 0 or 1, in which 0 signifies a situation where migration does not influence attitudes and behaviours towards FGM, and 1 suggests that there is an influence on subjecting girls to FGM and that the level of risk is reduced to zero (<sup>11</sup>). The influence of migration and acculturation is assessed through the qualitative information collected during the research and a complementary relevant literature review. The influence of migration and acculturation can be included in the FGM risk estimation according to this formula:

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

in which:

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

$a_c$  = first and second generation girls (originating from a particular country where FGM is documented) who, in the reference year (2011 for this study), had not yet reached the median age of cutting as customary in the particular country of origin;

$p_c$  = national prevalence rate of the age cohort 15–19 for that particular country (MICS divided by 100);

$m$  = migration and acculturation impact factor (either 1 or 0).

The calculation of FGM risk, taking into consideration the influence of migration and acculturation, considers two scenarios regarding the level of FGM risk in an EU Member State. These scenarios define an interval

within which FGM risk will be expressed. The scenarios are underpinned by different assumptions and represent a high and a low level of risk of FGM in European migration context. The calculation of FGM risk, taking into account influence of migration and acculturation that can be different for the first and the second generation girls, is made for each country where FGM is documented, and is expressed as follows:

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

in which:

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

$a_{c=first}$  = first generation girls (originating from a particular country where FGM is documented) who, in the reference year (2011 for this study), had not yet reached the median age of cutting as customary in the particular country of origin;

$a_{c=second}$  = second generation girls (born in an EU Member State from mothers originating from a particular country where FGM is documented) who, in the reference year (2011 for this study), had not yet reached the median age of cutting as customary in the particular country of origin;

$p_c$  = national prevalence rate of the age cohort 15–19 for that particular country (MICS divided by 100);

$m$  = migration and acculturation impact factor (either 0 or 1).

### High-FGM-risk scenario

The basic premise behind this scenario is that there is no influence of migration whatsoever, and that the number of girls originating from an FGM risk country and living in an EU country at risk of FGM would be the same as if they had never migrated. In this scenario, even in a migration context, migrants would keep their traditions and practices as if they were still living in their countries of origin. This hypothetical scenario is seen as constituting the

11 Further (qualitative) research on the influence of migration and acculturation towards FGM will ideally provide more refined migration and acculturation impact rates (ranging between 0% and 100%, possibly related to different population groups), which will enhance the accuracy of FGM risk estimations.



highest possible risk scenario, for which the calculation of girls at risk would yield the upper boundary.

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

### Low-FGM-risk scenario

In this scenario, it is assumed that there is influence of migration and acculturation on changing attitudes and

behaviours towards performing FGM procedures. In this case, although it is assumed that second generation girls (i.e. those born in an EU Member State) experience a lower risk of being subjected to FGM, for calculation purposes, the level of FGM risk for the second generation girls will be equal to zero (which should, however, not be interpreted in the strict sense that not a single girl in this group would no longer be at any risk of FGM). On the other hand, first generation girls whose age is lower than the median age of cutting are still considered to be at risk. In this scenario, the migration and acculturation impact factor for the second generation girls will be 1 ( $m=0$ ). This hypothetical scenario yields the lower boundary of estimated number of girls at risk.

### Example

The total number of girls coming from Somalia and aged under nine (median age of cutting in Somalia), living in a certain EU Member State, amounts to 95 (first generation), while those born in the same EU Member State to mothers originating from Somalia amounts to 55. According to MICS (2006), the national FGM prevalence rate (age cohort 15–19) for Somalia is 97 %.

Taking these data into account, the high-risk scenario is calculated as follows:

$$x_{\text{Somalia}} = (95 \times 0.97 \times (1-0)) + (55 \times 0.97 \times (1-0))$$

$$x_{\text{Somalia}} = 146$$

On the other hand, the low-risk scenario is calculated as follows:

$$x_{\text{Somalia}} = (95 \times 0.97 \times (1-0)) + (55 \times 0.97 \times (1-1))$$

$$x_{\text{Somalia}} = 92$$

Considering that the results are expressed in an interval, these calculations indicate that in a certain EU Member State the number of girls at risk of FGM ranges between 92 and 146.

## 16

### Communicate the statistical results of the FGM risk estimation and the findings of the qualitative research.

The statistical results of the FGM risk estimation are expressed in an interval (i.e. the number of girls at risk in a given country varies between  $x$  (low value) and  $y$  (high value)). The estimations are provided in both, full numbers, as well as percentages (i.e. expressed as the percentage of the absolute number of girls aged 0–18

originating from FGM risk countries and living in an EU Member State).

Be extremely careful when communicating numbers disaggregated by country of origin since members of small communities living in an EU Member State can be identified easily.

It is relevant to clearly explain which scenario describes the level of FGM risk in an EU Member State better (i.e. whether the actual risk is seen as closer to the lower or to the higher boundary of the interval). In this case, the existing knowledge and the findings of the qualitative research component are taken into consideration to ascertain which scenario better represents the influence of migration and acculturation on subjecting a girl to FGM in a certain country; if and when available, other data records such as health/medical or child protection records should also be considered. The ascertainment of a scenario needs to be well justified with references to literature and to the qualitative research findings.

FGM risk estimations need to be interpreted and communicated with caution in order to avoid the stigmatisation of migrant communities, to ensure that no girls at risk are overlooked when prevention and protection initiatives are implemented and to ensure that no girls who have been subjected to FGM are excluded from receiving care, support and protection (as, for example, FGM may be performed just before migration, even if

a girl is under the 'customary' age of cutting, as practised in the country of origin).

For policymaking purposes, it may be pertinent to disaggregate the data by region of residence in the country of destination (if and when this information exists and is made available). This may allow better planning of regional/local services in an EU Member State.

Although this mixed-method approach is designed to avoid under- and overestimations, the results must still be interpreted prudently. Each scenario includes a set of assumptions, but individual cases can contradict these suppositions. The methodology proposed aims at estimating, as accurately as possible, the risk of FGM in a certain EU Member State. However, the assumptions represent 'scenarios' and cannot be considered as absolute certainties. Depending on the resources available and other future research findings on estimating FGM risk, further refinements in the calculations may be considered. Medical/hospital records might also provide relevant insights on this matter.



## 5. Plan the next FGM risk estimation

In order to follow up on trends and on the impact of policies, FGM risk estimations need to be repeated on a regular basis. Make sure you plan the frequency with which you intend to conduct such research. Provided your country has a population register, FGM risk estimations can be completed more frequently (e.g. every year) in comparison to countries where only census data are available (usually collected every 10 years).

### Possible indicators of trends in FGM risk

Considering that the FGM risk estimation refers to data from a certain reference year (e.g. 2011, the year of the most recent census), it could be useful for policymaking purposes to attempt to assess indicators of trends regarding the level of FGM risk in an EU Member State. These indicators may include the following:

- Female migrant population — the number of female migrants (first and second generation) who originate from countries where FGM is commonly practised and are registered in the country. This information can be extracted from population registers.
- Migration flows — the inward and outward flow of migrants originating from countries where FGM is commonly practised.
- Female live births — although knowledge is lacking about the probability that girls born in an EU Member State to mothers originating from FGM risk countries would still be subjected to FGM, the number of annual births may be collected so that the development across the years is monitored.
- Female asylum seekers — despite the fact that the risk of being subjected to FGM might be lower for female asylum seekers <sup>(12)</sup>, the information on the annual total number of girls originating from countries where FGM is documented requesting asylum may be collected so that the development across the years can be followed up.

12 Push factors for migration for this population are different because they might, for instance, have fled from the country of origin based on the fear of FGM. However, the risk of seeing their asylum request denied for reasons of having undergone FGM may be a strong deterrent.

- Female migrants with temporary or permanent visas — the number of female migrants' originating from countries where FGM is commonly practised and holding visas (residence permits) to live in an EU Member State.

Some of the indicators mentioned above may not be available in all EU Member States. The data available in each country need to be assessed individually. For instance, the population register might already include information on other indicators listed above.

In order to be able to assess trends, data need to be collected on a regular basis (e.g. annually). At the least, all indicators need to be broken down by one-year age groups and country (and region) of origin.

These data can be useful for designing policies to raise awareness about the practice of FGM with the aim to protect girls from undergoing this procedure, as well as to provide services to those girls and women that might be (have already been) cut.

### Reflections and further research

Based on what can be learnt from existing FGM risk estimation experiences, based on consultations with experts and the experience gained through applying the methodology in three pilot countries within the *Study on the estimation of girls at risk of FGM in the EU*, feasible and not (yet) feasible options for calculating FGM risk were identified. These are presented in the matrix on the next page.

Within the feasible options, a standard approach is presented, as well as options that are both feasible and bring an added value to the methodological approach. On the other hand, there are options that are not (yet) feasible: those that are unrealistic (because they cannot be put into practice) and those that might be considered at a later date (depending on the situation in each country). The options that have been described above are the feasible ones (combining both the standard and the added-value options).

<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Not (yet) feasible</b></p>	<p><b>Unrealistic options</b></p> <ul style="list-style-type: none"> <li>Collect information about the father's country of origin</li> <li>Collect data about ethnicity</li> <li>Use micro-data from Eurostat about the concerned population living in the EU Member States (because, among other reasons, data are not aggregated by one-year age cohorts)</li> </ul>	<p><b>Options that might be considered later</b></p> <ul style="list-style-type: none"> <li>Use other sources of information if and when they are collected at central level and are easily accessible (e.g. medical/hospital records, child protection records, police and criminal justice records)</li> <li>Collect data about region of origin and use regional FGM prevalence rates (age cohort 15–19)</li> <li>Collect data about female irregular migrants</li> <li>Assess difference in risk between population groups, between girls born to one parent vs. to both parents originating from FGM-practising countries, among others</li> </ul>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Feasible</b></p>	<p><b>Standard options</b></p> <ul style="list-style-type: none"> <li>Use FGM prevalence rates from DHS and MICS</li> <li>Use census data about the female migrant population in a certain EU Member State originating from countries where FGM is commonly practised</li> <li>Apply the 'extrapolation-of-FGM-risk-countries-prevalence data method'</li> </ul>	<p><b>Value-added options</b></p> <ul style="list-style-type: none"> <li>Use FGM prevalence rates for women in the 15–19 age cohort in the country of origin</li> <li>Consider the median age of cutting as customary in the country of origin</li> <li>Include a qualitative methodology to assess the influence of migration on attitudes and behaviours towards FGM</li> <li>Use interval estimations to communicate the results</li> <li>Collect data on live births of girls born in the EU Member State to mothers from FGM risk countries and on female asylum seekers, among others, to monitor indicators of trends in FGM risk</li> </ul>

The options that might be considered later, described in the matrix above, are suggestions for 'upgrading' the 'common and basic' FGM risk estimation.

When considering options, the following aspects should be taken into account.

- Existence of data — different types of data might exist in a given country. Countries should at least be able to provide data on the female migrant population residing in the country.
- Availability of data — data might exist, but might not be available (e.g. data are not centrally collected). If certain types of data are available in a timely manner and are useful to the FGM risk estimation, they need to be requested and, if provided timely, analysed.
- Legal issues to access data — certain countries may not allow access to certain types of data.
- Processes and procedures to access data — these can be highly bureaucratic and might hamper the prompt access to data within the timeframe established for research. Data need to be requested following the processes and procedures established in a given country, but if data are not promptly provided, these cannot be considered.
- Up-to-date data — some data might be more up-to-date and differences might exist between countries. A common reference year for all datasets is needed. The reference year to be decided may correspond to the most recent EU-wide census year (2011).
- Costs — there might be costs associated to accessing certain types of data.





# Bibliography





## Bibliography

European Commission (2013). *Communication to the European Parliament and the Council — Towards the elimination of female genital mutilation* (COM(2013) 833 final).

European Institute for Gender Equality (2013). *Female genital mutilation in the European Union and Croatia — Report*. Available at: [http://eige.europa.eu/sites/default/files/EIGE-Report-FGM-in-the-EU-and-Croatia\\_0.pdf](http://eige.europa.eu/sites/default/files/EIGE-Report-FGM-in-the-EU-and-Croatia_0.pdf)

European Institute for Gender Equality (2015). *Estimation of girls at risk of female genital mutilation in the European Union*. Forthcoming at (to be completed when the study is released).

Eurostat (2011). 'EU legislation on the 2011 population and housing censuses — Explanatory notes'. *Methodologies and working papers*. Theme 'Population and social conditions'. Publications Office of the European Union, Luxembourg.

United Nations Children's Fund (2013). *Female genital mutilation/cutting: A statistical overview and exploration of the dynamics of change*. Unicef, New York. Available at: [http://www.unicef.org/publications/index\\_69875.html](http://www.unicef.org/publications/index_69875.html)

World Health Organisation (WHO) (2008). *Eliminating female genital mutilation: An interagency statement — OHCHR, Unaid, UNDP, UNECA, Unesco, UNFPA, UNHCR, Unicef, Unifem, WHO*, Geneva. Available at:

<http://www.who.int/reproductivehealth/publications/fgm/9789241596442/en/>

Yoder, P. S. (2011). *Challenges to assessing FGC prevalence in the USA*, ICF International, Calverton, MD (unpublished manuscript).

### Other useful sources

Council of Europe (2014). *The Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence — A tool to end female genital mutilation*. Available at: <http://www.coe.int/t/dghl/standardsetting/convention-violence/brochures/Istanbul-ConventionFGM%20Guide%20EN.pdf>

UN High Commissioner for Refugees (UNHCR) (2013). *Too much pain: Female genital mutilation and asylum in the European Union — A statistical overview*. Available at: <http://www.refworld.org/docid/512c72ec2.html>

UN High Commissioner for Refugees (UNHCR) (2014). *Too much pain: Female genital mutilation and asylum in the European Union — A statistical update* (March 2014). Available at: <http://www.unhcr.org/53187f379.html>

# Annexes





# Annexes

## Annex 1. Glossary

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

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

According to Eurostat, an 'asylum applicant' is a person having submitted an application for international protection or having been included in such application as a family member during the reference period. 'Application for international protection' is defined in Article 2(h) of Directive 2011/95/EU, i.e. a request made by a third-country national or a stateless person for protection from an EU Member State who seeks a refugee status or a subsidiary protection status and who does not explicitly request another kind of protection, outside the scope of this directive, that can be applied for separately. This definition is intended to refer to all who apply for protection on an individual basis, regardless of whether they lodge their application on arrival at the airport or land border, or from inside the country, and regardless of whether they entered the territory legally (e.g. as a tourist) or illegally (see Article 4.1(a) of the regulation). 'Asylum applicants considered to be unaccompanied minors' means all applicants for international protection who are considered by the national authority to be unaccompanied minors during the reference period and relates to Article 4.3(a) of the regulation. 'Unaccompanied minor' is defined in Article 2(l) of Directive 2011/95/EU, i.e. a minor who arrives to the territory of an EU Member State unaccompanied by an adult responsible for him or her whether by law or by the practice of the Member State concerned, and for as long as he or she is not effectively taken into the care of such a person; it

includes a minor who is left unaccompanied after he or she has entered the territory of the Member States.

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

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

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

### **Country of birth**

According to the Regulation (EC) No 862/2007, 'country of birth' means the country of residence (in its current borders, if the information is available) of the mother at the time of the birth or, in default, the country (in its current borders, if the information is available) in which the birth took place.

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

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

Twenty-nine countries where female genital mutilation is documented through national surveys: Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Côte d'Ivoire, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Iraq, Kenya, Liberia, Mali,

Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Somalia, Sudan, Togo, Uganda, United Republic of Tanzania and Yemen.

### Country of destination

An EU Member State where a person originating from a country where female genital mutilation is commonly practised decides to establish her or his residence, or where she or he has asked for international protection.

### Female genital mutilation (FGM)

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

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

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

### FGM prevalence in an EU Member State

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

### FGM risk estimation in an EU Member State

FGM risk estimation in an EU Member State is defined as the number of minor girls (either born in or born to mothers from FGM risk countries) living in an EU Member State who might be at risk of female genital mutilation, expressed as a proportion of the total number of girls aged 0–18 living in an EU country who originate from or are born to a mother from FGM risk countries.

### First generation

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

### Foreign-born

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

**Source:** [http://ec.europa.eu/eurostat/ramon/nomenclatures/index.cfm?TargetUrl=DSP\\_GLOSSARY\\_NOM\\_DTL\\_VIEW&StrNom=CODED2&StrLanguageCode=EN&IntKey=25532309&RdoSearch=BEGIN&TxtSearch=foreign-born&CboTheme=&IsTer=&IntCurrentPage=1&ter\\_valid=0](http://ec.europa.eu/eurostat/ramon/nomenclatures/index.cfm?TargetUrl=DSP_GLOSSARY_NOM_DTL_VIEW&StrNom=CODED2&StrLanguageCode=EN&IntKey=25532309&RdoSearch=BEGIN&TxtSearch=foreign-born&CboTheme=&IsTer=&IntCurrentPage=1&ter_valid=0)

### Girls potentially at risk of female genital mutilation

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

### Immigration

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

**Source:** [http://ec.europa.eu/eurostat/ramon/nomenclatures/index.cfm?TargetUrl=DSP\\_GLOSSARY\\_NOM\\_DTL\\_VIEW&StrNom=CODED2&StrLanguageCode=EN&IntKey=19273174&RdoSearch=BEGIN&TxtSearch=immigration&CboTheme=&IsTer=&IntCurrentPage=1&ter\\_valid=0](http://ec.europa.eu/eurostat/ramon/nomenclatures/index.cfm?TargetUrl=DSP_GLOSSARY_NOM_DTL_VIEW&StrNom=CODED2&StrLanguageCode=EN&IntKey=19273174&RdoSearch=BEGIN&TxtSearch=immigration&CboTheme=&IsTer=&IntCurrentPage=1&ter_valid=0)

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

The concept of 'irregular or undocumented migrant' refers to a group of people that do not, or no longer, fulfil the legal conditions for stay or residence in a country. Authorities are not able to track all individuals who are in this situation. Those who are found in this situation are defined as 'third-country nationals found to be illegally present' in a country. According to Regulation (EC) No 862/2007, 'third-country nationals found to be illegally present' means third-country nationals who are officially found to be on the territory of a Member State and who do not fulfil, or no longer fulfil, the conditions for stay or residence in that Member State. For statistical purposes, those referred to as 'irregular migrants' in this report refer to 'third-country nationals found to be illegally present' as identified by official authorities. However, it is recognised that these individuals are a fraction of those who might find themselves in an irregular situation in an EU Member State.

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



### Live birth

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

**Source:** [http://ec.europa.eu/eurostat/ramon/nomenclatures/index.cfm?TargetUrl=DSP\\_GLOSSARY\\_NOM\\_DTL\\_VIEW&StrNom=COD-ED2&StrLanguageCode=EN&IntKey=31126375&RdoSearch=BEGIN&TextSearch=live%20birth&CboTheme=&IsTer=&IntCurrentPage=1&ter\\_valid=0](http://ec.europa.eu/eurostat/ramon/nomenclatures/index.cfm?TargetUrl=DSP_GLOSSARY_NOM_DTL_VIEW&StrNom=COD-ED2&StrLanguageCode=EN&IntKey=31126375&RdoSearch=BEGIN&TextSearch=live%20birth&CboTheme=&IsTer=&IntCurrentPage=1&ter_valid=0)

### Refugee

According to Council Directive 2004/83/EC, a 'refugee' means a third-country national who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, political opinion or membership of a particular social group, is outside the country of nationality and is unable or, owing to this fear, unwilling to avail himself or herself of the protection of that country; or a stateless person, who, being outside of the country of former habitual residence for the same reasons as mentioned above, is unable or, owing to this fear, unwilling to return to it, and to whom Article 12 (of Council Directive 2004/83/EC) does not apply.

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

### Second generation

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

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

### Usual residence

According to the Regulation (EU) No 1260/2013, 'usual residence' means the place where a person normally spends the daily period of rest, regardless of temporary absences for purposes of recreation, holidays, visits to friends and relatives, business, medical treatment or religious pilgrimage. The following persons alone shall be considered to be usual residents of a specific geographical area:

- (i) those who have lived in their place of usual residence for a continuous period of at least 12 months before the reference time; or
- (ii) those who arrived in their place of usual residence during the 12 months before the reference time with the intention of staying there for at least one year.

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

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

### Year of arrival

The 'year of arrival' to be considered in a census shall be the calendar year in which a person most recently established usual residence in the country. The year of the most recent arrival in the country shall be reported rather than the year of first arrival (i.e. the topic 'year of arrival in the country' does not provide information on interrupted stays).

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

## Annex 2. Checklist for estimating FGM risk in the EU

### State-of-the-art

Review the FGM legal and policy frameworks in place in the EU Member State.

Review recent research focusing on FGM prevalence and risk in the country (or at EU level), and on the influence of migration on attitudes and behaviours towards FGM (both in English and in the official language(s) of the country).

### Quantitative component

Use the most recent DHS and MICS reports to collect the national FGM prevalence rates and age of FGM for the age cohort 15–19.

In case there are data about the region (or city) of origin of the migrant population in the country of destination, collect the regional FGM prevalence rates for the age cohort 15–19. In case regional FGM prevalence for the age cohort 15–19 is not available, take regional prevalence for the age cohort 15–49.

Identify the institutions holding data about female migrant population, female asylum seekers, female refugees and female irregular migrants.

Identify other records available in the EU Member State, such as medical/hospital, child protection, asylum and judicial/police records. In case any of these exist, find the organisation responsible for their (central) collection.

Draft guidelines explaining the study and its objectives, the data to be collected and the level of data disaggregation, as well as other specificities related to data collection.

Contact the institutions holding data and clearly indicate a deadline to receive the data.

Closely follow up the data collection (i.e. regularly call or e-mail the contact person).

After receiving the data, conduct a quality control in order to confirm that all requested data have been shared. Pay specific attention to the level of disaggregation of data.

### Qualitative component

Define the qualitative method(s) that are going to be used.

Clearly define your target groups, criteria for participation and a minimum and maximum number of participants. It might be useful to determine quota for the country and region of origin, age ranges, etc.

Search for a convenient venue to organise your activities.

Define the recruitment period (allowing sufficient time for recruiting participants).

Involve civil society organisations working with migrant communities, as well as people from the concerned community, in the recruitment phase. Other factors can also be considered (e.g. religious leaders).

Design the research instruments to conduct the qualitative research (e.g. questionnaire).

Prepare detailed consent forms.

Foresee a budget to cover participants' expenses or as a compensation for their cooperation.

Collect information about FGM-specific services available at regional and national level to be provided to the participants.

Report on the findings.

### FGM risk estimation

Calculate FGM risk based on the indications for each scenario.

Communicate the results using an interval estimation (provide numbers and percentages).

Based on insights from existing literature and the qualitative component of the study, assess where the actual risk is probably situated in the interval. Clearly justify the assessment.

Report on any data gaps encountered in the process and formulate explicit recommendations for facilitating improved data collection and FGM risk estimation.





### Annex 3. List of countries where FGM is documented; respective national FGM prevalence rates and median age of FGM (as of 21 August 2014)

Country	Year of most recent report		FGM prevalence rate among		FGM prevalence rate by region (%)		Median age of FGM
	(as of 21 August 2014)		girls and women aged 15–19 (%)	girls and women aged 15–49 (%)	lowest	highest	
Benin	DHS	2011/12	2	7	0	41	9
Burkina Faso	DHS/MICS	2010	58	76	55	90	4
Cameroon *	DHS	2004	0,4	1	0	5	9
Central African Republic *	MICS	2010	18	24	3	77	14
Chad **	MICS	2010	41	44	2	96	9
Côte d'Ivoire	DHS	2011/12	31	38	12	80	4
Djibouti **	MICS	2006	90	93	93	95	9
Egypt *	DHS	2008	81	91	66	96	10
Eritrea	DHS	2002	78	89	82	98	1
Ethiopia ***	DHS	2005	62	74	27	97	4
Gambia **	MICS	2010	77	76	49	99	4
Ghana **	MICS	2011	2	4	0	41	9
Guinea	DHS	2012	94	97	89	100	9
Guinea-Bissau **	MICS	2010	48	50	6	95	9
Iraq **	MICS	2011	5	8	0	58	9
Kenya	DHS	2008/09	15	27	1	98	11
Liberia *****	DHS	2007	36	58	1	87	14
Mali	DHS	2012/13	90	91	88	95	4

Country	Year of most recent report		FGM prevalence rate among		FGM prevalence rate by region (%)		Median age of FGM
	(as of 21 August 2014)		girls and women aged 15–19 (%)	girls and women aged 15–49 (%)	lowest	highest	
<b>Mauritania **</b>	MICS	2011	66	69	20	99	4
<b>Niger</b>	DHS	2012	1	2	0	9	4
<b>Nigeria</b>	DHS	2013	15	25	3	49	4
<b>Senegal</b>	DHS/MICS	2010/11	24	26	1	92	4
<b>Sierra Leone **</b>	MICS	2010/11	70	88	73	96	14
<b>Somalia ***</b>	MICS	2006	97	98	94	99	9
<b>Sudan ****</b>	Unicef	2013	84	88	65	99	7
<b>Togo **</b>	MICS	2010	1	4	1	14	14
<b>Uganda ****</b>	DHS	2011	1	1	0	5	7
<b>United Republic of Tanzania</b>	DHS	2010	7	15	1	59	4
<b>Yemen ****</b>	DHS	2013	16	19	0	85	7

Sources:

DHS: <http://www.measuredhs.com/Publications/Publications-by-Country.cfm>

MICS: [http://www.childinfo.org/mics\\_available.html](http://www.childinfo.org/mics_available.html)

Unicef: FGM/C: *A statistical overview and exploration of the dynamics of change*. 2013. Unicef, New York.

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

\* estimated by using data on age of FGM of the 15–49 year-old age group.

\*\* estimated by using data on age of FGM of the 15–49 year-old age group from Unicef 2013 report.

\*\*\* estimated by using data on age of FGM of the daughters from Unicef 2013 report.

\*\*\*\* estimated by using the average of median ages from 25 countries with estimated data.

\*\*\*\*\* assumption: median age is the same as in Sierra Leone, as these two countries have similar practices of rites of passage and secret societies.



## Annex 4. Guidelines on quantitative data collection to estimate FGM risk

### 1. Introduction

The ... [replace with the name of the organisation commissioning/funding the study] has commissioned the present study to ... [replace with the name of organization responsible for conducting the study] develop a methodology to estimate the number of girls at risk of undergoing female genital mutilation (FGM) who are living in [replace with the name of the relevant country]. The study involves both a qualitative and a quantitative component:

1. ... [list the qualitative methods to be used], aiming at understanding the influence of migration on attitudes and opinions about FGM;
2. estimating the number of girls at risk of FGM, based on secondary data.

These guidelines focus on the quantitative component of the study. We need to collect secondary data from different sources of information in order to estimate the number of girls at risk of FGM. These guidelines are targeted at the national statistical office, birth registration office and immigration and border services. Other potential sources of information might also be consulted, such as refugee centres, national health, child protection and judiciary services.

Whereas the study is running from ... [replace with respective dates], the data collection period will take place between ... [replace with respective dates]. During these months, ... [replace with name of organization responsible for conducting the study] will need your collaboration for collating relevant data to estimate FGM risk. Information about the data collection process is detailed below.

### 2. Which data do we need?

In general terms, the data collection will focus on the female migrant population originating from an FGM risk country living in an EU country, aged between 0 and 18 years. More detailed information about the disaggregation of these data is provided below. Table 1 gives an overview of the data we need to collect and possible data sources. A glossary is also provided in this document.

### 3. Why do we need this detailed information and which types of data are requested?

FGM varies between countries of origin, within regions in the countries and by age. FGM rate among younger age groups is generally lower than among older ones. Age of circumcision varies between countries, ranging from soon after birth until roughly age 15. FGM differs between ethnic groups or regions within a country. For our estimations, the region-of-origin and age-specific information is thus important, as the migrant population in an EU Member State may not be representative for the population in the country of origin. Using average national data from the country of origin may therefore result in over- or underestimations.

Below, we describe the type of data and level of disaggregation we need for conducting the study. Table 1 also provides possible alternatives in case the data we request are not available.

#### **Female migrant population originating from the 29 FGM risk countries**

By 'population' we mean 'registered' or 'de jure' population, i.e. residents. In this category we do not include refugees, asylum seekers or irregular migrants (these are in different categories that are described below; definitions are also provided in the glossary).

As an EU-wide census took place in 2011, this will be our reference year for collecting data ... [this sentence needs to be changed in case the population register will be used or in case a more recent census exists]. This census strived for an output harmonisation in order to have comparable data between EU Member States. We would like to receive information on age, country and region within the country of origin. We need one-year age cohorts in order to be able to apply different assumptions to different ages during the analysis.

In addition, we would like to know whether children were born in the country of origin (so called first generation) or born in ... [replace with the name of the relevant country] (second generation), because there is evidence that the two generations run different risks of FGM.

Finally, we would like to receive information regarding at what age girls from the first generation came to ... [replace with the name of the relevant country]. This is important so that we can estimate how many of these girls might have already been cut.

In case some of these variables are not available, we propose a few alternatives.

- Place of birth

In case no data are available on region within the country of origin, please indicate the place or city of birth.

1. For the first generation, we can recode their birth-places as the regions in the country of origin.
2. For the second generation, born in ... [replace with the name of the relevant country], we need to know the place of birth of their mothers. In case data on place of birth of mothers are not available, we assume that women between 19 and 49 are the potential mothers of these second generation girls. Therefore, you can provide data on the country of origin and place of birth of women aged 19–49 in 2011.

- Length of stay or year of arrival (first generation only)

1. In case no data are available on age of arrival, you can provide data on the length of stay in ... [replace with the name of the relevant country]. Again, the reference year is 2011. We then calculate the age of arrival by subtracting the age in 2011 by the length of stay (i.e. age of arrival = age in 2011 – length of stay).
2. In case length of stay is not available, year of arrival can be used. We then calculate the age of arrival as follows: age of arrival = age in 2011 – (2011 – year of arrival).

The column 'Alternatives' in Table 1 summarises the alternative variables listed above.

### **Female live births to mothers originating from FGM risk countries**

Please provide the number of female live births (from mothers originating from the FGM risk countries) by year (2011) and country and region within the country of origin of the mother.

Our research focuses on 2011, but the evolution of the number of girls at risk is also highly important. Therefore, we kindly ask you to provide more recent data for 2012 and 2013 ... [update years accordingly]. For these years, we would like to receive data on the number of female live births (born to mothers originating from FGM risk countries) by country of origin of the mother and by year.

### **Female asylum seekers and refugees originating from 'FGM risk countries'**

Female asylum seekers and refugees are also relevant for producing an accurate FGM risk estimation. Some of them may have fled their countries due to the fear of undergoing or having their daughters subjected to FGM. Asylum can be requested based on these grounds.

We would like to receive data broken down by one-year age cohorts and by country (and, if possible, by region within the country) of origin for both female asylum seekers and refugees for 2011.

Although our research focuses on 2011, the evolution of the number of girls at risk is also highly important. Therefore, more recent data are also kindly requested: from 2012 and 2013 ... [update years accordingly]. Please provide the number of female asylum seekers and refugees by year and country of origin.

### **Irregular female immigrants originating from FGM risk countries**

Information on undocumented or irregular migrants is the most difficult to obtain, but still pertinent in order to make a more accurate FGM risk estimation. Again, we need data disaggregated by one-year age cohorts, and by country (and, if possible, by region within the country of origin) for 2011. If available, more recent data disaggregated by country of origin and year should also be provided for 2012 and 2013 ... [update years accordingly].

### **FGM or risk of FGM among children under the age of 18 with parents originating from an FGM risk country and currently living in ... [replace by the name of the relevant country]**

Other sources may be available for retrieving more information on the risk of FGM. Table 1 lists a few examples. Each country may have different registration systems, such as medical/hospital records, child protection records, asylum records and police/judiciary records. In case data are available for 2011, 2012 and 2013 [update years accordingly], please provide them.



#### 4. How do we want to receive the data?

We prefer to receive the requested data in Excel sheets. A template Excel table (Annex 1) for collating data about the female migrant population aged 0–18 living in ... [replace by the name of the relevant country] is attached for a convenient reference. It gathers information on the country of origin, one-year age groups and generation (see first worksheet: Female population in EU country). You can use this file to fill in your data or make your own Excel sheet(s), as long as the requested information is included.

Please write down (per dataset) in a Word document:

- name of office or agency providing the data;
- data made available by your office/agency:
  - female migrant population: Yes/No/Not all variables (specify);
  - female live births: Yes/No/Not all variables (specify);
  - female asylum seekers: Yes/No/Not all variables (specify);
  - female refugees: Yes/No/Not all variables (specify);
  - irregular female immigrants: Yes/No/Not all variables (specify);
  - other sources of risk of FGM: Yes/No/Not all variables (specify);
- names of variables used (as named in your office/agency in case another research team wishes to replicate the study) (e.g. variable: 'migr\_fem\_resid');
- definitions used;
- whether extra data processing was needed or whether they were directly retrievable from your system;
- your name and e-mail address (in case our data analyst needs to get in touch with you to clarify any aspect concerning the data collated).

#### 5. How are we going to use these data?

The basic idea is to multiply the 2011 female migrant population (residents, asylum seekers, refugees, irregular migrants) in ... [replace with the name of the relevant country] with the FGM prevalence available for the age cohort 15–19 years old living in the (region within) country of origin. Other more sophisticated refinements will be made subsequently in order to gain a more accurate FGM risk estimation. Data covering 2012 and 2013 ... [update years accordingly] will be used to assess trends regarding the female live births, female asylum seekers, female refugees and female irregular migrants (possibly relevant for policymaking purposes). More information can be provided upon request.

#### 6. Your role in the data collection

We would truly appreciate your assistance in coordinating the data collection in your office. For more information or questions regarding specific data requirements, please contact [include name of researcher(s) and contact details].

The analysis will be conducted by our team.

#### 7. When do we need these data?

As mentioned above, this study has a tight timeframe: [replace with respective dates]. We would appreciate receiving these data before ... [replace with respective dates]. Please send your Excel and Word files to [include name of researcher(s) and contact details].

#### 8. Glossary

Check glossary available in the report *Estimation of girls at risk of female genital mutilation in the European Union* (EIGE, 2015).

**Table 1. Data to be collected in order to estimate the risk of FGM in the relevant country**

Data on	More specific variables	Alternatives	Possible sources (may depend on country)
Female migrant population in [replace with the name of the relevant country] originating from one of the FGM risk countries	<ul style="list-style-type: none"> <li>In 2011 (data from census 2011)</li> <li>By country of origin, one-year age group between 0 and 18 years old and first and second generation</li> <li>By region within the country of origin</li> <li>By age of arrival (first generation only) in [replace with the name of the relevant country]</li> </ul>	<ul style="list-style-type: none"> <li>—</li> <li>—</li> <li>Or: place/city of birth of first generation and place/city of birth of mothers of second generation (or place/city of birth of women (19–49) by country of origin)</li> <li>Or: length of stay or year of arrival in [replace with the name of the relevant country]</li> </ul>	<ul style="list-style-type: none"> <li>National statistical office</li> </ul>
Female live births in [replace with the name of the relevant country] to mothers originating from one of the FGM risk countries	<ul style="list-style-type: none"> <li>2011</li> <li>By country and region within the country of origin of the mother</li> </ul>	<ul style="list-style-type: none"> <li>—</li> </ul>	<ul style="list-style-type: none"> <li>Central birth registration office</li> <li>National statistical office</li> </ul>
Female live births in [replace with the name of the relevant country] to mothers originating from one of the FGM risk countries	<ul style="list-style-type: none"> <li>If possible: 2012 and 2013</li> <li>By country of origin of the mother</li> </ul>	<ul style="list-style-type: none"> <li>—</li> </ul>	<ul style="list-style-type: none"> <li>Central birth registration office</li> <li>National statistical office</li> </ul>
Female asylum seekers in [replace with the name of the relevant country] originating from one of the FGM risk countries	<ul style="list-style-type: none"> <li>In 2011</li> <li>By country of origin and one-year age between 0 and 18 years old and first and second generation</li> <li>By region within the country of origin</li> <li>By age of arrival in [replace with the name of the relevant country]</li> </ul>	<ul style="list-style-type: none"> <li>—</li> <li>—</li> <li>Or: place/city of birth</li> <li>Or: length of stay in [replace with the name of the relevant country]</li> </ul>	<ul style="list-style-type: none"> <li>Border and immigration services</li> <li>Agencies for the reception of asylum seekers or refugees</li> </ul>
Female asylum seekers in [replace with the name of the relevant country] originating from one of the FGM risk countries	<ul style="list-style-type: none"> <li>If possible: 2012 and 2013</li> <li>By country of origin</li> <li>No need for one-year age cohorts. Please provide the total number of girls aged 0 to 18 per country of origin</li> </ul>	<ul style="list-style-type: none"> <li>—</li> <li>—</li> </ul>	<ul style="list-style-type: none"> <li>Border and immigration services</li> <li>Agencies for the reception of asylum seekers or refugees</li> </ul>



Data on	More specific variables	Alternatives	Possible sources (may depend on country)
Female refugees in [replace with the name of the relevant country] originating from one of the FGM risk countries	<ul style="list-style-type: none"> <li>In 2011</li> <li>By country of origin and one-year age between 0 and 18 years and first and second generation</li> <li>By region within the country of origin</li> <li>By age of arrival in [replace with the name of the relevant country]</li> </ul>	<ul style="list-style-type: none"> <li>—</li> <li>—</li> <li>Or: place/city of birth</li> <li>Or: length of stay in [replace with the name of the relevant country]</li> </ul>	<ul style="list-style-type: none"> <li>Border and immigration services</li> <li>Agencies for the reception of asylum seekers or refugees</li> </ul>
Female refugees in [replace with the name of the relevant country] originating from one of the FGM risk countries	<ul style="list-style-type: none"> <li>If possible: 2012 and 2013</li> <li>By country of origin</li> <li>No need for one-year age cohorts. Please provide the total number of girls aged 0 to 18 per country of origin</li> </ul>	<ul style="list-style-type: none"> <li>—</li> <li>—</li> </ul>	<ul style="list-style-type: none"> <li>Border and immigration services</li> <li>Agencies for the reception of asylum seekers or refugees</li> </ul>
Irregular female migrants in [replace with the name of the relevant country] originating from one of the FGM risk countries	<ul style="list-style-type: none"> <li>2011</li> <li>By country of origin and one-year age between 0 and 18 years and first and second generation</li> <li>By region within the country of origin</li> </ul>	<ul style="list-style-type: none"> <li>—</li> <li>—</li> <li>Or: place/city of birth</li> </ul>	<ul style="list-style-type: none"> <li>Border and immigration services</li> </ul>
Irregular female migrants in [replace with the name of the relevant country] originating from one of the FGM risk countries	<ul style="list-style-type: none"> <li>If possible: 2012 and 2013</li> <li>By country of origin</li> <li>No need for one-year age cohorts. Please provide the total number of girls aged 0 to 18 per country of origin</li> </ul>	<ul style="list-style-type: none"> <li>—</li> <li>—</li> </ul>	<ul style="list-style-type: none"> <li>Border and immigration services</li> </ul>
Number of FGM or risk-of-FGM cases identified among children under age 18 with one or two parents who originate from an FGM-risk country and currently live in [replace with the name of the relevant country]	<ul style="list-style-type: none"> <li>In 2011, 2012, 2013</li> <li>By country of origin and one-year age between 0 and 18 years</li> <li>By first and second generation</li> <li>By region within the country of origin</li> <li>FGM status or risk-of-FGM status</li> <li>Other relevant data from these records</li> </ul>	<ul style="list-style-type: none"> <li>—</li> <li>—</li> <li>—</li> <li>Or: place/city of birth of first generation</li> </ul>	<ul style="list-style-type: none"> <li>Medical/hospital records</li> <li>Child protection records</li> <li>Police and judiciary records</li> <li>Asylum records</li> <li>Other sources where records with FGM data for children are kept</li> </ul>

## Annex 5. Suggestions to organise focus group discussions

When designing the focus group discussions, four distinct sets of tasks are to be considered. The following suggestions are based on experience gained during the implementation of the qualitative component of the study on *Estimation of girls at risk of female genital mutilation in the European Union* (EIGE, 2015).

### 1. Preparation and organisation

- a. Clearly define your target groups, criteria for participation, and a minimum and maximum number of participants per group. It might be useful to determine quota for the country and region of origin, age ranges, etc.
- b. Make sure that the dates of the focus groups do not collide with important religious celebrations or events (e.g. Ramadan, religious holidays), school vacations and summer periods. Weekends seem to be a safe choice for organising the discussions. Avoid the evenings on which migrants most commonly go to religious gatherings (e.g. mosques, churches).
- c. Organise the discussion in the facilities of a civil society organisation that works with the migrant community envisaged. This civil society organisation has built, throughout the years, a reputation that is recognised by specific migrant communities. This might be helpful in recruiting participants. On the other hand, organising the discussion on the premises of a civil society organisation that works with migrant communities may lead to confidentiality concerns of the potential participants. Therefore, a 'neutral' venue with good accessibility may also be considered.
- d. Considering the aims of the focus groups and existing knowledge, conceive a list of issues/questions to be discussed in the groups. Draft guidelines and other tools for the facilitation and note-taking.
- e. Collect and/or prepare informative materials about the groups and about FGM to give to the participants prior to, and at the end of, the session.
- f. Collect information about possible referral routes for health, protection, legal and psychological

support so that the facilitator can refer the participants to specialised support. Be informed about the accessibility of these services and whether they are free of charge. Provide this information to all participants at the end of the session.

- g. Prepare a detailed consent form to be signed by each participant.
- h. Prepare a socio-demographic information sheet to be completed by (or with) each of the participants (e.g. age, country and region of origin of the participant, her/his parents and her/his partner, ethnicity, age of arrival in country of destination, number of daughters and sons, level of education, resident status).
- i. Prepare a map with the location of the groups as some participants might have low levels of literacy and this allows a better spatial orientation.
- j. If relevant to the research, prepare a confidentiality and non-disclosure agreement to be signed by the co-facilitator and note-taker.
- k. Foresee a budget to cover participants' expenses (e.g. travel and childcare) and as a form of recognition of their cooperation.

### 2. Recruitment

- a. Allow sufficient time for recruitment. Snowballing seems to be effective, but it takes time to spread the word.
- b. Besides involving key civil society organisations working with migrant communities in the recruitment of participants, a relevant success factor is the involvement of people from the concerned community during the recruitment phase. Trust is important when it comes to recruiting participants with a migrant background for research on a topic such as FGM, as it will reduce suspicion regarding the purposes of the research. The involvement of religious leaders might also be considered as they are influential in the communities.
- c. Confirm the presence of the participants on the day before the focus group discussion. Remind the participants about the date, time and location.





Emphasise the need to arrive on time (foresee a timeframe for possible delays).

### 3. Facilitation

- a. In case the main facilitator is not a person from the community, it is advisable to ensure the presence of a co-facilitator and/or note-taker who shares a few characteristics with the target group, such as same sex (e.g. select a male co-facilitator and note-taker for a group targeting men) and able to speak the language or dialect of the target community.
- b. Besides (audio) recording the discussion, a note-taker proves useful as she or he will grasp the main aspects discussed and will be able to pay attention to non-verbal responses within the group.

- c. Foresee time for explaining the informed consent to each participant before the discussion starts.

- d. Due to the length of the focus group discussions (approximately 120–180 minutes), foresee time for short breaks with drinks and snacks. Offer suitable food, keeping in mind it may need to be Halal.

### 4. Reporting

- a. The notes, together with the recordings, serve as the basis for drafting the discussion report and to analyse the information gathered during the group discussion.
- b. If resources are available, consider transcribing the full focus group discussions and analyse them using specific software for qualitative and mixed-methods data analysis (e.g. MAXQDA, NVIVO).







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