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Estimation of the Prevalence of Girls and Women who have undergone or are at Risk of Undergoing Female Genital Mutilation in Belgium, 2022

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Sponsors: Institute for Gender Equality and FPS Health, Food Chain Safety and Environment

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Justification of the study

According to UNICEF, at least 200 million girls and women currently living in 30 countries in Africa, the Middle East, and Asia have undergone some form of female genital mutilation: clitoridectomy, excision, or infibulation (UNICEF 2016). Female genital mutilations (FGM) are a violation of human rights and a form of gender-based violence that can lead to various physical and psychological complications throughout life.

Families living in Europe continue the practice, albeit to a lesser extent, during holidays in the country of origin or in the host country. Belgium passed a specific law in 2001 punishing excision (Article 409 of the Penal Code). The issue has multiple components, as it involves not only protecting girls at risk of undergoing FGM but also addressing gynaecological-obstetric and psychosexual complications that may arise in women who have been subjected to the procedure.

The last prevalence estimation showed that as at 31 December 2016, our country hosted 17,575 women "very likely already subjected to FGM" and 8,342 girls "at risk of FGM", i.e. a total target population of 25,917, or a tripling of prevalence in 10 years (Dubourg & Richard 2018).

Belgium has continued to receive girls and women from high-prevalence countries such as Somalia, Guinea, and Eritrea since 2016. It is therefore necessary to update the data every 3-4 years in order to target better the actions of the services involved in protecting young girls and caring for women who have undergone FGM. This study corresponds to Measure 23 of the National Action Plan to combat gender-based violence 2021-2025.

Objectives of the study

This quantitative study aims to update the data on the prevalence of female genital mutilation in Belgium from 2016.

The specific objectives of this study are to update the data on:

- The number of excised girls and women living in Belgium
- The number of girls and women at risk of excision living in Belgium
- The target population of various medical-social services concerned with female genital mutilation.

Methods

The study was conducted in two stages[1] :

Stage 1: The most accurate possible estimate of the female population from each country concerned living on Belgian territory and girls born in Belgium to these mothers

Five additional sources were used:

- Data from the National Register (NR) provided by Statbel (Directorate-General Statistics - Statistics Belgium) of the FPS Economy, SMEs, Self-Employed, and Energy on the female population from one of the countries where female genital mutilation is practiced, living in Belgium as at 31 December 2020.
- Data from the Federal Agency for the Reception of Asylum Seekers (Fedasil) on female populations (who have or have not applied for asylum in Belgium) from one of the countries concerned housed in the reception network as at 31 December 2020.
- Data on undocumented female populations who received care in one of the branches of Doctors of the World Belgium during 2020.
- Data on births in Belgium to mothers from one of the countries concerned, provided by ONE and Opgroeien for the years 2003 to 2020.
- Data on the granting of refugee status and subsidiary protection from the Commissioner General for Refugees and Stateless Persons (CGRA) for girls under 18 as at 31 December 2020.

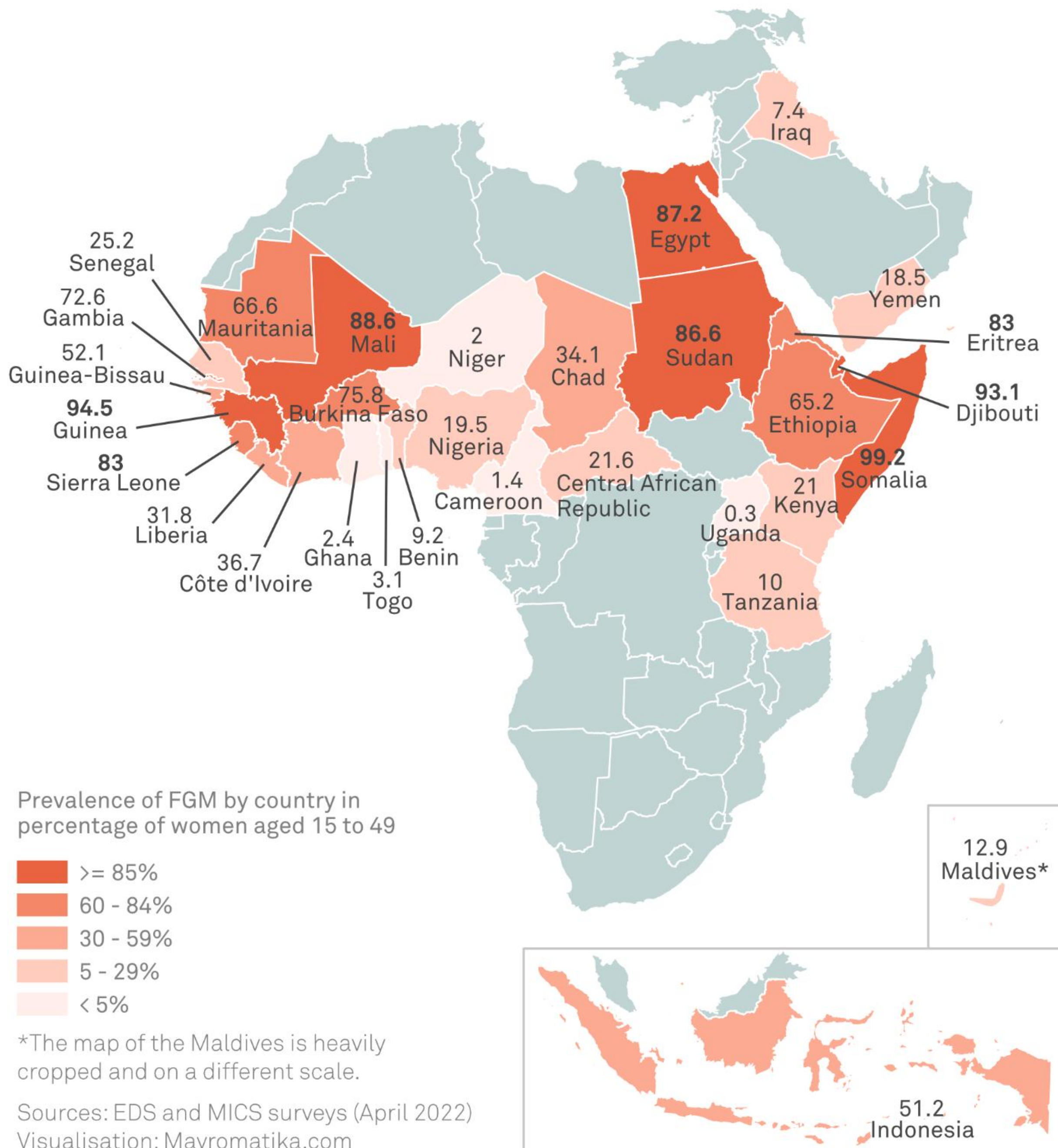
Stage 2: Application of the observed prevalence of FGM (by age group) in the country of origin where FGM is practised (EDS and MICS Studies))[2] to the population of girls and women living in Belgium.

- The prevalences of FGM by age group (from 15 to 49 years) from the most recent EDS and MICS studies were collected and applied to the female population determined in stage 1. The prevalence data were extracted from EDS and MICS studies published on 7 April 2022, on the official websites http://www.measuredhs.com and http://www.childinfo.org/mics4_surveys.html.
- The prevalence of 15- to 19-year olds was applied to all girls under 20 years old (0-4, 5-9, 10-14, 15-19). Prevalence in the 15-19 age group is an indicator of prevention efforts in different countries and represents the current level of practice (in contrast to national prevalence, which includes all age groups and takes longer to decrease). The prevalence of 15-19-year-olds reflects the current risk level of female genital mutilation (FGM) faced by girls and is used in statistical models to estimate the number of girls at risk of excision (EIGE 2018, UNICEF 2013).
- Specific prevalences by five-year age groups between 15 and 49 could be applied since they are available in EDS or MICS (15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49)
- The prevalence of 45-49 year olds was applied to women aged 50 and over as it is the closest one available.

[1] All the methodological details, strengths, and limitations of the study are included in the full version of the research report available on the website of the IGE and of the FPS Public Health.

[2] EDS : Demographic and Health Surveys MICS: Multiple Indicator Cluster Surveys

Figure 1. Geographic distribution and prevalence of female genital mutilation Type 1, 2, and 3 in Africa, the Middle East and Indonesia, 2020



What is new since the last study?

1. **15 new prevalence studies available in the countries of origin** have enabled us to get updates on the prevalence. A new country is available (the Maldives), but that has no impact on the results for Belgium.
2. **Age at arrival available for all data sources:** Fedasil and the Doctors of the Word provided data on the age at arrival, which was not possible for the 2016 study. This makes the estimations more precise.

Three calculation assumptions

3. **In the high assumption**, all girls and women born in a country where female genital mutilations are practised are (very likely) already excised or infibulated in the same proportion, at each age group, as in their country of origin when they arrive in Belgium.

   All girls **born in Belgium** or in another country where excision is not a known practice are intact but remain at risk of being excised if nothing is done to prevent it.
4. **In the average assumption**, all girls and women **who arrived in Belgium at the age of 5 or older** are (very likely) already excised or infibulated in the same proportion as in their country of origin when they arrive in Belgium.

   Girls who arrived in Belgium **before the age of 5 and those born in Belgium** remain at risk of being excised if nothing is done to prevent it.
5. **In the low assumption**, all girls and women born in a country where female genital mutilations are practised and who **arrived in Belgium at the age of 10 or older** are (very likely) already excised or infibulated in the same proportion as in their country of origin when they arrive in Belgium.

   Girls who arrived in Belgium **before the age of 10 and those born in Belgium** remain at risk of being excised if nothing is done to prevent it.

Limitations of the study

As for the previous study and other European studies, data on the ethnic group of women are not available. These data are crucial for certain countries where the practice of FGM is linked to the ethnic identity.

The authors of the study took into account various known methodological limitations (EIGE 2013, p 28-31 De Schrijver et al. 2020) in their calculation assumptions and results analysis. This study remains a statistical estimate of FGM prevalence in Belgium and is not based on clinical diagnosis, but it attempts to be as objective as possible by cross-referencing different data sources. Prevalences by age were applied to account for changes in practices over time. Regarding the category of “girls at risk,” while it is clear that with the impact of migration on the practice, not all these girls will undergo FGM, they still remain a target group for prevention actions by early childhood prevention services (ONE, Kind en Gezin) and schools

(PSE/PMS - CLB)[3]). This group has received particular attention with a view to assessing the prevention needs.

For this study, we were unable to obtain disaggregated data from the CGRA on girls who had already been excised or who were intact and had obtained international protection (by excision status and by age on arrival). We were consequently unable to introduce these data into the calculation formula for the estimation as we had done for the 2016 data.

Results

How many women affected by FGM live in Belgium?

Our study population consists of 93,685 girls and women whose nationality (of origin or current) is from a country where FGM is practised.

Table 1. Breakdown of the female population living in Belgium as at 31 December 2020 stemming from a country where FGM is practised by data source and age at arrival.

Data sources	Status	Country of birth	Age at arrival in Belgium			Total
			< 5 years	5-9 years	10 years and +	
National Register	Women and girls entered in the National Population Register in 2020	FGM countries	5,797	4,911	53,179	63,887
		Non-FGM countries				2,871
ONE - Opgroeien	Girls born of a mother from one of the countries where excision is practised between 2003 and 2020	Belgium				24,307
Fedasil	Girls and women who have applied for asylum in Belgium or who were accommodated in the reception network in 2020, even though they were not asylum seekers	FGM countries	275	177	1,899	2,351
Doctors of the World	Girls and women in an irregular situation who received care in one of the branches of Doctors of the World during 2020	FGM countries	3	3	263	269
Total			**6,075**	**5,091**	**55,341**	**93,685**

We applied prevalence rates by age group (from 15 to 49 years of age) from the most recent EDS and MICS studies to this group.

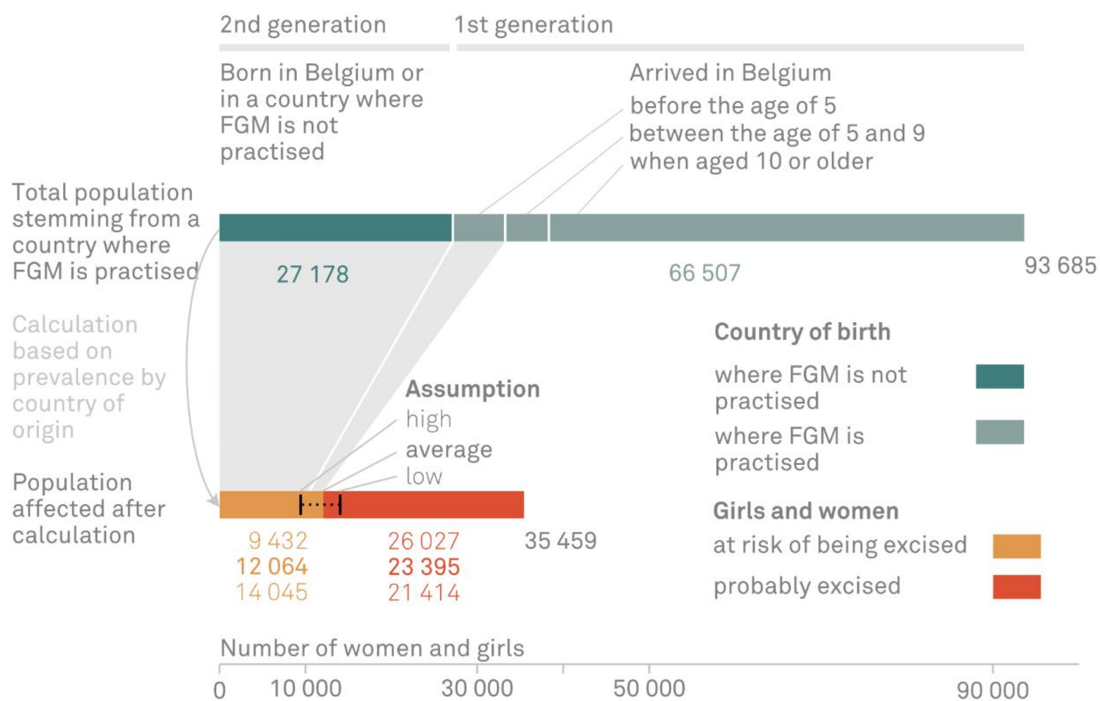
35,459 girls and women in all are affected by female genital mutilation, either because they have already undergone mutilation or because they are at risk.

[3] PMS: psycho-medico-social centers, PSE: health promotion at school, CLB: Centres for Student Guidance

Table 2 Breakdown of the female population affected by FGM as at 31 December 2020 by data source and age at arrival

Data sources	Status	Country of birth	Age at arrival in Belgium			Total
			< 5 years	5-9 years	10 years and +	
National Register	Women and girls entered in the National Population Register in 2020	FGM countries	2,483	1,884	20,062	24,430
	Women and girls entered in the National Population Register in 2020	Non-FGM countries				1,058
ONE - Opgroeien	Girls born of a mother from one of the countries where excision is practised between 2003 and 2020	Belgium				8 374
Fedasil	Girls and women who have applied for asylum in Belgium or who were accommodated in the reception network in 2020, even though they were not asylum seekers	FGM countries	148	97	1,184	1,428
Doctors of the World	Girls and women in an irregular situation who received care in one of the branches of Doctors of the World during 2020	FGM countries	0	0	168	168
Total			**2,631**	**1,981**	**21,414**	**35,459**

Figure 2. Estimation of the number of excised or at-risk girls and women living in Belgium as at 31 December 2020

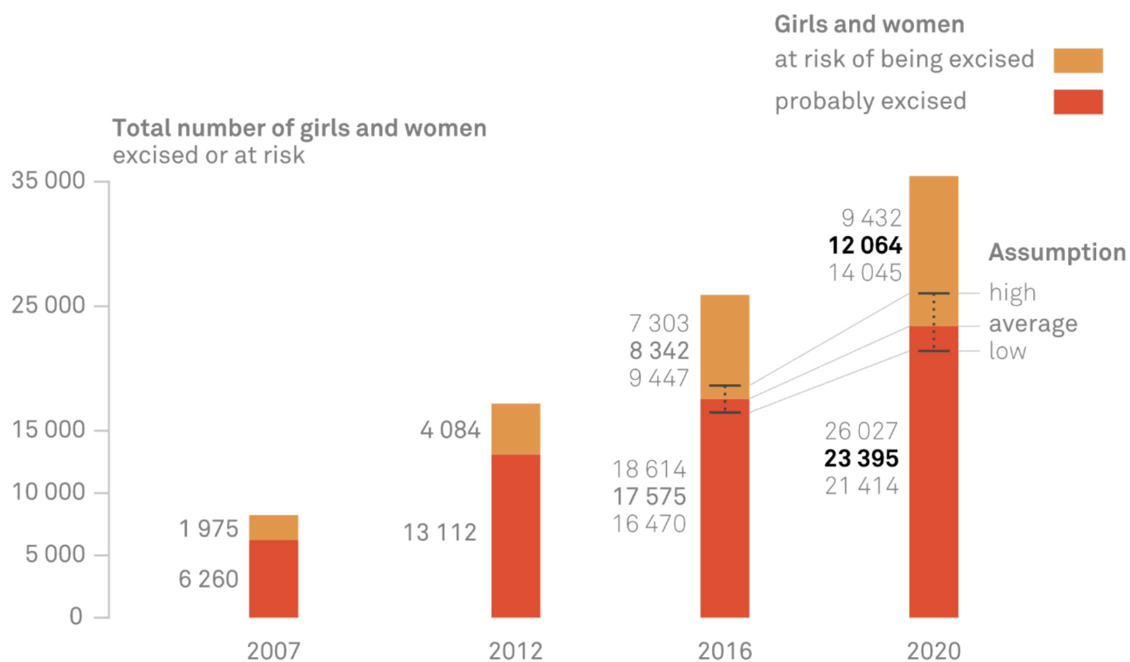


Has the number of girls and women who have undergone FGM or are at risk of FMG increased?

The last prevalence estimation showed that our country hosted 17,575 women "very likely already subjected to FGM" and 8,342 girls "at risk of FGM" as at 31 December 2016 (average assumption) (Dubourg & Richard 2018).

In 2020, information on the arrival date in Belgium obtained for all data sources enabled us to be more precise and especially to estimate with a high degree of certainty that, in **the medium hypothesis, 23,395 girls and women are already probably excised, and 12,064 girls and women are intact but at risk of being excised.**

Figure 3. Number of girls and women already excised or at risk of being excised living in Belgium between 2007 and 2020



Increase in the number of women who have probably already been excised due to the advent of new arrivals from Guinea (30% of the increase), Somalia (27% of the increase) and Eritrea (14% of the increase).

For girls at risk, the increase is mainly due to the birth in Belgium of girls to mothers of Guinean (40% of the increase), Somali (23%) and, to a lesser extent, Eritrean (6%) origin.

The number of asylum seekers affected by female genital mutilation increased compared with 2016 (1,428 girls and women in 2020 compared with 1,155 in 2016). The countries concerned are mainly Guinea and Eritrea. The three most represented nationalities in terms of populations affected are Guinea, Eritrea and Somalia. In the latter two countries, infibulation is the most severe form of mutilation, requiring special medical attention and training.

Who are these women and where do they live?

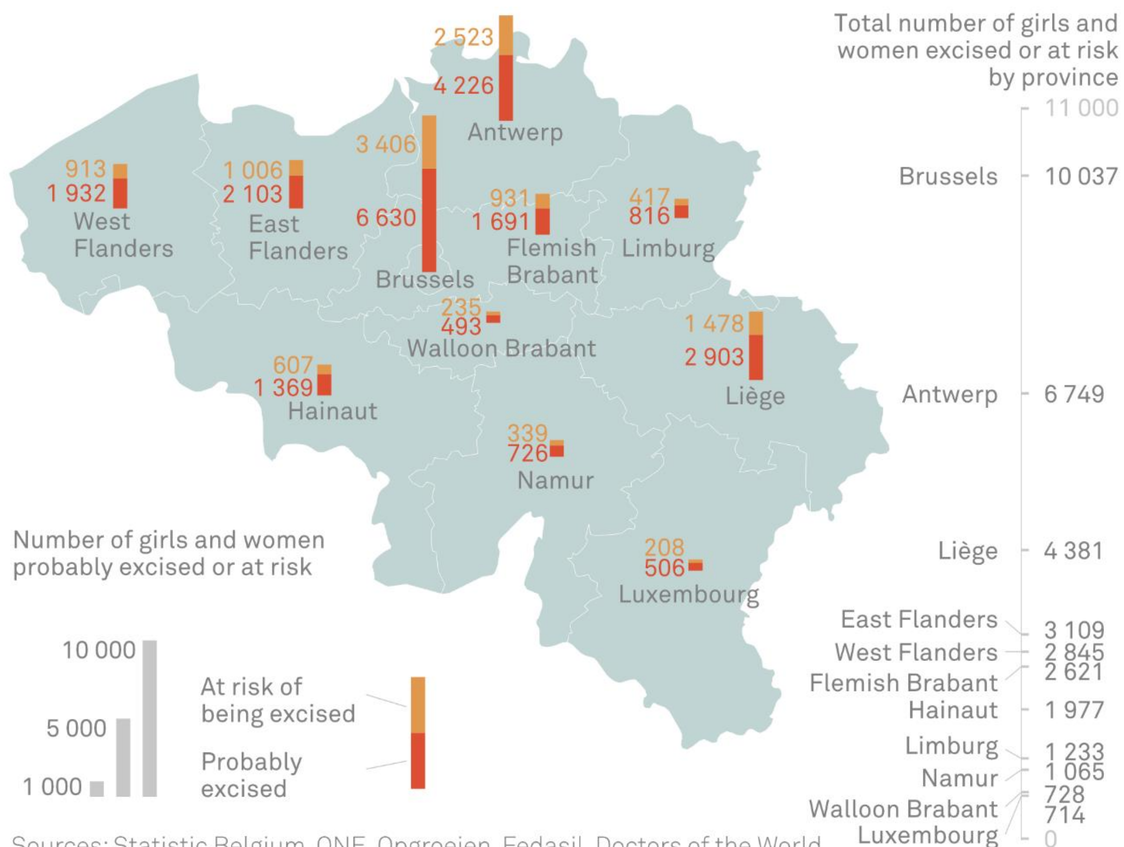
The most represented nationalities are Guinea, Somalia, Egypt, Ethiopia, and Côte d'Ivoire. Flanders is the region that hosts the most women concerned.

It is a young population: 12,730 girls are under 18 years old (minors) out of the 35,459 girls and women concerned. Approximately 1,700 excised women give birth each year in a Belgian maternity ward. More than half of these births were in Flanders.

Table 4. Female population affected by excision by age group and region as at 31 December 2020 (source Statistics Belgium, ONE, Opgroeien, Fedasil, Doctors of the World)

Age group	Flanders	Wallonia	Brussels-Capital	Fedasil	In an undocumented situation	Total Belgium	Of whom, born in an FGM country
< 5 years	2,013	867	877	112	-	3,869	310
5-19 years	4,471	2,337	2,679	319	20	9,826	4,735
20-49 years	8,433	4,255	5,386	966	144	19,183	18,472
50 years and older	1,173	531	842	31	4	2,581	2,510
Total	16,089	7,989	9,784	1,428	168	35,459	26,027

Figure 5. Female population very likely excised or at risk by province as at 31 December 2020 (Sources: Statistics Belgium, ONE, Opgroeien, Fedasil)



To keep in mind

- 93,685 girls and women from countries where female genital mutilation (FGM) is practised resided in Belgium as at 31 December 2020. Of these, **35,459 are affected by FGM (either already excised or at risk)**, including 12,730 minors (under 18 years old).
- **In the average assumption, 23,395 excised girls and women live in Belgium, and 12,064 are at risk of excision if no preventive work is done.**
- The increase in the population affected by FGM can be explained by the reception between 2016 and 2020 of new arrivals from countries affected by FGM (1st generation) and by births within the communities concerned (2nd generation)
- Brussels-Capital, the province of Antwerp, and the province of Liège are still the geographical areas that host the most girls and women concerned, as in the two previous studies.
- More than 16,500 excised or at-risk girls and women live in the Flemish Region, compared with 10,000 in the Brussels-Capital Region and 8,800 in the Walloon Region.
- Guinea, Somalia, Egypt, Ethiopia, and Côte d'Ivoire are the five most represented countries in the female population affected in Belgium.
- This study remains an indirect estimation of the prevalence (no medical examination) but is nonetheless a good basis for assessing the needs for prevention and care for this target population.

Recommendations

This work shows that there are significant needs for prevention (girls at risk of being excised) and medical and social care (women and girls who have already been excised) in Belgium.

In terms of prevention:

- There is an urgent need to raise awareness in the communities concerned, particularly in Flanders, by supporting grassroots associations which include survivors of FGM who can give prevention messages using cultural codes. GAMS Belgium does not have any community workers in Flanders at this time to carry out this peer awareness-raising work.
- An FGM pathway intended to identify, raise awareness among, and provide support to the families concerned, along the lines of what exists for girls and women seeking international protection, should also be put in place for families arriving through family reunification via the Immigration Office and the reception offices for new arrivals.
- Ongoing training for professionals (ONE, Opgroeien, PSE, CLB, SAJ, general practitioners, hospitals, reception network for asylum seekers) must be planned and organised in an efficient and sustainable way in order to cover the provinces most affected.
- The subject of FGM should be included in the basic curriculum of (health, welfare, legal) professionals given the number of people concerned in Belgium, as it is more difficult to reach people afterwards through continuing education. The Académie de

recherche et d'enseignement supérieur (ARES) [Academy of Research and Higher Education] in the French community made recommendations along these lines in November 2020, but they have not been implemented to date.

- Screening for FGM can be integrated with screening for incest and sexual violence among children. Belgium must adopt a standard policy in all schools for the early identification and support of child victims of sex violence. A seminar bringing together national and European experts (ethics, paediatrics, forensic medicine, children's rights, early childhood prevention services, school medicine, etc.) should be organised to validate a common approach to identification and support at national level (parents may take advantage of the difference in approach and the lack of transfer of information between services to move to another region to avoid follow-up) and organise the training of professionals accordingly.

In terms of care and support for women who have undergone excision:

- A national information campaign should be conducted to publicise the two accredited centres (CeMAViE at the St Pierre Medical Centre and the VrouwenKliniek at the University Medical Centre in Ghent) which offer comprehensive care for excised women (psychology, sexology, surgery) reimbursed by the INAMI [National Institute for Health and Disability Insurance] but which are not yet known to all the women concerned.
- The number of women who have undergone FGM is steadily increasing, especially in Flanders, and consequently, the number of births. Guidelines for births by excised women and indications for de-infibulation, validated by professional associations of gynaecologists and midwives, must be implemented in every maternity ward that admits women from countries affected by FGM.

In terms of research:

- These estimation should be updated in four years to take account of migration and new prevalence data in the countries of origin.
- The direct method by observation should be examined in Belgium, as was done in France. This can be done either through sampling in the population accessing healthcare services or through an exhaustive anonymous census of the excision status of female asylum seekers (all of whom are to undergo a gynaecological examination in the months following their arrival). This would make it possible to compare the prevalence of FGM in new arrivals with that applied in indirect estimations via DHS and MICS. If exhaustive, the systematic recording in hospitals via the Minimum Hospital Summary could also be a source of information on the number of excised women born in Belgium.
- A database system should be set up at the CGRA to facilitate the extraction of data on FGM (nationality, age at arrival, excision status) so as to consolidate estimates of FGM prevalence every four years.

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